U.S. DEPARTMENT OF VETERANS AFFAIRS

FY 2025 BUDGET SUBMISSION

Medical Programs

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Budget Overview

Mission Statement

To fulfill President Lincoln's promise to care for those who have served in our nation's military and for their families, caregivers, and survivors, the Department of Veterans Affairs (VA) is committed to providing Veterans and other eligible beneficiaries timely access to high-quality health services. VA's health care mission covers the continuum of care providing inpatient and outpatient services, including pharmacy, prosthetics and mental health care; long-term care in both institutional and non-institutional settings; and other health care programs, such as the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and Readjustment Counseling.

Budget Request

In 2025, the Budget reflects a discretionary advance appropriation request of $112.6 billion for VA Medical Care programs, equal to the level requested in the 2024 President's Budget. For 2026, the budget requests $131.4 billion in discretionary advance appropriations for Medical Care programs.

The Budget also reflects enactment of the Sergeant First Class (SFC) Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act), which established the Cost of War Toxic Exposures Fund (TEF) to ensure that there is sufficient funding available to cover costs associated with providing health care and benefits to Veterans exposed to environmental hazards. Consistent with the PACT Act and the enactment of the Fiscal Responsibility Act of 2023, which provided appropriations to the TEF for 2024 and 2025, VA's Medical Care budget reflects $17.1 billion in 2024 and $21.5 billion in 2025 in enacted TEF funding. The 2025 Budget also includes a 2026 advance appropriation request of $22.8 billion in the TEF for Medical Care.

When combining the requests for mandatory and discretionary appropriations across 2025 and 2026, this Budget request fulfills the Administration's commitment to provide reliable and timely resources to support the delivery of accessible and high-quality medical services for Veterans. The 2025 Medical Care estimated total obligations level is $149.5 billion and the 2026 Medical Care estimated total obligations level is $158.9 billion, afforded by the discretionary and mandatory appropriations requests combined with collections, reimbursements, transfers, reimbursements, and unobligated balances detailed later in this chapter.

Medical Care Category Obligations (Dollars in thousands)	2025 Revised Request	2026 Advance Approp.	+/- 2025-2026
Obligations by Category			
Medical Care Discretionary	$123,330,221	$135,479,711	$12,149,490
Medical Care Mandatory:			
Cost of War Toxic Exposures Fund	$25,029,971	$22,800,000	($2,229,971)
PACT Act, sec. 705	$40,608	$17,280	($23,328)
PACT Act, sec. 707	$808,558	$585,902	($222,656)
VACAA, sec. 801	$5,236	$0	($5,236)
Veterans Choice Fund	$304,826	$0	($304,826)
Medical Care Mandatory [Subtotal]	$26,189,199	$23,403,182	($2,786,017)
Medical Care [Total]	$149,519,420	$158,882,893	$9,363,473

Medical Care is composed of four appropriation categories: Medical Services, Medical Community Care, Medical Support and Compliance, and Medical Facilities.

Discretionary Appropriations

Dollars in Thousands ($000) Description	2025 Advance Approp. (AA)	2025 Revised Request (RR)	+/- 2025 AA 2025 RR	2026 Advance Approp. (AA)	+/- 2026 AA 2025 RR
Medical Services	$71,000,000	$71,000,000	$0	$75,039,000	$4,039,000
Medical Community Care	$20,382,000	$20,382,000	$0	$34,000,000	$13,618,000
Medical Support & Compliance	$11,800,000	$11,800,000	$0	$12,700,000	$900,000
Medical Facilities	$9,400,000	$9,400,000	$0	$9,700,000	$300,000
Discretionary Appropriation [Subtotal]	$112,582,000	$112,582,000	$0	$131,439,000	$18,857,000
Collections 1/	$4,389,678	$4,389,678	$0	$4,516,537	$126,859
Discretionary Appropriations & Collections [Total]	$4,389,678	$4,389,678	$0	$4,516,537	$126,859

Mandatory Appropriations

Dollars in Thousands ($000) Description	2025 Advance Approp. (AA)	2025 Revised Request (RR)	+/- 2025 AA 2025 RR	2026 Advance Approp. (AA)	+/- 2026 AA 2025 RR
Cost of War Toxic Exposures Fund 2/:					
Medical Services Category	$10,336,542	$11,683,896	$1,347,354	$11,800,000	$116,104
Medical Community Care Category	$10,118,000	$9,770,646	($347,354)	$11,000,000	$1,229,354
Medical Support & Compliance Category	$1,000,000	$0	($1,000,000)	$0	$0
Cost of War Toxic Exposures Fund [Subtotal]	$21,454,542	$21,454,542	$0	$22,800,000	$1,345,458
Medical Facilities (PACT Act, sec. 707)	$200,000	$200,000	$0	$400,000	$200,000
Mandatory Appropriation [Total]	$21,654,542	$21,654,542	$0	$23,200,000	$1,545,458

Appropriations and Collections - All Funding Sources by Category

Dollars in Thousands ($000) Description	2025 Advance Approp. (AA)	2025 Revised Request (RR)	+/- 2025 AA 2025 RR	2026 Advance Approp. (AA)	+/- 2026 AA 2025 RR
Medical Services Category	$81,336,542	$82,683,896	$1,347,354	$86,839,000	$4,155,104
Medical Community Care Category	$30,500,000	$30,152,646	($347,354)	$45,000,000	$14,847,354
Medical Support & Compliance Category	$12,800,000	$11,800,000	($1,000,000)	$12,700,000	$900,000
Medical Facilities Category	$9,600,000	$9,600,000	$0	$10,100,000	$500,000
Appropriations [Subtotal]	$134,236,542	$134,236,542	$0	$154,639,000	$20,402,458
Collections 1/	$4,389,678	$4,389,678	$0	$4,516,537	$126,859
Appropriations & Collections [Grand Total]	$138,626,220	$138,626,220	$0	$159,155,537	$20,529,317

1/ Collections in the 2025 advance appropriation column reflect the current estimate for 2025 rather than the estimate included in the 2024 President's Budget.
2/ The 2025 Revised Request for the Cost of War Toxic Exposures Fund (TEF) reflects a realignment of enacted TEF funding among categories compared to the 2025 Advance Appropriation estimate in the 2024 Budget.
Note: Amounts in the table above are prior to proposed transfers of discretionary appropriations among the Medical Care accounts in 2025 and prior to transfers to the DoD-VA Health Care Sharing Incentive Fund and to the Joint DoD-VA Medical Facility Demonstration Fund in 2025 and 2026.

Medical Services

- The 2025 Medical Services category estimated total obligations level is $86.5 billion for clinical staff salaries, pharmacy, prosthetics, beneficiary travel and medical equipment, afforded by discretionary and mandatory appropriations combined with collections, reimbursements, transfers, and unobligated balances. To realign funding among multiple sources, VA proposes to transfer $7.3 billion from the Medical Services 2025 Advance Appropriation to Medical Community Care.

- In 2026 the combination of all funding sources provides for an overall obligations level of $90.1 billion, an increase of $3.6 billion over 2025.

Medical Services Category Obligations (Dollars in thousands)	2025 Revised Request	2026 Advance Approp.	+/- 2025-2026
Obligations by Category			
Medical Services Discretionary	$72,462,629	$78,292,678	$5,830,049
Medical Services Mandatory:			
Cost of War Toxic Exposures Fund	$14,029,971	$11,800,000	($2,229,971)
VACAA, sec. 801	$4,980	$0	($4,980)
Medical Services Mandatory [Subtotal]	$14,034,951	$11,800,000	($2,234,951)
Medical Services [Total]	$86,497,580	$90,092,678	$3,595,098

Medical Community Care

- The 2025 Medical Community category estimated total obligations level is $40.9 billion for non-VA provided medical claims and grants for state home nursing, domiciliary, and adult day care services, afforded by the discretionary and mandatory appropriations combined with collections, reimbursements, transfers, and unobligated balances. To realign funding among multiple sources, VA proposes to transfer $7.3 billion from the Medical Services 2025 Advance Appropriation and $600 million from the Medical Facilities Advance Appropriation to Medical Community Care.

- In 2026 the combination of all funding sources provides for an overall obligations level of $45.8 billion, an increase of $4.9 billion over 2025.

Medical Community Care Category Obligations (Dollars in thousands)	2025 Revised Request	2026 Advance Approp.	+/- 2025-2026
Obligations by Category			
Medical Community Care Discretionary	$29,634,284	$34,819,380	$5,185,096
Medical Community Care Mandatory:			
Cost of War Toxic Exposures Fund	$11,000,000	$11,000,000	$0
Veterans Choice Fund	$304,826	$0	($304,826)
Medical Community Care Mandatory [Subtotal]	$11,304,826	$11,000,000	($304,826)
Medical Community Care [Total]	$40,939,110	$45,819,380	$4,880,270

Medical Support and Compliance

- The 2025 Medical Support and Compliance category estimated total obligations level is $12.1 billion for regional and medical facility administrators, including leadership teams; community care claim processing and program management; human capital, contracting, financial and similar administrative support activities; and police officers, afforded by discretionary appropriations combined with transfers, reimbursements, and unobligated balances.

- In 2026 the combination of all resources provides for an overall obligations level of $12.7 billion, an increase of $647 million over 2025.

Medical Support and Compliance Category Obligations (Dollars in thousands)	2025 Revised Request	2026 Advance Approp.	+/- 2025-2026
Obligations by Category			
Medical Support and Compliance Discretionary	$12,073,523	$12,720,404	$646,881
Medical Support and Compliance Mandatory:			
Cost of War Toxic Exposures Fund	$0	$0	$0
VACAA, sec. 801	$256	$0	($256)
Medical Support and Compliance Mandatory [Subtotal]	$256	$0	($256)
Medical Support and Compliance [Total]	$12,073,779	$12,720,404	$646,625

Medical Facilities

- The 2025 Medical Facilities category estimated total obligations level is $10.0 billion for facility maintenance, leasing, and energy costs. To realign funding among multiple sources, VA proposes to transfer $600 million from the Medical Facilities 2025 Advance Appropriation to Medical Community Care.

- In 2026 the combination of all resources provides for an overall obligations level of $10.3 billion, an increase of $241 million over 2025.

Medical Facilities Category Obligations (Dollars in thousands)	2025 Revised Request	2026 Advance Approp.	+/- 2025-2026
Obligations by Category			
Medical Facilities Discretionary	$9,159,785	$9,647,249	$487,464
Medical Facilities Mandatory:			
PACT Act, sec. 705	$40,608	$17,280	
PACT Act, sec. 707	$808,558	$585,902	($222,656)
VACAA, sec. 801	$0	$0	$0
Medical Facilities Mandatory [Subtotal]	$849,166	$603,182	($245,984)
Medical Facilities [Total]	$10,008,951	$10,250,431	$241,480

Cost of War Toxic Exposures Fund Request Methodology

The 2025 Budget includes mandatory funding appropriated to the TEF in the Fiscal Responsibility Act of 2023 for 2024 and 2025. The 2025 Budget includes medical care funding in the TEF of $17.1 billion in 2024 and $21.5 billion in 2025. The 2025 Budget also includes a 2026 advance appropriation request of $22.8 billion in the TEF for Medical Care. The PACT Act authorized the TEF to support incremental costs above 2021 for health care associated with environmental hazards and for any expenses incident to the delivery of health care and benefits associated with exposure to environmental hazards, as well as medical research relating to exposure to environmental hazards. Consistent with the law, the Budget limits the 2026 TEF request to those increases only and excludes costs not associated with exposure to environmental hazards. The budget requests that all other funding needs be provided in the traditional discretionary appropriations to ensure that Veterans have the care and benefits they earned.

There are two elements that reflect the increased costs above the 2021 level that comprise the 2026 medical care funding request for this account:

- **Baseline**. This represents the difference in health care costs from 2021 actuals for Veterans who would have been projected to receive VA Medical Care as result of exposure to environmental hazards during their military service prior to enactment of the PACT Act. The request uses the relative share of co-payment exempt care provided to a sample of Priority Group 6[1] Veterans as a proxy for the proportion of health care that could reasonably be associated with exposure to environmental hazards. This proxy was applied to the projected health care costs of Post-9/11 deployed and Gulf War deployed Veterans as well as Vietnam era Veterans based on their birthyear to determine the 2021 and outyear costs after discounting for lease costs (which are excluded by law).

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

The table below details the amounts of each element.

Cost of War Toxic Exposures Fund Request Methodology	
Description Dollars in Thousands ($000)	2026 Estimate
Cost of War Toxic Exposures Fund, request:	
Baseline Difference from 2021 Estimated Health Care Cost of Environmental Hazardous Exposure During Military Service	$19,900,000
Estimated Eligible Portion of Incremental Health Care from Titles I, III, and IV of the PACT Act.....	$2,900,000
Cost of War Toxic Exposures Fund Request [Total].....	$22,800,000

Key VA Priorities

VA is a diverse and inclusive organization welcoming all Veterans, including women Veterans, Veterans of color, and LGBTQ+ Veterans. In 2023, VHA provided more than 118 million clinical appointments with VA serving over 6.5 million patients, including more than 42 million in-person appointments, more than 29 million telehealth and telephone appointments, and approximately 47 million community care appointments. The 2025 request supports the following six VA health care priorities that are foundational in every decision supporting VHA's long-term goals.

Hire Faster and More Competitively

One of VHA's top priorities is to continue to improve the hiring process. Fulfilling VA's mission to provide the top-notch care that Veterans deserve is only possible with an enterprise-wide team of the best and brightest in their respective fields. To hire the best, VHA aims to have an efficient hiring process. To retain the best, VHA must take care of its employees with competitive wages and benefits so they can focus on taking care of Veterans.

[1] Priority Group 6 Veterans are enrolled in both Priority Group 6 and in either Priority Group 7 or Priority Group 8, as applicable, pursuant to 38 CFR § 17.38(d)(3)(iii). For any care that VA cannot find to have resulted from a cause other than the service, testing, or activity that resulted in the exposure to environmental hazards, VA furnishes this care without copayment liability pursuant to 38 U.S.C. § 1710(a)(2).

Since March 2022, VA has updated nearly 400 pay tables and increased salaries for more than 7,000 employees, due to the RAISE Act. VHA has increased inclusivity, diversity, equity, and access in VHA recruiting and established partnerships with Minority Serving Institution colleges and universities. Through authorities provided in the PACT Act, VA is implementing new hiring and retention authorities to strengthen and maintain a diverse, talented workforce with a shared mission to provide more care and more benefits to more Veterans.

In 2023, VHA achieved a record hiring of 61,490 new staff, a growth of nearly 7.4% in 2023, while also improving retention. Due to this record hiring, VA has the nationwide staffing level to accomplish the important objective of making sure that – whenever possible – all Veterans have an opportunity to receive care from a VA provider. VHA will continue to strategically focus its hiring in key areas, such as mental health, to provide Veterans with high-quality and timely health care services.

In 2024, VHA launched the Mental Health Optimization and Outpatient Staffing Enhancement and the Mental Health Staffing Pathways projects to ensure mental health programs remain adequately staffed. Through these initiatives, VHA is projecting demand for mental health services, proactively anticipating and addressing staffing gaps, and ensuring our staffing pipeline trains an interdisciplinary workforce optimal to providing the quality mental health care Veterans deserve.

The 2025 Budget builds upon these efforts and continues to support VHA's goals to onboard employees faster, accelerate training for human resources specialists, and invest in VA employees.

Connect Veterans to the Soonest and Best Care

To deliver the soonest and best care possible to Veterans, VHA is incorporating technology into all aspects of the health care experience from setting appointments to meeting with a provider. Technology allows Veterans to benefit from more convenient, patient-centered care. This includes access to electronic health records from home or through a mobile device via MyHealtheVet, as well as telehealth solutions that ensure Veterans get the right care in the right place at the right time, from a location of their choice.

In 2023 VA delivered more than 118 million clinical appointments to Veterans. Veterans continue to receive the majority of their outpatient care from VA providers. Veterans today have more options for care than ever. VA has over 1,300 sites that deliver care for Veterans, including 173 medical centers and 733 community-based outpatient clinics. VA offers care in-person, over the phone or through video appointments as clinically appropriate. VA's community care network has more than 1.3 million community care providers across all 50 States and U.S. Territories. Enrolled Veterans also have access to community urgent care, and all Veterans have access to emergent suicide care.

In 2023 alone, peer-reviewed studies showed that VA health care is better than or equal to non-VA health care; nearly 70% of VA hospitals received 4 or 5 stars in the annual CMS Hospital ratings, compared to just 41% of non-VA hospitals; VA hospitals outperformed non-VA hospitals in all 10 patient satisfaction metrics in Medicare's latest survey of patients; and – most importantly

of all – more than 91%_of the Veterans we serve trust VA with their care, a level unmatched anywhere in the private sector.[2]

To fulfill this priority, VA will build upon its access initiatives by supporting telehealth usage, resolving access gaps in underserved communities, and matching rare clinical expertise to Veterans with unique clinical needs. VHA will also improve the Veteran's journey from the point where care is identified to the time care is received by enhancing care coordination practices and will optimize coordination of care through patient identification and management. Finally, VHA will strengthen the referral coordination initiative to help build dress and improve Veteran experience by providing the Veteran timelier access to convenient and appropriate health care options.

Serve Veterans with Military Environmental Exposures

On August 10, 2022, the President signed into law the Sergeant First Class (SFC) Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act. This once-in-a-generation policy ensures Veterans qualify for benefits to treat illnesses resulting from exposure to toxins during deployment. It is now VA's responsibility to implement the PACT Act and deliver its promises to Veterans. VHA must swiftly and effectively prepare our delivery system to treat more Veterans affected by military environmental exposure, conduct additional research on military environmental exposures, and implement the authorities included in the Act to ensure we hire and retain the best staff possible to treat affected Veterans.

In 2023, 361,042 Veterans were newly enrolled into VA healthcare, an increase of more than 73,000 from fiscal year 2022. VA's health care enrollment efforts in 2023 focused primarily on bringing in Post-9/11 combat Veterans during a one-year special enrollment period created by section 111 of the PACT Act. This targeted effort contributed to one of the largest health care enrollment growth periods in VA history. The special enrollment period for combat Veterans ended in September 2023, and in that month alone, VHA enrolled 48,763 Veterans in VA health care.

VA is looking forward to widening access to care even further this year through the expedited implementation of Section 103 of the PACT Act. Originally planned to be phased in over several years, VA is making this new health care eligibility effective in its entirety in March. Specifically, all Veterans who were exposed to toxins and other hazards while serving our country – at home or abroad – will be eligible to enroll directly in VA health care without first applying for VA benefits. That includes all Veterans who served in the Vietnam War, the Gulf War, Iraq, Afghanistan, and any other combat zone after 9/11. It includes all Veterans who deployed in support of the Global War on Terror. It also includes Veterans who never deployed but were exposed to toxins or hazards while training or on active duty here at home – by working with chemicals, pesticides, lead, asbestos, certain paints, nuclear weapons, x-rays, and more.

The 2025 Budget supports continued implementation of the PACT Act to support VA's efforts to ensure every eligible Veteran receives the benefits and health care they have earned. The 2025

[2] Studies show VA health care is better than or equal to non-VA health care - VA News
Majority of VA health care facilities receive 4 or 5 stars in CMS quality ratings, outperforming non-VA facilities

Budget includes funding to support regular screening of enrolled Veterans for military-related toxic exposures, $59 million for Military Occupations and Environmental Exposures research in the Medical and Prosthetic Research appropriation, and $83 million for the Health Outcomes Military Exposures (HOME) program to continue its surveillance and studies on Veteran's health and health care outcomes related to exposures to contaminants and environmental hazards during military service.

Accelerate VA's Journey to a High Reliability Organization

Every day across VHA, dedicated employees work to deliver safe, high-quality care to Veterans. The healthcare high reliability organization (HRO) model is the managerial framework for transformational change. High reliability in health care means fewer accidents or events of harm, despite operating in a complex, high-risk environment. VHA is committing to an enterprise-wide journey to high reliability, focusing on the three pillars of an HRO: leadership commitment, culture of safety, and continuous process improvement.

VHA has identified its own path to high reliability to meet Veterans' unique needs. Starting in 2019, VHA began instilling HRO principles, tools and techniques at every level of the organization to address root causes, advance VA and VHA priorities. And ultimately achieve our vision of providing exceptional, coordinated and connected care, anytime and anywhere for Veteran health and wellbeing.

VHA has established a new National Zero Harm Focus Area to drive toward a true north of zero preventable harm to Veterans in VA care. Aligned with this Zero Harm Focus Area, VA medical centers will work to prevent and manage pressure ulcers, a targeted area of preventable harm. Over 349,000 VHA employees have completed HRO Baseline Training and created more than 8,600 improvement projects to improve the organization and Veteran care.

All VA medical centers have made remarkable progress by implementing one or more Foundational HRO Practices (Leader Rounding, Safety Huddles, Patient Safety Forums, and Visual Management Systems) to strengthen and support staff member trust in leadership, leader awareness of staff member concerns, and patient safety-focused communication.

VHA released the HRO Assessment and Planning Process, a standard four-part process that VA medical centers will apply to advance high reliability within their operations and culture to further accelerate VHA's HRO efforts in 2025 and beyond.

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

VHA empowers and equips Veterans to take charge of their health and well-being and live life to the fullest. When VHA treats the entire person, and not just a particular symptom or disease, we not only care for a Veteran's most immediate health concerns, but also consider what the Veteran needs and wants. VHA's Whole Health System of Care is already profoundly impacting Veterans' health and well-being. VHA is striving for an approach to health care that is comprehensive and integrated, while accounting for a Veteran's living situation, caregivers, and physical and mental health.

VHA is creating a system of care that is Veteran-centric by aligning with Veterans' mission, aspiration and purpose. Research has shown that having a sense of purpose in life equates to a longer and better quality of life. The Whole Health approach has positive effects on several facets of care to include decreased opioid use in those Veterans with chronic pain, improvement in their experiences within the VA, and engagement in health care and self-care, which ultimately leads to improved overall health and well-being. The Whole Health approach is also demonstrating benefits for employees including decreased levels of burnout and increased resiliency.

In 2023, 29% of all Veterans receiving care through VA also received Whole Health services. This translates to 1.8 million Veterans and 6.3 million Whole Health encounters. Also in 2023, 135,547 Veterans participated in 663,263 telehealth Whole Health encounters, an increase of 28% unique Veterans and 18% encounters over 2022. Robust formal evaluations continue to focus on outcomes for Veterans and employees, which includes a review of specific cost avoidance that is traceable to implementation of Whole Health Services (e.g., opioid use reduction, decrease in spinal procedures). The 2025 Budget includes $119 million for Whole Health. VA is fully committed to making the Whole Health approach an integral part of how we deliver care to Veterans and how we care for our employees.

In support of Whole Health, VHA will embed diversity, equity, and inclusion in everything we do while ensuring that providers are racially and ethnically diverse and trained in delivering culturally competent care; improve VHA's culture to further support the overall well-being of every employee by supporting VHA Reduce Employee Burnout and Optimizing Organizational Thriving (REBOOT) recommendations and employee whole health and well-being; promote healing environments that support Veterans, caregivers, and family members; provide world-class care while leveraging cutting-edge research in areas such as Long COVID; and expand access to Whole Health offerings via telehealth and for Veterans transitioning from active duty.

The 2025 Budget recognizes the important role of family caregivers in supporting the health and wellness of Veterans. The mission of the VHA Caregiver Support Program is to promote the health and well-being of family caregivers who care for the nation's Veterans, through education, resources, support and services. The $2.9 billion included in this budget supports staffing, stipend payments, and many other services to help empower family caregivers of eligible Veterans. In addition, this funding allows for potential program changes, allowing VA to reach and support more caregivers than before.

Prevent Veteran Suicide

Every Veteran suicide is a tragedy. Many Veterans have experienced first-hand the immeasurable pain suicide causes others. VHA's top clinical priority is preventing Veteran suicide and that will require a full public health approach, combining community and clinical based interventions. The National Strategy for Preventing Veteran Suicide, clinical practice guidelines for VA and Department of Defense (DoD), and the White House Strategy on Reducing Military and Veteran Suicide provide the foundation for VA's suicide prevention initiatives including Suicide Prevention (SP) 2.0 and SP Now. VA is calling on all partners, stakeholders, and communities to help us reach Veterans and reduce Veteran suicide. VA will never give up the fight to combat Veteran suicide, but we cannot win this fight alone.

Suicide is a complex issue with no single cause or solution. Addressing suicide requires a comprehensive approach that focuses on community and clinical interventions beyond individual care that focuses exclusively on mental health. Maintaining the integrity of VA's mental health care system is vitally important, but it is not enough. We know some Veterans may not receive any health care services from VA, which highlights VA alone cannot end Veteran suicide. This requires a nationwide effort.

To support this effort, the Budget includes $17.1 billion for mental health care, including suicide-specific medical treatment, and an additional $583 million for suicide prevention outreach programs.

In September 2023, the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP) awarded $52.5 million to 80 community-based organizations in 43 states, the District of Columbia, and American Samoa. These organizations provide or coordinate the provision of suicide services for Veterans and their families. VA has provided technical assistance to grantees, who have begun providing suicide prevention services in January 2023. Twenty-one (21) grantees serve tribal lands including Navajo Nation, Cherokee Nation, Choctaw Nation, Alaskan Native tribes and others. Funding decisions reflect VA's authority to prioritize the distribution of grants to rural communities, Tribal lands, Territories of the United States, medically underserved areas, areas with a high number or percentage of minority Veterans or women Veterans, and areas with a high number or percentage of calls to the Veterans Crisis Line. In alignment with VA's National Strategy for Preventing Veteran Suicide, this grant program assists in further implementing a public health approach that blends community-based prevention with evidence-based clinical strategies through community efforts.

The Veterans Comprehensive Preventions, Access to Care and Treatment Act of 2020 (COMPACT Act, Public Law 116-214 created a new program to allow VA to provide healthcare services to all eligible Veterans in imminent suicide crisis at no cost in both VA and the community. VA published the Interim Final Rule on January 17, 2023, and immediately began providing this new benefit to eligible Veterans. In its first of implementation, 49,714 Veterans and former service members have utilized this benefit, providing them with lifesaving care and saving more than $64 million in healthcare costs.

Women Veterans carry an especially high burden of mental health conditions. These include gender-specific conditions associated with heightened suicide risk, such as premenstrual dysphoric disorder, postpartum depression and perimenopausal depression. Among women Veterans receiving VHA care, more than half have at least one mental health condition and many struggle with multiple mental health concerns, medical comorbidities and psychosocial challenges. VA has implemented numerous initiatives to ensure that VHA mental health providers have the skills and expertise to address women Veterans' unique and diverse treatment needs and suicide risks. Examples include cutting-edge reproductive mental health programs and interventions, WoVeN in VA program, gender-specific peer support resources, and Women's Mental Health Champions at all VA medical centers.

Among the risk factors for suicide, substance use disorder is strongly implicated. In addition, drug overdose fatalities inclusive of suicide have escalated dramatically. Therefore, the need for

effective interventions to address substance use cannot be overstated. VA is expanding evidence-based substance use disorder treatment and harm reduction initiatives consistent with the Biden-Harris Statement of Drug Policy Priorities. The 2025 Budget invests $713 million toward opioid use disorder prevention and treatment programs, including using predictive analytics to stratify a patient's risk of overdose, provide augmented care as appropriate, and to support programs authorized in the Jason Simcakoski Memorial and Promise Act.

Furthermore, the 2025 Budget continues to support expansion of VHA's Psychotropic Drug Safety Initiative to address the growing crisis of stimulant use overdose fatalities. This initiative is ensuring the safe and appropriate prescribing of stimulant medications as well as expanding Veterans' access to evidence-based treatments for stimulant use disorder including cognitive-behavioral therapy and contingency management.

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

Women Veterans

In 2023, VA celebrated 100 years of providing health care to women Veterans. Today, VA remains more committed than ever to building upon our progress and rising to meet the needs of the fastest growing cohort of VA patients. VA understands the importance of comprehensive, trauma-informed care and strives to lead the Nation in provision of health care to women. VA will continue to invest in improving care for women Veterans because women Veterans belong at VA.

The 2025 Budget requests $264 million for women's health and childcare programs, which includes $210 million for the Women's Health Innovation and Staffing Enhancement Initiative (WHISE). VA is strategically enhancing services and access for women Veterans by hiring women's health personnel nationally to fill any gaps in capacity across all Veterans Integrated Service Networks. VA is also addressing clinical equipment needs such as those for mammography, exam tables designed for women with low mobility, and breastfeeding privacy pods. VA also continues to implement section 5107 of the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020*, Assistance for Childcare Services for Veterans by developing reimbursement models and onsite childcare locations.

In alignment with the White House Blueprint for Addressing the Maternal Health Crisis and in support of the *Protecting Moms Who Served Act of 2021* (Public Law 117-69), VA has expanded its Maternity Care Coordination Program to 12 full months post pregnancy. VA is committed to supporting Veteran families and improving Veterans' pregnancy and postpartum outcomes. Maternity care coordinators connect with pregnant and post-pregnancy Veterans to monitor the delivery of care, track maternal and newborn outcomes, collaborate with VA clinicians and

community providers, provide screenings for social determinants of health, mental health risk factors and health risks such as gestational diabetes and hypertensive disorders of pregnancy, and connect Veterans to vital resources.

The 2025 Budget continues to support reproductive health for Veterans across their lifespan. VHA meet the needs of the Veterans we serve, whether it be for contraception, medical and surgical treatment of gynecologic conditions, fertility services, pregnancy care, sexual health, or management of menopause and related conditions. VA also hosts national Women's Health Mini-Residencies, including Mini-Residencies focusing on rural health needs, which are intensive, interactive trainings for primary care and emergency care clinicians to learn the unique health issues faced by women Veterans. Since its inception in 2008, VA has trained over 11,000 clinicians and anticipates training at least 300 annually as the women Veteran population increases.

VA is implementing the *Dr. Kate Hendricks Thomas Supporting Expanded Review for Veterans in Combat Environments Act* (Public Law 117-133) and conducting breast cancer risk assessments to Veterans eligible under that Act (generally those who served in certain locations where burn pits were used during the Gulf War and the Post-9/11 era) with referral for mammography as clinically indicated. VA developed a data tool to assist primary care teams in identifying Veterans eligible for breast cancer risk assessments. Since March 2023, VA has contacted over 10,000 Veterans for assessment screening. Breast and cervical cancer screening programs require meticulous tracking to ensure that all eligible Veterans receive appropriate screening and receive results of screening tests, and that follow-up care is arranged as needed. VA policy requires each facility to have a process for tracking results and timely follow-up for breast and cervical cancer screening. VA policy also requires that facilities have personnel assigned to breast and cervical cancer care coordination. To ensure accuracy, timeliness and reliability, VA tracks the provision of breast and cervical cancer screening and the availability of breast and cervical cancer care coordinators across the system. The Breast and Gynecologic Cancer System of Excellence is providing state-of-the-art breast and gynecologic cancer care and care coordination across the system through VA's tele-oncology program.

To be a benchmark of excellence in cardiovascular care, VA established a Women Veteran Cardiovascular Working Group. The group consists of interdisciplinary subject matter experts, including cardiology, primary care, and pharmacy. The group will work to optimize cardiovascular health for women Veterans utilizing VA health care through planning evidence based national operational interventions, education, communications, and research. The goal will also be to raise awareness of cardiovascular (CV) risk in women, optimize CV screening, diagnosis, and treatment in women and to decrease disparities based on sex/gender, and race/ethnicity in these areas. VA collaborates with the American Heart Association to host Go Red events annually to build awareness related to cardiovascular disease and to educate clinicians on the unique cardiovascular risks in female Veterans.

Finally, VA continues to outreach to women Veterans through the Women Veteran Call Center, making outgoing calls, and receiving incoming calls, texts and chats to inform women Veterans about women's benefits and services. VA conducts monthly communications campaigns to ensure that women Veterans feel welcome and respected at every site of VA care.

Homelessness Programs

VA's longstanding support for Veterans who are homeless or at risk of homelessness is enhanced through a Whole Health lens. VA is committed to ending homelessness among Veterans because it is our nation's duty to ensure all Veterans have a place to call home. The effort to prevent and end Veteran homelessness is a partnership of Federal, state, and local government, and most importantly, the local community. No one agency or group can end Veteran homelessness alone. VA works with communities to help them develop the solutions that work best for them and their Veterans.

During calendar year 2023, VA permanently housed 46,552 homeless Veterans, surpassing the goal to house 38,000 Veterans by more than 22%. The 2025 Budget increases resources for Veterans' homelessness programs to $3.2 billion to continue to support VA's goal of ensuring every Veteran has permanent, sustainable housing with access to high-quality health care and other supportive services to end and prevent future Veteran homelessness. The Budget reinforces VA's goal of placing at least 76,000 unique Veterans into permanent housing and ensuring that at least 90% of at-risk Veterans are prevented from becoming homeless by the end of 2025.

The 2025 Budget includes funds to assist with the design and development of expanded services for aging and disabled Veterans, a growing need and area of focus for the Department of Housing and Urban Development (HUD) – VA Supportive Housing (VASH) program. In addition, funds will be used to provide a medical home model and population tailored approach to provide in-home primary care and wrap around services to Veterans actively enrolled in the HUD-VASH program, provide additional resources to increase outreach and community engagement efforts, as well as expansion of Veteran justice services, such as treatment courts and Veteran-focused criminal justice initiatives. Funding will also support the VA Grant and Per Diem (GPD) program to increase per diem rates to community partners actively supporting VA's effort to end Veteran homelessness.

On December 15, 2023, HUD released the 2023 Point-in-Time (PIT) Count, the annual effort to estimate the number of Americans, including Veterans, without permanent housing. Data show that on a single night in January 2023, 35,574 Veterans experienced homelessness in the U.S. This reflects a 7.4% increase in the number of Veterans experiencing homelessness from 2022. Looking deeper at the data, we see that of the Veterans counted, 20,067 experienced sheltered homelessness, and 15,507 experienced unsheltered homelessness. Since 2010, efforts by VA and our Federal partners have led to a more than 52% reduction in Veteran homelessness. Since 2015, there have been 83 communities and three States (Delaware, Connecticut and Virginia) that have met the criteria and benchmarks established by the U.S. Interagency Council on Homelessness, for effectively ending Veteran homelessness.

Cancer and Precision Oncology

VA is committed to promoting measurable progress toward President Biden's Cancer Moonshot initiative. To that end, VHA's research and clinical oncology programs collaborate with the National Cancer Institute (NCI) and other external entities to maximize Veterans' benefit from cutting edge improvements in oncology care (for example, by increasing Veterans' access to

clinical trials). The 2025 Budget includes $95 million to support cancer research projects to improve VA's ability to diagnose and treat cancers.

Within the total investment of $95 million to support cancer research in the 2025 Budget, VA is investing $45 million within VA research programs, together with an additional $215 million within the VA Medical Care program, for precision oncology and to provide access to the best possible cancer care for veterans. This funding will support research and programs that address cancer care, rare cancers, and cancers in women, as well as genetic counseling and consultation that advance tele-oncology and precision oncology care to improve veterans' health outcomes.

The vision of VA's Precision Oncology Initiative is for Veterans to have access to care as close to their homes as possible that is comparable to the Nation's leading cancer centers. This investment will also support clinical trials that are often part of standard clinical care for patients with cancer and are a second area of clinical-research integration in precision oncology. Together, these elements form a System of Excellence for the full spectrum of care for a particular cancer type. The VA research program will add additional molecular testing capabilities, enhance its pathology and laboratory infrastructure, and partner with the Department of Defense and NCI to improve cancer care through the Applied Proteogenomic Organizational Learning and Outcomes (APOLLO) program.

Methods Used to Formulate the Budget Request

The Department of Veterans Affairs (VA) uses three actuarial models to support formulation of the majority of the VA health care budget, to conduct strategic and capital planning, and to assess the impact of potential policies and changes in a dynamic health care environment. The three actuarial models are the VA Enrollee Health Care Projection Model (EHCPM), the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) Model, and the Program of Comprehensive Assistance for Family Caregivers (PCAFC) Model. Activities and programs that are not projected by any of these three models are called "non-modeled" and can change from year to year. In general, they include non-recurring maintenance (NRM), community care network contract administration, state-based long-term services and supports programs (LTSS), readjustment counseling, recently enacted programs, some components of CHAMPVA programs (Camp Lejeune family member program, spina bifida, foreign medical program, children of women Vietnam Veterans), and some components for the PCAFC program (caregiver travel, VA oversight, administrative salaries, and contracts). Detailed information on the three actuarial models can be found in the Actuarial Model Projections chapter.

The VA EHCPM supports approximately 89% 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. 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.

Key Drivers of Growth in Projected Resource Requirements

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

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

The Sergeant First Class (SFC) Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act became Public Law No 117-168 in August of 2022, expanding benefits for Veterans exposed to certain toxins in the course of their military service, with a focus on Gulf War era Veterans as well as new groups of Vietnam Veterans who were exposed to Agent Orange. The 2023 EHCPM projects enrollment and utilization for Title I, which changes enrollment eligibility timelines, and Titles III and IV, which expand eligibility based on conditions presumed to be associated with hazardous exposures. VA accounted for interaction between Titles I, III, and IV, to remove "double-counting" impacts on the estimates. All other PACT Act-associated costs were evaluated separately.

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 2023 EHCPM incorporated the actual experience and projected impact of the MISSION Act, including changes to eligibility to receive care in the community based on geographic access standards (including grandfathered Veterans Choice andAccountability (Choice) Act of 2014 enrollees), best medical interest provision, wait time standards, and urgent and emergency care benefits.

The MISSION Act policies continue to drive increases in services available in both Va facilities and the community, particularly the use of outpatient primary and specialty care and inpatient care. The MISSION growth assumptions were increased and extended in the 2021 EHCPM to reflect higher than anticipated growth in community care workload in 2020=2022 and continue to remain elevated in the 2023 EHCPM. However, is assumed that growth will slow as the impact of MISSION is saturated within the eligible enrollee population.

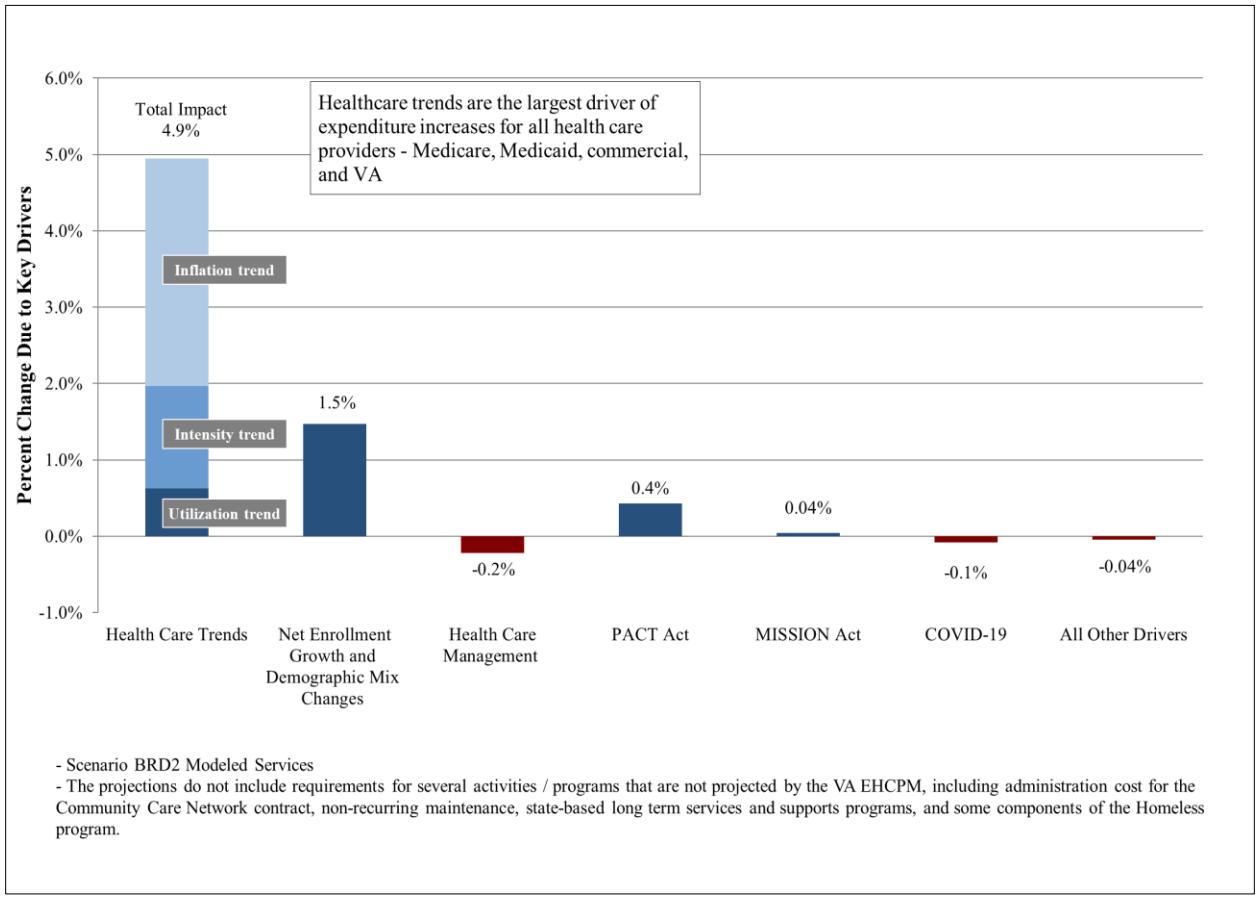
The COVID-19 pandemic continued to have a significant impact on VA health care in 2022, though in many areas the effects of the pandemic have largely subsided. For enrollment, by the end of FY 2022 new enrollment rates had largely recovered from the decline that followed the initial onset of the pandemic. Also, in many service areas, including ambulatory and acute inpatient care, enrollee health care utilization had returned to pre-pandemic expected levels (or close to it), or settled at a "new normal" that reflects a longer-term shift in health care utilization. For other service areas, particularly mental health care, LTSS, and inpatient rehabilitation care,

the effects of COVID-19 deferred care remain and it is expected that there will be continued recovery of health care utilization in FY 2023 and beyond.

VHA staffing levels increased throughout the COVID-19 pandemic. The higher staffing levels, combined with reduced direct care workload led to a significant increase in direct care unit costs over the course of the pandemic. This trend persisted into FY 2022. VHA modeled a decrease in projected staffing levels for FY 2025 and FY 2026 to reflect VHA's response to that trend. These changes are assumed to be independent of total enrollee reliance on VA, so that projected decreases in VHA capacity are modeled with a complementary increase in community care utilization, although the overall year-over-year increase in community care is slowing. Only inpatient and ambulatory services available in both VA direct and community care settings are impacted by these FTE changes.

Figure A quantifies the key drivers of the projected increase in expenditure requirements for 2025 for all modeled services. Health care trends, net enrollment growth and demographic mix changes, and health care management and their impact on the resources required to provide health care to enrolled Veterans are discussed in detail in the following sections. MISSION Act, COVID-19 and PACT Act are discussed throughout the Actuarial Model Projections chapter.

Figure A. Key Drivers of Projected Expenditure Change, 2024 – 2025



Veterans Affairs Medical Care Program, Third Category

Starting in 2026, the Budget separates VA medical care as a third category within the discretionary budget based on a recognition that VA medical care has grown much more rapidly than other discretionary spending over time, largely due to systemwide growth in healthcare costs. The Budget requests $131.4 billion in advance appropriations inn 2026 for VA medical care and proposes such spending be treated as a third category of discretionary spending, alongside the Defense Category and the Non-Defense Category. The Administration's proposal to create a third category of discretionary spending would allow the Congress to consider the funding needs for Veterans' health care holistically, taking into account both discretionary and mandatory funding streams. Setting a separate budget allocation for VA medical care accomplishes two important goals. First, it helps ensure adequate funding for Veterans' health care without adversely impacting other critical programs, whether inside or outside of VA. Second, it also ensures that other critical priorities--both defense and non-defense--will not adversely impact Veterans' health care.

Medical Care Budgetary Resources

The following tables display:

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

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

		2024		2025	2026		
	2023 Actual	Budget Estimate	Current Estimate	**Revised Request**	**Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Appropriations							
Discretionary Appropriations 1/							
Medical Services (0160)	$70,584,116	$74,004,000	$74,004,000	$71,000,000	$75,039,000	($3,004,000)	$4,039,000
Medical Community Care (0140)	$28,456,659	$33,000,000	$33,000,000	$20,382,000	$34,000,000	($12,618,000)	$13,618,000
Medical Support & Compliance (0152)	$11,073,409	$12,300,000	$12,300,000	$11,800,000	$12,700,000	($500,000)	$900,000
Medical Facilities (0162/1124XN)	$8,633,816	$8,800,000	$8,800,000	$9,400,000	$9,700,000	$600,000	$300,000
Proposed Cancellation of Available Unobligated Balances:							
Medical Services		($4,933,113)	($4,933,113)			$4,933,113	$0
Medical Community Care		($1,909,069)	($1,909,069)			$1,909,069	$0
Medical Facilities		($250,515)	($250,515)			$250,515	$0
Discretionary Appropriations [Subtotal]	**$118,748,000**	**$121,011,303**	**$121,011,303**	**$112,582,000**	**$131,439,000**	**($8,429,303)**	**$18,857,000**
MCCF Collections 2/	$4,131,611	$4,269,198	$4,269,199	$4,389,678	$4,516,537	$120,479	$126,859
Discretionary Appropriations, Transformational Fund, and Collections [Total]	**$122,879,611**	**$125,280,501**	**$125,280,502**	**$116,971,678**	**$135,955,537**	**($8,308,824)**	**$18,983,859**
Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act) for Medical Care 3/							
Section 707:							
Medical Facilities (0162)	$1,880,000	$100,000		$200,000	$400,000	$200,000	$200,000
Section 707 [Subtotal]	**$1,880,000**	**$100,000**	**$0**	**$200,000**	**$400,000**	**$200,000**	**$200,000**
PACT Act Mandatory Appropriations [Subtotal]	**$1,880,000**	**$100,000**	**$0**	**$200,000**	**$400,000**	**$200,000**	**$200,000**
Cost of War Toxic Exposures Fund for Medical Care (1126) 4/							
Medical Services Category	$3,822,377	$9,525,428	$9,525,428	$11,683,896	$11,800,000	$2,158,468	$116,104
Medical Community Care Category	$0	$6,740,264	$6,740,264	$9,770,646	$11,000,000	$3,030,382	$1,229,354
Medical Support & Compliance Category	$0	$850,000	$850,000	$0	$0	($850,000)	$0
Appropriations [Subtotal]	**$3,822,377**	**$17,115,692**	**$17,115,692**	**$21,454,542**	**$22,800,000**	**$4,338,850**	**$1,345,458**
Mandatory Appropriations [Total]	**$5,702,377**	**$17,215,692**	**$17,115,692**	**$21,654,542**	**$23,200,000**	**$4,538,850**	**$1,545,458**
Discretionary and Mandatory Appropriations (Including Discretionary Collections and Transformational Fund) [Grand Total]	**$128,581,988**	**$142,496,193**	**$142,396,194**	**$138,626,220**	**$159,155,537**	**($3,769,974)**	**$20,529,317**

Note: A full-year 2024 appropriations Act was not enacted at the time the 2025 President's Budget was prepared. The 2024 Current Estimate assumes the 2024 President's Budget request for 2024 with updates to unobligated balances, reimbursements, transfers, and medical care collections.

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

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

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

4/ The 2025 Revised Request for the Cost of War Toxic Exposures Fund (TEF) reflects a realignment of enacted TEF funding among categories compared to the 2025 Advance Appropriation estimate in the 2024 Budget.

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

	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Obligations 1/							
Discretionary Obligations:							
Regular Obligations:							
Medical Services (0160)	$73,736,179	$74,210,146	$71,244,944	$72,462,629	$78,292,678	$1,217,685	$5,830,049
Medical Community Care (0140)	$29,843,166	$27,082,317	$31,028,999	$29,634,284	$34,819,380	($1,394,715)	$5,185,096
Medical Support & Compliance (0152)	$9,654,760	$11,473,673	$10,669,499	$12,073,523	$12,720,404	$1,404,024	$646,881
Medical Facilities (0162/1124XN)	$8,709,941	$13,532,238	$8,971,923	$9,159,785	$9,647,249	$187,862	$487,464
Discretionary Obligations [Subtotal]	**$121,944,046**	**$126,298,374**	**$121,915,365**	**$123,330,221**	**$135,479,711**	**$1,414,856**	**$12,149,490**
Mandatory Obligations:							
Veterans Choice Act Section 801 2/							
Medical Services (0160)	$7,367	$5,678	$3,837	$4,980	$0	$1,143	($4,980)
Medical Support & Compliance (0152)	$3,543	$3,524	$3,373	$256	$0	($3,117)	($256)
Medical Facilities (0162)	$1,058	$3,791	$10,394	$0	$0	($10,394)	$0
Veterans Choice Act Section 801 [Subtotal]	**$11,968**	**$12,993**	**$17,604**	**$5,236**	**$0**	**($12,368)**	**($5,236)**
Veterans Choice Fund (0172) [Subtotal] 3/	**$401**	**$272,550**	**$0**	**$304,826**	**$0**	**$304,826**	**($304,826)**
American Rescue Plan Act Mandatory Obligations for Medical Care 4/							
Section 8002, the Veterans Medical Care and Health Fund (0173):							
Medical Services Category	$818,560						
Medical Community Care Category	$1,987,643						
Medical Support & Compliance Category	$555,686						
Medical Facilities Category	$815,754						
Veterans Medical Care and Health Fund [Subtotal]	**$4,177,643**						
Section 8007:							
Medical Services (0160)	$932						
Copayment Reimbursement (5287)	$0						
Medical Community Care (0140)	$0						
Section 8007 [Subtotal]	**$932**						
Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act) for Medical Care 5/							
Section 705:							
Medical Facilities (0162)	$45,549	$0	$41,375	$40,608	$17,280	($767)	($23,328)
Section 705 [Subtotal]	**$45,549**	$0	$41,375	$40,608	$17,280	**($767)**	**($23,328)**
Section 707:							
Medical Facilities (0162)	$24,002	$786,724	$183,591	$808,558	$585,902	$624,967	($222,656)
Section 707 [Subtotal]	**$24,002**	**$786,724**	**$183,591**	**$808,558**	**$585,902**	**$624,967**	**($222,656)**
Cost of War Toxic Exposures Fund for Medical Care (1126):							
Medical Services Category	$14,999	$8,187,428	$10,994,806	$14,029,971	$11,800,000	$3,035,165	($2,229,971)
Medical Community Care Category	$0	$5,510,910	$5,510,910	$11,000,000	$11,000,000	$5,489,090	$0
Medical Support & Compliance Category	$0	$850,000	$876,049	$0	$0	($876,049)	$0
Obligations [Subtotal]	**$14,999**	**$14,548,338**	**$17,381,765**	**$25,029,971**	**$22,800,000**	**$7,648,206**	**($2,229,971)**
Mandatory Obligations [Subtotal]	**$4,275,494**	**$15,620,605**	**$17,624,335**	**$26,189,199**	**$23,403,182**	**$8,564,864**	**($2,786,017)**
Discretionary and Mandatory Obligations [Total]	**$126,219,540**	**$141,918,979**	**$139,539,700**	**$149,519,420**	**$158,882,893**	**$9,979,720**	**$9,363,473**

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

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

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

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

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

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

		2024		2025	2026		
	2023 Actual	Budget Estimate	Current Estimate	**Revised Request**	**Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary and Mandatory Obligations by Category							
Medical Services	$74,578,037	$82,403,252	$82,243,587	$86,497,580	$90,092,678	$4,253,993	$3,595,098
Community Care	$31,831,210	$32,865,777	$36,539,909	$40,939,110	$45,819,380	$4,399,201	$4,880,270
Medical Support & Compliance	$10,213,989	$12,327,197	$11,548,921	$12,073,779	$12,720,404	$524,858	$646,625
Medical Facilities	$9,596,304	$14,322,753	$9,207,283	$10,008,951	$10,250,431	$801,668	$241,480
Obligations [Grand Total]	**$126,219,540**	**$141,918,979**	**$139,539,700**	**$149,519,420**	**$158,882,893**	**$9,979,720**	**$9,363,473**
Full-Time Equivalent (FTE) 1/							
Discretionary Funding							
Medical Services	282,395	293,544	297,651	290,658	290,372	(6,993)	(286)
Medical Support & Compliance	59,487	66,534	68,045	66,658	66,589	(1,387)	(69)
Medical Facilities	21,586	26,501	26,855	25,839	25,790	(1,016)	(49)
Discretionary Funding [Subtotal]	**363,468**	**386,579**	**392,551**	**383,155**	**382,751**	**(9,396)**	**(404)**
Mandatory Funding							
Veterans Medical Care and Health Fund - Medical Services 2/	2,193	0	0	0	0	0	0
Veterans Medical Care and Health Fund - Medical Support & Compliance 2/	3,824	0	0	0	0	0	0
Veterans Medical Care and Health Fund - Medical Facilities 2/	4,453	0	0	0	0	0	0
Cost of War Toxic Exposures Fund - Medical Services	0	13	0	0	0	0	0
Veterans Choice Act, Sec. 801, FTE 3/	59	41	59	31	0	(28)	(31)
Veterans Choice Act, Sec. 802, FTE	0	0	0	0	0	0	0
Mandatory Funding [Subtotal]	**10,529**	**54**	**59**	**31**	**0**	**(28)**	**(31)**
FTE [Total]	**373,997**	**386,633**	**392,610**	**383,186**	**382,751**	**(9,424)**	**(435)**

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

2/ FTEs funded by ARP Act resources in 2023 have been merged into their respective Medical Care category discretionary appropriations in 2024 as remaining balances diminish.

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

Medical Care Obligations by Program

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

Table: Medical Care Total Obligations by Program

(Includes All Funding Sources)
(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Health Care Services:							
Ambulatory Care 1/ 2/	$46,952,824	$58,125,322	$53,281,406	$57,583,114	$60,729,385	$4,301,708	$3,146,271
Dental Care	$2,396,448	$2,573,291	$2,676,069	$2,975,647	$3,249,465	$299,578	$273,818
Inpatient Care	$23,614,262	$26,766,548	$25,004,013	$25,973,867	$27,289,051	$969,854	$1,315,184
Mental Health Care 3/	$14,423,510	$16,587,825	$15,968,840	$17,053,718	$18,212,861	$1,084,878	$1,159,143
Pharmacy 2/	$12,033,736	$12,675,441	$13,579,020	$14,880,740	$16,178,905	$1,301,720	$1,298,165
Prosthetic and Sensory Aids Services	$4,427,416	$4,571,956	$4,859,172	$5,343,218	$5,804,765	$484,046	$461,547
Rehabilitation Care	$1,370,443	$1,491,565	$1,430,254	$1,461,684	$1,486,835	$31,430	$25,151
Health Care Services [Subtotal]	**$105,218,639**	**$122,791,948**	**$116,798,774**	**$125,271,988**	**$132,951,267**	**$8,473,214**	**$7,679,279**
Long-Term Services & Supports (LTSS):							
Institutional LTSS							
VA Community Living Centers (VA CLC)	$5,122,366	$5,292,497	$5,380,099	$5,470,160	$5,662,369	$90,061	$192,209
Community Nursing Home	$1,782,153	$1,529,213	$1,921,465	$2,078,128	$2,188,225	$156,663	$110,097
State Home Nursing	$1,447,138	$1,438,784	$1,617,932	$1,745,012	$1,887,231	$127,080	$142,219
State Home Domiciliary	$45,278	$55,402	$56,992	$62,662	$69,085	$5,670	$6,423
Institutional LTSS [Subtotal]	$8,396,935	$8,315,896	$8,976,488	$9,355,962	$9,806,910	$379,474	$450,948
Non-Institutional LTSS							
State Home Adult Day Care	$2,460	$1,892	$1,836	$1,986	$2,147	$150	$161
Other Non-Institutional LTSS	$6,584,894	$4,622,996	$7,251,656	$7,678,612	$8,060,679	$426,956	$382,067
Non-Institutional LTSS [Subtotal]	$6,587,354	$4,624,888	$7,253,492	$7,680,598	$8,062,826	$427,106	$382,228
LTSS [Subtotal]	**$14,984,289**	**$12,940,784**	**$16,229,980**	**$17,036,560**	**$17,869,736**	**$806,580**	**$833,176**
Other Health Care Programs:							
Camp Lejeune Families (P.L. 112-154)	$2,159	$7,597	$4,443	$4,606	$4,837	$163	$231
Caregiver Support Program 4/	$1,676,028	$2,422,410	$2,422,410	$2,913,000	$3,500,000	$490,590	$587,000
CHAMPVA & Other Dependent Prgs. 5/	$2,474,653	$2,335,332	$2,621,810	$2,898,351	$3,185,466	$276,541	$287,115
Homeless Program Grants 6/	$1,009,688	$1,067,265	$1,067,265	$983,946	$983,946	($83,319)	$0
PACT Act § 705 Enhanced-Use Leases	$45,549	$0	$41,375	$40,608	$17,280	($767)	($23,328)
Readjustment Counseling	$302,982	$353,643	$353,643	$370,361	$370,361	$16,718	$0
Other Health Care Programs [Subtotal]	**$5,511,059**	**$6,186,247**	**$6,510,946**	**$7,210,872**	**$8,061,890**	**$699,926**	**$851,018**
Obligations [Subtotal]	**$125,713,987**	**$141,918,979**	**$139,539,700**	**$149,519,420**	**$158,882,893**	**$9,979,720**	**$9,363,473**
Recoveries of prior year paid & unpaid obligations	$505,553	$0	$0	$0	$0	$0	$0
Obligations [Total]	$126,219,540	$141,918,979	$139,539,700	$149,519,420	$158,882,893	$9,979,720	$9,363,473

Notes: Dollars may not add due to rounding in this and subsequent charts. A full-year 2024 appropriations Act was not enacted at the time the 2025 Budget was prepared. The funding level in the 2024 Current Estimate column assumes the 2024 President's Budget request for 2024 with updates to unobligated balances, reimbursements, collections, and transfers.

1/ Ambulatory Care in this table excludes pharmacy costs, which had been included in previous Congressional Justifications, as part of the the data reorganization in the Medical Services Chapter. Ambulatory Care includes the cost adjustments made outside of the Enrollee Health Care Projection Model (EHCPM). Remaining modeled service lines are inflated by their respective EHCPM growth rates.

2/ Pharmacy costs have been separated from ambulatory care in this budget cycle's display. The Pharmacy table and narrative has been moved from the Medical Services Chapter to the Medical Care Chapter.

[3/] 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).

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

[5/] Excludes administrative costs except in the 2024 Budget estimate column.

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

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

Table: Programs Included in Medical Care Obligations

(Includes All Funding Sources)
(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate 1/3/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Medical Care Programs: (Included Above)							
Activations	$391,194	$865,249	$623,359	$623,359	$623,359	$0	$0
Blind Rehabilitation Treatment	$158,708	$168,746	$175,670	$193,232	$211,960	$17,562	$18,728
Education & Training	$2,629,755	$2,911,961	$2,991,218	$3,048,609	$3,139,174	$57,391	$90,565
Food Security Program Office 1/	$1,117	N/A	$1,682	$16,985	$16,985	$15,303	$0
Health Professionals Educational Assistance Program	$208,228	$303,356	$303,356	$377,450	$377,450	$74,094	$0
Indian Health Service/THP/UIO Reimbursement	$30,852	$38,259	$36,501	$37,924	$41,717	$1,423	$3,793
Intimate Partner Violence program	$23,008	$36,879	$30,432	$31,373	$31,373	$941	$0
Leases	$1,153,605	$2,305,729	$1,408,903	$2,263,759	$2,185,902	$854,856	($77,857)
Mental Health Topics:							
Opioid Prevention:							
Treatment Modalities	$430,591	$460,878	$440,925	$458,562	$476,446	$17,637	$17,884
Opioid Prevention Programs (Includes Jason's Law) 2/	$206,450	$254,478	$254,478	$254,487	$254,487	$9	$0
Substance Use Disorder Initiative	$94,662	$230,947	$230,947	$263,881	$264,824	$32,934	$943
Suicide Prevention:							
Medical Treatment 3/	$2,414,568	$2,475,629	$2,544,820	$2,667,713	$2,785,664	$122,893	$117,951
Outreach Programs	$517,024	$558,794	$570,956	$582,554	$586,019	$11,598	$3,465
Women Veterans Peer Support Initiative (WoVeN) 1/	$1,286	N/A	$1,415	$1,698	$1,698	$283	$0
National Center for Posttraumatic Stress Disorder 4/	$42,302	$42,000	$42,000	$42,000	$42,000	$0	$0
National Veterans Sports Program	$26,457	$30,414	$30,414	$30,542	$30,542	$128	$0
Neurology Centers of Excellence 4/							
Epilepsy (Including Multiple Sclerosis)	$15,093	$23,585	$23,585	$23,871	$23,871	$286	$0
Headaches	$19,086	$21,476	$15,000	$22,092	$22,092	$7,092	$0
Multiple Sclerosis 1/	$4,620	N/A	$4,620	$5,300	$5,300	$680	$0
Parkinson's Disease Research, Education and Clinical Centers 1/	$10,522	N/A	$9,673	$10,200	$10,200	$527	$0
Non-Recurring Maintenance (Lands & Structure only) 5/	$3,223,244	$5,750,000	$2,028,415	$2,027,648	$2,007,560	($767)	($20,088)
Precision Oncology Initiative	$145,753	$215,433	$215,433	$215,433	$215,433	$0	$0
Regional Readiness Centers	$51,992	$155,481	$36,455	$41,404	$41,404	$4,949	$0
Rural Health 4/	$297,074	$337,455	$337,455	$337,455	$337,455	$0	$0
Spinal Cord Injury Treatment	$849,591	$821,609	$956,627	$1,081,569	$1,219,994	$124,942	$138,425
Supply Chain Management	$57,171	$144,603	$147,563	$148,866	$148,866	$1,303	$0
Telehealth:							
Home & Clinic Based Telehealth 6/	$4,922,866	$5,210,577	$5,733,653	$5,958,100	$6,382,109	$224,447	$424,009
Office of Connected Care Program	$288,919	$408,061	$408,061	$439,920	$439,920	$31,859	$0
Veterans Homelessness Programs	$2,953,422	$3,111,148	$3,168,707	$3,210,276	$3,235,065	$41,569	$24,789
Whole Health	$79,070	$107,848	$107,848	$119,289	$119,289	$11,441	$0

1/ Information not previously displayed in the 2024 Congressional Justification.

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

3/ A correction has been made in this table to the 2024 Budget Estimate column for medical treatment that had double counted Mental Health Care in the Emergency Room. More information on suicide prevention can be found later in this chapter.

4/ 2023 actuals are represented by allocated amounts rather than obligations.

5/ Please see the Medical Facilities chapter for the 2023 actual that includes supporting full time equivalent (FTE) employees and contract-related costs pertaining to non-recurring maintenance, which are not included in this table.

6/ The display for 2024 in the 2024 Congressional Justification excluded obligations for certain home telehealth modalities. These obligations have been included in all columns in this display except for the 2024 Budget Estimate.

Table: Veteran Population Obligations in Medical Care Obligations
(Includes All Funding Sources)
(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
AIDS/HIV Program	$1,789,483	$1,818,782	$1,920,571	$2,062,108	$2,212,952	$141,538	$150,844
Health Outcomes Military Exposures (HOME):							
Gulf War Program	$7,218,584	$8,268,010	$8,582,788	$10,106,231	$11,785,074	$1,523,443	$1,678,843
OEF/OIF/OND/OIR	$14,429,901	$15,820,981	$16,856,009	$19,580,291	$22,572,919	$2,724,282	$2,992,628
Program Office	$49,004	$81,938	$81,938	$82,838	$82,838	$900	$0
Traumatic Brain Injury and Polytrauma System of Care:							
OEF/OIF/OND/OIR	$313,394	$346,429	$338,768	$359,553	$382,709	$20,785	$23,156
All Veteran Care	$1,084,461	$1,329,518	$1,180,755	$1,285,527	$1,403,174	$104,771	$117,647
Women Veterans Health Care:							
Program Office & Initiative Budget	$111,820	$256,926	$256,926	$263,660	$263,660	$6,734	$0
Gender-Specific Care	$851,443	$1,022,170	$940,709	$1,059,784	$1,165,521	$119,075	$105,737
All Care	$11,316,932	$12,632,131	$12,497,616	$13,657,684	$14,763,288	$1,160,068	$1,105,604

Medical Care Collections Fund

VA estimates medical care collections of $4.4 billion in 2025 and $4.5 billion in 2026. Projected collections for 2024 through 2026 reflect the impact of the PACT Act implementation, recent collections trends, including the increased use of telehealth as a provision of care.

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

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Medical Care Collections Fund:							
First Party Payments:							
1st Party Other Co-payments	$143,615	$133,239	$133,239	$117,873	$115,660	($15,366)	($2,213)
Community Care Collections 1st Party	$41,142	$23,515	$23,515	$33,520	$32,891	$10,005	($629)
Long-Term Care Co-Payments	$1,429	$1,761	$1,761	$1,712	$1,664	($49)	($48)
Pharmacy Co-payments	$393,465	$335,858	$335,858	$376,251	$384,003	$40,393	$7,752
First Party Payments [Subtotal]	**$579,651**	**$494,373**	**$494,373**	**$529,356**	**$534,218**	**$34,983**	**$4,862**
Third Party Payments:							
3rd Party Insurance Collections	$2,537,382	$2,710,516	$2,710,518	$2,778,378	$2,866,524	$67,860	$88,146
3rd Party RX Insurance	$157,103	$173,176	$173,176	$183,717	$192,306	$10,541	$8,589
Community Care Collections 3rd Party	$814,282	$861,133	$861,132	$868,227	$893,489	$7,095	$25,262
Third Party Payments [Subtotal]	**$3,508,767**	**$3,744,825**	**$3,744,826**	**$3,830,322**	**$3,952,319**	**$85,496**	**$121,997**
Other MCCF:							
Comp. & Pension Living Expenses	$1,511	$1,506	$1,506	$1,506	$1,506	$0	$0
Comp. Work Therapy Collections	$36,324	$24,622	$24,622	$24,622	$24,622	$0	$0
Enhanced-Use Revenue	$1,227	$672	$672	$672	$672	$0	$0
Parking Fees	$4,131	$3,200	$3,200	$3,200	$3,200	$0	$0
Other MCCF [Subtotal]	**$43,193**	**$30,000**	**$30,000**	**$30,000**	**$30,000**	**$0**	**$0**
Total Collections	**$4,131,611**	**$4,269,198**	**$4,269,199**	**$4,389,678**	**$4,516,537**	**$120,479**	**$126,859**
JALFHCC amount (included above)	$16,086	$20,444	$16,860	$17,336	$17,837	$476	$501

[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 $4.1 billion were received by VA in 2023. 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 $4.1 billion was transferred from the Medical Care Collections Fund to the receiving accounts, reflecting collections received from September 2022 through

August 2023: $3.3 billion to Medical Services, $857.2 million to Medical Community Care and $16.1 million to the Joint DoD-VA Medical Demonstration Fund. The funds collected in September 2021 were transferred in 2024.

VA Staffing

The budget assumes a full-time equivalent employee (FTE) level of 383,186 in 2025 and 382,751 in 2025. Due to record hiring in 2023, VA has the nationwide staffing level to accomplish the important objective of making sure that – whenever possible – all Veterans have an opportunity to receive care from a VA provider. VA will continue to focus its hiring in key areas, such as mental health, to provide Veterans with high-quality and timely health care services.

Table: Employment Summary (FTE)

Employment Summary (FTE)

Account	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Medical Services	282,395	293,544	297,651	290,658	290,372	(6,993)	(286)
Medical Community Care	0	0	0	0	0	0	0
Medical Support & Compliance	59,487	66,534	68,045	66,658	66,589	(1,387)	(69)
Medical Facilities	21,586	26,501	26,855	25,839	25,790	(1,016)	(49)
Total Discretionary Medical Care	363,468	386,579	392,551	383,155	382,751	(9,396)	(404)

	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Veterans Medical Care and Health Fund - Medical Services 1/	2,193	0	0	0	0	0	0
Veterans Medical Care and Health Fund - Medical Support & Compliance 1/.	3,824	0	0	0	0	0	0
Veterans Medical Care and Health Fund - Medical Facilities 1/	4,453	0	0	0	0	0	0
Cost of War Toxic Exposures Fund - Medical Services	0	13	0	0	0	0	0
Veterans Choice Act, Sec. 801, FTE 2/	59	41	59	31	0	(28)	(31)
Veterans Choice Act, Sec. 802, FTE 3/	0	0	0	0	0	0	0
Total Mandatory Medical Care	10,529	54	59	31	0	(28)	(31)

1/FTEs funded by ARP Act resources in 2023 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.

	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Estimate	+/- 2024-2025
Grand Total Medical Care FTE	**373,997**	**386,633**	**392,610**	**383,186**	**382,751**	**(9,424)**	**(435)**

	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Estimate	+/- 2024-2025
Canteen Service	2,215	2,065	2,210	2,200	(10)
Medical & Prosthetic Research 4/	4,537	4,716	4,649	4,626	(23)
Veterans Medical Care and Health Fund - Research 1/	123	0	0	0	0
Cost of War Toxic Exposures Fund - Research	6	113	113	113	0
DOD-VA Health Care Sharing Fund - VA Civilian	28	34	31	31	0
DOD-VA Health Care Sharing Fund - DoD Personnel	55	55	63	50	(13)
James A. Lovell Federal Healthcare Center					
Civilian	2,300	2,490	2,491	2,491	0
DoD Uniformed Military	719	826	826	826	0
Joint DoD-VA Med. Fac. Demo. Fund Total	3,019	3,316	3,317	3,317	0

Table: FTE by Type, Medical Care

FTE by Type
Medical Care

Account	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Physicians	24,391	25,452	25,685	25,099	25,087	(586)	(12)
Dentists	1,373	1,448	1,435	1,402	1,400	(33)	(2)
Registered Nurses	73,453	76,081	78,039	76,302	76,223	(1,737)	(79)
LP Nurse/LV Nurse/Nurse Assistant	27,450	29,769	28,959	28,281	28,250	(678)	(31)
Non-Physician Providers	19,898	19,772	20,873	20,391	20,371	(482)	(20)
Health Technicians/Allied Health	87,024	90,405	91,403	89,281	89,187	(2,122)	(94)
Wage Board/Purchase & Hire	24,253	28,883	28,880	27,920	27,874	(960)	(46)
All Other 1/	105,626	114,769	117,277	114,479	114,359	(2,798)	(120)
SubTotal	363,468	386,579	392,551	383,155	382,751	(9,396)	(404)
American Rescue Plan, FTE	10,470	0	0	0	0	0	0
Cost of War Toxic Exposures Fund - Medical Services	0	13	0	0	0		
Veterans Choice Act, Sec. 801, FTE	59	41	59	31	0	(28)	(31)
Veterans Choice Act, Sec. 802, FTE	0	0	0	0	0	0	0
Total	373,997	386,633	392,610	383,186	382,751	(9,424)	(435)

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

Table: FTE by Type, Medical Services

Account	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Physicians	23,621	24,621	24,896	24,309	24,297	(587)	(12)
Dentists	1,361	1,431	1,423	1,390	1,388	(33)	(2)
Registered Nurses	69,569	72,108	73,991	72,253	72,174	(1,738)	(79)
LP Nurse/LV Nurse/Nurse Assistant	27,368	29,768	28,873	28,195	28,164	(678)	(31)
Non-Physician Providers	19,590	19,430	20,535	20,053	20,033	(482)	(20)
Health Technicians/Allied Health	85,916	88,969	90,077	87,961	87,867	(2,116)	(94)
Wage Board/Purchase & Hire	5,532	5,868	5,791	5,655	5,649	(136)	(6)
All Other 1/	49,438	51,349	52,065	50,842	50,800	(1,223)	(42)
SubTotal	282,395	293,544	297,651	290,658	290,372	(6,993)	(286)
American Rescue Plan, FTE	2,193	0	0	0	0	0	0
Cost of War Toxic Exposures Fund - Medical Services	0	13	0	0	0	0	0
Veterans Choice Act, Sec. 801, FTE	31	17	31	31	0	0	(31)
Total	284,619	293,574	297,682	290,689	290,372	(6,993)	(317)

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	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Physicians	770	831	789	790	790	1	0
Dentists	12	17	12	12	12	0	0
Registered Nurses	3,881	3,973	4,048	4,049	4,049	1	0
LP Nurse/LV Nurse/Nurse Assistant	81	1	86	86	86	0	0
Non-Physician Providers	308	342	338	338	338	0	0
Health Technicians/Allied Health	1,125	1,266	1,166	1,166	1,166	0	0
Wage Board/Purchase & Hire	1,230	1,360	1,305	1,305	1,305	0	0
All Other 1/	52,080	58,744	60,301	58,912	58,843	(1,389)	(69)
SubTotal	59,487	66,534	68,045	66,658	66,589	(1,387)	(69)
American Rescue Plan, FTE	3,824	0	0	0	0	0	0
Veterans Choice Act, Sec. 801, FTE	27	24	27	0	0	(27)	0
Total	63,338	66,558	68,072	66,658	66,589	(1,414)	(69)

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	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
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	0	0	0	0	0	0	0
Health Technicians/Allied Health	(17)	170	160	154	154	(6)	0
Wage Board/Purchase & Hire	17,491	21,655	21,784	20,960	20,920	(824)	(40)
All Other 1/	4,108	4,676	4,911	4,725	4,716	(186)	(9)
SubTotal	21,586	26,501	26,855	25,839	25,790	(1,016)	(49)
American Rescue Plan, FTE	4,453	0	0	0	0	0	0
Veterans Choice Act, Sec. 801, FTE	1	0	1	0	0	(1)	0
Total	26,040	26,501	26,856	25,839	25,790	(1,017)	(49)

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: Medical Care FTE by Grade, 2023 Actuals
(Includes All Funding Sources)

	2023			
General Schedule Grade or Title 38	Medical Services Category	Medical Support & Compliance Category	Medical Facilities Category	Medical Care
Senior Executive Service	0	182	0	182
Title 38	111,556	5,236	5,167	121,959
15 or Higher	323	681	1	1,005
14	2,155	2,497	124	4,776
13	15,001	6,111	474	21,586
12	22,910	8,233	1,012	32,155
11	20,375	6,690	945	28,010
10	2,141	274	54	2,469
9	12,212	8,489	460	21,161
8	6,864	2,453	30	9,347
7	14,795	8,601	353	23,749
6	47,674	7,095	289	55,058
5	20,165	3,857	170	24,192
4	2,030	1,444	30	3,504
3	934	178	73	1,185
2	31	27	2	60
1	3	2	1	6
Wage Board	5,450	1,288	16,855	23,593
FTE Total	284,619	63,338	26,040	373,997

Table: Medical Care FTE by OPM Occupational Groups, 2023 Actual
(Includes All Funding Sources)

Office of Personnel Management (OPM) Occupational Groups and Families	2023 Medical Services Category	2023 Medical Support & Compliance Category	2023 Medical Facilities Category	2023 Total Medical Care
0000 –Miscellaneous Occupations Group	825	5,946	810	7,581
0100 – Social Science, Psychology, And Welfare Group	31,692	594	4	32,290
0200 – Human Resources Management Group	3	8,826	0	8,829
0300 – General Administrative, Clerical, And Office Services Group	11,894	14,420	1,038	27,352
0400 – Natural Resources Management And Biological Sciences Group	76	21	1	98
0500 – Accounting And Budget Group	349	5,462	45	5,856
0600 –Medical, Hospital, Dental, And Public Health Group	229,506	15,134	597	245,237
0800 – Engineering And Architecture Group	473	205	1,754	2,432
0900 – Legal And Kindred Group	234	1,066	1	1,301
1000 – Information And Arts Group	216	619	217	1,052
1100 – Business And Industry Group	1,044	3,651	49	4,744
1300 – Physical Sciences Group	32	63	28	123
1400 – Library And Archives Group	75	53	0	128
1500 –Mathematical Sciences Group	36	67	0	103
1600 – Equipment, Facilities, And Services Group	1,347	22	218	1,587
1700 – Education Group	808	935	32	1,775
1800 – Inspection, Investigation, Enforcement, And Compliance Group	0	120	0	120
2000 – Supply Group	303	4,004	53	4,360
2100 – Transportation Group	253	833	162	1,248
2600 – Electronic Equipment Installation And Maintenance Family	10	0	279	289
2800 – Electrical Installation And Maintenance Family	31	2	838	871
3500 – General Services And Support Work Family	22	9	11,018	11,049
4100 – Painting And Paperhanging Family	1	0	458	459
4200 – Plumbing And Pipefitting Family	0	2	693	695
4600 –Wood Work Family	2	4	489	495
4700 – General Maintenance And Operations Work Family	10	11	2,477	2,498
4800 – General Equipment Maintenance Family	38	16	133	187
5000 – Plant And Animal Work Family	5	2	247	254
5300 – Industrial Equipment Maintenance Family1	2	1	919	922
5400 – Industrial Equipment Operation Family	5	0	750	755
5700 – Transportation/Mobile Equipment Operation Family	91	281	1,655	2,027
6900 –Warehousing And Stock Handling Family	24	935	80	1,039
7300 – Laundry, Dry Cleaning, And Pressing Family	0	0	768	768
7400 – Food Preparation And Serving Family	5,112	0	1	5,113
OPM Occupational Groups and Families Not Covered Above1/	100	34	226	360
Grand Total	284,619	63,338	26,040	373,997

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 2025 request supports the treatment of 7.3 million patients and 142.6 million outpatient visits.

Table: Unique Patients

Unique Patients 1/

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Priority Levels							
1-6	5,386,925	5,413,128	5,456,474	**5,556,227**	**5,636,742**	99,753	80,515
7-8	878,013	964,465	849,456	**788,930**	**746,733**	(60,526)	(42,197)
Veterans [Subtotal]	6,264,938	6,377,593	6,305,930	**6,345,157**	**6,383,475**	39,227	38,318
Non-Veterans [Subtotal] 2/	918,014	1,003,158	935,624	**949,871**	**959,444**	14,247	9,573
Unique Patients [Total]	**7,182,952**	**7,380,751**	**7,241,554**	**7,295,028**	**7,342,919**	**53,474**	**47,891**

Unique Enrollees 3/4/5/

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Priority Levels							
1-6	7,447,139	7,344,165	7,552,657	7,678,671	7,771,785	126,015	93,114
7-8	1,650,720	1,703,878	1,518,120	1,415,360	1,336,155	(102,760)	(79,205)
Unique Enrollees [Total]	**9,097,859**	**9,048,043**	**9,070,776**	**9,094,031**	**9,107,940**	**23,255**	**13,909**

Users as a Percent of Enrollees

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Priority Levels							
1-6	72.3%	73.7%	72.2%	**72.4%**	**72.5%**	0.1%	0.2%
7-8	53.2%	56.6%	56.0%	**55.7%**	**55.9%**	-0.2%	0.1%
Unique Enrollees [Total]	**68.9%**	**70.5%**	**69.5%**	**69.8%**	**70.1%**	0.3%	0.3%

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

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

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

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

5/ The unique enrollment counts do not include Veterans in Priority Group 8 sub-priorities e and g.

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

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Outpatient Visits (000):							
Ambulatory Care:							
Staff	87,538	98,806	92,023	89,078	88,999	(2,945)	(79)
Community Care	42,426	39,392	46,317	52,125	56,649	5,808	4,524
Subtotal	129,964	138,198	138,340	141,203	145,648	2,863	4,445
Readjustment Counseling:							
Visits	1,291	1,499	1,339	1,412	1,489	73	77
Grand Total	131,255	139,697	139,679	142,615	147,137	2,936	4,522
Patients Treated:							
Inpatient Care	823,303	826,150	811,610	800,720	798,394	(10,890)	(2,326)
Rehabilitation Care	11,618	13,247	12,833	13,850	14,401	1,017	551
Mental Health Care Total	178,686	159,170	190,431	207,158	217,561	16,727	10,403
Acute Psychiatry	*59,851*	*56,152*	*59,851*	*56,003*	*54,265*	*(3,848)*	*(1,738)*
Community Care Hospital (Psych)	*89,396*	*74,530*	*96,310*	*112,568*	*124,375*	*16,258*	*11,807*
Residential Recovery Programs	*29,439*	*28,488*	*34,270*	*38,587*	*38,921*	*4,317*	*334*
Long-Term Care: Institutional	108,974	81,762	120,057	130,713	135,743	10,656	5,030
Subacute Care	1,078	1,223	1,069	1,048	1,025	(21)	(23)
Inpatient Facilities, Total	1,123,659	1,081,552	1,136,000	1,153,489	1,167,124	17,489	13,635
Average Daily Census:							
Inpatient Care	13,872	15,633	13,918	13,932	14,072	14	140
Rehabilitation Care	925	892	968	1,007	1,028	39	21
Mental Health Care Total	7,062	7,482	7,757	8,333	8,407	576	74
Acute Psychiatry	*1,657*	*1,571*	*1,657*	*1,530*	*1,464*	*(127)*	*(66)*
Community Care Hospital (Psych)	*1,651*	*1,894*	*1,730*	*1,966*	*2,121*	*236*	*155*
Residential Recovery Programs	*3,754*	*4,017*	*4,370*	*4,837*	*4,822*	*467*	*(15)*
Long-Term Care: Institutional	35,771	31,778	39,386	41,208	42,329	1,822	1,121
Subacute Care	39	41	42	44	45	2	1
Inpatient Facilities, Total	57,669	55,826	62,071	64,524	65,881	2,453	1,357
Length of Stay:							
Inpatient Care	6.1	6.9	6.3	6.4	6.4	0.1	0.0
Rehabilitation Care	29.1	24.6	27.6	26.5	26.1	(1.1)	(0.4)
Mental Health Care	14.4	17.2	14.9	14.7	14.1	(0.2)	(0.6)
Long-Term Care: Institutional	119.8	141.9	120.1	115.1	113.8	(5.0)	(1.3)
Subacute Care	13.2	12.2	14.4	15.3	16.0	0.9	0.7
Dental Procedures (000)	7,498	8,315	8,068	8,407	8,770	339	363
CHAMPVA/FMP/Spina Bifida:							
Unique Patients	505,647	511,745	524,385	546,041	570,186	21,656	24,145

Table: Global RVUs for VA and Non-VA Facilities

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

Description	2023 Projection	2024 Projection	2025 Projection	2026 Projection	+/- 2024-2025	+/- 2025-2026
VA System Delivered:						
Outpatient	378,861,863	397,702,264	384,734,341	384,340,290	(12,967,923)	(394,052)
Inpatient	179,228,026	180,482,998	170,948,809	166,758,272	(9,534,188)	(4,190,537)
All other workload	334,827,413	357,098,296	375,678,124	392,258,813	18,579,828	16,580,689
VA System Delivered [Subtotal]	892,917,301	935,283,558	931,361,274	943,357,375	(3,922,284)	11,996,100
Community Delivered:						
Outpatient	243,861,083	259,222,092	301,740,598	334,694,067	42,518,506	32,953,469
Inpatient	216,815,459	229,267,497	247,045,699	262,495,838	17,778,202	15,450,139
All other workload	137,582,607	147,291,265	155,956,927	162,219,703	8,665,663	6,262,776
Community Delivered [Subtotal]	598,259,148	635,780,854	704,743,224	759,409,609	68,962,370	54,666,384
Total VA Delivered:						
Outpatient	622,722,946	656,924,356	686,474,939	719,034,357	29,550,583	32,559,418
Inpatient	396,043,484	409,750,495	417,994,508	429,254,111	8,244,013	11,259,602
All other workload	472,410,019	504,389,561	531,635,051	554,478,516	27,245,490	22,843,465
Total Delivered [Subtotal]	**1,491,176,450**	**1,571,064,412**	**1,636,104,499**	**1,702,766,983**	**65,040,087**	**66,662,485**

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

The EHCPM Global RVUs build on the CMS RBRVS to cover services that are not assigned CMS RBRVS RVUs, including inpatient care, pharmacy, prosthetics and VA's special programs. In addition, the CMS RBRVS only assigns RVUs to the services billed by professional providers; RVUs are not assigned to services billed by hospitals or other medical facilities, nor are they assigned to professional services typically not covered by Medicare. The Global RVUs address this issue by assigning RVUs for these facility and non-covered professional costs that are consistent with CMS's physician RVU schedule. Thus, the EHCPM Global RVUs cover all workload and expenditures associated with VA health care.

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

- Because the EHCPM Global RVUs assign RVUs for facility costs, EHCPM Global RVUs cover the total resource requirements for each health care service, not just the professional resource requirements covered by the CMS RBRVS. For some services such as surgeries, the professional resource requirements represented by the CMS RBRVS are only a small portion of the total resources required to provide the service.
- Because the EHCPM Global RVUs assign a consistent resource unit to all health care services, health care services of unequal intensity (e.g., immunizations and surgeries) can be aggregated and compared on an equivalent basis.

- Aggregating health care services using expenditures introduces the effect of variations in unit cost that may exist for the same service from one locality, provider or care location to another.
- In addition, for care VA purchases in the community, year-to-year comparisons of total expenditures can under- or over-state the volume of care purchased due to known changes in the level of Medicare allowable reimbursement in different contract mechanisms and over time.

- The Global RVUs facilitate an accurate comparison of workload between VA facility and community care and between different geographic areas (e.g., Community Care Network contract regions, VISNS, facilities).
  - The EHCPM Global RVUs reflect differences in workload mix and intensity but do not reflect cost differences between the care locations.
  - The EHCPM Global RVUs reflect the workload mix differences between care locations (i.e., 100 surgeries in the VA facility do not necessarily require the same resources as 100 surgeries in the community). Global RVUs account for these differences by assigning RVU values that represent the intensity of each surgery (e.g., a heart transplant will have a higher total Global RVU value than an appendectomy).

Types of Resource-Based Relative Value Scales

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

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

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

EHCPM Global RVUs: EHCPM Global RVUs are used to aggregate data across health care services, for use in reliance analyses, setting EHCPM adjustment tables, developing modeling

expenditure targets, the Medicare Allowable Cost analysis and other ad hoc analyses. Beginning in the 2020 (Base Year 2019) EHCPM, EHCPM Global RVUs were integrated into the EHCPM. EHCPM Global RVUs are assigned to all services VA provides. As such, they represent the total resource requirements to provide VA health care.

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

Veteran Enrollment Priority Group Definitions

Priority Groups Eligibility Criteria (38 C.F.R. § 17.36(b)) [3]

Priority Group 1	Veterans with a singular or combined rating of 50% or greater based on one or more service-connected disabilities or unemployability and Veterans awarded the Medal of Honor.
Priority Group 2	Veterans with a singular or combined rating of 30% or 40% based on one or more service-connected disabilities.
Priority Group 3	Veterans who are former prisoners of war. Veterans awarded the Purple Heart. Veterans with a singular or combined disability rating of 10% or 20% based on one or more service-connected disabilities. Veterans who were discharged or released from active military service for a disability incurred or aggravated in the line of duty. Veterans who receive disability compensation under 38 U.S.C. § 1151. Veterans whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. § 1151, but only to the extent that such Veterans' continuing eligibility for that care is provided for in the judgment or settlement described in 38 U.S.C. § 1151. Veterans whose entitlement to disability compensation is suspended because of the receipt of military retired pay. Veterans receiving compensation at the 10% rating level based on multiple non-compensable service-connected disabilities that clearly interfere with normal employability.
Priority Group 4	Veterans who receive increased pension based on their need for regular aid and attendance or by reason of being permanently housebound. Veterans who are determined to be catastrophically disabled by the Chief of Staff (or equivalent clinical official) at the VA facility where they were examined.
Priority Group 5	Veterans not covered by Priority Groups 1-4 who are determined to be unable to defray the expenses of necessary care under 38 U.S.C. § 1722(a).
Priority Group 6	Veterans of the Mexican border period or of World War I. Veterans solely seeking care for a disorder associated with exposure to a toxic substance or radiation, for a disorder associated with service in the Southwest Asia theater of operations during the Gulf War (the period between August 2, 1990, and November 11, 1998), or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as provided and limited in 38 U.S.C. § 1710(e). Camp Lejeune Veterans pursuant to 38 C.F.R. § 17.400. Veterans with 0% service-connected disabilities who are nevertheless compensated, including Veterans receiving compensation for inactive tuberculosis.

[3] Additional detail can be found under the electronic Code of Federal Regulations (ECFR): eCFR :: 38 CFR 17.36 -- Enrollment—provision of hospital and outpatient care to veterans.

	Additionally, World War II Veterans will be included based on division U § 101 of P.L. 117-328.
Priority Group 7	Veterans who agree to pay to the United States the applicable copayment determined under 38 U.S.C. § 1710(f) and 1710(g) if their income for the previous year constitutes low income under the geographical income limits established by the Department of Housing and Urban Development for the FY that ended on September 30 of the previous calendar year.
Priority Group 8	Veterans not included in Priority Groups 4 or 7, who are eligible for care only if they agree to pay to the United States the applicable copayment determined under 38 U.S.C. § 1710(f) and 1710(g). Specifically, the following subcategories are eligible to be enrolled: (i) Non-compensable 0% service-connected Veterans who were in an enrolled status on January 17, 2003, or who are moved from a higher Priority Group or subcategory due to no longer being eligible for inclusion in such Priority Group or subcategory and who subsequently do not request disenrollment. (ii) Non-compensable 0% service-connected Veterans not included in clause (i) of this section and whose income is not greater than 10% more than the income that would permit their enrollment in Priority Group 5 or Priority Group 7, whichever is higher. (iii) Nonservice-connected Veterans who were in an enrolled status on January 17, 2003, or who are moved from a higher Priority Group or subcategory due to no longer being eligible for inclusion in such Priority Group or subcategory and who subsequently do not request disenrollment. (iv) Nonservice-connected Veterans not included in clause (iii) of this section and whose income is not greater than 10% more than the income that would permit their enrollment in Priority Group 5 or Priority Group 7, whichever is higher.

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. Their patient records indicate a non-Veteran status. These non-Veteran categories include the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), Foreign Medical Program (FMP), Spina Bifida Health Care Program (SB) and Children of Women Vietnam Veterans Health Care Benefits Program (CWVV).[4]

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

Veterans' Health Administration (VHA) Facility Non-Veterans

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

Table: Unique Patients [1/]

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Priority Levels							
Priority 1	2,990,365	3,046,068	3,139,689	**3,323,484**	**3,481,717**	183,795	158,233
Priority 2	444,345	450,901	437,305	**426,691**	**418,309**	(10,614)	(8,382)
Priority 3	765,073	801,753	766,939	**756,615**	**752,602**	(10,324)	(4,013)
Priority 4	120,167	117,418	111,748	**102,086**	**93,515**	(9,662)	(8,571)
Priority 5	822,777	778,893	759,704	**698,083**	**638,923**	(61,621)	(59,160)
Priority 6	244,198	218,096	241,089	**249,268**	**251,676**	8,179	2,408
Priority 7	215,424	250,279	222,419	**217,779**	**218,948**	(4,640)	1,169
Priority 8	662,589	714,186	627,037	**571,151**	**527,785**	(55,886)	(43,366)
Veterans [Subtotal]	6,264,938	6,377,594	6,305,930	**6,345,157**	**6,383,475**	39,227	38,318
Non-Veterans 2/							
CHAMPVA/SB/FMP/CW Non-Vet (less CITI)	494,630	482,792	513,410	**535,209**	**559,434**	21,799	24,225
N : Non-Veteran	3,620	4,402	3,619	**3,586**	**3,517**	(33)	(69)
N0: Non-Vet, Catastro Disab	36	46	36	**36**	**36**	0	0
N1: Non-Vet, CHAMPVA Ben	11,017	10,743	10,976	**10,832**	**10,754**	(144)	(78)
N2: Non-Vet, Collaterals	119,065	95,652	120,149	**125,881**	**130,038**	5,732	4,157
N3: Non-Vet, VA Employee	165,082	200,733	159,196	**143,299**	**123,057**	(15,897)	(20,242)
N4: Non-Vet, Other Federal	20,110	99,983	20,613	**22,099**	**22,359**	1,486	260
N5: Non-Vet, Allied Veterans	1,538	1,513	1,542	**1,565**	**1,581**	23	16
N6: Non-Vet, Humanitarian	35,058	35,441	35,197	**35,827**	**36,223**	630	396
N7: Non-Vet, Sharing Agreement	8,959	8,467	8,776	**8,224**	**7,935**	(552)	(289)
N9: Non-Vet, TRICARE/CHAMPUS	2,677	3,225	2,681	**2,701**	**2,715**	20	14
NF : FHC Active Duty 3/	56,222	60,160	59,429	**60,612**	**61,795**	1,183	1,183
Non-Veterans [Subtotal]	918,014	1,003,157	935,624	**949,871**	**959,444**	14,247	9,573
Unique Patients [Total]	**7,182,952**	**7,380,751**	**7,241,554**	**7,295,028**	**7,342,919**	53,474	47,891
OEF/OIF/OND/OIR (Incl. Above)	1,302,977	1,313,399	1,372,422	**1,440,372**	**1,506,497**	67,950	66,125

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

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

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

Table: Unique Patients Under Age 65 [1/]

	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Priority Levels							
Priority 1	1,882,678	1,952,759	2,002,568	**2,146,081**	**2,269,130**	143,513	123,049
Priority 2	232,887	238,374	226,306	**216,954**	**208,004**	(9,352)	(8,950)
Priority 3	323,562	339,874	318,622	**307,300**	**297,183**	(11,322)	(10,117)
Priority 4	20,940	17,313	16,625	**11,854**	**7,038**	(4,771)	(4,816)
Priority 5	295,564	256,676	252,037	**205,802**	**157,845**	(46,235)	(47,957)
Priority 6	99,111	66,430	99,477	**107,114**	**113,710**	7,637	6,596
Priority 7	81,502	105,323	84,244	**81,678**	**80,335**	(2,566)	(1,343)
Priority 8	218,630	263,809	210,102	**191,808**	**175,143**	(18,294)	(16,665)
Veterans [Subtotal]	3,154,874	3,240,558	3,209,981	**3,268,591**	**3,308,388**	58,610	39,797
Non-Veterans 2/							
CHAMPVA/SB/FMP/CW Non-Vet (less CITI)	470,942	460,057	488,797	**509,573**	**532,630**	20,776	23,057
N : Non-Veteran	3,070	3,777	3,068	**3,036**	**2,972**	(32)	(64)
N0: Non-Vet, Catastro Disab	34	44	34	**34**	**34**	0	0
N1: Non-Vet, CHAMPVA Ben	9,423	8,801	9,369	**9,166**	**9,049**	(203)	(117)
N2: Non-Vet, Collaterals	80,210	63,058	80,935	**84,716**	**87,422**	3,781	2,706
N3: Non-Vet, VA Employee	158,164	193,581	152,562	**137,479**	**118,131**	(15,083)	(19,348)
N4: Non-Vet, Other Federal	7,705	51,878	7,990	**8,608**	**8,418**	618	(190)
N5: Non-Vet, Allied Veterans	1,334	1,314	1,337	**1,358**	**1,374**	21	16
N6: Non-Vet, Humanitarian	28,741	28,436	28,840	**29,276**	**29,542**	436	266
N7: Non-Vet, Sharing Agreement	7,436	4,854	7,254	**6,703**	**6,414**	(551)	(289)
N9: Non-Vet, TRICARE/CHAMPUS	2,303	2,635	2,305	**2,317**	**2,327**	12	10
NF : FHC Active Duty 3/	56,222	60,160	59,429	**60,612**	**61,795**	1,183	1,183
Non-Veterans [Subtotal]	825,584	878,595	841,920	**852,878**	**860,108**	10,958	7,230
Unique Patients [Total]	**3,980,458**	**4,119,153**	**4,051,901**	**4,121,469**	**4,168,496**	69,568	47,027

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

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

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

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

	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Priority Levels							
Priority 1	1,107,687	1,093,309	1,137,121	**1,177,403**	**1,212,587**	40,282	35,184
Priority 2	211,458	212,527	210,999	**209,737**	**210,305**	(1,262)	568
Priority 3	441,511	461,879	448,317	**449,315**	**455,419**	998	6,104
Priority 4	99,227	100,105	95,123	**90,232**	**86,477**	(4,891)	(3,755)
Priority 5	527,213	522,217	507,667	**492,281**	**481,078**	(15,386)	(11,203)
Priority 6	145,087	151,666	141,612	**142,154**	**137,966**	542	(4,188)
Priority 7	133,922	144,956	138,175	**136,101**	**138,613**	(2,074)	2,512
Priority 8	443,959	450,377	416,935	**379,343**	**352,642**	(37,592)	(26,701)
Veterans [Subtotal]	3,110,064	3,137,036	3,095,949	**3,076,566**	**3,075,087**	(19,383)	(1,479)
Non-Veterans 2/							
CHAMPVA/SB/FMP/CW Non-Vet (less CITI)	23,688	22,735	24,613	**25,636**	**26,804**	1,023	1,168
N : Non-Veteran	550	625	551	**550**	**545**	(1)	(5)
N0: Non-Vet, Catastro Disab	2	2	2	**2**	**2**	0	0
N1: Non-Vet, CHAMPVA Ben	1,594	1,942	1,607	**1,666**	**1,705**	59	39
N2: Non-Vet, Collaterals	38,855	32,594	39,214	**41,165**	**42,616**	1,951	1,451
N3: Non-Vet, VA Employee	6,918	7,152	6,634	**5,820**	**4,926**	(814)	(894)
N4: Non-Vet, Other Federal	12,405	48,105	12,623	**13,491**	**13,941**	868	450
N5: Non-Vet, Allied Veterans	204	199	205	**207**	**207**	2	0
N6: Non-Vet, Humanitarian	6,317	7,005	6,357	**6,551**	**6,681**	194	130
N7: Non-Vet, Sharing Agreement	1,523	3,613	1,522	**1,521**	**1,521**	(1)	0
N9: Non-Vet, TRICARE/CHAMPUS	374	590	376	**384**	**388**	8	4
NF : FHC Active Duty 3/	0	0	0	**0**	**0**	0	0
Non-Veterans [Subtotal]	92,430	124,562	93,704	**96,993**	**99,336**	3,289	2,343
Unique Patients [Total]	**3,202,494**	**3,261,598**	**3,189,653**	**3,173,559**	**3,174,423**	(16,094)	864

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

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

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

Table: Unique Obligations by Priority Group

Unique Patients 1/

	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Priority Levels							
1-6	5,386,925	5,413,128	5,456,474	**5,556,227**	**5,636,742**	99,753	80,515
7-8	878,013	964,465	849,456	**788,930**	**746,733**	(60,526)	(42,197)
Veterans [Subtotal]	6,264,938	6,377,593	6,305,930	**6,345,157**	**6,383,475**	39,227	38,318
Non-Veterans 2/	918,014	1,003,158	935,624	**949,871**	**959,444**	14,247	9,573
Unique Patients [Total]	**7,182,952**	**7,380,751**	**7,241,554**	**7,295,028**	**7,342,919**	**53,474**	**47,891**

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

	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Priority Levels							
1-6	$112,284,845	$125,073,726	$124,140,068	**$133,056,647**	**$141,437,729**	$8,916,579	$8,381,082
7-8	$10,720,884	$13,347,767	$11,891,231	**$12,713,888**	**$13,419,901**	$822,657	$706,013
Veterans [Subtotal]	$123,005,729	$138,421,492	$136,031,299	**$145,770,535**	**$154,857,630**	$9,739,236	$9,087,095
Non-Veterans 2/	$3,213,811	$3,497,487	$3,508,401	**$3,748,885**	**$4,025,263**	$240,484	$276,378
Obligations [Total]	**$126,219,540**	**$141,918,979**	**$139,539,700**	**$149,519,420**	**$158,882,893**	$9,979,720	$9,363,473

Obligations Per Unique Patient
(dollars)

	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Priority Levels							
1-6	$20,844	$23,106	$22,751	**$23,947**	**$25,092**	$1,196	$1,145
7-8	$12,210	$13,840	$13,999	**$16,115**	**$17,971**	$2,116	$1,856
Veterans [Subtotal]	$19,634	$21,704	$21,572	**$22,974**	**$24,259**	$1,402	$1,285
Non-Veterans 2/	$3,501	$3,486	$3,750	**$3,947**	**$4,195**	$197	$248
Obligations Per Unique Patient [Total]	**$17,572**	**$19,228**	**$19,269**	**$20,496**	**$21,638**	**$1,227**	**$1,142**

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.

Tables: Funding Crosswalks 2023-2026

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

2023 Actual Dollars in Thousands ($000)	Discretionary				
Description	Medical Services 0160	Medical Community Care 0140	Medical Support & Compl 0152	Medical Facilities 0162/1124XN	Medical Care Total
APPROPRIATION					
Advance Appropriation	$70,323,116	$24,156,659	$9,673,409	$7,133,816	$111,287,000
Annual Appropriation Adjustment	$261,000	$4,300,000	$1,400,000	$1,500,000	$7,461,000
Appropriation [sub-total]	$70,584,116	$28,456,659	$11,073,409	$8,633,816	$118,748,000
TRANSFERS TO (-)					
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
Medical Community Care (0140)	$0	$0	($1,500,000)	$0	($1,500,000)
JALFHCC (0169)	($233,005)	($67,500)	($32,144)	($142,715)	($475,364)
Transfers to [sub-total]	($248,005)	($67,500)	($1,532,144)	($142,715)	($1,990,364)
TRANSFERS FROM (+)					
Medical Support & Compliance (0152)	$0	$1,500,000	$0	$0	$1,500,000
Medical Care Collections Fund (5287)	$3,258,336	$857,189	$0	$0	$4,115,525
Transfers from [sub-total]	$3,258,336	$2,357,189	$0	$0	$5,615,525
REIMBURSEMENTS	$119,759	$0	$64,706	$16,571	$201,036
UNOBLIGATED BALANCE (SOY)					
P.L. 117-328 § 252 (EO 14507 no-year, 1124XN) 1/	$0	$0	$0	$75,000	$75,000
P.L. 117-103 § 253 (Infrastructure no-year)	$0	$0	$0	$108,824	$108,824
P.L. 115-244 § 248 (NRM no-year)	$0	$0	$0	$139,162	$139,162
P.L. 115-141 § 255 (NRM no-year)	$0	$0	$0	$30,667	$30,667
P.L. 111-32 (H1N1 no-year)	$7	$0	$111	$5	$123
P.L. 110-28 (Emergency Supplemental no-year)	$136	$0	$0	$5,800	$5,936
No-Year (all other)	$3,130,601	$155,299	$0	$10,861	$3,296,761
2-Year	$500,826	$176,374	$199,636	$315,248	$1,192,084
Unobligated Balance (SOY) [sub-total]	$3,631,570	$331,673	$199,747	$685,567	$4,848,557
UNOBLIGATED BALANCE (EOY)					
P.L. 117-328 § 252 (EO 14507 no-year, 1124XN) 1/	$0	$0	$0	($75,000)	($75,000)
P.L. 117-103 § 253 (Infrastructure no-year)	$0	$0	$0	($85,871)	($85,871)
P.L. 115-244 § 248 (NRM no-year)	$0	$0	$0	($58,366)	($58,366)
P.L. 115-141 § 255 (NRM no-year)	$0	$0	$0	($3,932)	($3,932)
P.L. 111-32 (H1N1 no-year)	($7)	$0	($111)	($5)	($123)
P.L. 110-28 (Emergency Supplemental no-year)	($136)	$0	$0	($5,800)	($5,936)
No-Year (all other)	($2,663,890)	($182,096)	$0	($8,252)	($2,854,238)
2-Year	($1,050,837)	($1,213,957)	($150,690)	($267,385)	($2,682,869)
Unobligated Balance (EOY) [sub-total]	($3,714,870)	($1,396,053)	($150,801)	($504,611)	($5,766,335)
LAPSE	($851)	($150)	($185)	($45)	($1,231)
OBLIGATIONS [sub-total]	$73,630,055	$29,681,818	$9,654,732	$8,688,583	$121,655,188
PRIOR YEAR RECOVERIES	$106,124	$161,347	$28	$21,358	$288,857
OBLIGATIONS [total]	$73,736,179	$29,843,166	$9,654,760	$8,709,941	$121,944,046
FTE	282,395	0	59,487	21,586	363,468

1/ P.L. 117-328, the Consolidated Appropriations Act, 2023 made $75 million in the Recurring Expenses Transformational Fund (RETF) available for NRM.

2023 Actual Dollars in Thousands ($000)	Mandatory											
									Other Purposes			
	Medical Care Purposes											
	Veterans Medical Care and Health Fund				Medical							
Description	Medical Services	Medical Support & Compliance	Medical Facilities	Community Care	Medical Services	Community Care	Copay Refunds	Medical Care Total	Research	Information Technology OIT	Grants for Construction of State Extended Care Facilities	Grand Total
UNOBLIGATED BALANCE (SOY)												
ARP Act § 8002 (3-year, 0173)	$733,253	$502,305	$772,056	$1,987,643	$0	$0	$0	$3,995,257	$30,109	$769,242	$0	$4,794,608
ARP Act § 8004 (no-year)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$938	$938
ARP Act § 8007 (no-year)	$0	$0	$0	$0	$2,847	$176	$16,861	$19,884	$0	$0	$0	$19,884
Unobligated Balance (SOY) [Subtotal]	$733,253	$502,305	$772,056	$1,987,643	$2,847	$176	$16,861	$4,015,141	$30,109	$769,242	$938	$4,815,430
UNOBLIGATED BALANCE (EOY)												
ARP Act § 8002 (3-year, 0173)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8004 (no-year)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($938)	($938)
ARP Act § 8007 (no-year)	$0	$0	$0	$0	($2,850)	($176)	($16,861)	($19,887)	$0	$0	$0	($19,887)
Unobligated Balance (EOY) [Subtotal]	$0	$0	$0	$0	($2,850)	($176)	($16,861)	($19,887)	$0	$0	($938)	($20,825)
LAPSE (§ 8002)	($55)	($1)	($13)	$0	$0	$0	$0	($69)	($3)	$0	$0	($72
OBLIGATIONS [Subtotal]	$733,198	$502,304	$772,043	$1,987,643	($3)	$0	$0	$3,995,185	$30,106	$769,242	$0	$4,794,533
PRIOR YEAR RECOVERIES	$85,362	$53,382	$43,711	$0	$935	$0	$0	$183,390	$174	$4,932	$0	$188,496
OBLIGATIONS	$818,560	$555,686	$815,754	$1,987,643	$932	$0	$0	$4,178,575	$30,280	$774,174	$0	$4,983,029
FTE ARP Act	2,193	3,824	4,453	0	0	0	0	10,470	123	0	0	10,593

2023 Actual Dollars in Thousands ($000)	Mandatory							
	Medical Care Purposes						Other Purposes	
	Cost of War Toxic Exposure Fund (TEF)					Medical		
Description	Medical Services	Community Care	Medical Support & Compliance	Medical Facilities	Medical Facilities	Care Total	TEF Research	Grand Total
MANDATORY APPROPRIATION								
PACT Act § 707	$0	$0	$0	$0	$1,880,000	$1,880,000	$0	$1,880,000
P.L. 117-328 (5-year, TEF)	$3,822,377	$0	$0	$0	$0	$3,822,377	$1,830	$3,824,207
Mandatory Appropriation [Subtotal]	$3,822,377	$0	$0	$0	$1,880,000	$5,702,377	$1,830	$3,824,207
UNOBLIGATED BALANCE (SOY)								
PACT Act § 705	$0	$0	$0	$0	$275,205	$275,205	$0	$275,205
PACT Act § 707	$0	$0	$0	$0	$0	$0	$0	$0
PACT Act § 806 (3-year, TEF)	$7,981	$0	$26,143	$0	$0	$34,124	$650	$34,774
Unobligated Balance (EOY) [Subtotal]	$7,981	$0	$26,143	$0	$275,205	$309,329	$650	$309,979
REALIGNMENT								
PACT Act § 705	$0	$0	$0	$0	$0	$0	$0	$0
PACT Act § 806 (3-year, TEF)	$94	$0	($94)	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (EOY)								
PACT Act § 705	$0	$0	$0	$0	($229,656)	($229,656)	$0	($229,656)
PACT Act § 707 (base year 2023)	$0	$0	$0	$0	($1,855,998)	($1,855,998)	$0	($1,855,998)
PACT Act § 806 (3-year, TEF)	$0	$0	($26,049)	$0	$0	($26,049)	($12)	($26,061)
P.L. 117-328 (5-year, TEF)	($3,815,453)	$0	$0	$0	$0	($3,815,453)	($226)	($3,815,679)
Unobligated Balance (EOY) [Subtotal]	($3,815,453)	$0	($26,049)	$0	($2,085,654)	($5,927,156)	($238)	($5,927,394)
OBLIGATIONS	$14,999	$0	$0	$0	$69,551	$84,550	$2,242	$86,792
Mandatory FTE PACT Act	0	0	0	0	0	0	3	3

2023 Actual
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	Sustain. 0167XO	Pay & Adm 0167XZ	Section 801 Grand Total
UNOBLIGATED BALANCE (SOY)									
No-Year	$16,123	$7,172	$10,884	$34,179	$1,702	$1,026	$0	$0	$36,907
UNOBLIGATED BALANCE (EOY)									
No-Year	($8,817)	($3,629)	($10,394)	($22,840)	($8,805)	($1,029)	$0	$0	($32,674)
OBLIGATIONS [Subtotal]	$7,306	$3,543	$490	$11,339	($7,103)	($3)	$0	$0	$4,233
PRIOR Year Recoveries	$61	$0	$568	$629	$7,839	$3	$0	$0	$8,471
OBLIGATIONS [Total]	$7,367	$3,543	$1,058	$11,968	$736	$0	$0	$0	$12,704
FTE	31	27	1	59	0	0	0	0	59

2023 Actual
Dollars in Thousands ($000)

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

Description	Mandatory: Admin. 0172XA	Medical Care 0172XB	Emerg. Hepatitis C 0172XC	Emerg. Com. Care 0172XE	Med. Com Care (Mission) 0172XG	Medical Care Total (continued)	Mandatory Information Technology: Dev. 0172XD	Sustain. 0172XO	Pay & Adm 0172XZ	Section 802 Grand Total
UNOBLIGATED BALANCE (SOY)										
No-Year	$2,554	$76,624	$0	$772	$192,600	$272,550	$0	$0	$0	$272,550
REPROGRAMMING										
Within the Veterans Choice Fund	($1,554)	($72,743)	$0	($772)	$75,069	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (EOY)										
No-Year	($1,000)	($36,056)	$0	($101)	($267,669)	($304,826)	$0	$0	$0	($304,826)
OBLIGATIONS [Subtotal]	$0	($32,175)	$0	($101)	$0	($32,276)	$0	$0	$0	($32,276)
PRIOR Year Recoveries	$0	$32,575	$0	$102	$0	$32,677	$0	$0	$0	$32,677
OBLIGATIONS [Total]	$0	$400	$0	$1	$0	$401	$0	$0	$0	$401
FTE [Total]	0	0	0	0	0	0	0	0	0	0

Medical Care Obls., Discretionary	**$121,944,046**
Medical Care Obls., ARP Act	**$4,178,575**
Medical Care Obls., Toxic Exposures Fund and PACT Act	**$84,550**
Medical Care Obls., VACAA, Section 801	**$11,968**
Medical Care Obls., VACAA, Section 802	**$401**
Medical Care Obligations [Grand Total]	**$126,219,540**
Medical Care FTE, Regular	**363,468**
Medical Care FTE, ARP	**10,470**
Medical Care Obls., Toxic Exposures Fund and PACT Act	**0**
Medical Care FTE, VACAA, Section 801	**59**
Medical Care FTE, VACAA, Section 802	**0**
Medical Care FTE [Grand Total]	**373,997**

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

2024 Budget Estimate
Dollars in Thousands ($000)

Description	Mandatory							
	Medical Care Purposes						Other Purposes	VHA PACT Sections
	Cost of War Toxic Exposure Fund					Medical Care	TEF	Grand
	Medical Services	Medical Support & Compliance	Medical Facilities	Community Care	Medical Facilities	Total	Research	Total
MANDATORY APPROPRIATION								
PACT Act § 707	$0	$0	$0	$0	$100,000	$100,000	$0	$100,000
Annual Appropriation Adjustment	$9,525,428	$850,000	$0	$6,740,264	$0	$17,115,692	$46,000	$17,161,692
Mandatory Appropriation [Subtotal]	$9,525,428	$850,000	$0	$6,740,264	$100,000	$17,215,692	$46,000	$17,261,692
UNOBLIGATED BALANCE (SOY)								
PACT Act § 705	$0	$0	$0	$0	$275,205	$275,205	$0	$275,205
PACT Act § 707	$0	$0	$0	$0	$1,829,719	$1,829,719	$0	$1,829,719
PACT Act § 806	$0	$0	$0	$0	$0	$0	$0	$0
5-year (Base Year 2023)	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	$0	$0	$0	$0	$2,104,924	$2,104,924	$0	$2,104,924
REAPPORTIONMENT								
PACT Act § 806	$0	$0	$0	$0	$0	$0	$0	$0
5-year (Base Year 2023)	$0	$0	$0	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (EOY)								
PACT Act § 705	$0	$0	$0	$0	($275,205)	($275,205)	$0	($275,205)
PACT Act § 707	$0	$0	$0	$0	($1,142,995)	($1,142,995)	$0	($1,142,995)
PACT Act § 806	$0	$0	$0	$0	$0	$0	$0	$0
5-year (Base Year 2023)	$0	$0	$0	$0	$0	$0	$0	$0
No-year (Base Year 2024)	($1,338,000)	$0	$0	($1,229,354)	$0	($2,567,354)	$0	($2,567,354)
Unobligated Balance (EOY) [Subtotal]	($1,338,000)	$0	$0	($1,229,354)	($1,418,200)	($3,985,554)	$0	($3,985,554)
OBLIGATIONS	$8,187,428	$850,000	$0	$5,510,910	$786,724	$15,335,062	$46,000	$15,381,062
Mandatory FTE PACT Act	13	0	0	0	0	13	113	126

2024 Budget Estimate
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	$10,658	$3,780	$3,791	$18,229	$1,702	$1,026	$0	$0	$20,957
UNOBLIGATED BALANCE (EOY)									
No-Year	($4,980)	($256)	$0	($5,236)	($1,702)	($1,026)	$0	$0	($7,964)
OBLIGATIONS [Total]	$5,678	$3,524	$3,791	$12,993	$0	$0	$0	$0	$12,993
FTE	17	24	0	41	0	0	0	0	41

2024 Budget Estimate
Dollars in Thousands ($000)

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

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

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

2024 Current Estimate Dollars in Thousands ($000)	Discretionary				
Description	Medical Services 0160	Medical Community Care 0140	Medical Support & Compl 0152	Medical Facilities 0162/1124XN	Medical Care Total
APPROPRIATION					
Advance Appropriation	$74,004,000	$33,000,000	$12,300,000	$8,800,000	$128,104,000
Proposed Cancellation 1/	($4,933,113)	($1,909,069)	$0	($250,515)	($7,092,697)
Appropriation [sub-total]	$69,070,887	$31,090,931	$12,300,000	$8,549,485	$121,011,303
TRANSFERS TO (-)					
Medical Services (0160)	$0	($748,908)	($1,150,000)	$0	($1,898,908)
Medical Facilities (0162)	$0	$0	($400,000)	$0	($400,000)
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
JALFHCC (0169)	($332,510)	($81,000)	($44,887)	($75,452)	($533,849)
Transfers to [sub-total]	($347,510)	($829,908)	($1,594,887)	($75,452)	($2,847,757)
TRANSFERS FROM (+)					
Medical Community Care (0140)	$748,908	$0	$0	$0	$748,908
Medical Support & Compliance (0152)	$1,150,000	$0	$0	$400,000	$1,550,000
Medical Care Collections Fund (5287)	$3,367,692	$884,647	$0	$0	$4,252,339
Transfers from [sub-total]	$5,266,600	$884,647	$0	$400,000	$6,551,247
REIMBURSEMENTS	$119,759	$0	$64,706	$16,571	$201,036
UNOBLIGATED BALANCE (SOY)					
P.L. 117-328 § 252 (EO 14507 no-year, 1124XN) 2/	$0	$0	$0	$75,000	$75,000
P.L. 117-103 § 253 (Infrastructure no-year)	$0	$0	$0	$85,871	$85,871
P.L. 115-244 § 248 (NRM no-year)	$0	$0	$0	$58,366	$58,366
P.L. 115-141 § 255 (NRM no-year)	$0	$0	$0	$3,932	$3,932
P.L. 111-32 (H1N1 no-year)	$7	$0	$111	$5	$123
P.L. 110-28 (Emergency Supplemental no-year)	$136	$0	$0	$5,800	$5,936
No-Year (all other)	$2,663,890	$182,096	$0	$8,252	$2,854,238
2-Year	$1,050,837	$1,213,957	$150,690	$267,385	$2,682,869
Unobligated Balance (SOY) [sub-total]	$3,714,870	$1,396,053	$150,801	$504,611	$5,766,335
UNOBLIGATED BALANCE (EOY)					
P.L. 117-328 § 252 (EO 14507 no-year, 1124XN) 2/	$0	$0	$0	$0	$0
P.L. 117-103 § 253 (Infrastructure no-year)	$0	$0	$0	$0	$0
P.L. 115-244 § 248 (NRM no-year)	$0	$0	$0	$0	$0
P.L. 115-141 § 255 (NRM no-year)	$0	$0	$0	$0	$0
P.L. 111-32 (H1N1 no-year)	($7)	$0	($111)	($5)	($123)
P.L. 110-28 (Emergency Supplemental no-year)	($136)	$0	$0	($5,800)	($5,936)
No-Year (all other)	($4,579,519)	$0	$0	($8,252)	($4,587,771)
2-Year	($2,000,000)	($1,512,724)	($251,010)	($409,235)	($4,172,969)
Unobligated Balance (EOY) [sub-total]	($6,579,662)	($1,512,724)	($251,121)	($423,292)	($8,766,799)
OBLIGATIONS [total]	$71,244,944	$31,028,999	$10,669,499	$8,971,923	$121,915,365
FTE	297,651	0	68,045	26,855	392,551

2024 Current Estimate
Dollars in Thousands ($000)

Description	Medical Services	Medical Community Care	Copay Refunds	Medical Care Total	Other Volume II Accounts Construction of State Extended Care Facilities	Grand Total
UNOBLIGATED BALANCE (SOY)						
ARP Act § 8004 (no-year)	$0	$0	$0	$0	$938	$938
ARP Act § 8007 (no-year)	$2,850	$176	$16,861	$19,887	$0	$19,887
Unobligated Balance (SOY) [Subtotal]	$2,850	$176	$16,861	$19,887	$938	$20,825
UNOBLIGATED BALANCE (EOY)						
ARP Act § 8004 (no-year)	$0	$0	$0	$0	$0	$0
ARP Act § 8007 (no-year)	($2,850)	($176)	($16,861)	($19,887)	$0	($19,887)
Unobligated Balance (EOY) [Subtotal]	($2,850)	($176)	($16,861)	($19,887)	$0	($19,887)
OBLIGATIONS [Total]	$0	$0	$0	$0	$938	$938
FTE ARP Act	0	0	0	0	0	0

2024 Current Estimate
Dollars in Thousands ($000)

	Mandatory							
	Medical Care Purposes						Other Purposes	
	Cost of War Toxic Exposure Fund (TEF)							
Description	Medical Services	Community Care	Medical Support & Compliance	Medical Facilities	Medical Facilities	Medical Care Total	TEF Research	Grand Total
MANDATORY APPROPRIATION								
PACT Act § 707	$0	$0	$0	$0	$100,000	$100,000	$0	$100,000
P.L. 118-5 (5-year, TEF)	$9,525,428	$6,740,264	$850,000	$0	$0	$17,115,692	$46,000	$17,161,692
Mandatory Appropriation [Subtotal]	$9,525,428	$6,740,264	$850,000	$0	$100,000	$17,215,692	$46,000	$17,261,692
UNOBLIGATED BALANCE (SOY)								
PACT Act § 705	$0	$0	$0	$0	$229,656	$229,656	$0	$229,656
PACT Act § 707 (base year 2023)	$0	$0	$0	$0	$1,855,998	$1,855,998	$0	$1,855,998
PACT Act § 806 (3-year, TEF)	$0	$0	$26,049	$0	$0	$26,049	$12	$26,061
P.L. 117-328 (5-year, TEF)	$3,815,453	$0	$0	$0	$0	$3,815,453	$226	$3,815,679
Unobligated Balance (EOY) [Subtotal]	$3,815,453	$0	$26,049	$0	$2,085,654	$5,927,156	$238	$5,927,394
REALIGNMENT								
PACT Act § 705	$0	$0	$0	$0	$0	$0	$0	$0
PACT Act § 806 (3-year, TEF)	$0	$0	$0	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (EOY)								
PACT Act § 705	$0	$0	$0	$0	($188,281)	($188,281)	$0	($188,281)
PACT Act § 707 (base year 2023)	$0	$0	$0	$0	($1,772,407)	($1,772,407)	$0	($1,772,407)
PACT Act § 707 (base year 2024+)	$0	$0	$0	$0	$0	$0	$0	$0
P.L. 117-328 (5-year, TEF)	($1,008,075)	$0	$0	$0	$0	($1,008,075)		($1,008,075)
P.L. 118-5 (5-year, base year 2024, TEF)	($1,338,000)	($1,229,354)	$0	$0	$0	($2,567,354)		($2,567,354)
Unobligated Balance (EOY) [Subtotal]	($2,346,075)	($1,229,354)	$0	$0	($1,960,688)	($5,536,117)	$0	($5,536,117)
OBLIGATIONS	$10,994,806	$5,510,910	$876,049	$0	$224,966	$17,606,731	$46,238	$17,652,969
Mandatory FTE PACT Act	0	0	0	0	0	0	113	113

2024 Current Estimate
Dollars in Thousands ($000)

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

Description	Medical Services 0160XA	Medical Support & Compl 0152XA	Medical Facilities 0162XA	Medical Care Total (continued)	Minor Cons. 0111XA	Information Technology Dev. 0167XD	Information Technology Sustain. 0167XO	Information Technology Pay & Adm 0167XZ	Section 801 Grand Total
	Mandatory								
UNOBLIGATED BALANCE (SOY)									
No-Year	$8,817	$3,629	$10,394	$22,840	$8,805	$1,029	$0	$0	$32,674
UNOBLIGATED BALANCE (EOY)									
No-Year	($4,980)	($256)	$0	($5,236)	($8,805)	($1,029)	$0	$0	($15,070)
OBLIGATIONS [Total]	$3,837	$3,373	$10,394	$17,604	$0	$0	$0	$0	$17,604
FTE	31	27	1	59	0	0	0	0	59

2024 Current Estimate
Dollars in Thousands ($000)

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

Description	Admin. 0172XA	Medical Care 0172XB	Emerg. Hepatitis C 0172XC	Emerg. Com. Care 0172XE	Med. Com Care (Mission) 0172XG	Medical Care Total (continued)
	Mandatory					
UNOBLIGATED BALANCE (SOY)						
No-Year	$1,000	$36,056	$0	$101	$267,669	$304,826
UNOBLIGATED BALANCE (EOY)						
No-Year	($1,000)	($36,056)	$0	($101)	($267,669)	($304,826)
OBLIGATIONS [Total]	$0	$0	$0	$0	$0	$0
FTE [Total]	0	0	0	0	0	0

Medical Care Obls., Discretionary	**$121,915,365**
Medical Care Obls., ARP Act	**$0**
Medical Care Obls., Toxic Exposures Fund and PACT Act	**$17,606,731**
Medical Care Obls., VACAA, Section 801	**$17,604**
Medical Care Obls., VACAA, Section 802	**$0**
Medical Care Obligations [Grand Total]	**$139,539,700**
Medical Care FTE, Regular	**392,551**
Medical Care FTE, ARP	**0**
Medical Care Obls., Toxic Exposures Fund and PACT Act	**0**
Medical Care FTE, VACAA, Section 801	**59**
Medical Care FTE, VACAA, Section 802	**0**
Medical Care FTE [Grand Total]	**392,610**

2025 Revised Request Dollars in Thousands ($000)	Discretionary				
Description	Medical Services 0160	Medical Community Care 0140	Medical Support & Compl 0152	Medical Facilities 0162/1124XN	Medical Care Total
APPROPRIATION					
Advance Appropriation	$71,000,000	$20,382,000	$11,800,000	$9,400,000	$112,582,000
Annual Appropriation Adjustment	$0	$0	$0	$0	$0
Appropriation [sub-total]	$71,000,000	$20,382,000	$11,800,000	$9,400,000	$112,582,000
TRANSFERS TO (-)					
Medical Community Care (0140)	($7,307,318)	$0	$0	($600,000)	($7,907,318)
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
JALFHCC (0169)	($384,926)	($93,500)	($42,193)	($66,021)	($586,640)
Transfers to [sub-total]	($7,707,244)	($93,500)	($42,193)	($666,021)	($8,508,958)
TRANSFERS FROM (+)					
Medical Services (0160)	$0	$7,307,318	$0	$0	$7,307,318
Medical Facilities (0162)	$0	$600,000	$0	$0	$600,000
Medical Care Collections Fund (5287)	$3,470,595	$901,747	$0	$0	$4,372,342
Transfers from [sub-total]	$3,470,595	$8,809,065	$0	$0	$12,279,660
REIMBURSEMENTS	$119,759	$0	$64,706	$16,571	$201,036
UNOBLIGATED BALANCE (SOY)					
P.L. 117-328 § 252 (EO 14507 no-year, 1124XN) 1/	$0	$0	$0	$0	$0
P.L. 117-103 § 253 (Infrastructure no-year)	$0	$0	$0	$0	$0
P.L. 115-244 § 248 (NRM no-year)	$0	$0	$0	$0	$0
P.L. 115-141 § 255 (NRM no-year)	$0	$0	$0	$0	$0
P.L. 111-32 (H1N1 no-year)	$7	$0	$111	$5	$123
P.L. 110-28 (Emergency Supplemental no-year)	$136	$0	$0	$5,800	$5,936
No-Year (all other)	$4,579,519	$0	$0	$8,252	$4,587,771
2-Year	$2,000,000	$1,512,724	$251,010	$409,235	$4,172,969
Unobligated Balance (SOY) [sub-total]	$6,579,662	$1,512,724	$251,121	$423,292	$8,766,799
UNOBLIGATED BALANCE (EOY)					
P.L. 117-328 § 252 (EO 14507 no-year, 1124XN) 1/	$0	$0	$0	$0	$0
P.L. 117-103 § 253 (Infrastructure no-year)	$0	$0	$0	$0	$0
P.L. 115-244 § 248 (NRM no-year)	$0	$0	$0	$0	$0
P.L. 115-141 § 255 (NRM no-year)	$0	$0	$0	$0	$0
P.L. 111-32 (H1N1 no-year)	($7)	$0	($111)	($5)	($123)
P.L. 110-28 (Emergency Supplemental no-year)	($136)	$0	$0	($5,800)	($5,936)
No-Year (all other)	$0	$0	$0	($8,252)	($8,252)
2-Year	($1,000,000)	($976,005)	$0	$0	($1,976,005)
Unobligated Balance (EOY) [sub-total]	($1,000,143)	($976,005)	($111)	($14,057)	($1,990,316)
OBLIGATIONS [total]	$72,462,629	$29,634,284	$12,073,523	$9,159,785	$123,330,221
FTE	290,658	0	66,658	25,839	383,155

2025 Revised Request
Dollars in Thousands ($000)

Description	Medical Services	Medical Community Care	Copay Refunds	Medical Care Total	Other Volume II Accounts Construction of State Extended Care Facilities	Grand Total
UNOBLIGATED BALANCE (SOY)						
ARP Act § 8004 (no-year)	$0	$0	$0	$0	$0	$0
ARP Act § 8007 (no-year)	$2,850	$176	$16,861	$19,887	$0	$19,887
Unobligated Balance (SOY) [Subtotal]	$2,850	$176	$16,861	$19,887	$0	$19,887
UNOBLIGATED BALANCE (EOY)						
ARP Act § 8004 (no-year)	$0	$0	$0	$0	$0	$0
ARP Act § 8007 (no-year)	($2,850)	($176)	($16,861)	($19,887)	$0	($19,887)
Unobligated Balance (EOY) [Subtotal]	($2,850)	($176)	($16,861)	($19,887)	$0	($19,887)
OBLIGATIONS [Total]	$0	$0	$0	$0	$0	$0
FTE ARP Act	0	0	0	0	0	0

2025 Revised Request
Dollars in Thousands ($000)

	Mandatory							
	Medical Care Purposes						Other Purposes	
	Cost of War Toxic Exposure Fund (TEF)					Medical Care Total	TEF Research	Grand Total
Description	Medical Services	Community Care	Medical Support & Compliance	Medical Facilities	Medical Facilities			
MANDATORY APPROPRIATION								
PACT Act § 707	$0	$0	$0	$0	$200,000	$200,000	$0	$200,000
P.L. 118-5 (5-year, TEF)	$11,683,896	$9,770,646	$0	$0	$0	$21,454,542	$59,000	$21,513,542
Mandatory Appropriation [Subtotal]	$11,683,896	$9,770,646	$0	$0	$200,000	$21,654,542	$59,000	$21,713,542
UNOBLIGATED BALANCE (SOY)								
PACT Act § 705	$0	$0	$0	$0	$188,281	$188,281	$0	$188,281
PACT Act § 707 (base year 2023)	$0	$0	$0	$0	$1,772,407	$1,772,407	$0	$1,772,407
PACT Act § 707 (base year 2024+)	$0	$0	$0	$0	$0	$0	$0	$0
P.L. 117-328 (5-year, TEF)	$1,008,075	$0	$0	$0	$0	$1,008,075	$0	$1,008,075
P.L. 118-5 (5-year, base year 2024, TEF)	$1,338,000	$1,229,354	$0	$0	$0	$2,567,354	$0	$2,567,354
Unobligated Balance (EOY) [Subtotal]	$2,346,075	$1,229,354	$0	$0	$1,960,688	$5,536,117	$0	$5,536,117
UNOBLIGATED BALANCE (EOY)								
PACT Act § 705	$0	$0	$0	$0	($147,673)	($147,673)	$0	($147,673)
PACT Act § 707 (base year 2023)	$0	$0	$0	$0	($982,218)	($982,218)		($982,218)
PACT Act § 707 (base year 2024+)	$0	$0	$0	$0	($181,631)	($181,631)	$0	($181,631)
P.L. 117-328 (5-year, TEF)	$0	$0	$0	$0	$0	$0	$0	$0
P.L. 118-5 (5-year, base year 2024, TEF)	$0	$0	$0	$0	$0	$0	$0	$0
P.L. 118-5 (5-year, base year 2025, TEF)	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	$0	$0	$0	$0	($1,311,522)	($1,311,522)	$0	($1,311,522)
OBLIGATIONS	$14,029,971	$11,000,000	$0	$0	$849,166	$25,879,137	$59,000	$25,938,137
Mandatory FTE PACT Act	0	0	0	0	0	0	113	113

2025 Revised Request
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	Sustain. 0167XO	Pay & Adm 0167XZ	Section 801 Grand Total
UNOBLIGATED BALANCE (SOY)									
No-Year	$4,980	$256	$0	$5,236	$8,805	$1,029	$0	$0	$15,070
UNOBLIGATED BALANCE (EOY)									
No-Year	$0	$0	$0	$0	($8,805)	($1,029)	$0	$0	($9,834)
OBLIGATIONS [Total]	$4,980	$256	$0	$5,236	$0	$0	$0	$0	$5,236
FTE	31	0	0	31	0	0	0	0	31

2025 Revised Request
Dollars in Thousands ($000)

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

Description	Mandatory: Admin. 0172XA	Medical Care 0172XB	Emerg. Hepatitis C 0172XC	Emerg. Com. Care 0172XE	Med. Com Care (Mission) 0172XG	Medical Care Total (continued)
UNOBLIGATED BALANCE (SOY)						
No-Year	$1,000	$36,056	$0	$101	$267,669	$304,826
UNOBLIGATED BALANCE (EOY)						
No-Year	$0	$0	$0	$0	$0	$0
OBLIGATIONS [Total]	$1,000	$36,056	$0	$101	$267,669	$304,826
FTE [Total]	0	0	0	0	0	0

Medical Care Obls., Discretionary	**$123,330,221**
Medical Care Obls., ARP Act	**$0**
Medical Care Obls., Toxic Exposures Fund and PACT Act	**$25,879,137**
Medical Care Obls., VACAA, Section 801	**$5,236**
Medical Care Obls., VACAA, Section 802	**$304,826**
Medical Care Obligations [Grand Total]	**$149,519,420**
Medical Care FTE, Regular	**383,155**
Medical Care FTE, ARP	**0**
Medical Care Obls., Toxic Exposures Fund and PACT Act	**0**
Medical Care FTE, VACAA, Section 801	**31**
Medical Care FTE, VACAA, Section 802	**0**
Medical Care FTE [Grand Total]	**383,186**

2026 Advance Appropriation Dollars in Thousands ($000)	Discretionary				
Description	Medical Services 0160	Medical Community Care 0140	Medical Support & Compl 0152	Medical Facilities 0162/1124XN	Medical Care Total
APPROPRIATION					
Advance Appropriation	$75,039,000	$34,000,000	$12,700,000	$9,700,000	$131,439,000
Appropriation [sub-total]	$75,039,000	$34,000,000	$12,700,000	$9,700,000	$131,439,000
TRANSFERS TO (-)					
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
JALFHCC (0169)	($423,401)	($107,000)	($44,302)	($69,322)	($644,025)
Transfers to [sub-total]	($438,401)	($107,000)	($44,302)	($69,322)	($659,025)
TRANSFERS FROM (+)					
Medical Care Collections Fund (5287)	$3,572,320	$926,380	$0	$0	$4,498,700
Transfers from [sub-total]	$3,572,320	$926,380	$0	$0	$4,498,700
REIMBURSEMENTS	$119,759	$0	$64,706	$16,571	$201,036
UNOBLIGATED BALANCE (SOY)					
P.L. 117-328 § 252 (EO 14507 no-year, 1124XN) 1/	$0	$0	$0	$0	$0
P.L. 117-103 § 253 (Infrastructure no-year)	$0	$0	$0	$0	$0
P.L. 115-244 § 248 (NRM no-year)	$0	$0	$0	$0	$0
P.L. 115-141 § 255 (NRM no-year)	$0	$0	$0	$0	$0
P.L. 111-32 (H1N1 no-year)	$7	$0	$111	$5	$123
P.L. 110-28 (Emergency Supplemental no-year)	$136	$0	$0	$5,800	$5,936
No-Year (all other)	$0	$0	$0	$8,252	$8,252
2-Year	$1,000,000	$976,005	$0	$0	$1,976,005
Unobligated Balance (SOY) [sub-total]	$1,000,143	$976,005	$111	$14,057	$1,990,316
UNOBLIGATED BALANCE (EOY)					
P.L. 117-328 § 252 (EO 14507 no-year, 1124XN) 1/	$0	$0	$0	$0	$0
P.L. 117-103 § 253 (Infrastructure no-year)	$0	$0	$0	$0	$0
P.L. 115-244 § 248 (NRM no-year)	$0	$0	$0	$0	$0
P.L. 115-141 § 255 (NRM no-year)	$0	$0	$0	$0	$0
P.L. 111-32 (H1N1 no-year)	($7)	$0	($111)	($5)	($123)
P.L. 110-28 (Emergency Supplemental no-year)	($136)	$0	$0	($5,800)	($5,936)
No-Year (all other)	$0	$0	$0	($8,252)	($8,252)
2-Year	($1,000,000)	($976,005)	$0	$0	($1,976,005)
Unobligated Balance (EOY) [sub-total]	($1,000,143)	($976,005)	($111)	($14,057)	($1,990,316)
OBLIGATIONS [total]	$78,292,678	$34,819,380	$12,720,404	$9,647,249	$135,479,711
FTE	290,372	0	66,589	25,790	382,751

2026 Advance Appropriation
Dollars in Thousands ($000)

Description	Medical Services	Medical Community Care	Copay Refunds	Medical Care Total	Other Volume II Accounts Construction of State Extended Care Facilities	Grand Total
UNOBLIGATED BALANCE (SOY)						
ARP Act § 8004 (no-year)	$0	$0	$0	$0	$0	$0
ARP Act § 8007 (no-year)	$2,850	$176	$16,861	$19,887	$0	$19,887
Unobligated Balance (SOY) [Subtotal]	$2,850	$176	$16,861	$19,887	$0	$19,887
UNOBLIGATED BALANCE (EOY)						
ARP Act § 8004 (no-year)	$0	$0	$0	$0	$0	$0
ARP Act § 8007 (no-year)	($2,850)	($176)	($16,861)	($19,887)	$0	($19,887)
Unobligated Balance (EOY) [Subtotal]	($2,850)	($176)	($16,861)	($19,887)	$0	($19,887)
OBLIGATIONS [Total]	$0	$0	$0	$0	$0	$0
FTE ARP Act	0	0	0	0	0	0

2026 Advance Appropriation
Dollars in Thousands ($000)

	Mandatory							
	Medical Care Purposes						Other Purposes	
	Cost of War Toxic Exposure Fund (TEF)					Medical Care	TEF	Grand
Description	Medical Services	Community Care	Medical Support & Compliance	Medical Facilities	Medical Facilities	Total	Research	Total
MANDATORY APPROPRIATION								
PACT Act § 707	$0	$0	$0	$0	$400,000	$400,000	$0	$400,000
Advance Appropriation	$11,800,000	$11,000,000	$0	$0	$0	$22,800,000	$0	$22,800,000
Mandatory Appropriation [Subtotal]	$11,800,000	$11,000,000	$0	$0	$400,000	$23,200,000	$0	$23,200,000
UNOBLIGATED BALANCE (SOY)								
PACT Act § 705	$0	$0	$0	$0	$147,673	$147,673	$0	$147,673
PACT Act § 707 (base year 2023)	$0	$0	$0	$0	$982,218	$982,218	$0	$982,218
PACT Act § 707 (base year 2024+)	$0	$0	$0	$0	$181,631	$181,631	$0	$181,631
P.L. 117-328 (5-year, TEF)	$0	$0	$0	$0	$0	$0	$0	$0
P.L. 118-5 (5-year, base year 2024, TEF)	$0	$0	$0	$0	$0	$0	$0	$0
P.L. 118-5 (5-year, base year 2025, TEF)	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	$0	$0	$0	$0	$1,311,522	$1,311,522	$0	$1,311,522
UNOBLIGATED BALANCE (EOY)								
PACT Act § 705	$0	$0	$0	$0	($130,393)	($130,393)	$0	($130,393)
PACT Act § 707 (base year 2023)	$0	$0	$0	$0	($977,947)	($977,947)	$0	($977,947)
PACT Act § 707 (base year 2024+)	$0	$0	$0	$0	$0	$0	$0	$0
P.L. 117-328 (5-year, TEF)	$0	$0	$0	$0	$0	$0	$0	$0
P.L. 118-5 (5-year, base year 2024, TEF)	$0	$0	$0	$0	$0	$0	$0	$0
P.L. 118-5 (5-year, base year 2025, TEF)	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	$0	$0	$0	$0	($1,108,340)	($1,108,340)	$0	($1,108,340)
OBLIGATIONS	$11,800,000	$11,000,000	$0	$0	$603,182	$23,403,182	$0	$23,403,182
Mandatory FTE PACT Act	0	0	0	0	0	0	0	0

Medical Care Obls., Discretionary	**$135,479,711**
Medical Care Obls., ARP Act	**$0**
Medical Care Obls., Toxic Exposures Fund and PACT Act	**$23,403,182**
Medical Care Obligations [Grand Total]	**$158,882,893**
Medical Care FTE, Regular	**382,751**
Medical Care FTE, ARP	**0**
Medical Care Obls., Toxic Exposures Fund and PACT Act	**0**
Medical Care FTE [Grand Total]	**382,751**

Tables: Obligations by Object Class by Medical Care Category

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 obligations for the Information Technology, Grants for Construction of State Extended Care Facilities, Medical and Prosthetics Research and all other non-VHA Medical Care accounts.

In 2023 obligations from section 8002 of the American Rescue Plan Act are included in the Medical Services, Medical Support and Compliance, Medical Facilities and Medical Community Care as obligations in the Veterans Medical Care and Health Fund. Funding from the Cost of War Toxic Exposures Fund has been included in Medical Services, Medical Support and Compliance, and Medical Community Care categories.

Obligations from the Medical Facilities portion of the Recurring Expenses Transformational Fund are included in the Medical Facilities category. Obligations from the Veterans Choice Fund are included in the Medical Community Care category.

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

(dollars in thousands)

Description	Discretionary Appropriations Medical Services FY 2023	FY 2024	FY 2025	FY 2026	Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA) FY 2023	FY 2024	FY 2025	FY 2026	Mandatory Appropriations American Resuce Plan Act, sec. 8002, 8007 FY 2023	FY 2024	FY 2025	FY 2026
10 Personnel Compensation and Benefits:												
Physicians	$9,046,029	$10,055,350	$10,168,591	$10,552,165	$4,287	$2,309	$2,994	$0	$84,658	$0	$0	$0
Dentists	$387,060	$434,288	$446,182	$469,998	$0	$0	$0	$0	$304	$0	$0	$0
Registered Nurses	$11,850,970	$13,664,030	$14,015,959	$14,775,116	$0	$0	$0	$0	$221,057	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$2,614,733	$3,037,080	$3,202,460	$3,476,927	$44	$24	$31	$0	$19,598	$0	$0	$0
Non-Physician Providers	$3,974,060	$4,535,102	$4,684,079	$4,974,636	$277	$150	$195	$0	$11,052	$0	$0	$0
Health Technicians/Allied Health	$11,207,901	$12,894,586	$13,478,703	$14,500,431	$655	$354	$460	$0	$37,296	$0	$0	$0
Wage Board/Purchase & Hire	$452,775	$511,555	$524,636	$553,017	$0	$0	$0	$0	$367	$0	$0	$0
All Other	$4,193,299	$4,823,135	$4,984,699	$5,299,324	$1,852	$1,000	$1,300	$0	$47,921	$0	$0	$0
Permanent Change of Station	$4,783	$4,880	$4,979	$5,080	$0	$0	$0	$0	$0	$0	$0	$0
Employee Compensation Pay	$281,026	$286,731	$292,552	$298,491	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$44,012,636	$50,246,737	$51,802,840	$54,905,185	$7,115	$3,837	$4,980	$0	$422,253	$0	$0	$0
21 Travel & Transportation of Persons:					$40	$0	$0	$0				
Employee	$64,653	$92,239	$97,929	$101,748	$0	$0	$0	$0	$54	$0	$0	$0
Beneficiary	$1,936,202	$2,011,900	$2,126,009	$2,264,956	$0	$0	$0	$0	$13,958	$0	$0	$0
Other	$40,940	$67,578	$72,281	$75,100	$40	$0	$0	$0	$0	$0	$0	$0
Subtotal	$2,041,795	$2,171,717	$2,296,219	$2,441,804	$40	$0	$0	$0	$14,012	$0	$0	$0
22 Transportation of Things	$34,161	$35,527	$36,948	$38,389	$0	$0	$0	$0	($66)	$0	$0	$0
23 Rent, Communications, and Utilities:												
Rental of Equipment	$300,435	$317,952	$330,670	$343,566	$0	$0	$0	$0	$11	$0	$0	$0
Communications	$499,625	$525,110	$546,114	$567,412	$0	$0	$0	$0	$84	$0	$0	$0
Utilities	$416	$0	$0	$0	$0	$0	$0	$0	$118	$0	$0	$0
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$21,461	$0	$0	$0	$0	$0	$0	$0	$1,485	$0	$0	$0
Subtotal	$821,937	$843,062	$876,784	$910,978	$0	$0	$0	$0	$1,698	$0	$0	$0
24 Printing & Reproduction:	$21,701	$22,569	$23,472	$24,387	$0	$0	$0	$0	$0	$0	$0	$0
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$6,953	$0	$0	$0	$0	$0	$0	$0	$25	$0	$0	$0
Medical and Nursing Care in the Community	$326,400	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Furniture/Equipment	$388,909	$0	$0	$0	$0	$0	$0	$0	$995	$0	$0	$0
Maintenance & Repair Contract Services	$63,005	$0	$0	$0	$0	$0	$0	$0	$124	$0	$0	$0
Care in the Community Hospital Care	($2)	$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	$347,856	$381,591	$419,841	$456,256	$0	$0	$0	$0	$2	$0	$0	$0
Home Oxygen	$208,334	$228,538	$251,447	$273,256	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$29,978	$0	$0	$0	$0	$0	$0	$0	$169	$0	$0	$0
Personal Services Contracts	$106,603	$0	$0	$0	$0	$0	$0	$0	$737	$0	$0	$0
House Staff Disbursing Agreement	$820,057	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Scarce Medical Specialists	$264,991	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Medical Contract Services	$1,867,265	$0	$424,399	$479,548	$16	$0	$0	$0	$5,185	$0	$0	$0
Administrative Contract Services	$1,489,500	$0	$909,043	$0	$6	$0	$0	$0	$2,377	$0	$0	$0
Training Contract Services	$127,619	$0	$0	$0	$47	$0	$0	$0	$0	$0	$0	$0
Caregiver Stipends	$1,232,679	$1,982,190	$2,465,239	$2,983,817	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$12,456	$22,766	$26,113	$29,040	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$7,292,603	$2,615,085	$4,496,082	$4,221,917	$69	$0	$0	$0	$9,614	$0	$0	$0

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

(dollars in thousands)

Description	Discretionary Appropriations Medical Services FY 2023	FY 2024	FY 2025	FY 2026	Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA) FY 2023	FY 2024	FY 2025	FY 2026	Mandatory Appropriations American Resuce Plan Act, sec. 8002, 8007 FY 2023	FY 2024	FY 2025	FY 2026
26 Supplies & Materials:												
Provisions	$139,407	$144,983	$150,782	$156,662	$0	$0	$0	$0	$46	$0	$0	$0
Drugs & Medicines	$9,517,431	$5,039,688	$2,769,114	$3,795,827	$0	$0	$0	$0	$300,422	$0	$0	$0
Blood & Blood Products	$54,698	$61,722	$67,639	$73,540	$0	$0	$0	$0	$2,510	$0	$0	$0
Medical/Dental Supplies	$2,272,038	$2,003,400	$3,576,536	$2,777,267	$0	$0	$0	$0	($34,030)	$0	$0	$0
Operating Supplies	$289,039	$300,601	$312,625	$324,817	($36)	$0	$0	$0	$1,642	$0	$0	$0
Maintenance & Repair Supplies	$45,725	$0	$0	$0	($23)	$0	$0	$0	$22	$0	$0	$0
Other Supplies	$252,302	$262,394	$272,890	$283,533	$49	$0	$0	$0	$152	$0	$0	$0
Prosthetic Appliances	$3,479,904	$3,817,385	$4,200,037	$4,564,326	$0	$0	$0	$0	($1)	$0	$0	$0
Home Respiratory Therapy	$249,306	$273,484	$300,897	$326,996	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$16,299,850	$11,903,657	$11,650,520	$12,302,968	-$10	$0	$0	$0	$270,763	$0	$0	$0
31 Equipment	$1,930,478	$2,128,700	$0	$2,158,499	$92	$0	$0	$0	$3,278	$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	$3,211	$3,339	$3,473	$3,608	$0	$0	$0	$0	$122	$0	$0	$0
Subtotal	$3,211	$3,339	$3,473	$3,608	$0	$0	$0	$0	$122	$0	$0	$0
41 Grants, Subsidies & Contributions:												
State Home	$439	$457	$475	$494	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$1,143,814	$1,245,567	$1,246,148	$1,253,624	$0	$0	$0	$0	$11,521	$0	$0	$0
Veteran Adoption Reimbursement	$2	$2	$2	$2	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,144,255	$1,246,026	$1,246,625	$1,254,120	$0	$0	$0	$0	$11,521	$0	$0	$0
42 - Insurance Claims and Indemnities	$27,428	$28,525	$29,666	$30,823	$0	$0	$0	$0	$0	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$73,630,055	$71,244,944	$72,462,629	$78,292,678	$7,306	$3,837	$4,980	$0	$733,195	$0	$0	$0
Prior Year Recoveries	$106,124	$0	$0	$0	$61	$0	$0	$0	$86,297	$0	$0	$0
Obligations [Total]	**$73,736,179**	**$71,244,944**	**$72,462,629**	**$78,292,678**	**$7,367**	**$3,837**	**$4,980**	**$0**	**$819,492**	**$0**	**$0**	**$0**

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

Description	Mandatory Appropriations Cost of War Toxic Exposures Fund FY 2023	FY 2024	FY 2025	FY 2026	Discretionary and Mandatory Grand Total Medical Services Category FY 2023	FY 2024	FY 2025	FY 2026
10 Personnel Compensation and Benefits:								
Physicians	$0	$0	$0	$0	$9,134,974	$10,057,659	$10,171,585	$10,552,165
Dentists	$0	$0	$0	$0	$387,364	$434,288	$446,182	$469,998
Registered Nurses	$0	$0	$0	$0	$12,072,027	$13,664,030	$14,015,959	$14,775,116
LP Nurse/LV Nurse/Nurse Assistant	$0	$0	$0	$0	$2,634,375	$3,037,104	$3,202,491	$3,476,927
Non-Physician Providers	$0	$0	$0	$0	$3,985,389	$4,535,252	$4,684,274	$4,974,636
Health Technicians/Allied Health	$0	$0	$0	$0	$11,245,852	$12,894,940	$13,479,163	$14,500,431
Wage Board/Purchase & Hire	$0	$0	$0	$0	$453,142	$511,555	$524,636	$553,017
All Other	$0	$0	$0	$0	$4,243,072	$4,824,135	$4,985,999	$5,299,324
Permanent Change of Station	$0	$0	$0	$0	$4,783	$4,880	$4,979	$5,080
Employee Compensation Pay	$0	$0	$0	$0	$281,026	$286,731	$292,552	$298,491
Subtotal	$0	$0	$0	$0	$44,442,004	$50,250,574	$51,807,820	$54,905,185
21 Travel & Transportation of Persons:								
Employee	$0	$0	$0	$0	$64,707	$92,239	$97,929	$101,748
Beneficiary	$0	$0	$0	$0	$1,950,160	$2,011,900	$2,126,009	$2,264,956
Other	$0	$0	$0	$0	$40,980	$67,578	$72,281	$75,100
Subtotal	$0	$0	$0	$0	$2,055,847	$2,171,717	$2,296,219	$2,441,804
22 Transportation of Things	$0	$0	$0	$0	$34,095	$35,527	$36,948	$38,389
23 Rent, Communications, and Utilities:								
Rental of Equipment	$0	$0	$0	$0	$300,446	$317,952	$330,670	$343,566
Communications	$0	$0	$0	$0	$499,709	$525,110	$546,114	$567,412
Utilities	$0	$0	$0	$0	$534	$0	$0	$0
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$0	$0	$0	$0	$22,946	$0	$0	$0
Subtotal	$0	$0	$0	$0	$823,635	$843,062	$876,784	$910,978
24 Printing & Reproduction:	$0	$0	$0	$0	$21,701	$22,569	$23,472	$24,387
25 Other Contractual Services:								
Care in the Community Outpatient Dental Care	$0	$6,953	$7,231	$7,513	$6,978	$6,953	$7,231	$7,513
Medical and Nursing Care in the Community	$0	$326,400	$339,456	$352,695	$326,400	$326,400	$339,456	$352,695
Repairs to Furniture/Equipment	$0	$388,909	$404,465	$420,239	$389,904	$388,909	$404,465	$420,239
Maintenance & Repair Contract Services	$0	$63,005	$65,525	$68,080	$63,129	$63,005	$65,525	$68,080
Care in the Community Hospital Care	$0	$0	$0	$0	-$2	$0	$0	$0
Community Nursing Homes	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$0	$0	$0	$0	$347,858	$381,591	$419,841	$456,256
Home Oxygen	$0	$0	$0	$0	$208,334	$228,538	$251,447	$273,256
Organ Procurement	$0	$29,978	$31,177	$32,393	$30,147	$29,978	$31,177	$32,393
Personal Services Contracts	$0	$106,603	$110,867	$115,191	$107,340	$106,603	$110,867	$115,191
House Staff Disbursing Agreement	$0	$820,057	$852,859	$886,121	$820,057	$820,057	$852,859	$886,121
Scarce Medical Specialists	$0	$264,991	$275,591	$286,339	$264,991	$264,991	$275,591	$286,339
Other Medical Contract Services	$0	$1,670,890	$0	$0	$1,872,466	$1,670,890	$424,399	$479,548
Administrative Contract Services	$14,999	$1,489,500	$580,457	$493,529	$1,506,882	$1,489,500	$1,489,500	$493,529
Training Contract Services	$0	$127,619	$132,724	$137,900	$127,666	$127,619	$132,724	$137,900
Caregiver Stipends	$0	$0	$0	$0	$1,232,679	$1,982,190	$2,465,239	$2,983,817
CHAMPVA	$0	$0	$0	$0	$12,456	$22,766	$26,113	$29,040
Subtotal	$14,999	$5,294,905	$2,800,352	$2,800,000	$7,317,285	$7,909,990	$7,296,434	$7,021,917

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

(dollars in thousands)

Description	Mandatory Appropriations Cost of War Toxic Exposures Fund FY 2023	FY 2024	FY 2025	FY 2026	Discretionary and Mandatory Grand Total Medical Services Category FY 2023	FY 2024	FY 2025	FY 2026
26 Supplies & Materials:								
Provisions	$0	$0	$0	$0	$139,453	$144,983	$150,782	$156,662
Drugs & Medicines	$0	$5,699,901	$9,000,000	$9,000,000	$9,817,853	$10,739,589	$11,769,114	$12,795,827
Blood & Blood Products	$0	$0	$0	$0	$57,208	$61,722	$67,639	$73,540
Medical/Dental Supplies	$0	$0	$0	$0	$2,238,008	$2,003,400	$3,576,536	$2,777,267
Operating Supplies	$0	$0	$0	$0	$290,645	$300,601	$312,625	$324,817
Maintenance & Repair Supplies	$0	$0	$0	$0	$45,724	$0	$0	$0
Other Supplies	$0	$0	$0	$0	$252,503	$262,394	$272,890	$283,533
Prosthetic Appliances	$0	$0	$0	$0	$3,479,903	$3,817,385	$4,200,037	$4,564,326
Home Respiratory Therapy	$0	$0	$0	$0	$249,306	$273,484	$300,897	$326,996
Subtotal	$0	$5,699,901	$9,000,000	$9,000,000	$16,570,603	$17,603,558	$20,650,520	$21,302,968
31 Equipment	$0	$0	$2,229,619	$0	$1,933,848	$2,128,700	$2,229,619	$2,158,499
32 Lands & Structures:								
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$0	$0	$0	$0	$3,333	$3,339	$3,473	$3,608
Subtotal	$0	$0	$0	$0	$3,333	$3,339	$3,473	$3,608
41 Grants, Subsidies & Contributions:								
State Home	$0	$0	$0	$0	$439	$457	$475	$494
Grants	$0	$0	$0	$0	$1,155,335	$1,245,567	$1,246,148	$1,253,624
Veteran Adoption Reimbursement	$0	$0	$0	$0	$2	$2	$2	$2
Subtotal	$0	$0	$0	$0	$1,155,776	$1,246,026	$1,246,625	$1,254,120
42 - Insurance Claims and Indemnities	$0	$0	$0	$0	$27,428	$28,525	$29,666	$30,823
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$14,999	$10,994,806	$14,029,971	$11,800,000	$74,385,555	$82,243,587	$86,497,580	$90,092,678
Prior Year Recoveries	$0	$0	$0	$0	$192,482	$0	$0	$0
Obligations [Total]	**$14,999**	**$10,994,806**	**$14,029,971**	**$11,800,000**	**$74,578,037**	**$82,243,587**	**$86,497,580**	**$90,092,678**

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

Description	Discretionary Appropriations Medical Support And Compliance				Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA)				Mandatory Appropriations American Resuce Plan Act, sec. 8002			
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026
10 Personnel Compensation and Benefits:												
Physicians	$326,760	$360,755	$378,044	$399,714	$622	$654	$0	$0	$10,223	$0	$0	$0
Dentists	$4,996	$5,522	$5,757	$6,080	$0	$0	$0	$0	$161	$0	$0	$0
Registered Nurses	$698,122	$794,944	$824,995	$871,495	$218	$229	$0	$0	$36,085	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$7,127	$7,717	$7,623	$7,645	$16	$17	$0	$0	$492	$0	$0	$0
Non-Physician Providers	$71,130	$82,826	$86,821	$92,551	$79	$83	$0	$0	$4,852	$0	$0	$0
Health Technicians/Allied Health	$175,142	$197,554	$208,702	$224,388	$40	$42	$0	$0	$4,977	$0	$0	$0
Wage Board/Purchase & Hire	$98,322	$110,634	$114,013	$119,501	$0	$0	$0	$0	$4,656	$0	$0	$0
All Other	$5,835,234	$7,369,691	$7,495,439	$7,933,138	$2,215	$2,330	$0	$0	$425,793	$0	$0	$0
Permanent Change of Station	$9,972	$10,174	$10,381	$10,592	$0	$0	$0	$0	$0	$0	$0	$0
Employee Compensation Pay	$36,732	$38,464	$39,245	$40,042	$0	$0	$0	$0	$967	$0	$0	$0
Subtotal	$7,263,537	$8,978,281	$9,171,020	$9,705,146	$3,190	$3,355	$0	$0	$488,206	$0	$0	$0
21 Travel & Transportation of Persons:												
Employee	$67,656	$70,362	$73,176	$76,030	$33	$0	$0	$0	$51	$0	$0	$0
Beneficiary	$351	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other	$7,036	$7,317	$7,610	$7,907	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$75,043	$77,679	$80,786	$83,937	$33	$0	$0	$0	$51	$0	$0	$0
22 Transportation of Things	$19,186	$19,953	$20,751	$21,560	$0	$0	$0	$0	$923	$0	$0	$0
23 Rent, Communications, and Utilities:												
Rental of Equipment	$75,206	$81,714	$84,983	$88,297	$0	$0	$0	$0	$1,556	$0	$0	$0
Communications	$79,663	$86,350	$89,804	$93,306	$0	$0	$0	$0	$2,374	$0	$0	$0
Utilities	$14	$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	$5,775	$0	$0	$0	$0	$0	$0	$0	-$268	$0	$0	$0
Subtotal	$160,658	$168,064	$174,787	$181,603	$0	$0	$0	$0	$3,662	$0	$0	$0
24 Printing & Reproduction:	$25,061	$26,063	$27,106	$28,163	$0	$0	$0	$0	$244	$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	$2,309	$0	$0	$0	$0	$0	$0	$0	$65	$0	$0	$0
Repairs to Furniture/Equipment	$2,330	$2,423	$2,520	$2,618	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Contract Services	$3,084	$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	$12,092	$12,576	$13,079	$13,589	$0	$0	$0	$0	$80	$0	$0	$0
House Staff Disbursing Agreement	$17	$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	$17,415	$18,112	$18,836	$19,571	$0	$0	$0	$0	$120	$0	$0	$0
Administrative Contract Services	$1,796,199	$1,062,386	$2,247,963	$2,340,751	$1	$18	$256	$0	$4,654	$0	$0	$0
Training Contract Services	$54,178	$56,345	$58,599	$60,884	$22	$0	$0	$0	$270	$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	$1,887,624	$1,151,842	$2,340,997	$2,437,413	$23	$18	$256	$0	$5,189	$0	$0	$0

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

(dollars in thousands)

Description	Discretionary Appropriations Medical Support And Compliance				Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA)				Mandatory Appropriations American Resuce Plan Act, sec. 8002			
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026
26 Supplies & Materials:												
Provisions	$2,559	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Drugs & Medicines	$22	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$1,502	$0	$0	$0	$12	$0	$0	$0	$49	$0	$0	$0
Operating Supplies	$42,000	$52,180	$54,267	$56,383	$70	$0	$0	$0	$1,267	$0	$0	$0
Maintenance & Repair Supplies	$740	$0	$0	$0	$2	$0	$0	$0	$0	$0	$0	$0
Other Supplies	$82,734	$94,543	$98,325	$102,160	$22	$0	$0	$0	$2,686	$0	$0	$0
Prosthetic Appliances	$2	$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	$129,559	$146,723	$152,592	$158,543	$106	$0	$0	$0	$4,002	$0	$0	$0
31 Equipment	$67,806	$74,859	$78,408	$75,907	$191	$0	$0	$0	$9	$0	$0	$0
32 Lands & Structures:												
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$1,222	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,222	$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	$2	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$2	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
42 - Insurance Claims and Indemnities	$25,034	$26,035	$27,076	$28,132	$0	$0	$0	$0	$18	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$9,654,732	$10,669,499	$12,073,523	$12,720,404	$3,543	$3,373	$256	$0	$502,304	$0	$0	$0
Prior Year Recoveries	$28	$0	$0	$0	$0	$0	$0	$0	$53,382	$0	$0	$0
Obligations [Total]	**$9,654,760**	**$10,669,499**	**$12,073,523**	**$12,720,404**	**$3,543**	**$3,373**	**$256**	**$0**	**$555,686**	**$0**	**$0**	**$0**

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

Description	Mandatory Appropriations Cost of War Toxic Exposures Fund				Discretionary and Mandatory Grand Total Medical Support And Compliance Category			
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026
10 Personnel Compensation and Benefits:								
Physicians	$0	$0	$0	$0	$337,605	$361,409	$378,044	$399,714
Dentists	$0	$0	$0	$0	$5,157	$5,522	$5,757	$6,080
Registered Nurses	$0	$0	$0	$0	$734,425	$795,173	$824,995	$871,495
LP Nurse/LV Nurse/Nurse Assistant	$0	$0	$0	$0	$7,635	$7,734	$7,623	$7,645
Non-Physician Providers	$0	$0	$0	$0	$76,061	$82,909	$86,821	$92,551
Health Technicians/Allied Health	$0	$0	$0	$0	$180,159	$197,596	$208,702	$224,388
Wage Board/Purchase & Hire	$0	$0	$0	$0	$102,978	$110,634	$114,013	$119,501
All Other	$0	$0	$0	$0	$6,263,242	$7,372,021	$7,495,439	$7,933,138
Permanent Change of Station	$0	$0	$0	$0	$9,972	$10,174	$10,381	$10,592
Employee Compensation Pay	$0	$0	$0	$0	$37,699	$38,464	$39,245	$40,042
Subtotal	$0	$0	$0	$0	$7,754,933	$8,981,636	$9,171,020	$9,705,146
21 Travel & Transportation of Persons:								
Employee	$0	$0	$0	$0	$67,740	$70,362	$73,176	$76,030
Beneficiary	$0	$0	$0	$0	$351	$0	$0	$0
Other	$0	$0	$0	$0	$7,036	$7,317	$7,610	$7,907
Subtotal	$0	$0	$0	$0	$75,127	$77,679	$80,786	$83,937
22 Transportation of Things	$0	$0	$0	$0	$20,109	$19,953	$20,751	$21,560
23 Rent, Communications, and Utilities:								
Rental of Equipment	$0	$0	$0	$0	$76,762	$81,714	$84,983	$88,297
Communications	$0	$0	$0	$0	$82,037	$86,350	$89,804	$93,306
Utilities	$0	$0	$0	$0	$14	$0	$0	$0
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$0	$0	$0	$0	$5,507	$0	$0	$0
Subtotal	$0	$0	$0	$0	$164,320	$168,064	$174,787	$181,603
24 Printing & Reproduction:	$0	$0	$0	$0	$25,305	$26,063	$27,106	$28,163
25 Other Contractual Services:								
Care in the Community Outpatient Dental Care	$0	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$0	$0	$0	$0	$2,374	$0	$0	$0
Repairs to Furniture/Equipment	$0	$0	$0	$0	$2,330	$2,423	$2,520	$2,618
Maintenance & Repair Contract Services	$0	$0	$0	$0	$3,084	$0	$0	$0
Care in the Community Hospital Care	$0	$0	$0	$0	$0	$0	$0	$0
Community Nursing Homes	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$0	$0	$0	$0	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$0	$0	$0	$0	$12,172	$12,576	$13,079	$13,589
House Staff Disbursing Agreement	$0	$0	$0	$0	$17	$0	$0	$0
Scarce Medical Specialists	$0	$0	$0	$0	$0	$0	$0	$0
Other Medical Contract Services	$0	$0	$0	$0	$17,535	$18,112	$18,836	$19,571
Administrative Contract Services	$0	$876,049	$0	$0	$1,800,854	$1,938,453	$2,248,219	$2,340,751
Training Contract Services	$0	$0	$0	$0	$54,470	$56,345	$58,599	$60,884
Caregiver Stipends	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$876,049	$0	$0	$1,892,836	$2,027,909	$2,341,253	$2,437,413

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

(dollars in thousands)

Description	Mandatory Appropriations Cost of War Toxic Exposures Fund FY 2023	FY 2024	FY 2025	FY 2026	Discretionary and Mandatory Grand Total Medical Support And Compliance Category FY 2023	FY 2024	FY 2025	FY 2026
26 Supplies & Materials:								
Provisions	$0	$0	$0	$0	$2,559	$0	$0	$0
Drugs & Medicines	$0	$0	$0	$0	$22	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$0	$0	$0	$0	$1,563	$0	$0	$0
Operating Supplies	$0	$0	$0	$0	$43,337	$52,180	$54,267	$56,383
Maintenance & Repair Supplies	$0	$0	$0	$0	$742	$0	$0	$0
Other Supplies	$0	$0	$0	$0	$85,442	$94,543	$98,325	$102,160
Prosthetic Appliances	$0	$0	$0	$0	$2	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$133,667	$146,723	$152,592	$158,543
31 Equipment	$0	$0	$0	$0	$68,006	$74,859	$78,408	$75,907
32 Lands & Structures:								
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$0	$0	$0	$0	$1,222	$0	$0	$0
Subtotal	$0	$0	$0	$0	$1,222	$0	$0	$0
41 Grants, Subsidies & Contributions:								
State Home	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$0	$0	$0	$0	$0	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$2	$0	$0	$0
Subtotal	$0	$0	$0	$0	$2	$0	$0	$0
42 - Insurance Claims and Indemnities	$0	$0	$0	$0	$25,052	$26,035	$27,076	$28,132
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$876,049	$0	$0	$10,160,579	$11,548,921	$12,073,779	$12,720,404
Prior Year Recoveries	$0	$0	$0	$0	$53,410	$0	$0	$0
Obligations [Total]	**$0**	**$876,049**	**$0**	**$0**	**$10,213,989**	**$11,548,921**	**$12,073,779**	**$12,720,404**

Obligations by Object - Medical Facilities Category (MF) Part 1 of 3
(dollars in thousands)

Description	Discretionary Appropriations Medical Facilities				Discretionary Appropriations Recurring Expenses Transformational Funding				Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA)			
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026
10 Personnel Compensation and Benefits:												
Physicians	-$92	$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	$794	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$61	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Physician Providers	-$67	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Health Technicians/Allied Health	$12,340	$17,486	$17,896	$19,446	$0	$0	$0	$0	$0	$0	$0	$0
Wage Board/Purchase & Hire	$1,563,791	$2,176,970	$2,195,539	$2,347,590	$0	$0	$0	$0	$69	$73	$0	$0
All Other	$513,354	$720,015	$727,040	$778,399	$0	$0	$0	$0	$0	$0	$0	$0
Permanent Change of Station	$643	$656	$669	$683	$0	$0	$0	$0	$0	$0	$0	$0
Employee Compensation Pay	$33,544	$34,505	$35,205	$35,920	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$2,124,368	$2,949,632	$2,976,349	$3,182,038	$0	$0	$0	$0	$69	$73	$0	$0
21 Travel & Transportation of Persons:												
Employee	$6,606	$6,870	$7,145	$7,424	$0	$0	$0	$0	$0	$0	$0	$0
Beneficiary	$218	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other	$56,800	$59,072	$61,435	$63,831	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$63,624	$65,942	$68,580	$71,255	$0	$0	$0	$0	$0	$0	$0	$0
22 Transportation of Things	$17,907	$18,623	$19,368	$20,123	$0	$0	$0	$0	$0	$0	$0	$0
23 Rent, Communications, and Utilities:												
Rental of Equipment	$15,929	$16,566	$17,229	$17,901	$0	$0	$0	$0	$0	$0	$0	$0
Communications	$33,884	$35,239	$36,649	$38,078	$0	$0	$0	$0	$0	$0	$0	$0
Utilities	$627,267	$731,358	$760,612	$790,276	$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	$911,742	$1,043,295	$1,207,674	$1,317,808	$0	$0	$0	$0	$1	$1	$0	$0
Subtotal	$1,588,822	$1,826,458	$2,022,164	$2,164,063	$0	$0	$0	$0	$1	$1	$0	$0
24 Printing & Reproduction:	$94	$98	$102	$106	$0	$0	$0	$0	$0	$0	$0	$0
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$7	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$69	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Furniture/Equipment	$23,370	$24,305	$25,277	$26,263	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Contract Services	$376,544	$411,939	$428,417	$454,550	$0	$0	$0	$0	$29	$30	$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	$1	$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	$5	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$5,230	$5,439	$5,657	$5,878	$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	$16,573	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Administrative Contract Services	$638,383	$746,862	$465,680	$739,480	$0	$0	$0	$0	$266	$9,981	$0	$0
Training Contract Services	$2,250	$2,340	$2,434	$2,529	$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	$1,062,432	$1,190,885	$927,465	$1,228,700	$0	$0	$0	$0	$295	$10,011	$0	$0

Obligations by Object - Medical Facilities Category (MF) Part 1 of 3

(dollars in thousands)

Description	Discretionary Appropriations Medical Facilities				Discretionary Appropriations Recurring Expenses Transformational Funding				Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA)			
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026
26 Supplies & Materials:												
Provisions	$57	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Drugs & Medicines	$658	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$3,589	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Operating Supplies	$172,498	$181,398	$188,654	$196,012	$0	$0	$0	$0	$37	$38	$0	$0
Maintenance & Repair Supplies	$214,073	$224,636	$234,621	$243,771	$0	$0	$0	$0	$157	$163	$0	$0
Other Supplies	$81,364	$86,619	$90,084	$93,597	$0	$0	$0	$0	$0	$0	$0	$0
Prosthetic Appliances	$24	$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	$472,263	$492,653	$513,359	$533,380	$0	$0	$0	$0	$194	$201	$0	$0
31 Equipment	$141,504	$156,895	$161,871	$156,708	$0	$0	$0	$0	$104	$108	$0	$0
32 Lands & Structures:												
Non-Recurring Maintenance	$2,998,988	$1,925,000	$2,000,000	$2,000,000	$0	$75,000	$0	$0	-$149	$0	$0	$0
All Other Lands & Structures	$208,928	$262,700	$462,169	$282,192	$0	$0	$0	$0	-$24	$0	$0	$0
Subtotal	$3,207,916	$2,187,700	$2,462,169	$2,282,192	$0	$75,000	$0	$0	-$173	$0	$0	$0
41 Grants, Subsidies & Contributions:												
State Home	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$2	$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	$2	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
42 - Insurance Claims and Indemnities	$9,651	$8,037	$8,358	$8,684	$0	$0	$0	$0	$0	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$8,688,583	$8,896,923	$9,159,785	$9,647,249	$0	$75,000	$0	$0	$490	$10,394	$0	$0
Prior Year Recoveries	$21,358	$0	$0	$0	$0	$0	$0	$0	$568	$0	$0	$0
Obligations [Total]	**$8,709,941**	**$8,896,923**	**$9,159,785**	**$9,647,249**	**$0**	**$75,000**	**$0**	**$0**	**$1,058**	**$10,394**	**$0**	**$0**

Obligations by Object - Medical Facilities Category (MF) Part 2 of 3
(dollars in thousands)

Description	Mandatory Appropriations American Resuce Plan Act, sec. 8002				Mandatory Appropriations PACT Act, sec. 705				Mandatory Appropriations PACT Act, sec. 707			
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026
10 Personnel Compensation and Benefits:												
Physicians	$100	$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	$180	$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	$175	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Health Technicians/Allied Health	$2,706	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Wage Board/Purchase & Hire	$322,760	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
All Other	$110,180	$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	$274	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$436,375	$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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other	$1,445	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,445	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
22 Transportation of Things	$332	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
23 Rent, Communications, and Utilities:												
Rental of Equipment	$1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Communications	$2,869	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Utilities	$39,744	$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	$47,427	$0	$0	$0	$0	$0	$0	$0	$0	$4,271	$16,998	$17,661
Subtotal	$90,041	$0	$0	$0	$0	$0	$0	$0	$0	$4,271	$16,998	$17,661
24 Printing & Reproduction:	$2	$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	-$298	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Contract Services	$6,514	$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	$138	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Administrative Contract Services	$15,428	$0	$0	$0	$10,190	$12,960	$12,960	$9,720	$0	$28,683	$5,642	$0
Training Contract Services	$2	$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	$21,784	$0	$0	$0	$10,190	$12,960	$12,960	$9,720	$0	$28,683	$5,642	$0

Obligations by Object - Medical Facilities Category (MF) Part 2 of 3
(dollars in thousands)

Description	Mandatory Appropriations American Resuce Plan Act, sec. 8002				Mandatory Appropriations PACT Act, sec. 705				Mandatory Appropriations PACT Act, sec. 707			
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026
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	$2,426	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Supplies	$4,863	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Supplies	$2,018	$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	$9,307	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
31 Equipment	$2,034	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
32 Lands & Structures:												
Non-Recurring Maintenance	$189,046	$0	$0	$0	$35,359	$28,415	$27,648	$7,560	$0	$0	$0	$0
All Other Lands & Structures	$23,667	$0	$0	$0	$0	$0	$0	$0	$24,002	$150,637	$785,918	$568,241
Subtotal	$212,713	$0	$0	$0	$35,359	$28,415	$27,648	$7,560	$24,002	$150,637	$785,918	$568,241
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	-$1,990	$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	$772,043	$0	$0	$0	$45,549	$41,375	$40,608	$17,280	$24,002	$183,591	$808,558	$585,902
Prior Year Recoveries	$43,711	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	**$815,754**	**$0**	**$0**	**$0**	**$45,549**	**$41,375**	**$40,608**	**$17,280**	**$24,002**	**$183,591**	**$808,558**	**$585,902**

Obligations by Object - Medical Facilities Category (MF) Part 3 of 3
(dollars in thousands)

Description	Discretionary and Mandatory Grand Total Medical Facilities Category			
	FY 2023	FY 2024	FY 2025	FY 2026
10 Personnel Compensation and Benefits:				
Physicians	$8	$0	$0	$0
Dentists	$0	$0	$0	$0
Registered Nurses	$974	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$61	$0	$0	$0
Non-Physician Providers	$108	$0	$0	$0
Health Technicians/Allied Health	$15,046	$17,486	$17,896	$19,446
Wage Board/Purchase & Hire	$1,886,620	$2,177,043	$2,195,539	$2,347,590
All Other	$623,534	$720,015	$727,040	$778,399
Permanent Change of Station	$643	$656	$669	$683
Employee Compensation Pay	$33,818	$34,505	$35,205	$35,920
Subtotal	$2,560,812	$2,949,705	$2,976,349	$3,182,038
21 Travel & Transportation of Persons:				
Employee	$6,606	$6,870	$7,145	$7,424
Beneficiary	$218	$0	$0	$0
Other	$58,245	$59,072	$61,435	$63,831
Subtotal	$65,069	$65,942	$68,580	$71,255
22 Transportation of Things	$18,239	$18,623	$19,368	$20,123
23 Rent, Communications, and Utilities:				
Rental of Equipment	$15,930	$16,566	$17,229	$17,901
Communications	$36,753	$35,239	$36,649	$38,078
Utilities	$667,011	$731,358	$760,612	$790,276
GSA Rent	$0	$0	$0	$0
Other Real Property Rental	$959,170	$1,047,567	$1,224,672	$1,335,469
Subtotal	$1,678,864	$1,830,730	$2,039,162	$2,181,724
24 Printing & Reproduction:	$96	$98	$102	$106
25 Other Contractual Services:				
Care in the Community Outpatient Dental Care	$7	$0	$0	$0
Medical and Nursing Care in the Community	$69	$0	$0	$0
Repairs to Furniture/Equipment	$23,072	$24,305	$25,277	$26,263
Maintenance & Repair Contract Services	$383,087	$411,969	$428,417	$454,550
Care in the Community Hospital Care	$0	$0	$0	$0
Community Nursing Homes	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$1	$0	$0	$0
Home Oxygen	$0	$0	$0	$0
Organ Procurement	$5	$0	$0	$0
Personal Services Contracts	$5,230	$5,439	$5,657	$5,878
House Staff Disbursing Agreement	$0	$0	$0	$0
Scarce Medical Specialists	$0	$0	$0	$0
Other Medical Contract Services	$16,711	$0	$0	$0
Administrative Contract Services	$664,267	$798,486	$484,282	$749,200
Training Contract Services	$2,252	$2,340	$2,434	$2,529
Caregiver Stipends	$0	$0	$0	$0
CHAMPVA	$0	$0	$0	$0
Subtotal	$1,094,701	$1,242,539	$946,067	$1,238,420

Obligations by Object - Medical Facilities Category (MF) Part 3 of 3
(dollars in thousands)

Description	Discretionary and Mandatory Grand Total Medical Facilities Category			
	FY 2023	FY 2024	FY 2025	FY 2026
26 Supplies & Materials:				
Provisions	$57	$0	$0	$0
Drugs & Medicines	$658	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0
Medical/Dental Supplies	$3,589	$0	$0	$0
Operating Supplies	$174,961	$181,436	$188,654	$196,012
Maintenance & Repair Supplies	$219,093	$224,799	$234,621	$243,771
Other Supplies	$83,382	$86,619	$90,084	$93,597
Prosthetic Appliances	$24	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0
Subtotal	$481,764	$492,854	$513,359	$533,380
31 Equipment	$143,642	$157,003	$161,871	$156,708
32 Lands & Structures:				
Non-Recurring Maintenance	$3,223,244	$2,028,415	$2,027,648	$2,007,560
All Other Lands & Structures	$256,573	$413,337	$1,248,087	$850,433
Subtotal	$3,479,817	$2,441,752	$3,275,735	$2,857,993
41 Grants, Subsidies & Contributions:				
State Home	$0	$0	$0	$0
Grants	$2	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0
Subtotal	$2	$0	$0	$0
42 - Insurance Claims and Indemnities	$7,661	$8,037	$8,358	$8,684
43 Imputed Interest	$0	$0	$0	$0
Subtotal	$9,530,667	$9,207,283	$10,008,951	$10,250,431
Prior Year Recoveries	$65,637	$0	$0	$0
Obligations [Total]	**$9,596,304**	**$9,207,283**	**$10,008,951**	**$10,250,431**

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

Description	Discretionary Appropriations Medical Community Care				Mandatory Appropriations Veterans Choice Fund				Mandatory Appropriations American Resuce Plan Act, sec. 8002, 8007			
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026
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	$0	$0	$0	$0	$1	$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	$1	$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:					$0	$0	$0	$0				
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	$1,035,678	$133,629	$1,576,100	$1,813,024	($22)	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$9,122,577	$12,642,248	$13,380,195	$16,084,569	($32,478)	$0	$303,826	$0	$1,350	$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	$8,139,378	$5,867,955	$1,521,913	$2,999,930	($47)	$0	$0	$0	$1,986,440	$0	$0	$0
Community Nursing Homes	$1,572,224	$1,755,747	$1,893,463	$1,993,705	$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	$36,846	$38,320	$39,853	$41,407	$0	$0	$0	$0	-$147	$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	$6,548,620	$6,810,565	$7,082,988	$7,359,225	$463	$0	$0	$0	$0	$0	$0	$0
Administrative Contract Services	$11,636	$0	$0	$0	($193)	$0	$1,000	$0	$0	$0	$0	$0
Training Contract Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Caregiver Stipends	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$1,720,396	$2,100,835	$2,327,454	$2,562,627	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$28,187,355	$29,349,299	$27,821,966	$32,854,487	($32,277)	$0	$304,826	$0	$1,987,643	$0	$0	$0

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

Description	Discretionary Appropriations Medical Community Care				Mandatory Appropriations Veterans Choice Fund				Mandatory Appropriations American Resuce Plan Act, sec. 8002, 8007			
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026
26 Supplies & Materials:												
Provisions	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Drugs & Medicines	$7,283	$2,940	$2,658	$6,430	$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	$39	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Operating Supplies	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Supplies	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Supplies	($4,335)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prosthetic Appliances	$4	$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	$2,991	$2,940	$2,658	$6,430	$0	$0	$0	$0	$0	$0	$0	$0
31 Equipment	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
32 Lands & Structures:												
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
41 Grants, Subsidies & Contributions:												
State Home	$1,491,472	$1,676,760	$1,809,660	$1,958,463	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,491,472	$1,676,760	$1,809,660	$1,958,463	$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	$29,681,818	$31,028,999	$29,634,284	$34,819,380	($32,276)	$0	$304,826	$0	$1,987,643	$0	$0	$0
Prior Year Recoveries	$161,347	$0	$0	$0	$32,677	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	**$29,843,166**	**$31,028,999**	**$29,634,284**	**$34,819,380**	**$401**	**$0**	**$304,826**	**$0**	**$1,987,643**	**$0**	**$0**	**$0**

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

Description	Mandatory Appropriations Cost of War Toxic Exposures Fund				Discretionary and Mandatory Grand Total Medical Community Care Category			
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026
10 Personnel Compensation and Benefits:								
Physicians	$0	$0	$0	$0	$0	$0	$0	$0
Dentists	$0	$0	$0	$0	$0	$0	$0	$0
Registered Nurses	$0	$0	$0	$0	$0	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$0	$0	$0	$0	$0	$0	$0	$0
Non-Physician Providers	$0	$0	$0	$0	$0	$0	$0	$0
Health Technicians/Allied Health	$0	$0	$0	$0	$0	$0	$0	$0
Wage Board/Purchase & Hire	$0	$0	$0	$0	$0	$0	$0	$0
All Other	$0	$0	$0	$0	$0	$0	$0	$0
Permanent Change of Station	$0	$0	$0	$0	$0	$0	$0	$0
Employee Compensation Pay	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
21 Travel & Transportation of Persons:								
Employee	$0	$0	$0	$0	$0	$0	$0	$0
Beneficiary	$0	$0	$0	$0	$1	$0	$0	$0
Other	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$1	$0	$0	$0
22 Transportation of Things	$0	$0	$0	$0	$0	$0	$0	$0
23 Rent, Communications, and Utilities:								
Rental of Equipment	$0	$0	$0	$0	$0	$0	$0	$0
Communications	$0	$0	$0	$0	$0	$0	$0	$0
Utilities	$0	$0	$0	$0	$0	$0	$0	$0
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
24 Printing & Reproduction:	$0	$0	$0	$0	$0	$0	$0	$0
25 Other Contractual Services:								
Care in the Community Outpatient Dental Care	$0	$0	$0	$0	$1,035,656	$133,629	$1,576,100	$1,813,024
Medical and Nursing Care in the Community	$0	$0	$0	$0	$9,091,449	$12,642,248	$13,684,021	$16,084,569
Repairs to Furniture/Equipment	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Contract Services	$0	$0	$0	$0	$0	$0	$0	$0
Care in the Community Hospital Care	$0	$5,510,910	$11,000,000	$11,000,000	$10,125,771	$11,378,865	$12,521,913	$13,999,930
Community Nursing Homes	$0	$0	$0	$0	$1,572,224	$1,755,747	$1,893,463	$1,993,705
Repairs to Prosthetic Appliances	$0	$0	$0	$0	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$0	$0	$0	$0	$36,699	$38,320	$39,853	$41,407
House Staff Disbursing Agreement	$0	$0	$0	$0	$0	$0	$0	$0
Scarce Medical Specialists	$0	$0	$0	$0	$0	$0	$0	$0
Other Medical Contract Services	$0	$0	$0	$0	$6,549,083	$6,810,565	$7,082,988	$7,359,225
Administrative Contract Services	$0	$0	$0	$0	$11,443	$0	$1,000	$0
Training Contract Services	$0	$0	$0	$0	$0	$0	$0	$0
Caregiver Stipends	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$0	$0	$0	$0	$1,720,396	$2,100,835	$2,327,454	$2,562,627
Subtotal	$0	$5,510,910	$11,000,000	$11,000,000	$30,142,721	$34,860,209	$39,126,792	$43,854,487

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

Description	Mandatory Appropriations Cost of War Toxic Exposures Fund				Discretionary and Mandatory Grand Total Medical Community Care Category			
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026
26 Supplies & Materials:								
Provisions								
Drugs & Medicines	$0	$0	$0	$0	$7,283	$2,940	$2,658	$6,430
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$0	$0	$0	$0	$39	$0	$0	$0
Operating Supplies	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Supplies	$0	$0	$0	$0	$0	$0	$0	$0
Other Supplies	$0	$0	$0	$0	($4,335)	$0	$0	$0
Prosthetic Appliances	$0	$0	$0	$0	$4	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$2,991	$2,940	$2,658	$6,430
31 Equipment	$0	$0	$0	$0	$0	$0	$0	$0
32 Lands & Structures:								
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
41 Grants, Subsidies & Contributions:								
State Home	$0	$0	$0	$0	$1,491,472	$1,676,760	$1,809,660	$1,958,463
Grants	$0	$0	$0	$0	$0	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$1,491,472	$1,676,760	$1,809,660	$1,958,463
42 - Insurance Claims and Indemnities	$0	$0	$0	$0	$0	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$5,510,910	$11,000,000	$11,000,000	$31,637,185	$36,539,909	$40,939,110	$45,819,380
Prior Year Recoveries	$0	$0	$0	$0	$194,024	$0	$0	$0
Obligations [Total]	**$0**	**$5,510,910**	**$11,000,000**	**$11,000,000**	**$31,831,210**	**$36,539,909**	**$40,939,110**	**$45,819,380**

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

Description	Medical Care Total (Discretionary) FY 2023	FY 2024	FY 2025	FY 2026	Medical Care Total (Mandatory) FY 2023	FY 2024	FY 2025	FY 2026	Medical Care Grand Total (Discretionary & Mandatory) FY 2023	FY 2024	FY 2025	FY 2026
10 Personnel Compensation and Benefits:												
Physicians	$9,372,697	$10,416,105	$10,546,635	$10,951,879	$99,890	$2,963	$2,994	$0	$9,472,587	$10,419,068	$10,549,629	$10,951,879
Dentists	$392,056	$439,810	$451,939	$476,078	$465	$0	$0	$0	$392,521	$439,810	$451,939	$476,078
Registered Nurses	$12,549,886	$14,458,974	$14,840,954	$15,646,611	$257,540	$229	$0	$0	$12,807,426	$14,459,203	$14,840,954	$15,646,611
LP Nurse/LV Nurse/Nurse Assistant	$2,621,921	$3,044,797	$3,210,083	$3,484,572	$20,150	$41	$31	$0	$2,642,071	$3,044,838	$3,210,114	$3,484,572
Non-Physician Providers	$4,045,123	$4,617,928	$4,770,900	$5,067,187	$16,435	$233	$195	$0	$4,061,558	$4,618,161	$4,771,095	$5,067,187
Health Technicians/Allied Health	$11,395,383	$13,109,626	$13,705,301	$14,744,265	$45,674	$396	$460	$0	$11,441,057	$13,110,022	$13,705,761	$14,744,265
Wage Board/Purchase & Hire	$2,114,888	$2,799,159	$2,834,188	$3,020,108	$327,852	$73	$0	$0	$2,442,740	$2,799,232	$2,834,188	$3,020,108
All Other	$10,541,887	$12,912,841	$13,207,178	$14,010,861	$587,961	$3,330	$1,300	$0	$11,129,848	$12,916,171	$13,208,478	$14,010,861
Permanent Change of Station	$15,398	$15,710	$16,029	$16,355	$0	$0	$0	$0	$15,398	$15,710	$16,029	$16,355
Employee Compensation Pay	$351,302	$359,700	$367,002	$374,453	$1,241	$0	$0	$0	$352,543	$359,700	$367,002	$374,453
Subtotal	$53,400,541	$62,174,650	$63,950,209	$67,792,369	$1,357,208	$7,265	$4,980	$0	$54,757,749	$62,181,915	$63,955,189	$67,792,369
21 Travel & Transportation of Persons:												
Employee	$138,915	$169,471	$178,250	$185,202	$138	$0	$0	$0	$139,053	$169,471	$178,250	$185,202
Beneficiary	$1,936,771	$2,011,900	$2,126,009	$2,264,956	$13,959	$0	$0	$0	$1,950,730	$2,011,900	$2,126,009	$2,264,956
Other	$104,776	$133,967	$141,326	$146,838	$1,485	$0	$0	$0	$106,261	$133,967	$141,326	$146,838
Subtotal	$2,180,462	$2,315,338	$2,445,585	$2,596,996	$15,582	$0	$0	$0	$2,196,044	$2,315,338	$2,445,585	$2,596,996
22 Transportation of Things	$71,254	$74,103	$77,067	$80,072	$1,189	$0	$0	$0	$72,443	$74,103	$77,067	$80,072
23 Rent, Communications, and Utilities:												
Rental of Equipment	$391,570	$416,232	$432,882	$449,764	$1,568	$0	$0	$0	$393,138	$416,232	$432,882	$449,764
Communications	$613,172	$646,699	$672,567	$698,796	$5,327	$0	$0	$0	$618,499	$646,699	$672,567	$698,796
Utilities	$627,697	$731,358	$760,612	$790,276	$39,862	$0	$0	$0	$667,559	$731,358	$760,612	$790,276
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$938,978	$1,043,295	$1,207,674	$1,317,808	$48,645	$4,272	$16,998	$17,661	$987,623	$1,047,567	$1,224,672	$1,335,469
Subtotal	$2,571,417	$2,837,584	$3,073,735	$3,256,644	$95,402	$4,272	$16,998	$17,661	$2,666,819	$2,841,856	$3,090,733	$3,274,305
24 Printing & Reproduction:	$46,856	$48,730	$50,680	$52,656	$246	$0	$0	$0	$47,102	$48,730	$50,680	$52,656
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$1,042,638	$133,629	$1,576,100	$1,813,024	$3	$6,953	$7,231	$7,513	$1,042,641	$140,582	$1,583,331	$1,820,537
Medical and Nursing Care in the Community	$9,451,355	$12,642,248	$13,380,195	$16,084,569	-$31,063	$326,400	$643,282	$352,695	$9,420,292	$12,968,648	$14,023,477	$16,437,264
Repairs to Furniture/Equipment	$414,609	$26,728	$27,797	$28,881	$697	$388,909	$404,465	$420,239	$415,306	$415,637	$432,262	$449,120
Maintenance & Repair Contract Services	$442,633	$411,939	$428,417	$454,550	$6,667	$63,035	$65,525	$68,080	$449,300	$474,974	$493,942	$522,630
Care in the Community Hospital Care	$8,139,376	$5,867,955	$1,521,913	$2,999,930	$1,986,393	$5,510,910	$11,000,000	$11,000,000	$10,125,769	$11,378,865	$12,521,913	$13,999,930
Community Nursing Homes	$1,572,224	$1,755,747	$1,893,463	$1,993,705	$0	$0	$0	$0	$1,572,224	$1,755,747	$1,893,463	$1,993,705
Repairs to Prosthetic Appliances	$347,857	$381,591	$419,841	$456,256	$2	$0	$0	$0	$347,859	$381,591	$419,841	$456,256
Home Oxygen	$208,334	$228,538	$251,447	$273,256	$0	$0	$0	$0	$208,334	$228,538	$251,447	$273,256
Organ Procurement	$29,983	$0	$0	$0	$169	$29,978	$31,177	$32,393	$30,152	$29,978	$31,177	$32,393
Personal Services Contracts	$160,771	$56,335	$58,589	$60,874	$670	$106,603	$110,867	$115,191	$161,441	$162,938	$169,456	$176,065
House Staff Disbursing Agreement	$820,074	$0	$0	$0	$0	$820,057	$852,859	$886,121	$820,074	$820,057	$852,859	$886,121
Scarce Medical Specialists	$264,991	$0	$0	$0	$0	$264,991	$275,591	$286,339	$264,991	$264,991	$275,591	$286,339
Other Medical Contract Services	$8,449,873	$6,828,677	$7,526,223	$7,858,344	$5,922	$1,670,890	$0	$0	$8,455,795	$8,499,567	$7,526,223	$7,858,344
Administrative Contract Services	$3,935,718	$1,809,248	$3,622,686	$3,080,231	$47,728	$2,417,191	$600,315	$503,249	$3,983,446	$4,226,439	$4,223,001	$3,583,480
Training Contract Services	$184,047	$58,685	$61,033	$63,413	$341	$127,619	$132,724	$137,900	$184,388	$186,304	$193,757	$201,313
Caregiver Stipends	$1,232,679	$1,982,190	$2,465,239	$2,983,817	$0	$0	$0	$0	$1,232,679	$1,982,190	$2,465,239	$2,983,817
CHAMPVA	$1,732,852	$2,123,601	$2,353,567	$2,591,667	$0	$0	$0	$0	$1,732,852	$2,123,601	$2,353,567	$2,591,667
Subtotal	$38,430,014	$34,307,111	$35,586,510	$40,742,517	$2,017,529	$11,733,536	$14,124,036	$13,809,720	$40,447,543	$46,040,647	$49,710,546	$54,552,237

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 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026	FY 2023	FY 2024	FY 2025	FY 2026
26 Supplies & Materials:												
Provisions	$142,023	$144,983	$150,782	$156,662	$46	$0	$0	$0	$142,069	$144,983	$150,782	$156,662
Drugs & Medicines	$9,525,394	$5,042,628	$2,771,772	$3,802,257	$300,422	$5,699,901	$9,000,000	$9,000,000	$9,825,816	$10,742,529	$11,771,772	$12,802,257
Blood & Blood Products	$54,698	$61,722	$67,639	$73,540	$2,510	$0	$0	$0	$57,208	$61,722	$67,639	$73,540
Medical/Dental Supplies	$2,277,168	$2,003,400	$3,576,536	$2,777,267	($33,969)	$0	$0	$0	$2,243,199	$2,003,400	$3,576,536	$2,777,267
Operating Supplies	$503,537	$534,179	$555,546	$577,212	$5,406	$38	$0	$0	$508,943	$534,217	$555,546	$577,212
Maintenance & Repair Supplies	$260,538	$224,636	$234,621	$243,771	$5,021	$163	$0	$0	$265,559	$224,799	$234,621	$243,771
Other Supplies	$412,065	$443,556	$461,299	$479,290	$4,927	$0	$0	$0	$416,992	$443,556	$461,299	$479,290
Prosthetic Appliances	$3,479,934	$3,817,385	$4,200,037	$4,564,326	($1)	$0	$0	$0	$3,479,933	$3,817,385	$4,200,037	$4,564,326
Home Respiratory Therapy	$249,306	$273,484	$300,897	$326,996	$0	$0	$0	$0	$249,306	$273,484	$300,897	$326,996
Subtotal	$16,904,663	$12,545,973	$12,319,129	$13,001,321	$284,362	$5,700,102	$9,000,000	$9,000,000	$17,189,025	$18,246,075	$21,319,129	$22,001,321
31 Equipment	$2,139,788	$2,360,454	$240,279	$2,391,114	$5,708	$108	$2,229,619	$0	$2,145,496	$2,360,562	$2,469,898	$2,391,114
32 Lands & Structures:												
Non-Recurring Maintenance	$2,998,988	$2,000,000	$2,000,000	$2,000,000	$224,256	$28,415	$27,648	$7,560	$3,223,244	$2,028,415	$2,027,648	$2,007,560
All Other Lands & Structures	$213,361	$266,039	$465,642	$285,800	$47,767	$150,637	$785,918	$568,241	$261,128	$416,676	$1,251,560	$854,041
Subtotal	$3,212,349	$2,266,039	$2,465,642	$2,285,800	$272,023	$179,052	$813,566	$575,801	$3,484,372	$2,445,091	$3,279,208	$2,861,601
41 Grants, Subsidies & Contributions:												
State Home	$1,491,911	$1,677,217	$1,810,135	$1,958,957	$0	$0	$0	$0	$1,491,911	$1,677,217	$1,810,135	$1,958,957
Grants	$1,143,816	$1,245,567	$1,246,148	$1,253,624	$11,521	$0	$0	$0	$1,155,337	$1,245,567	$1,246,148	$1,253,624
Veteran Adoption Reimbursement	$4	$2	$2	$2	$0	$0	$0	$0	$4	$2	$2	$2
Subtotal	$2,635,731	$2,922,786	$3,056,285	$3,212,583	$11,521	$0	$0	$0	$2,647,252	$2,922,786	$3,056,285	$3,212,583
42 Insurance Claims and Indemnities	$62,113	$62,597	$65,100	$67,639	($1,972)	$0	$0	$0	$60,141	$62,597	$65,100	$67,639
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$121,655,188	$121,915,365	$123,330,221	$135,479,711	$4,058,798	$17,624,335	$26,189,199	$23,403,182	$125,713,986	$139,539,700	$149,519,420	$158,882,893
Prior Year Recoveries	$288,857	$0	$0	$0	$216,696	$0	$0	$0	$505,553	$0	$0	$0
Obligations [Total]	**$121,944,046**	**$121,915,365**	**$123,330,221**	**$135,479,711**	**$4,275,494**	**$17,624,335**	**$26,189,199**	**$23,403,182**	**$126,219,540**	**$139,539,700**	**$149,519,420**	**$158,882,893**

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Medical Care Areas of Focus

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

Table: Total Medical Care Obligations by Program

(Includes All Funding Sources)
(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Health Care Services:							
Ambulatory Care 1/ 2/	$46,952,824	$58,125,322	$53,281,406	$57,583,114	$60,729,385	$4,301,708	$3,146,271
Dental Care	$2,396,448	$2,573,291	$2,676,069	$2,975,647	$3,249,465	$299,578	$273,818
Inpatient Care	$23,614,262	$26,766,548	$25,004,013	$25,973,867	$27,289,051	$969,854	$1,315,184
Mental Health Care 3/	$14,423,510	$16,587,825	$15,968,840	$17,053,718	$18,212,861	$1,084,878	$1,159,143
Pharmacy 2/	$12,033,736	$12,675,441	$13,579,020	$14,880,740	$16,178,905	$1,301,720	$1,298,165
Prosthetic and Sensory Aids Services	$4,427,416	$4,571,956	$4,859,172	$5,343,218	$5,804,765	$484,046	$461,547
Rehabilitation Care	$1,370,443	$1,491,565	$1,430,254	$1,461,684	$1,486,835	$31,430	$25,151
Health Care Services [Subtotal]	**$105,218,639**	**$122,791,948**	**$116,798,774**	**$125,271,988**	**$132,951,267**	**$8,473,214**	**$7,679,279**
Long-Term Services & Supports (LTSS):							
Institutional LTSS							
VA Community Living Centers (VA CLC)	$5,122,366	$5,292,497	$5,380,099	$5,470,160	$5,662,369	$90,061	$192,209
Community Nursing Home	$1,782,153	$1,529,213	$1,921,465	$2,078,128	$2,188,225	$156,663	$110,097
State Home Nursing	$1,447,138	$1,438,784	$1,617,932	$1,745,012	$1,887,231	$127,080	$142,219
State Home Domiciliary	$45,278	$55,402	$56,992	$62,662	$69,085	$5,670	$6,423
Institutional LTSS [Subtotal]	$8,396,935	$8,315,896	$8,976,488	$9,355,962	$9,806,910	$379,474	$450,948
Non-Institutional LTSS							
State Home Adult Day Care	$2,460	$1,892	$1,836	$1,986	$2,147	$150	$161
Other Non-Institutional LTSS	$6,584,894	$4,622,996	$7,251,656	$7,678,612	$8,060,679	$426,956	$382,067
Non-Institutional LTSS [Subtotal]	$6,587,354	$4,624,888	$7,253,492	$7,680,598	$8,062,826	$427,106	$382,228
LTSS [Subtotal]	**$14,984,289**	**$12,940,784**	**$16,229,980**	**$17,036,560**	**$17,869,736**	**$806,580**	**$833,176**
Other Health Care Programs:							
Camp Lejeune Families (P.L. 112-154)	$2,159	$7,597	$4,443	$4,606	$4,837	$163	$231
Caregiver Support Program 4/	$1,676,028	$2,422,410	$2,422,410	$2,913,000	$3,500,000	$490,590	$587,000
CHAMPVA & Other Dependent Prgs. 5/	$2,474,653	$2,335,332	$2,621,810	$2,898,351	$3,185,466	$276,541	$287,115
Homeless Program Grants 6/	$1,009,688	$1,067,265	$1,067,265	$983,946	$983,946	($83,319)	$0
PACT Act § 705 Enhanced-Use Leases	$45,549	$0	$41,375	$40,608	$17,280	($767)	($23,328)
Readjustment Counseling	$302,982	$353,643	$353,643	$370,361	$370,361	$16,718	$0
Other Health Care Programs [Subtotal]	**$5,511,059**	**$6,186,247**	**$6,510,946**	**$7,210,872**	**$8,061,890**	**$699,926**	**$851,018**
Obligations [Subtotal]	**$125,713,987**	**$141,918,979**	**$139,539,700**	**$149,519,420**	**$158,882,893**	**$9,979,720**	**$9,363,473**
Recoveries of prior year paid & unpaid obligations	$505,553	$0	$0	$0	$0	$0	$0
Obligations [Total]	$126,219,540	$141,918,979	$139,539,700	$149,519,420	$158,882,893	$9,979,720	$9,363,473

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

2. A full-year 2024 appropriations Act was not enacted at the time the 2025 Budget was prepared. The funding level in the 2024 Current Estimate column assumes the 2024 President's Budget request for 2024 with updates to unobligated balances, reimbursements, collections, and transfers.

[1/] Ambulatory Care excludes all pharmacy costs, which had been included in this health care service category in prior years' Congressional Justifications, to align with the data reorganization in the Medical Services chapter. The Ambulatory Care category includes cost adjustements made outside of the Enrollee Health Care Projection Model (EHCPM) to account for certain programmatic funding levels. All other service lines projected by the EHCPM are inflated by their respective EHCPM growth rates. (See the Actuarial Models Projections chapter for more information about the EHCPM.)

[2/] Pharmacy costs have been separated from ambulatory care in this display to align with the data reorganization in the Medical Services chapter. The Pharmacy table and narrative have been moved from the Medical Services chapter to the Medical Care chapter.

[3/] 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).

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

[5/] Excludes administrative costs in all columns except the 2024 Budget Estimate; also excludes CHAMPVA benefits provided in the Caregivers Support Program

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

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

Description	2023 Actual	2024 Budget Estimate 1/3/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Medical Care Programs: (Included Above)							
Activations	$391,194	$865,249	$623,359	$623,359	$623,359	$0	$0
Blind Rehabilitation Treatment	$158,708	$168,746	$175,670	$193,232	$211,960	$17,562	$18,728
Education & Training	$2,629,755	$2,911,961	$2,991,218	$3,048,609	$3,139,174	$57,391	$90,565
Food Security Program Office 1/	$1,117	N/A	$1,682	$16,985	$16,985	$15,303	$0
Health Professionals Educational Assistance Program	$208,228	$303,356	$303,356	$377,450	$377,450	$74,094	$0
Indian Health Service/THP/UIO Reimbursement	$30,852	$38,259	$36,501	$37,924	$41,717	$1,423	$3,793
Intimate Partner Violence program	$23,008	$36,879	$30,432	$31,373	$31,373	$941	$0
Leases	$1,153,605	$2,305,729	$1,408,903	$2,263,759	$2,185,902	$854,856	($77,857)
Mental Health Topics:							
Opioid Prevention:							
Treatment Modalities	$430,591	$460,878	$440,925	$458,562	$476,446	$17,637	$17,884
Opioid Prevention Programs (Includes Jason's Law) 2/	$206,450	$254,478	$254,478	$254,487	$254,487	$9	$0
Substance Use Disorder Initiative	$94,662	$230,947	$230,947	$263,881	$264,824	$32,934	$943
Suicide Prevention:							
Medical Treatment 3/	$2,414,568	$2,475,629	$2,544,820	$2,667,713	$2,785,664	$122,893	$117,951
Outreach Programs	$517,024	$558,794	$570,956	$582,554	$586,019	$11,598	$3,465
Women Veterans Peer Support Initiative (WoVeN) 1/	$1,286	N/A	$1,415	$1,698	$1,698	$283	$0
National Center for Posttraumatic Stress Disorder 4/	$42,302	$42,000	$42,000	$42,000	$42,000	$0	$0
National Veterans Sports Program	$26,457	$30,414	$30,414	$30,542	$30,542	$128	$0
Neurology Centers of Excellence 4/							
Epilepsy (Including Multiple Sclerosis)	$15,093	$23,585	$23,585	$23,871	$23,871	$286	$0
Headaches	$19,086	$21,476	$15,000	$22,092	$22,092	$7,092	$0
Multiple Sclerosis 1/	$4,620	N/A	$4,620	$5,300	$5,300	$680	$0
Parkinson's Disease Research, Education and Clinical Centers 1/	$10,522	N/A	$9,673	$10,200	$10,200	$527	$0
Non-Recurring Maintenance (Lands & Structure only) 5/	$3,223,244	$5,750,000	$2,028,415	$2,027,648	$2,007,560	($767)	($20,088)
Precision Oncology Initiative	$145,753	$215,433	$215,433	$215,433	$215,433	$0	$0
Regional Readiness Centers	$51,992	$155,481	$36,455	$41,404	$41,404	$4,949	$0
Rural Health 4/	$297,074	$337,455	$337,455	$337,455	$337,455	$0	$0
Spinal Cord Injury Treatment	$849,591	$821,609	$956,627	$1,081,569	$1,219,994	$124,942	$138,425
Supply Chain Management	$57,171	$144,603	$147,563	$148,866	$148,866	$1,303	$0
Telehealth:							
Home & Clinic Based Telehealth 6/	$4,922,866	$5,210,577	$5,733,653	$5,958,100	$6,382,109	$224,447	$424,009
Office of Connected Care Program	$288,919	$408,061	$408,061	$439,920	$439,920	$31,859	$0
Veterans Homelessness Programs	$2,953,422	$3,111,148	$3,168,707	$3,210,276	$3,235,065	$41,569	$24,789
Whole Health	$79,070	$107,848	$107,848	$119,289	$119,289	$11,441	$0

1/ Information not previously displayed in the 2024 Congressional Justification.

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

3/ A correction has been made in this table to the 2024 Budget Estimate column for medical treatment that had double counted Mental Health Care in the Emergency Room. More information on suicide prevention can be found later in this chapter.

4/ 2023 actuals are represented by allocated amounts rather than obligations.

5/ Please see the Medical Facilities chapter for the 2023 actual that includes supporting full time equivalent (FTE) employees and contract-related costs pertaining to non-recurring maintenance, which are not included in this table.

6/ The display for 2024 in the 2024 Congressional Justification excluded obligations for certain home telehealth modalities. These obligations have been included in all columns in this display except for the 2024 Budget Estimate.

Table: Programs for Select Veteran Populations

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
AIDS/HIV Program	$1,789,483	$1,818,782	$1,920,571	$2,062,108	$2,212,952	$141,538	$150,844
Health Outcomes Military Exposures (HOME):							
Gulf War Program	$7,218,584	$8,268,010	$8,582,788	$10,106,231	$11,785,074	$1,523,443	$1,678,843
OEF/OIF/OND/OIR	$14,429,901	$15,820,981	$16,856,009	$19,580,291	$22,572,919	$2,724,282	$2,992,628
Program Office	$49,004	$81,938	$81,938	$82,838	$82,838	$900	$0
Traumatic Brain Injury and Polytrauma System of Care:							
OEF/OIF/OND/OIR	$313,394	$346,429	$338,768	$359,553	$382,709	$20,785	$23,156
All Veteran Care	$1,084,461	$1,329,518	$1,180,755	$1,285,527	$1,403,174	$104,771	$117,647
Women Veterans Health Care:							
Program Office & Initiative Budget	$111,820	$256,926	$256,926	$263,660	$263,660	$6,734	$0
Gender-Specific Care	$851,443	$1,022,170	$940,709	$1,059,784	$1,165,521	$119,075	$105,737
All Care	$11,316,932	$12,632,131	$12,497,616	$13,657,684	$14,763,288	$1,160,068	$1,105,604

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

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

Ambulatory Care without Pharmacy

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

Table: Ambulatory Care without Pharmacy

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$26,749,049	$30,402,355	$28,205,475	$29,988,308	$31,142,800	$1,782,833	$1,154,492
Medical Community Care (0140):	$10,895,223	$11,367,959	$13,309,180	$15,144,985	$17,869,472	$1,835,805	$2,724,487
Medical Support and Compliance (0152):	$4,527,780	$5,735,105	$4,991,443	$5,650,426	$5,953,207	$658,983	$302,781
Medical Facilities (0162):	$3,968,780	$6,749,791	$4,085,876	$4,206,989	$4,433,853	$121,113	$226,864
Recurring Expenses Transformational Fund (1124XN)	$0	$0	$75,000	$0	$0	($75,000)	$0
Discretionary Total	**$46,140,832**	**$54,255,210**	**$50,591,974**	**$54,990,708**	**$59,399,332**	**$4,398,734**	**$4,408,624**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$2,772,885	$2,029,745	$1,928,186	$1,073,351	($101,559)	($854,835)
Veterans Medical Care and Health Fund (0173)	$166,918	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	($898)	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$3,153	$5,678	$3,837	$4,980	$0	$1,143	($4,980)
Mandatory Obligations [Subtotal]	**$169,173**	**$2,778,563**	**$2,033,582**	**$1,933,166**	**$1,073,351**	**($100,416)**	**($859,815)**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$3,476	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	($32,593)	$21,875	$0	$304,826	$0	$304,826	($304,826)
Mandatory Obligations [Subtotal]	**($29,117)**	**$21,875**	**$0**	**$304,826**	**$0**	**$304,826**	**($304,826)**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$278,896	$497,086	$0	$0	($497,086)	$0
Veterans Medical Care and Health Fund (0173)	$259,300	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$1,741	$3,524	$3,373	$256	$0	($3,117)	($256)
Mandatory Obligations [Subtotal]	**$261,041**	**$282,420**	**$500,459**	**$256**	**$0**	**($500,203)**	**($256)**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$10,510	$786,724	$80,391	$354,158	$256,702	$273,767	($97,456)
Veterans Medical Care and Health Fund (0173)	$400,457	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	($72)	$530	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$410,895**	**$787,254**	**$80,391**	**$354,158**	**$256,702**	**$273,767**	**($97,456)**
Mandatory Total	**$811,992**	**$3,870,112**	**$2,614,432**	**$2,592,406**	**$1,330,053**	**($22,026)**	**($1,262,353)**
Combined Discretionary and Mandatory by Category							
Medical Services	$26,918,222	$33,180,918	$30,239,057	**$31,921,474**	**$32,216,151**	$1,682,417	$294,677
Medical Community Care	$10,866,106	$11,389,834	$13,309,180	**$15,449,811**	**$17,869,472**	$2,140,631	$2,419,661
Medical Support and Compliance	$4,788,821	$6,017,525	$5,491,902	**$5,650,682**	**$5,953,207**	$158,780	$302,525
Medical Facilities	$4,379,675	$7,537,045	$4,241,267	**$4,561,147**	**$4,690,555**	$319,880	$129,408
Obligations [Grand Total]	**$46,952,824**	**$58,125,322**	**$53,281,406**	**$57,583,114**	**$60,729,385**	**$4,301,708**	**$3,146,271**

Note: Ambulatory Care excludes all pharmacy costs, which had been included in this health care service category in prior years' Congressional Justifications, to align with the data reorganization in the Medical Services chapter. The Ambulatory Care category includes cost adjustments made outside of the Enrollee Health Care Projection Model (EHCPM) to account for certain programmatic funding levels.

Authority for Action: Title 38, United States Code (USC), Chapter 17

Recent Legislation

- P.L. 117-168, *Honoring our PACT Act of 2022*. The PACT Act expanded and extended eligibility for VA health care for Veterans with toxic exposures and Veterans of the Vietnam era, Gulf War era, and Post-9/11 era

Types of Services Provided

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

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

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

Nutrition and Food Services: Nutrition and Food Service (NFS) develops and provides comprehensive evidence-based nutrition services through a modernized, Veteran-centric NFS program that empowers and engages a diverse workforce, educates future nutrition professionals, and advances nutrition practice through research and continuous quality improvement. Registered Dietitian Nutritionists (RDN) and clinical nutrition staff and trainees provide medical nutrition therapy, education and counseling to Veterans, and support the expanding Veteran population of toxic exposures, most of whom have diagnoses that warrant nutrition support. In 2023, RDNs increased outpatient encounters by 20% (1.71 million) and expanded virtual access with 33% of

these encounters as VA Video Connect (VVC) modality. NFS also addresses food security through Veteran referrals and facility or community partnerships.

Emergency Medicine Services: Emergency Medicine (EM) provides acute, emergent, and urgent care on-demand to over 2.5 million Veterans annually, through our 110 VHA emergency departments (ED) and 30 urgent care centers (UCC). VHA Emergency and Urgent Care Medicine serves as a critical safety net for our Nation's Veterans, offering immediately accessible care with a focus on geriatric and mental health emergency care.

Specialty Care Services: Specialty care refers to advanced care that is specific to a demographic, disease, or skill set and can serve many purposes across the continuum of care – from preventative screenings, to addressing one-time (episodic) incidences, to chronic disease management – and ideally be coordinated by the patient's primary care provider. Specialty care is integral across all parts of the care continuum. In 2023, Specialty care appointments/encounters increased by approximately 670,000 over 2022. Telephone encounters decreased, while CVT and in person appointments both increased. Some specialty services are heavily utilized by the general population, such as optometry (eyeglasses), whereas others are less frequently utilized such as genomic medicine. The lower-volume, less utilized services are often harder to deliver successfully due to resource challenges, including staffing, infrastructure requirements, and implementing and maintaining costly technologies. While there is overlap care models with increasing utilization of virtual technologies across all specialties, specialty care delivery can be categorized at a high levels by, 1) procedural outpatient care, including cardiology, dialysis, gastroenterology, ophthalmology, Mohs surgery (dermatology), podiatry; 2) outpatient virtual care, where a significant amount of the care provided can be provided virtually, including sleep medicine, dermatology, eye care and genomic medicine; and 3) outpatient brick and mortar, which would include specialties such as allergy, endocrinology, infectious diseases, kidney medicine (nephrology), and rheumatology.

Recent Trends:

Telehealth: In 2023, VA continued to make the most of its legal and operational authority and business processes to integrate virtual care to Veterans at home in the following areas:

- PC is leading implementation of PACT Act § 603, ensuring enrolled Veterans receive service-related toxic exposures screening (TES) at least every five years to connect them to benefits, promote research, and establish exposures informed health care. The TES was launched November 8, 2022, with the goal of ultimately screening all 9.0 million enrolled Veterans. Phase 1 involved screening Veterans coming in for PC visits. As of February 25, 2004, VA had completed over 5 million TES.. Over 40% of those endorsed having at least one exposure concern while in the Military. The screening process was linked to providing information on exposures related health concerns, clinically evaluating, and addressing any new symptoms related to the exposures, actively supporting the Veteran in submitting claims for presumptive conditions and adding the exposures concern to the Veteran's problem list in the electronic health record (EHR). The overall goal is to create a more exposures informed care model for all Veterans. We have now entered Phase 2, with broader implementation of TES screening into all clinical settings.

- 91% of VHA PC and MH providers have completed at least one synchronous telehealth visit using video.
- More than 11.6 million video telehealth visits were conducted in 2023. This includes 9.4 million of these video visits (over) were completed with Veterans at home or some other non-VA location, and more than 2.9 million telehealth episodes of care to rural Veterans.
- Providing collaborative PCMHI care to approximately 8.3% of Veterans enrolled at all primary care sites across 1.4 million encounters, which represents 104% of the encounter volume, compared to the year prior and demonstrates ongoing resilience of PAC team clinical functions.
- Podiatry includes medical and surgical foot and ankle care and the Prevention of Amputation in Veterans Everywhere (PAVE) program. This includes the amputation/ulcer database and the high-risk amputation pyramid cubes. The National Podiatry Program provides clinical guidance, policy and oversight and provided nearly 1.4 million in-person and over 16,000 clinical video telehealth (CVT) encounters in 2022. Podiatry also includes the Remote Temperature Monitoring Program, a program for high-risk patients, where they enrolled and monitored for the prevention of diabetic foot ulcers. Enrollment in this program is working to reduce ulcers and amputations from diabetic foot ulcers.
- Dermatology, Eye Care and Sleep testing have had a focus on standardizing access to care. These targeted specialty services were included in the 2022/2023 Agency Priority Goals as well as the 2023 Priority to Action (P2A) initiative. The focus to provide Veterans with consistent access to dermatology assessments, eye care screenings, and sleep disorder screenings across community-based outpatient clinics (CBOCs) by leveraging in-person care or asynchronous telehealth.
- Between 2022 and 2023, targeted TeleSpecialty care services (Sleep, Dermatology, Eye Care) and TeleUrgent Care services grew 35%. Dermatology services were added to an additional 82 locations where Veterans receive primary care (12% increase) and Eye Care services were added to an additional 61 sites where Veterans receive primary care (9% increase).

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

- Recent data from the VA Clinical Assessment, Reporting and Tracking Program (CART) indicates that elective percutaneous coronary intervention in the community as compared with the VA is associated with worse clinical outcomes. (Waldo et al., 2020).
- Veteran reliance on VA for dialysis services remains steady. In 2022 the VA provided 27,159 Veterans with dialysis; VA intramural dialysis program served 4,289 Veterans delivering over 250,000 dialysis treatments, whereas 22,870 Veterans were served by VA Community Care (CC) with VA purchasing 2.5 million treatments in the community.
- VA Direct Care (DC) New Nephrology encounters increased by same count as CC New Nephrology decreased (approximately 1,300) Q1 F2022 as compared to Q1 2023. Four

VISNs account for nearly half of Community Care Nephrology referrals: VISNs 7,10,16,17 account for 47% of total quarterly CC volume.

- In 2023, 108,000 Veterans received home sleep testing, a 31% increase from 2022.
- As part of VHAs robust antimicrobial stewardship initiative to reduce drug resistance in infections, since 2011, there has been a decreased use of up to 68% in certain classes of commonly used antibiotics (e.g., fluoroquinolones) in the ambulatory setting.
- In 2023, the Specialty Care Program Office (SCPO) sponsored a Specialty Care Staffing national workgroup to address significant disparities in support staffing for specialty care providers in VA compared to the private sector. The key recommendation would be to bring support staffing levels up 2.0 FTEE support staff per MD/APP FTEE during clinic sessions and 1.0 FTEE support staff for non-clinic support. This is projected to be up to 4,628 FTEE (plus 10% FTEE replacement factor). Implementation of this recommendation would reduce the bifurcation of care and referring Veterans to community care who would rather receive their specialty care through VA.
- VA health care demonstrated significantly better performance than commercial health maintenance organizations (HMO) and Medicaid HMOs for all 16 outpatient effectiveness measures and was significantly better for 14 measures, compared with Medicare HMOs (Price and others, 2018).
- VHA primary care clinics with the most patient centered medical home (PCMH) components had greater improvements in several chronic disease quality measures than the lowest PCMH clinics. In adjusted models containing 808 clinics, the 77 clinics with the most PAC components in place had significantly larger improvements in five of seven chronic disease intermediate outcome measures (for example, BP < 160/100 in diabetes), ranging from 1.3% to 5.2% of the patient population meeting measures and two of eight process measures (HbA1c measurement, LDL measurement in CAD) than the 69 clinics with the least PAC components. Clinics with moderate levels of PAC components showed few significantly larger improvements than the lowest PAC clinics (Rosland 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. VA sites across the country are strengthening ties with extended team CPPs in managing hypertension and other chronic diseases.
- Veterans with multiple chronic conditions (that is, multimorbidity), those seen in clinics with the greatest PCMH implementation compared to the least PCMH implementation had better chronic disease outcome measures (for 5 of 15 metrics), but as patients had more illnesses, this relationship was reduced (only 2 of 15), in adjusted models. This suggests more complex patients may have competing demands that interfere with chronic disease care (Schuttner and others, 2020).
- Veterans with multimorbidity seen in clinics with greater PCMH implementation reported a clinically significant, 2.0 (out of 100 points) higher physical health-related quality of life

score, in adjusted models. This difference was greatest for patients at clinics with better performance for communication, continuity, and shared decision-making (Schuttner et al., 2020).

- Veterans with comorbid mental and physical health conditions receiving care in PAC clinics with greater PCMH implementation had significantly lower rates of hospitalization. Specifically, Veterans receiving care in clinics with the greatest versus lowest quartile of implementation of team-based care had a 3.5% lower rate of hospitalization (Germack et al., 2021).
- Programs such as the Video Blood Pressure Visit (VBPV) program, a three-year Office of Rural Health (ORH) funded initiative, showed strong improvement in patient blood pressure outcomes for 2021-22. Efficacy analysis focused on monitoring change in BP readings from initial VBPV to follow up BP reading, with a specified time increment between the two events. An example of the improvement is seen in 25-35 days after a VBPV. A sample size of 4,253 patients saw a decrease is systolic pressures by 68.7% and a decrease in diastolic pressures by 60.7%. 60, 90 and 120 days demonstrated similar decreases.
- 2022 showed integration of the PAC CPP into measurement of Veteran experience. A total of 743 Veteran surveys were completed with a response rate of 20%. For primary care specifically, responses to the outpatient health care visit survey showed ease and simplicity was rated as a 4-5 response 94.6% of the time, quality 93.2%, employee helpfulness 96.1%, satisfaction 96.1% and confidence/trust 94.0% (McFarland and others, 2022).

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Dental Care

Dental Care
(dollars in thousands)

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$893,031	$924,469	$955,940	$966,347	$986,841	$10,407	$20,494
Medical Community Care (0140):	$1,140,709	$1,102,822	$1,333,629	$1,576,100	$1,813,024	$242,471	$236,924
Medical Support and Compliance (0152):	$174,862	$213,100	$193,200	$218,600	$230,300	$25,400	$11,700
Medical Facilities (0162):	$185,141	$332,900	$188,700	$194,300	$204,600	$5,600	$10,300
Discretionary Total	**$2,393,743**	**$2,573,291**	**$2,671,469**	**$2,955,347**	**$3,234,765**	**$283,878**	**$279,418**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$1,845	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$99	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,944**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$20	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$63	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$83**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$602	$0	$4,600	$20,300	$14,700	$15,700	($5,600)
Veterans Medical Care and Health Fund (0173)	$55	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$21	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$678**	**$0**	**$4,600**	**$20,300**	**$14,700**	**$15,700**	**($5,600)**
Mandatory Total	**$2,705**	**$0**	**$4,600**	**$20,300**	**$14,700**	**$15,700**	**($5,600)**
Combined Discretionary and Mandatory by Category							
Medical Services	$894,975	$924,469	$955,940	$966,347	$986,841	$10,407	$20,494
Medical Community Care	$1,140,709	$1,102,822	$1,333,629	$1,576,100	$1,813,024	$242,471	$236,924
Medical Support and Compliance	$174,945	$213,100	$193,200	$218,600	$230,300	$25,400	$11,700
Medical Facilities	$185,819	$332,900	$193,300	$214,600	$219,300	$21,300	$4,700
Obligations [Grand Total]	**$2,396,448**	**$2,573,291**	**$2,676,069**	**$2,975,647**	**$3,249,465**	**$299,578**	**$273,818**

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

Population Covered: There are over 9 million Veterans enrolled in VA health. At the end of 2023 there were approximately 1.8 million enrolled Veterans eligible for comprehensive dental care (22.5% of all enrolled Veterans). During 2023, VA dental services managed the care of 582,000 Veterans eligible for comprehensive dental care. An additional 102,000 were eligible and provided dental care due to medical necessity, totaling 690,000 Veterans. Some Veterans eligible for limited care become eligible for comprehensive dental care during the year due to a change in their disability rating.

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

Recent Trends: Prior to the implementation of PACT the number of Veterans eligible for comprehensive dental care increased by approximately 8.6% annually in the five years before 2023 from 1.2 million in 2018 to over 1.7 million in 2022. During 2023 the number of Veterans eligible for comprehensive dental care grew by 11.7% from 1.6 million at the beginning of 2023 to 1.8 million at the end of 2023. From 2018 to 2023, the number of dental treatment rooms increased by 1.5% on average per year, for a total increase of 7.7%. During the same five years the total number of dental staff increased by 4.8%, led by an increase in dental hygienists of 15.6%, followed by an increase of 9.7 % for dentists and 2.9% for dental assistants. In 2023, 238 VA dental clinics managed the care of 690,000 Veterans. 567,000 Veterans received dental care on-site in a VA clinic, at which 5.1 million procedures were completed during 1.9 million encounters. The remaining 123,000 Veterans received dental care exclusively through community care.

Projections for the Future: Dental access rate is defined as the number of Veterans provided comprehensive dental care during a fiscal year out of the total number of Veterans eligible for comprehensive dental care. In 2023, the dental access rate was 31% (568,000 Veterans provided comprehensive dental care divided by 1.8 million eligible Veterans), which decreased from the previous year due to the influx of Veterans eligible for dental care resulting from the PACT Act.

Most VA dental clinics operate at or near full capacity. It is expected that the increased number of Veterans eligible for dental care and those living outside the 60-minute average drive time access

standard will lead to further increased community care dental costs as more Veterans utilize their dental entitlement to match closer access rates of the private sector, which is near 65%. The cost of community care per unique Veteran has historically been approximately 20% higher than that of in-house care. From 2018 to 2023, dental treatment rooms increased by nearly 7.7% and dental staffing increased by 1% per year. The Office of Dentistry projects a target in-house access rate of 42% within five years. Given the historical annual growth rate of 9.5% (2019 – 2023) for Veterans eligible for comprehensive dental care, the VA Office of Dentistry forecasts about 2.78 million Veterans will be eligible for comprehensive care by 2028. The number of unique Veterans forecasted to serve in 2028 is projected at 1.2 million for comprehensive dental care and 220,411 Veterans for focused care due to medical necessity, for a total of 1.4 million.

Studies by the American Dental Association (ADA) (Nasseh & Vujicic, 2016) and the Centers for Disease Control and Prevention (CDC, 2017) show yearly dental service utilization up to 65% for those with third-party payor coverage in the U.S. population. These studies show there is significant potential for growth in VA dentistry.

Year	Unique Veterans Seen	Access Rate
2018	512,790	47%
2019	541,291	45%
2020 (Pandemic)	462,823	34%
2021 (Pandemic)	464,603	32%
2022	514,385	32%
2023	567,638	31%
Forecast Access Rate		
2024	637,194	34%
2025	682,151	36%
2026	699,205	38%
2027	716,685	40%
2028	734,602	42%
2029	752,967	44%

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Inpatient Care

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$10,814,808	$9,023,615	$9,093,170	$9,234,518	$10,182,882	$141,348	$948,364
Medical Community Care (0140):	$7,270,730	$6,330,838	$4,712,697	$0	$989,884	($4,712,697)	$989,884
Medical Support and Compliance (0152):	$1,699,015	$1,829,300	$1,877,600	$2,124,700	$2,238,500	$247,100	$113,800
Medical Facilities (0162):	$1,548,519	$1,668,100	$1,577,900	$1,624,500	$1,711,000	$46,600	$86,500
Discretionary Total	**$21,333,072**	**$18,851,853**	**$17,261,367**	**$12,983,718**	**$15,122,266**	**($4,277,649)**	**$2,138,548**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$14,999	$1,672,454	$1,982,535	$1,883,338	$1,048,385	($99,197)	($834,953)
Veterans Medical Care and Health Fund (0173)	$164,143	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$9	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$1,217	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$180,368**	**$1,672,454**	**$1,982,535**	**$1,883,338**	**$1,048,385**	**($99,197)**	**($834,953)**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$5,510,910	$5,510,910	$10,943,411	$11,000,000	$5,432,501	$56,589
Veterans Medical Care and Health Fund (0173)	$1,774,506	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	($12)	$250,675	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,774,494**	**$5,761,585**	**$5,510,910**	**$10,943,411**	**$11,000,000**	**$5,432,501**	**$56,589**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$479,314	$207,009	$0	$0	($207,009)	$0
Veterans Medical Care and Health Fund (0173)	$131,308	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$659	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$131,967**	**$479,314**	**$207,009**	**$0**	**$0**	**($207,009)**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$4,847	$0	$37,100	$163,400	$118,400	$126,300	($45,000)
Veterans Medical Care and Health Fund (0173)	$189,320	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$194	$1,342	$5,092	$0	$0	($5,092)	$0
Mandatory Obligations [Subtotal]	**$194,361**	**$1,342**	**$42,192**	**$163,400**	**$118,400**	**$121,208**	**($45,000)**
Mandatory Total	**$2,281,190**	**$7,914,695**	**$7,742,646**	**$12,990,149**	**$12,166,785**	**$5,247,503**	**($823,364)**
Combined Discretionary and Mandatory by Category							
Medical Services	$10,995,176	$10,696,069	$11,075,705	**$11,117,856**	**$11,231,267**	$42,151	$113,411
Medical Community Care	$9,045,224	$12,092,423	$10,223,607	**$10,943,411**	**$11,989,884**	$719,804	$1,046,473
Medical Support and Compliance	$1,830,982	$2,308,614	$2,084,609	**$2,124,700**	**$2,238,500**	$40,091	$113,800
Medical Facilities	$1,742,880	$1,669,442	$1,620,092	**$1,787,900**	**$1,829,400**	$167,808	$41,500
Obligations [Grand Total]	**$23,614,262**	**$26,766,548**	**$25,004,013**	**$25,973,867**	**$27,289,051**	**$969,854**	**$1,315,184**

Authority for Action: 38 U.S.C. 17

Recent Legislation

- P.L. 117-168, *Honoring our PACT Act of 2022*. The PACT Act expanded and extended eligibility for VA health care for Veterans with toxic exposures and Veterans of the Vietnam era, Gulf War era, and Post-9/11 era.

Types of Services Provided

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

matter expertise (SME) in the management of critically ill surgical and non-surgical patients and oversight of surgical patients requiring interventional postoperative pain management.

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

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

Pulmonary and Critical Care Medicine: Pulmonary and Critical Care provides direct care to Veterans admitted to any of the 158 intensive care units with 1952 beds across the enterprise. They also provide consultative care for inpatients with lung related illnesses as well as outpatient services for lung disease. Most of the disease processes associated with toxic exposure involve the lung making this service extremely important for Veterans suffering from toxic exposure.

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

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

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

The comparisons listed in the table below are based on the most recent VA data sent to CMS for posting on their Care Compare website (CMS, 2024) and the most current published national non-VA benchmarks. Inpatient quality indicator (IQI) measures have been removed from this report. The following overall trends are noted:

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

- Adverse events, as measured using patient safety indicators (PSI), are generally similar or lower, with one exception. *Note: PSI 03 – Pressure Ulcer Rate – is higher, a difference partially 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*.
- Rates of health care associated infection are comparable to the private sector.

CMS data, including hospital-specific data, for VA and the private sector is available for public download (CMS, Provider Data Catalog, 2024), 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 (Blay, et al., 2017; Anhang Price, et al., 2018; Weeks and West, 2018).

Table: Quality Outcomes (Mortality and Readmission)

Quality Outcomes (Mortality and Readmission)	**VA July 1, 2019– June 30, 2022**	**CMS July 1, 2019 – June 30, 2022**
Mortality	**Rate**	**Rate**
30-day risk standardized mortality rate - Congestive Heart Failure (CHF RSMR)	8.5	11.8
30-day risk standardized mortality rate - Pneumonia (Pneumonia RSMR)	15.2	18.2
30-day risk standardized mortality rate – Acute Myocardial Infarction (AMI RSMR)	11.9	12.6
30-day risk standardized mortality rate – Chronic Obstructive Pulmonary Disease (COPD RSMR)	8	9.2
Readmission	**Rate**	**Rate**
30-day risk standardized readmission rate - Congestive Heart Failure (CHF RSRR)	21	20.2
30-day risk standardized readmission rate - Pneumonia (Pneumonia RSRR)	17.2	16.9
30-day risk standardized readmission rate - Acute Myocardial Infarction (AMI RSRR)	15.1	14
30-day risk standardized readmission rate – Chronic Obstructive Pulmonary Disease (COPD RSRR)	20.3	19.3
30-day risk standardized readmission rate - Hospital Wide Readmission (HWR)	17	14.6

Patient Safety Indicators (PSIs)	VA Risk Adjusted Rate per 1,000 Discharges from October 1, 2021 – September 30, 2023[1]	CMS Reported Nationwide Mean Smoothed Rate per 1,000 Discharges from July 1, 2018 – December 31, 2019[2]
Pressure Ulcer Rate (PSI 03)	1.12	0.58
Inpatient Surgical Deaths (PSI 04)	117.08	143.00
Collapsed lung due to medical treatment (PSI 06)	0.27	0.19
Postoperative Hip Fracture (PSI 08)	0.14	0.08
Perioperative Bleeding/Bruise (PSI 09)	2.02	2.38
Postoperative Kidney and Diabetic Complications (PSI 10)	0.46	0.91
Postoperative Respiratory Failure (PSI 11)	4.91	6.59
Perioperative Blood Clot/Embolism (PSI 12)	2.62	3.37
Postoperative Sepsis (PSI 13)	2.56	4.08
A wound that splits open after surgery on the abdomen or pelvis (PSI 14)	0.61	0.80
Accidental puncture or laceration from medical treatment (PSI 15)	1.62	1.05

[1]Rates in this column are VA mean risk adjusted rates calculated using International Classification of Diseases – 10th Edition (ICD-10) diagnoses and Centers for Medicare & Medicaid Services (CMS) v.12 software based on discharge data from 10/1/2021 through 9/30/2023.

[2]Rates in this column are CMS reported nationwide mean smoothed rates based on an analysis of discharge data from Medicare fee-for-service discharge data from 3,252 Inpatient Prospective Payment System hospitals and 126 VA hospitals from 7/1/2018 through 12/31/2019.

Healthcare-Associated Infections (HAIs)	VA[3] (January – December 2022)	NHSN/CDC[4]
	Mean	Median SIR[5]
1. Central Line Associated Bloodstream Infection Rate (CLABSI) per 1,000-line days		
Acute Care	00.620	0.775
ICU	1.33	0.959
2. Catheter Associated Urinary Tract Infection (CAUTI) per 1,000 catheter days		
Acute Care	0.881	0.794
ICU	0.539	0.584
		NHSN[6]
3. Total Bloodstream (BSI) Infection rates per 100 patient months		
Outpatient Dialysis Treatment Center	0.65	0.64

4. Access-Related Bloodstream (ARB) Infection rates per 100 patient months		
Outpatient Dialysis Treatment Center	0.35	0.49
5. Total Bloodstream Standardized Infection Ratio (SIR)		
Outpatient Dialysis Treatment Center	0.82	1.0

[3]2021 SIR rate is the average of the four quarters for the calendar year.
[4]Note: NHSN/CDC data from Centers for Disease Control and Prevention. (2023).
[5]SIR: Standardized Infection Rate.
[6]Note: NHSN data from Nguyen, et al. (2017)

Recent Trends: Reductions in staffed nursing home and long-term care beds in local communities have led to a backup of patients in VA inpatient beds. At some VA facilities up to a third or half of the inpatient medicine census may be comprised of Veterans who no longer need acute inpatient care but whose post-discharge options are limited. These patients often have underlying cognitive and or behavioral disorders and can present management challenges.

Projections for the Future: Increased use of Tele-Medicine is expected, in line with the expansion of Tele-Critical Care. Tele-Hospital Medicine, Tele-Subspecialty Care, and even Tele-Nursing are expected to change how team-based inpatient healthcare is delivered. These technologies hold the promise to broadly expand access to expertise.

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Mental Health

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$10,260,598	$11,103,529	$11,035,347	$11,329,959	$12,096,864	$294,612	$766,905
Medical Community Care (0140):	$1,055,963	$1,112,740	$1,444,073	$1,973,128	$2,512,558	$529,055	$539,430
Medical Support and Compliance (0152):	$1,248,375	$1,449,400	$1,379,600	$1,561,100	$1,644,700	$181,500	$83,600
Medical Facilities (0162):	$1,445,084	$2,577,800	$1,472,500	$1,516,000	$1,596,700	$43,500	$80,700
Discretionary Total	**$14,010,020**	**$16,243,469**	**$15,331,520**	**$16,380,187**	**$17,850,822**	**$1,048,667**	**$1,470,635**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$306,674	$532,591	$505,942	$281,639	($26,649)	($224,303)
Veterans Medical Care and Health Fund (0173)	$44,098	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$936	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$45,034**	**$306,674**	**$532,591**	**$505,942**	**$281,639**	**($26,649)**	**($224,303)**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$56,589	$0	$56,589	($56,589)
Veterans Medical Care and Health Fund (0173)	$207,503	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$207,503**	**$0**	**$0**	**$56,589**	**$0**	**$56,589**	**($56,589)**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$36,481	$76,852	$0	$0	($76,852)	$0
Veterans Medical Care and Health Fund (0173)	$48,748	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$467	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$49,215**	**$36,481**	**$76,852**	**$0**	**$0**	**($76,852)**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$3,297	$0	$25,200	$111,000	$80,400	$85,800	($30,600)
Veterans Medical Care and Health Fund (0173)	$108,267	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$174	$1,201	$2,677	$0	$0	($2,677)	$0
Mandatory Obligations [Subtotal]	**$111,738**	**$1,201**	**$27,877**	**$111,000**	**$80,400**	**$83,123**	**($30,600)**
Mandatory Total	**$413,490**	**$344,356**	**$637,320**	**$673,531**	**$362,039**	**$36,211**	**($311,492)**
Combined Discretionary and Mandatory by Category							
Medical Services	$10,305,632	$11,410,203	$11,567,938	$11,835,901	$12,378,503	$267,963	$542,602
Medical Community Care	$1,263,466	$1,112,740	$1,444,073	$2,029,717	$2,512,558	$585,644	$482,841
Medical Support and Compliance	$1,297,590	$1,485,881	$1,456,452	$1,561,100	$1,644,700	$104,648	$83,600
Medical Facilities	$1,556,822	$2,579,001	$1,500,377	$1,627,000	$1,677,100	$126,623	$50,100
Obligations [Grand Total]	**$14,423,510**	**$16,587,825**	**$15,968,840**	**$17,053,718**	**$18,212,861**	**$1,084,878**	**$1,159,143**

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, *Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life*, 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 mental health care.
- **Non-VA Inpatient Hospital.** Purchased community inpatient bed based acute mental health care.
- **Compensated Work Therapy - Transitional Residence.** 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 intensive mental health and substance use treatment services augmented by use of other VA outpatient services.
- **Non-VA Domiciliary Residential Rehabilitation Treatment**. Purchased community residential mental health and substance use care.
- **VA Outpatient Clinics.** The full range of VA outpatient medical health clinics, providing mental health services from Psychiatrists, Psychologists, Licensed Professional Counselors, Marriage and Family Therapists 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 use disorder and homelessness.
- **Non-VA Outpatient.** General mental health services purchased from the community.

Suicide Prevention. VA Suicide Prevention services include the Veteran Crisis Line, Suicide Coordinators, comprehensive suicide risk assessment at VA facilities, 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 Settings. 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 Levels of Care. 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 or a medical unit.

Major Characteristics of Mental Health Services for Veterans with Serious Mental Illness. The major characteristics in this section break out the care provided to Veterans with serious mental 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 a primary care clinic.

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

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Treatment Modality ($000):							
VA Inpatient Hospital	$2,170,794	$2,549,291	$2,338,031	$2,308,491	$2,335,706	($29,540)	$27,215
Contract Inpatient Hospital	$1,371,523	$1,036,738	$1,490,593	$2,025,261	$2,417,671	$534,668	$392,410
Psychiatric and VA Dom Res. Rehab. Trmt	$1,090,645	$1,281,162	$1,171,291	$1,426,272	$1,610,900	$254,981	$184,628
VA Outpatient Clinics	$7,844,098	$9,197,509	$8,717,216	$8,905,637	$9,335,830	$188,421	$430,193
Non-VA Outpatient	$338,309	$417,287	$509,950	$565,569	$614,169	$55,619	$48,600
Subtotal Direct Mental Health	$12,815,369	$14,481,987	$14,227,081	$15,231,230	$16,314,276	$1,004,149	$1,083,046
Non-Add included above:							
Suicide Prevention Treatment in MH setting	*$1,852,684*	*$1,816,787*	$1,952,626	$2,046,921	$2,137,424	*$94,295*	*$90,503*
Suicide Prevention Outreach 1/:							
Suicide Prevention Direct Program, SP	$433,600	$485,532	$485,532	$493,713	$493,713	$8,181	$0
Suicide Prevention Coordinators, GP	$83,422	$73,262	$85,424	$88,841	$92,306	$3,417	$3,465
Subtotal Suicide Prevention Program Subtotal	$517,022	$558,794	$570,956	$582,554	$586,019	$11,598	$3,465
Suicide Prevention Treatment in Non MH Setting	$561,884	$658,842	$592,194	$620,792	$648,240	$28,598	$27,448
Contract Homeless	$210,389	$199,958	$225,602	$242,153	$261,713	$16,551	$19,560
VA - Mental Health in non MH Setting	$318,846	$688,244	$353,007	$376,989	$402,613	$23,982	$25,624
Total Mental Health	**$14,423,510**	**$16,587,825**	**$15,968,840**	**$17,053,718**	**$18,212,861**	**$1,084,878**	**$1,159,143**
Major Characteristics of Program ($000):							
SMI - PTSD	$390,721	$455,471	$424,579	$460,034	$499,530	$35,455	$39,496
SMI - Substance Abuse	$822,207	$892,230	$921,754	$1,023,402	$1,125,090	$101,648	$101,688
SMI - Other Than PTSD & SA	$7,197,461	$7,356,245	$7,988,195	$8,777,079	$9,542,777	$788,884	$765,698
Subtotal, SMI	$8,410,389	$8,703,946	$9,334,528	$10,260,515	$11,167,397	$925,987	$906,882
Suicide Prevention Outreach	$517,022	$558,794	$570,956	$582,554	$586,019	$11,598	$3,465
Other Mental Health (Non-SMI)	$5,496,099	$7,325,085	$6,063,356	$6,210,649	$6,459,445	$147,293	$248,796
Total Mental Health	**$14,423,510**	**$16,587,825**	**$15,968,840**	**$17,053,718**	**$18,212,861**	**$1,084,878**	**$1,159,143**
Included Above:							
OEF/OIF/OND POPULATION *ONLY*:							
SMI - PTSD	$183,839	$230,226	$209,745	$231,614	$254,062	$21,869	$22,448
SMI - Substance Abuse	$240,304	$263,524	$274,168	$302,754	$332,097	$28,586	$29,343
SMI - Other Than PTSD & SA	$1,536,210	$2,000,069	$1,752,693	$1,935,435	$2,123,019	$182,742	$187,584
Subtotal, SMI	$1,960,353	$2,493,819	$2,236,606	$2,469,803	$2,709,178	$233,197	$239,375
Other Mental Health (Non-SMI)	$1,431,098	$1,284,167	$1,632,769	$1,803,007	$1,977,757	$170,238	$174,750
Total OEF/OIF/OND	$3,391,451	$3,777,986	$3,869,375	$4,272,810	$4,686,935	$403,435	$414,125
Average Daily Census:							
Acute Psychiatry	1,657	1,571	1,657	1,530	1,464	(127)	(66)
Contract Hospital (Psych)	1,654	1,894	1,730	1,966	2,121	236	155
Psy Residential Rehab	3,754	4,017	4,370	4,837	4,822	467	(15)
Total	7,065	7,482	7,757	8,333	8,407	576	74
Outpatient Visits:							
VA Care - Mental Health	16,071,763	17,861,570	17,242,061	16,836,046	16,852,006	(406,015)	15,960
Non-VA Care - Mental Health	1,683,906	1,622,952	1,821,739	2,872,826	3,630,257	1,051,087	757,430
Not Included Above:							
VA - Mental Health in non MH Setting 2/	589,522	2,279,999	652,684	697,025	744,402	44,341	47,377

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.

2/ In prior Congressional Justifications, the visits associated with "VA - Mental Health in non-MH Setting" were incorrectly included in the "Non-VA Care – Mental Health" outpatient visits total. The outpatient visits in all categories have been corrected in this chart in all columns except for 2024 Budget Estimate, which shows the same data as in the 2024 Congressional Justification.

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 1.96 million Veterans (32% of all VHA patients) receiving mental health services in a VHA specialty mental health setting in 2023, defined as individual or group treatment provided by a mental health professional.

Across VA settings of care, more than 575,000 Veterans were seen in 2023 for a substance use disorder diagnosis. The proportions of VHA health-service users who receive mental health treatment vary across age groups. The proportions of VHA health-service users who receive mental health treatment are highest among younger Veterans and decline with age but women in the older age groups are more likely to access mental health treatment compared to men. Among women, 50% of Veterans using VHA care in 2023 were under age 50, whereas among men, the comparable figure was 22%.

In 2023, the rate of all VHA users under age 50 who use VA mental health services was 45% while the rate for Veterans over age 50 was 23%. However, given the size of the older cohort of male Veterans, 53% of all users of VHA mental health services in 2023 were men over age 50, many of whom are over 65.

Type of Services Provided: 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 acute inpatient mental health services for the full range of mental health conditions. VA proactively screens for symptoms of depression, PTSD, problematic use of alcohol use, experiences of military sexual trauma (MST), and suicide risk. VHA mental health services are based on a recovery-oriented and evidence-based 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 Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service, dated April 27, 2023.

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 telemental 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

- 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. From January to November 2023, VHA hired 3,943 new (external) employees for clinical mental health roles.
- The increase in the number of outpatient mental health encounters or treatment visits has been dramatic; almost doubling between FYs 2008 through 2023 from 11.4 million to 21.8 million encounters/visits. In 2023, the number of face-to-face and telehealth visits was stable at 20.1 million encounters.
- Between 2008 and 2023, the number of Veterans who received mental health care from the VHA grew by 83%. 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 2008, 22% of VHA users received mental health services, and in 2023, the figure was 32%.
- In 2023, over 271,000 women Veterans received VHA mental health care, representing approximately 47% 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. As of October 2023, there over 1,400 peer specialists currently working in VHA. Examples of where peer specialists work include outpatient, inpatient and residential mental health and substance use treatment programs, intensive community mental health recovery services, psychosocial rehabilitation recovery centers, primary care patient aligned care teams, vocational rehabilitation services, homeless programs, Veterans Justice Program, and the Veterans Crisis Line's Peer Support Outreach Center. 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. Through 2023, VHA's EBP Provider Training Program has trained over 14,500 unique providers to

competency in one or more of these EBPs. In 2023, 38% of new PC-MHI patients had a same-day, warm hand-off between the Primary Care Provider and a PC-MHI provider.

- In 2017, VA began offering emergent mental health services to former Servicemembers with Other than Honorable administrative discharges. In 2023, 5,962 Servicemembers with an "other than honorable" discharge received mental health services.
- VA continued efforts to expand 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. Data suggests that in comparison to control groups, Veterans identified by REACH VET exhibited:
    - Increases in outpatient appointments.
    - Decreases in percent of missed appointments.
    - Greater initiation of suicide prevention safety plans.
    - Decreases in inpatient mental health admissions.
    - Reduced Emergency Department visit days.
    - Reduced documented suicide attempts.
- VA's Stratification Tool for Opioid Risk Mitigation (STORM) uses VHA administrative data and predictive modeling to help improve opioid safety by identifying patients at the highest risk for overdose or suicide-related events and assigning them a risk score. STORM is updated nightly and provides risk scores and risk mitigation strategies for patients with an active outpatient opioid prescription or who have an opioid use disorder. Since VA mandated case reviews for all Veterans identified as very high risk for overdose or suicide by STORM, a randomized program evaluation found a 22% reduction in all-cause mortality among patients targeted by this prevention program.
- The VA Opioid Overdose Education and Naloxone Distribution (OEND) program aims to decrease opioid-related overdose deaths among VHA patients by providing education on opioid overdose prevention, recognition of opioid overdose, and training on the rescue response, including provision of naloxone. Since implementation of the OEND program in 2014, over 59,250 VHA prescribers, representing all VHA facilities, have prescribed naloxone, and more than 1,196,000 naloxone prescriptions have been dispensed to over 519,000 Veterans (as of 12/11/23). Further, as documented through spontaneous reporting of overdose reversal events as well as through a national note template, over 4,666 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 mental health services will continue to grow.
- 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. In 2024, VA will begin to advance a hiring initiative for mental health with an expanded focus on growing the mental health workforce through the Mental Health Staffing Pathways project. Mental health staff are also being integrated into settings such as pain clinics and oncology clinics.
- 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.
- Continue expansion of 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	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Treatment Modality ($000):							
MH Inpatient	$120,384	$126,184	$123,273	$128,204	$133,204	$4,931	$5,000
MH Clinics	$151,847	$128,966	$155,491	$161,711	$168,018	$6,220	$6,307
MH Dom/RRT	$62,181	$72,736	$63,673	$66,220	$68,803	$2,547	$2,583
Methadone	$38,115	$42,004	$39,030	$40,591	$42,174	$1,561	$1,583
Other Inpatient	$14,696	$13,206	$15,049	$15,651	$16,261	$602	$610
Other OPC	$21,459	$54,174	$21,974	$22,853	$23,744	$879	$891
Subtotal Treatment	**$408,682**	**$437,270**	**$418,490**	**$435,230**	**$452,204**	**$16,740**	**$16,974**
Pharmacy	$21,909	$23,608	$22,435	$23,332	$24,242	$897	$910
Total Treatment	**$430,591**	**$460,878**	**$440,925**	**$458,562**	**$476,446**	**$17,637**	**$17,884**
Jason Simcakoski Memorial and Promise Act (*Jason's Law*) 1/ 2/ 3/:							
Pain and Opioid Management Services	$173,298	$215,712	$215,712	$211,158	$211,158	($4,554)	$0
Pain and Opioid Management Administration	$5,836	$5,806	$5,806	$10,360	$10,360	$4,554	$0
Patient Centered Care Services	$25,371	$29,857	$29,857	$29,857	$29,857	$0	$0
Patient Centered Care Administration	$1,945	$3,112	$3,112	$3,112	$3,112	$0	$0
Program [Subtotal]	**$206,450**	**$254,487**	**$254,487**	**$254,487**	**$254,487**	**$0**	**$0**

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

Authority for Action

- 38 U.S.C. § 1701
- 38 C.F.R. § 1.7.38
- Jason Simcakoski Memorial and Promise Act, P.L. 114-198 § 901-933

Purpose: VA continues to pursue a comprehensive strategy that promotes high quality effective pain management, safe opioid prescribing, treatment of Opioid Use Disorder (OUD) and prevention of opioid overdose. Through authorities established by the enactment of the Comprehensive Addiction and Recovery Act of 2016 (CARA; P.L. 114 – 198, Title IX), otherwise known as *Jason's Law*, the Pain Management Program in Specialty Care Services (SCS), within the Specialty Care Program Office (SCPO), expanded to form the Pain Management, Opioid Safety and Prescription Drug Monitoring Program (PMOP) in 2020.

1. Opioid Overdose Education and Naloxone Distribution (OEND):

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

In September 2018, Veterans Health Administration (VHA) launched a Rapid Naloxone Initiative consisting of three elements: (1) OEND to VA patients at-risk for opioid overdose; (2) VA Police Naloxone; and (3) Automated External Defibrillator (AED) Cabinet Naloxone

(Oliva et al., 2021). VHA's efforts include continuing to fund naloxone free to high-risk VHA patients (as mandated by Jason's Law) and free to facilities (to reduce barriers to distribution), development and delivery of new educational and training materials (for Academic Detailing and field use) and providing support to the expansion of naloxone to first responders (VA Police) and in AED cabinets. In February 2021, VHA released the memorandum titled *Naloxone Distribution to Veterans Diagnosed with Opioid Use Disorder* (OUD), which aims to increase naloxone distribution among this high-risk population. In December 2022, VA updated the memorandum expanding efforts from patients diagnosed with OUD to reach patients diagnosed with stimulant use disorder (given the high rates of stimulant overdose deaths involving opioids) as well as patients with a previous non-fatal opioid- or stimulant-overdose and patients identified as "Very High" risk by the VA Stratification Tool for Opioid Risk Mitigation (STORM). Between fiscal year (FY) 2021 quarter one (Q1) and FY 2023 Q4 there was a 30% increase in naloxone distribution among patients with OUD (from 39% to 69%). A portion of the requested funding in 2025 will support the continued growth and replenishment of the OEND program.

VA is a national and international leader in naloxone distribution to healthcare patients (Oliva et al., 2017) and its achievements through 2023 include:

- Since implementing the OEND program in 2014, VHA has dispensed nearly 1,134,000 naloxone prescriptions written by over 56,000 VHA prescribers (representing all VHA facilities) to over 497,000 patients with over 4,400 reported opioid overdose reversals (through FY 2023 Q4). VHA reached the milestone of dispensing one million naloxone prescriptions on May 1, 2023.
- In 2018, VA dispensed a naloxone prescription for 1 in 6 patients on high-dose opioids (Oliva et al., 2021) compared to 1 in 69 patients in the private sector (Guy et al., 2019).
- Across VA, facilities have deployed naloxone in at least 1,095 AED cabinets and equipped 3,552 VA Police Officers with naloxone. The impact of these efforts is apparent across VHA, with an additional 146 reversals reported from AED cabinet and VA Police naloxone (10 and 136 reversals, respectively, since April 2021.
- Academic Detailers (specially trained VA pharmacists) promoted OEND through individualized, evidence-based educational outreach visits and consultations for clinicians by clinicians, having completed more than 36,400 such visits with more than 24,800 health care professionals nationwide through FY 2023 Q4.
- VA Clinical Pharmacist Practitioners (CPP) provide outreach to Veterans through comprehensive medication management services to optimize OEND. CPPs focus on ensuring high-risk Veterans have naloxone on hand, are educated about overdose prevention and are offered enhanced risk mitigation strategies to further reduce the risk of overdose. In November 2022, the Clinical Pharmacy Practice Office (CPPO) released an OEND Population Health Outreach Scripting Tool to support population health outreach while promoting inclusive, non-stigmatizing language. In FY 2023, VA CPPs have prescribed 21% of all naloxone prescriptions ever written for Veterans with 62% of CPPs in the field prescribing this life-saving care.

- VHA's Rapid Naloxone Initiative received the 2020 John M. Eisenberg National Level Innovation in Patient Safety and Quality Award. This prestigious award from The Joint Commission (TJC) and National Quality Forum recognizes those who have made significant and long-lasting contributions to improving patient safety and care healthcare quality.

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

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

To support the implementation of *Jason's Law*, PMOP will utilize funds to support current and newly established field-based positions to support the VA Pain Management Teams (PMTs) and the expansion of the Opioid Safety Initiative (OSI). Since 2021, PMOP has funded the support of hiring PMOP Coordinators for each VA Medical Center (VAMC) and Veterans Integrated Service Network (VISN). The PMOP Coordinators work closely with the clinical leaders for pain from specialty care (Pain Point of Contacts, Pain Consultants) and from Primary Care (PACT Pain Champions) for the coordination and oversight of pain care and opioid safety at VISNs and facilities. The PMOP Coordinator's role is critical to continue and expand opioid stewardship initiatives and for assessment of OSI effectiveness, addressing new and evolving evidence-based best practices and tracking trends in the opioid epidemic nationwide as mandated by TJC. This includes collaboration with Integrated Veteran Care (IVC) regarding opioid risk mitigation strategies for community care prescribers, mandated by the Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act) (P.L. 115 – 182) and Office of the Inspector General (OIG) recommendations. Additional collaboration entails work with the Office of Information Technology (OIT) and Office of Electronic Health Record Modernization (OEHRM) to integrate a network of individual, state, regional and Department of Defense (DoD) Prescription Drug Monitoring Programs (PDMPs) into VHA's electronic health record (EHR), as recommended in the NDCS of the ONDCP.

To additionally support the implementation of *Jason's Law*, PMOP will utilize funds to support the development and implementation of the data infrastructure needed to monitor the progress of the expanded OSI. The 2025 PMOP budget will continue to support VA VISN and facility pain and opioid safety leadership positions to expand and monitor the progress of the OSI. In 2025, funding will back the development of an operational dashboard that will report upon national, VISN and facility-level data on pain management, opioid safety, and PDMP-related outcomes. This dashboard will report on metrics of compliance with a VHA memo titled "Implementing Recommendations in the Veterans Affairs (VA) Office of Inspector General

(OIG) Comprehensive Healthcare Inspection (CHIP) Summary Report: Evaluation of Medication Management in Veterans Health Administration (VHA) Facilities Fiscal Year (FY) 2020", (OIG Report 21-01507-61) that was distributed to the field in February 2023. This memo detailed requirements aimed at fulfilling the recommendations in VA OIG Report 21-01507-61, *Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2020*. Further, 2025 funding will support the nationwide implementation of a controlled substances note template that is currently being designed to document the completion of the OIG report requirements for Long-Term Opioid Therapy. This template is intended to document the completion of best practices and other requirements associated with the prescribing of opioid therapy and other controlled substances.

The achievements under the opioid safety activities through 2023 include:

- Since 2022, PMOP has expanded communication to the field by hosting a monthly community of practice calls for Behavioral Pain Management and for PMOP Coordinators. There are currently over 350 VHA staff actively participating in these channels.
- PMOP supports funding the Center of Innovation for Veteran-Centered and Value-Drive Care (COIN) Emergency Department (ED) Medication for Opioid Use Disorder
- PMOP has funded 25 capstone projects over three cohorts for the VA Addiction Scholars Program.
- PMOP has many evaluative efforts underway including a PMOP Measures Initiative to explore measures and metrics that will be used to develop a core minimum measure set for reportable data across VA. Data efforts include expanding patient-reported outcomes using computerized adaptive technology, legacy measures and an evaluation of facility-level variations in pain specialty care services, including PMTs and pain clinics.
- PMOP supports funding of medication mail back envelopes for Veterans, ensuring Veterans have a means of safely disposing of expired or unwanted prescription and over-the-counter drugs. The envelopes are free to Veterans and do not require postage.
- PMOP has collaborated with the VHA Support Service Center (VSSC) to create a database with an end user associated dashboard to track the hiring and onboarding of PMOP funded staff for PMOP's seven field hiring initiatives. These initiatives are detailed in the TelePain and Pain Management Team sections. The database is linked to VA's national human resources tracking system to automate the reporting of full-time equivalent employees (FTE) associated data to support hiring across the nation. In 2023, PMOP held five national training events to support the knowledge application for individuals hired into one of the seven hiring initiatives.
- PMOP continues to fund a Sterile Syringe Program (SSP) to provide treatment services to Veterans who inject drugs as well as provide preventative services like vaccinations, naloxone to prevent overdose, and Pre-Exposure prophylaxis (PrEP) prescriptions-medication that prevents Human Immunodeficiency Virus (HIV).

- In 2018, MISSION Act created 38 U.S.C. 1730B which established regulatory authority to assert federal supremacy for licensed VA health care providers and their authorized delegates to access the network of state-based PDMPs or any individual state or regional PDMP. The term `delegate' was defined in the statute to include a person or automated system accessing those PDMPs at the direction or under the supervision of a licensed health care provider. Led by VHA's PMOP program, VA modernized the legacy Computerized Patient Record System (CPRS) by successfully deploying an integrated PDMP solution enterprise-wide in November 2020. The solution allows authorized VA providers, pharmacists, and delegates to query the network of participating PDMPs directly from within the Veteran's electronic health record, providing greater efficiency and satisfaction for providers while supporting the safe prescribing of controlled substances. The solution now connects to 52 of the 54 individual states, regional, and Department of Defense (DoD) PDMPs. In November 2023, the integrated PDMP solution for CPRS reached its three-year milestone. Since launch through end of calendar year 2023, VA clinicians have utilized the solution to execute over 8.8 million queries to help guide treatment decisions. VA staff are now executing more than a quarter million queries every month through the integrated PDMP solution. This does not include queries that are done manually, for example, from the two states that are not yet participating in VA's solution.

3. PMT and Pain Clinic Staffing:

Section 911(c) of *Jason's Law* requires the identification and designation of a pain management team of health care professionals, which may include board certified pain medicine specialists, responsible for coordinating and overseeing pain management therapy at all VHA facilities for patients experiencing acute and chronic pain that is non-cancer related. VA's 2025 pain management and opioid safety budget will support these *Jason's Law*-mandated interdisciplinary PMTs through field funding to sustain and enhance staffing of a high functioning PMT at each VAMC. VAMCs have made great strides in establishing and training the PMTs. Based on a synthesis of data gathered in 2022, 135 of 139 sites have at least a partial pain team, with staffing and represented disciplines varying greatly. Fifty-six reported having a fully staffed PMT. Even at those facilities reporting fully implemented interdisciplinary PMTs, the volume of Veterans with complex, chronic pain conditions often overwhelms the capacity of these programs, including many with high risk due to concurrent mental health conditions including PTSD, suicidality, or substance use. This generates problematic pressure on other services, particularly primary care, and limits Veteran access to evidence-based treatment modalities which requires additional staffing support from the PMTs. Further, expansion and training of PMTs will improve patient care outcomes by increasing provider utilization of pain specialty care services including e-consults and pain behavioral health. PMTs empower the provider to manage patients experiencing complex chronic pain through education and outreach initiatives.

VA's PMOP budget is utilized to establish positions that support Jason's Law-mandated interdisciplinary PMTs to staff an active PMT at all VA sites. Since 2021, funds have been provided for dedicated staffing at VISNs and facilities to ensure oversight, reporting and

coordination of pain and opioid initiatives. Through 2026, VISNs and facilities can apply a portion of existing PMOP-supplied resources for hiring and retaining staff and training/education (see Training and Outreach below for more detail). The PMOP budget will further support efforts to bolster the Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited Interdisciplinary Pain Rehabilitation Programs (IPRPs) in all VISNs.

Since 2022, PMOP has supported four initiatives with five-year seed funding to promote the establishment and sustainment of PMTs to provide access to comprehensive specialty care. PMOP-funded initiatives include:

- The Active Management of Pain initiative delivers multimodal pain rehabilitation accessible in a Pain Clinic setting that maximizes resources in a small team setting.
- The Medication Management in Pain Management Teams initiative focuses on safe opioid prescribing in pain specialty care clinics and integrated access to medication for opioid use disorder (MOUD) through the integration of CPPs and Nurse Practitioners/Physician Assistants to provide collaborative pain and opioid addiction medication management services.
- The Whole Health Coaches in Pain Management Teams initiative seeks to staff pain clinics with Whole Health coaches to support the self-management pillar of the stepped care pain model.
- The Mental Health Integration in Pain Clinics initiative seeks to hire mental health providers to be integrated into pain clinics to provide mental health care and suicide prevention.

In addition to the positions above, funding continues to support the PMOP Coordinator positions (see Opioid Stewardship), Pain Points of Contact/Consultants (0.25 FTE), and Primary Care Pain Champions (0.25 FTE).

Inpatient consultation and acute pain care services in 2025:

- Support the establishment of the Acute Pain Service throughout VA facilities that will implement and support perioperative pain management protocols, evidence-supported enhanced recovery after surgery (ERAS) protocols, and regional anesthesia techniques for surgical patients and provide inpatient consultative services for non-surgical acute pain and acute-on-chronic pain patients. VA has the opportunity to enhance patient access and care that will yield a significant impact on the opioid epidemic through evidence-based quality interventional and other non-pharmacological pain treatment modalities through opioid-sparing surgical and non-surgical pain treatment protocols. In addition, the expansion of pain consultation will allow VA to identify and support patients in inpatient care settings on opioid medication with high risk during their acute care treatment, provide opioid reduction strategies when indicated, and provide for a seamless transition to outpatient care.

Evidence: As mandated in the P.L. 114-198, Title IX, Comprehensive Addiction and Recovery Act of 2016, a PMT must include a Medical Provider with Pain Expertise, Addiction Medicine (or Addiction Psychiatry) to provide evaluation for OUD and access to Medication Assisted

Treatment, Behavioral Medicine with the availability of at least one evidence-based behavioral therapy and Rehabilitation Medicine discipline. PMOP Staffing Survey conducted in March and April 2022 by the Pain Services Evaluation Program, a partnership between PMOP and the Pain Research, Informatics, Multi-morbidities, and Education (PRIME) Center of Innovation at VA Connecticut, highlighted that only 40% of all VHA facilities had a PMT with all four roles. The PMOP-funded initiatives continue to support the PMT staffing efforts.

4. <u>TelePain (including prevention and treatment of OUD):</u>

In alignment with VHA's goal of delivering high-quality, accessible, and integrated health care by strategically expanding virtual care and giving Veterans the choice to receive appropriate care, SCPO plans to further expand VA access to specialty care through virtual modalities for Veterans, their family members, and their caregivers. VA's 2025 budget supports increasing access to care via telehealth to ensure all Veterans, including those living in rural settings and with difficulty traveling, have access to timely, quality care. Many aspects of complex chronic-pain care may be managed on a regular basis through these remote capabilities, decreasing the need for patients to travel to their closest clinic. The limited availability of pain specialty providers nationwide, especially in rural settings, has contributed to inadequate staffing of pain teams at some VA facilities. Therefore, the 2025 budget request includes efforts to expand TelePain models at VISNs and facilities to provide multimodal pain care including pharmacological, behavioral, restorative, and integrative pain care modalities, and provide oversight of opioid therapy including risk mitigation and OUD prevention and treatment with evidence-based approaches, in particular MOUD. This budget request supports staffing both at the program and field levels, training, supplies, equipment, and other tools needed to support the program. Ongoing national program office resources will be required to support the effort throughout the life of the program. Full time, centralized support of the program is essential.

Additionally, the ONDCP's NDCS (2022) and the ONDCP National Treatment Plan for Substance Use Disorder, Principle 1: Improve Treatment Engagement by Meeting People Where They are, reflects the compelling need to provide access to evidence-based treatment modalities related to pain care and opioids for rural Veterans. VA is committed to addressing the unique challenges presented by a rural population that has been ravaged by the impacts of the opioid crisis.

The PMOP budget will expand capacity for TelePain efforts in the field, including:

- Clinical and Staffing resources including training, supplies, equipment, and other tools needed to support the program.
- Implementing and expanding pain and opioid-related care using the tele-hub structure of VISN-based "Clinical Resource Hubs" (CRH) with interdisciplinary TelePain pain speciality teamsfor chronic pain and opioid use disorder treatment, with access to medical, behavioral, restorative, and integrative modalities added to each VISN hub site. Implementation of such CRH TelePain teams began in 2022. Currently, 12 of 18 VISNs are actively building CRH TelePain programs as of 2023, and one additional VISN has an alternative TelePain program across their network (VISN 23).

Furthermore, expansion of services and new programming within current VISNs is planned to begin in 2025 and beyond.

- The Pain Empowerment Anywhere (PEAK) Program is a CARF-accredited 5-week, fully virtual TelePain tertiary level Interdisciplinary Pain Rehabilitation Program available to Veterans across the entire VA system. PMOP provides ongoing support to this unique national program, with referrals from more than 30 states to the program through May 2023. PEAK launched a women's track in spring 2023 and is collaborating with the Department of Defense to expand PEAK access to Active-Duty Service Members. Outcomes reflect patient increases in functioning and quality of life as well as decreased pain. PEAK participants are highly satisfied with the program and their gains and would recommend PEAK to others with chronic pain.
- PMOP's creation of VHA's first TelePain Neuromodulation program across the enterprise as part of the development of the TelePain Evaluation for Neuromodulation Treatment (TENT) to include evidence-based interventions for pain management following appropriate biopsychosocial evaluation and determination of benefit. The purpose of the TelePain Neuromodulation Program is to increase the standardization of neuromodulation for pain management processes across the VA, in particular expand access to psychosocial and medical assessments by means of telehealth services, prior to neuromodulation trial and implantation. This program will have a virtual hub to support Veterans nationwide.

Evidence: VA has been committed to increasing access to care via telehealth to ensure all Veterans, including those living in rural settings and with difficulty traveling, have access to timely, quality care. CRH TelePain programs are virtual interdisciplinary pain management teams available in select VISNs and designed to bring multimodal pain care to Veterans with limited mobility, preference for virtual care and to those residing in rural areas who due to distance and transportation difficulties experience inequality within healthcare. CRH TelePain programs utilize a hub-and-spoke telehealth model that leverages centrally located providers who utilize telehealth technology to bring specialized care, particularly to historically underserved areas. Currently, 11 out of 12 existing CRH TelePain programs are in the implementation phase and providing care to Veterans across the nation. In 2022, there were 304 unique encounters for rural Veterans seen within CRH TelePain with only three VISNs in an implementation phase at that time. In 2023, there were a total of 1,097 unique encounters for rural Veterans, translating into a 261% increase in access to rural Veterans. At the current time, as indicated above there are 11 VISNs in implementation phase.

Implementation Plan: CRH TelePain programs are expected to expand their services into new spoke sites (i.e., facilities across the VISN) within six months of implementation. The continued development of the implementation phase within CRH TelePain programs with expansion to new spoke sites will increase equitable access to high quality pain care for rural veterans. Additionally, implementing opioid-related care using the existing tele-hub structure of the VISN-based CRH TelePain programs with additional specialists in chronic pain management and opioid safety with access to medical, behavioral, rehabilitation and complementary and integrative health modalities added to each VISN hub site planned for 2025 through subsequent fiscal years.

5. Education and Outreach:

Training and education are critical to the successful and accelerated implementation of pain management and opioid safety services under Jason's Law. VA, as the largest healthcare organization in the US, sets the example of addressing training disparities across the health care workforce by creating a robust platform and infrastructure demonstrating success and sharing best practices. As a high reliability organization, it is crucial for VA to embrace strategies to support Veteran pain care needs. Expanded multidisciplinary PMT services are an integral part of the solution to physician shortages and to the interprofessional, collaborative team-based care for Veterans.

In 2023, PMOP collaborated with partner program offices to provide training and education for staff hired as part of the Active Management of Pain (AMP), Medication Management in Pain Management Teams (MMPMT), and Whole Health Coaches in Pain Management Teams (WHCPMT) Initiatives supported by PMOP through 2026. PMOP funded and hosted five equivalent PMOP-Focused Initiative (PFI) Collaboration and Integration Workshops where 33 faculty provided training for 316 total attendees consisting of physicians, nurse practitioners, physical therapists, psychologists, pharmacists, physician assistants, social workers, and whole health coaches. The curriculum focused on the foundational elements of practice collaboration, integration, and optimization of services; identifying tools and resources to foster optimization of practice impact; and strategies to successfully integrate new team members into interdisciplinary team-based care to improve access and quality of care for Veterans.

Continued development of educational programs such as these will increase the number of practitioners ready and able to care for Veterans, improve team efficiency, reduce breaks in care, and reduce provider burden and burnout. With this focus, VA's 2025 PMOP budget will support education and training for dedicated staff including individuals hired to support the PMTs in pain clinics including:

- Developing and enhancing the Joint Pain Education Program, which provides training to clinical providers and teams across VHA and DoD with a special emphasis on educating clinicians in core concepts and modern approaches to safe and effective pain management, including safe opioid prescribing, as well as providing education to Veterans and their families.
- Providing system-wide training for clinical educators in general pain management, including integrative medicine, psychological and physical therapies, as well as evidence-based approaches to opioid prescribing, thereby enabling training to interdisciplinary clinical teams in primary care, known as PACT, and education for Veterans and their families.
- ADEPT Developing and implementing the Pain Management Consult Support Certificate Program previously known as the Pain Mini-Residencies. This training will include didactics and procedural videos as well as hands-on training to support adherence to standard pain management guidelines.

In 2023, PMOP continued to provide funding for 35 hours of accredited educational webinars annually through the Veterans Affairs Extension for Community Healthcare Outcomes (VA-ECHO) to address pertinent topics related to pain management and opioid safety.

- Supporting focused pain management and opioid safety related continuing education delivered through the VA Academic Detailing Service's (ADS) framework including a trained healthcare professional's visits to individual clinicians to provide practical, evidence-based information.
- In collaboration with Integrated Veteran Care (IVC), the 2025 PMOP budget will support educational initiatives centered around pain management, opioid safety and prescription drug monitoring for Community Care providers.
- Supporting the development of educational materials including Clinician and Provider guides, quick reference guides, fact sheets, and patient education materials.

Budget Request: The PMOP budget request for 2025 is $254.5 million, continue to support the PMT staffing model as designated by CARA. The PMOP budget will continue to provide targeted support for pain management and opioid safety programs primarily at the facility level, with national support, to ensure successful implementation and increase access to care across the enterprise, especially in rural areas.

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Substance Use Disorder Program Initiative

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations							
Medical Services (0160):	$94,139	$228,220	$228,220	$260,504	$261,428	$32,284	$924
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$315	$2,727	$2,727	$3,377	$3,396	$650	$19
Medical Facilities (0162):	$208	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$94,662**	**$230,947**	**$230,947**	**$263,881**	**$264,824**	**$32,934**	**$943**

Authority for Action

- 38 U.S.C. § 1720A
- 38 C.F.R. § 1701, 17.38 and 17.80
- Department of Veterans Affairs (VA) / Department of Defense (DoD) Clinical Practice Guideline (CPG) for Management of Substance Use Disorder (SUD)

While VA is a national leader in the prevention and treatment of SUD, gaps exist. In its 2020 National Survey on Drug Use and Health, the Substance Abuse Mental Health and Services Administration (SAMHSA) estimated less than 10% of Veterans with SUD receive treatment for their SUD. Among Veterans receiving care within the Veterans Health Administration (VHA), over 575,000 had an SUD diagnosis in 2023 with less than 25% receiving SUD specialty services.

Purpose: SUD commonly involves the use of multiple substances. The number of Veterans served within VHA with amphetamine, cannabis, and alcohol use disorders (AUD) is rising. The number of Veterans with an amphetamine use disorder has increased by 12% since 2018 and the number with cannabis use disorder has increased 18%. 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	2018	2019	2020[1,2]	2021	2022	2023	Percent Change 2018–2023
Alcohol	393,531	416,590	397,986	405,850	411,615	438,094	11.3%
Cannabis	123,754	135,766	128,732	132,776	139,336	146,177	18.1%
Cocaine	72,258	73,272	66,419	61,754	61,127	61,922	(14.3%)
Opioid	71,471	71,327	68,773	67,548	67,198	66,463	(7.0%)
Amphetamine	37,290	43,720	39,889	38,852	40,185	41,736	11.9%

[1]Data for 2020 were significantly impacted by changes in health care utilization due to the COVID-19 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.
[2]Data Source: CDC Drug Overdose data dashboard available from https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#dashboard

Overdose Deaths: Opioid and Stimulant Use Disorders

From 2010 to 2019, the rate of opioid overdose mortality among Veterans increased 93.4% and the rate of stimulant overdose mortality among Veterans increased 333.4% (Begley et al., 2022). While there was a slight decline in the number of overdose deaths during 2018, review of overdose death data for 2019 and 2020 suggest a reversal of those trends with rising overdose rates (Centers for Disease Control, 2024). The Centers for Disease Control and Prevention estimates that overdose fatalities during the COVID-19 pandemic increased by nearly 40%.

VA has made considerable progress with efforts targeted towards prevention of opioid use disorder (OUD) and opioid overdose deaths (see Opioid Prevention, Treatment and Program narrative). Emerging data suggest that the opioid crisis is evolving. The overdose mortality rate for Veterans increased from 16.1 per 100,000 in 2010 to 24.6 per 100,000 population in 2019, and there was a 53% increase in age-adjusted overdose mortality rates for Veterans from 2010 to 2019 (Begley et al., 2022). The increases in opioid overdoses were largely driven by non-methadone synthetic opioids (for example, fentanyl) and heroin overdoses but in the more recent few years there have also been an increasing number of stimulant-related overdose deaths, especially methamphetamine and cocaine. In 2019, data documents over 4,800 Veteran overdose deaths, over 3,100 related to opioids and over 2,000 related to stimulants (with overlap of both drug classes being involved in many of the overdose fatalities). This suggests the need to target future efforts more directly to address OUD and stimulant use disorders.

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

NDCS/NDCA

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

Initiatives to support the NDCS/NDCA are part of the 2025 SUD request and are responsive to Congressional expectations outlined in appropriations conference reports (for example, SUD services for women Veterans, universal screening for OUD, 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.

The SUD budget for 2025 outlined below closely aligns with The Biden-Harris Administration's Statement of Drug Policy Priorities, supports the NDCS, and 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,
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 and
4. establishing a comprehensive strategy specific to harm reduction (formal area of focus in the 2024 budget request).

Implementation - Access to Care:

<u>Stepped Care for SUD</u>

Of the more than 575,000 Veterans receiving SUD care within VHA during 2023, less than 25% received specialty SUD treatment with less than 4% receiving intensive SUD services. Current efforts to expand access to medications for OUD and AUD have had an impact, with 48% of Veterans diagnosed with OUD and 15% of Veterans with AUD receiving CPG recommended medications during 2023.

Table 2: Number and Percent of Veterans Receiving Indicated Medications for Treatment of OUD and AUD

Substance	2017	2018	2019	2020	2021	2022	2023
Alcohol Use	31,905 (8.2%)	37,651 (9.45%)	42,305 (10.2%)	42,530 (10.8%)	45,038 (11%)	57,158 (13.7%)	63,734 (15.1%)
Opioid Use	24,069 (34.8%)	24,696 (34.9%)	26,415 (40.4%)	27,571 (44.4%)	27,358 (45.8%)	27,456 (46.3%)	27,516 (48.1%)

To address evidence-based medication for OUD treatment, VHA launched the Stepped Care for OUD – Train the Trainer (SCOUTT) initiative in May 2018. Eighteen of our Phase 1 clinic-based teams comprised of staff from primary care, general MH and pain management participated in the training. Between August 2018 and September 2023, the teams evidenced a 196% increase in the number of Veterans receiving buprenorphine for the treatment of OUD and a 291% increase in the number of providers prescribing medication treatment for OUD with buprenorphine. Since the initiative launch, over 3,477 patients have been started on buprenorphine.

Provision of treatment for SUD in settings outside of specialty care is not fully captured in the current VA Medical Center (VAMC) budgets. The SCOUTT initiative has demonstrated that medication for 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 continues to request support to expand and sustain access to SUD services outside of the specialty care setting, specifically targeting general MH and primary care clinics (see Opioid Prevention, Treatment and Program narrative). There is also additional sustained support needed for the Clinical Resource Hubs (CRH) in each VISN to address gaps in access to SUD services for Veterans who primarily receive care in Community Based Outpatient Clinics. The sustainment plan provides for at least two full-time equivalent employees (FTE) per CRH funded in 2022 with funds for sustainment proposed through 2025, as well as staff targeted to VAMCs to support provision of SUD treatment within Behavioral Health Interdisciplinary Program teams or through Primary Care MH Integration. The resources request would support:

- Expansion and sustainment of approximately 330 staff hired in 2022 with sustainment through 2025 to provide SUD services with capacity for each CRH to provide medications for OUD and AUD as well as SUD counseling.
- 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 MH clinics.
- Shifting pharmacy infrastructure efforts to focus on developing mobile methadone clinic capacity to treat Veterans with OUD in underserved and rural communities.
- VA Central Office infrastructure to support facilitated implementation, training and evaluation.

<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 SUD. This includes inpatient withdrawal management and stabilization in numerous medical and general MH 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. In addition to the Domiciliary SUD programs, specialty treatment for SUD occurs throughout the MH RRTP continuum with 97% of all Veterans with a completed episode of care during 2023 having a SUD diagnosis.

At the end of September 2023, there were 120 locations of care providing MH RRTP services with 72 operational Domiciliary SUD programs focused specifically on intensive, medically monitored residential SUD treatment and an additional 16 programs that are formally designated as providing residential treatment for SUD. All MH RRTPs are expected to provide treatment for SUD with over 6,600 official operational beds at the end of 2023. VHA anticipates an additional eight locations of care will be established through 2026 with seven new Domiciliary SUD programs and two new Domiciliary SUD programs specifically for women expected to open. During 2023 the average time between screening for residential treatment and admission to a SUD residential bed within VHA was 20 days, significantly longer than current standards of care. Further, the wait time does not include the time between referral and screening.

Preliminary data for 2024 suggests the average time between referral and admission is around 22 days. The COVID-19 pandemic has had a significant and sustained impact on residential operations with reduced capacity and wait times that are not consistent with current expectations. Over the last two years, progress has been made as VHA has executed on plans to develop new Domiciliary SUD programs and to increase staffing levels within existing Domiciliary SUD programs to support improved access. As required by section 503 of the Support the Resiliency of Our Nation's Great Veterans Act of 2022 (STRONG Veterans Act of 2022), VHA anticipates submitting a detailed report with recommendations regarding the need for additional MH RRTP services across VHA.

In response to identified concerns from Congressional stakeholders, Veteran Service Organizations and Veterans, VA is moving forward a comprehensive plan that will transform the ways in which MH RRTP services are accessed with particular attention to the needs of Veterans requiring residential treatment for SUD and/or co-occurring MH concerns. The path forward will include policy changes that clarify expectations for priority admission as well as routine admission in addition to a plan to centralize and standardize screening procedures.

The 2025 SUD budget request builds on 2024 efforts supporting efforts that are already underway to expand services for women Veterans and ensure capacity to provide withdrawal management within domiciliary SUD programs. In addition, the budget would provide for additional support to transform the MH RRTP continuum of care with the goal of initiating the MH RRTP admission process within 48-hours of identified need, establishing an infrastructure that would support more timely admission supported by a centralized processes for screening and coordination of admission. This will require:

- Sustained expansion of approximately 300 staff to increase access within existing Domiciliary SUD programs and SUD-track programs within General Domiciliary to support expansion of medically monitored withdrawal management and more timely admission. Hiring efforts began in 2022 with current funds requested to support

sustainment while services are established. Funding also supports the expansion of Domiciliary SUD services, including two new Domiciliary SUD programs for women Veterans.

- New funding to support the establishment of centralized screening teams that operate at the VISN level.
- National SUD program office infrastructure to support development of clinical informatic tools to facilitate referral and admission processes (for example, real-time report with bed availability, number pending admission and projected waits) as well as to support implementation and management of new MH RRTP access transformation efforts.

Peer Specialists and Health Navigators – SUD Service Engagement

Peer Specialists: To close the treatment gap as required by the NDCS/NDCA and to provide a recovery environment as detailed in The Biden-Harris Administration's Statement of Drug Policy Priorities, NCDS and PRS, services specific to Veteran engagement are required. The NDCS emphasizes that unmet needs for staffing harm reduction programs should primarily be addressed by recruiting and training new staff to serve such as peer support staff. In addition, the PRS identifies the need to expand peer-led recovery. Peer support is one of the 10 fundamental components of recovery according to the National Consensus Statement on MH Recovery. VA supports peer support services and continues outreach, engagement and intervention efforts by peer specialists working in VHA.

Since 2005, peer support staff have been working in the VA health care system. VHA Handbook 1160.01 (2008), Uniform MH Services in VAMCs and Clinics mandated the availability of peer support services for Veterans. That same year, The Veterans' MH and Other Care Improvements Act Of 2008 (P.L. 110-387), 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 MH and/or SUD and who are certified to provide peer support services. Since that time, VHA has continued its mandate to have peer support services available to Veterans. VHA Directive 1160.01 (2023), Uniform Mental Health Services in VHA Medical Points of Service, stipulated that if access to peer support services is not able to be delivered at the point of care (e.g., residential care, Psychosocial Rehabilitation and Recovery Center (PRRC) services, SUD Intensive Outpatient Programs (IOP) or Intensive Community Mental Health Recovery (ICMHR) services), then they must be made available to Veterans either via telehealth or referral for peer support services in the community. Staffing models for several VHA health care service programs have evolved to now stipulate including peer specialists as part of the interdisciplinary teams that provide health care services to Veterans with mental illnesses, substance use disorders, and/or chronic health conditions, as well as Veterans experiencing homelessness, unemployment, and those involved with the criminal justice system. Peer specialists are professionally trained, through their required peer specialist certification, to effectively use their personal lived experience with recovery to inspire hope and serve as relatable role models of recovery for other Veterans. They assist Veterans with identifying their personal strengths, needed VA and community resources, and desirable skills that support their personal goals. Peer specialists use a host of recovery tools to help Veterans of diverse ages, genders, races, and ethnic backgrounds to enhance healthy coping strategies and

improve self-management skills over their health conditions. They support Veterans to empower themselves to address self-care, advocate for themselves, access available resources in and outside VA, reconnect with others and find a sense of belonging in their communities.

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 for individuals who received peer support services as part of their MH care services (Bassuk et al., 2016; Chinman et al., 2015; Druss et al., 2018; Fortuna et al., 2018; Ashford et al., 2019; McCarthy et al., 2019; Fortuna et al., 2020). There are reported benefits specifically for Veterans in working with peer specialists in the VA health care system, including increased hopefulness, increased treatment engagement, reduced isolation, reduced symptoms of mental illness, improved functioning, and increased community integration (Chinman et al., 2015, McCarthy et al., 2019, Resnik et al., 2017; Shaw et al., 2020). An additional benefit reported for Veterans in their work with peer specialists is that the peer specialists have personal understanding of the Veterans' unique experiences in a military context. For Veterans, being aware that they are working with a fellow Veteran who has had similar military experiences and post-military personal struggles builds trust in the peer specialist as someone who can help because the peer specialist "has been there too" (Kumar et al., 2019). Peer specialists also facilitate opportunities for Veterans to reduce their isolation and socially connect with fellow Veterans in their communities which has additionally been seen as a benefit for Veterans who receive peer support services in the VA health care system (Gorman et al., 2018).

VHA has hired hundreds of Veterans as peer specialists over time and is now the U.S.'s single largest employer of peer specialists. There are currently almost 1,420 peer support staff work throughout the VA health care system. Examples of programs where peer specialists work include inpatient and outpatient MH and SUD programs, residential treatment programs, ICMHR, PRRCs, primary care patient-aligned care teams, homeless programs, vocational rehabilitation services, Veterans Justice Program, and the Veterans Crisis Line's Peer Support Outreach Center. Despite the array of programs where peer specialists have been providing peer support services in VHA, there was limited capacity to target peer support services specifically toward supporting Veterans' SUD treatment engagement and retention prior to 2022. Since 2022, 279 peer specialist positions were awarded to the field to specifically focus on supporting Veterans with SUD in their treatment engagement, treatment retention, and recovery efforts. The 2025 proposed budget request supports continued hiring and sustains funding for these peer specialist positions.

Supportive Services for Veterans and their Families (SSVF) Health Navigators Serving Homeless Population: Data on overdose deaths and current utilization rates of SUD services within VHA suggest a need to engage Veterans where they live. For Veterans who are homeless or at risk for homelessness, this will require partnering with community providers. In addition to access to peer support services, the NDCS also requires VA to increase access to vulnerable populations such as the homeless. SUD disproportionately impact Veterans who are homeless. VHA's existing infrastructure within the Homeless Program Office provides a foundation by which VHA can quickly direct resources to community providers with the intent of rapidly engaging or re-engaging Veterans with SUD services specific to their treatment needs.

The SUD budget directly addresses the requirements of the Biden-Harris Administration's Statement of Drug Policy Priorities and NDCS through the expansion of peer support services to SUD treatment services with a targeted focus on engagement in treatment using a stepped care approach. Peer specialists hired by facilities to work as members of the SUD treatment team prioritize treatment engagement for those Veterans presenting on inpatient units and in emergency departments with substance-related concerns. In addition, working in collaboration with the Homeless Program Office, the budget provides additional sustained support for SUD case managers to work with the SSVF and VHA Homeless Programs. The principal objective of the proposal is to link a VAMC 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 256 SSVF grantees serving communities throughout the country and U.S. territories. SSVF served 115,834 Veterans and their family members in 2023, 78,116 of whom were Veterans. As approximately 85% of the Veterans served are VHA-eligible (68,000) and 60% of these Veterans will need assistance from a VA MH provider, potentially 41,000 Veterans would be linked to care.

Details of Peer Specialists and SSVF Health Navigators Plan:

- Expansion and sustainment of approximately 275 peer specialists to work in SUD specialty care.
- National Program office support for training and certification of peer 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 MH concerns.
- Partnered research to evaluate implementation of SUD-specific peer support services.
- Expansion of approximately 130 FTE SUD case managers to work directly with SSVF grantees and homeless program staff with the goal of engaging or re-engaging Veterans in SUD treatment.

<u>Responding to Emerging Drug Threats</u>

As previously noted, overdose deaths associated with stimulants including methamphetamine are increasing. Amphetamine use disorder diagnoses among those served in VHA increased 39% from 2017 through 2023. Contingency Management (CM) is among the most evidence-based treatments for stimulant (including amphetamines) and cannabis use disorders and has been shown to be cost effective, however, implementation often is limited by challenges in funding incentives for the program as well as the availability of point of care toxicology testing important to CM's treatment approach. VHA's Centers for Excellence in Substance Addiction Treatment and Education

(CESATE) implemented a CM program in 2011. CM is a core component of VA's efforts to respond to the emerging threat posed by methamphetamine.

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

The ability to respond to emerging drug threats, including fentanyl adulterated with xylazine, requires timely access to data on substance use and overdose. VA OIG's report, *Illicit Fentanyl Use and Urine Drug Screening Practices in a Domiciliary Residential Rehabilitation Treatment Program at the Bath VAMC*, 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 VA Health Services Research and Development (HSRD) State of The Art (SOTA) Conference 15, Effective Management of Pain and Addiction, recommended that VHA treat overdose in a manner like that of suicide. In July 2021, VHA mandated use of a national medical record note template to report all overdoses (e.g., Suicide Behavior and Overdose Report), with a focus on improving post-overdose care by ensuring review of the event and supporting Veteran engagement in treatment following a non-fatal overdose. In December 2022, VHA further mandated interdisciplinary team review of all overdoses in the past year with a goal of facilitating rapid engagement in specialty SUD or mental health services when appropriate. VHA's response plan to fentanyl adulterated with xylazine includes efforts surrounding testing (e.g., mandating that fentanyl be included as part of VA's basic panel for urine drug tests), evidence-based prevention, harm reduction, and treatment implementation and capacity building (e.g., development of patient and provider education, disseminating emerging practices, tracking, standardized collection of exposure), and basic and applied research (e.g., designating as a research area of special interest). VHA infrastructure identified for monitoring and development of clinical informatic tools have already been developed to be responsive to this requirement. VA is also utilizing natural language processing to aid case finding efforts.

These efforts are supported by VA/DoD CPG for the Management of SUDs and recommendations outlined in Treatment of Stimulant Use Disorders (SAMHSA, 2020).

Use of Technology

Individuals experiencing SUDs often face barriers to care such as lack of access to transportation necessary to access services. The NDCS outlines the importance of mobile technologies and mobile units to support access to SUD treatment. We have been working with SUD subject matter experts to identify SUD treatment support features for inclusion in a SUD app. We have been able to differentiate those desired features according to level of technological complexity.

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 further development of a phased deployment of mobile applications to support treatment of SUDs. Initial implementation will target implementation of pilots during 2024 with continued expansion in 2025 and sustainment in 2026 and beyond. The budget aligns resources within the CESATEs responsible for identifying the mobile app solutions that will be made available and developing the necessary infrastructure to

support implementation. The budget seeks support for partnered research to evaluate implementation of the stepped care model and CESATE infrastructure to support facilitated implementation, training, and evaluation.

In addition to our efforts to develop a app to make the full range of SUD treatment services available in a mobile platform, we also are developing an online SUD education course for Veterans, their caregivers, and family members. This course will allow the end user to choose an educational pathway consistent with their interests, e.g. learn more about how to assist a loved one with addressing substance use, or helping Veterans examine their own substance use and the risks it poses to their well-being.

Implementation - Enhancement of Employment Opportunities for Veterans in Recovery: During 2023, over 60% of Veterans newly enrolled in VHA vocational services had a SUD diagnosis. However, research has shown that Veterans are frequently not assessed for, or if assessed, not referred to vocational services suggesting the number of Veterans in need of vocational support may be higher. The NDCS emphasizes the need for VA to explore opportunities to support expanded access to employment for those in recovery. VA supported employment is currently available to Veterans diagnosed with SMI. Expansion has been phased in over 2022 and 2023 with sustainment needed at least through 2025 to hire additional staff at VAMCs to provide the necessary vocational supports as well as support for implementation to include mechanisms for monitoring fidelity to the supported employment model of care. Review of the literature suggests the supported employment 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 and Mares, 2007; Mueser et al., 2011). The 2025 budget request seeks to increase access to supported employment services for Veterans diagnosed with a SUD with support for over 45 FTE during 2022 (targeted to a subset of VAMCs) with anticipated expansion during 2023 to support at least 156 total new staff. The 2025 SUD budget request sustains these efforts, along with requisite funding for vehicles and consultative fidelity reviews that are central to implementing this evidence-based model that supports Veterans in obtaining and maintaining community-integrated, competitive employment.

Implementation - Education, Training and Consultation

<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. CBT Coping Skills Group Intervention. At the current time, the EBPs that have been deployed do not address the full scope of recommended treatments defined by the VA / DoD CPGs for the Management of SUD. In addition, several of these current EBPs can only be delivered by licensed providers via individual psychotherapy – the exceptions being Motivational Enhancement Therapy and CBT Coping Skills Group Intervention which can be delivered by non-licensed provides, e.g., Addiction Therapists. The SUD budget is addressing access to evidence-based psychotherapies for SUD through the development, expansion and

implementation of evidence-based services that began in 2022. For example, the focus at this time is to expand access to the following evidence-based psychotherapies for SUD:

- CBT-SUD
- CBT Coping Skills Group Intervention
- Motivational Enhancement Therapy

The 2025 SUD budget request will provide the resources necessary for the development of needed training materials, validation that the materials reliably equip providers to deliver the 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.

Expanding the Addictions Workforce

The NDCS defines a current gap in the number of trained addiction treatment professionals. VHA is a leader in training health care professionals, including those working in SUD treatment settings. The VA Office of Academic Affiliations (OAA) currently provides support for the Interprofessional Advanced Fellowship in Addiction Treatment, which consists of seven local VA sites supported by a national Coordinating Center. To date, 82 fellows have participated in the program, with 72% of alumni obtaining VA employment or affiliation after fellowship. The program has nine current and five incoming trainees. The SUD budget continues to align support for the Coordinating Center within OMHSP to build on the foundation already established by OAA. The alignment sustains the infrastructure necessary for a planned increase to 10 Advanced Addiction Fellowship sites in 2025 and to better coordinate the work between the Advanced Fellowships and the current Associated Health Education training activities. Further, synergies gained by aligning within OMHSP and in coordination with the CESATEs is enhancing existing efforts to address training for current staff and trainees across multiple disciplines.

Addressing Stigma and Shifting the Culture

The HSRD SOTA Conference 15, *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 common 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 addition, OMHSP in collaboration with the National Expert Consultation & Specialized Services — Mental Health (NEXCSS-MH) has deployed a national consultation resource, AskTheExpert-SUD@va.gov. Triaging of consults for this service is currently being managed by

a team of providers from NEXCSS-MH Substance-Related and Addictive Disorders Program with subject matter expertise provided by SUD Program Office, CESATE staff, and representatives from various other program offices. Since its launch in March 2020, consultation requests are submitted routinely. In 2023 the AskTheExpert e-mail received incoming consultations from 349 unique clinicians. Recommendations by the OUD Workgroup from the SOTA conference included the establishment of a National SUD Consultation program comparable to the National Center for Posttraumatic Stress Disorder (NC-PTSD) Consultation Program as well as similar resources for Military Sexual Trauma and Suicide Risk Management. In addition, consultation plays an important role in directly addressing stigma and improving access to care. The SUD budget would sustain the formal establishment of a National SUD Consultation resource with dedicated resources to sustain operations. The plan leverages expertise currently available within the CESATEs and aligns the consultation program with the CESATEs within OMHSP through collaboration with the NEXCSS-MH. The level of resources needed for sustainment identified in the 2025 budget request are consistent with recommendations from experts at the NC-PTSD.

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

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

Implementation - Establishing a Coordinated Harm Reduction Approach in VA: As the largest civilian health care system in the United States, the VHA is uniquely positioned to implement enterprise-wide harm reduction strategies aimed at reducing negative consequences associated with drug use among people who use drugs, particularly people who inject drugs (PWID). Harm reduction includes syringe services programs (SSP), low barrier buprenorphine treatment for OUD, opioid overdose education and naloxone distribution, Human Immunodeficiency Virus (HIV) Pre-Exposure Prophylaxis (PrEP), testing and linkage to care for bloodborne infectious diseases such as HIV and viral hepatitis, linkage to patient-centric care, and wound care among other initiatives. Harm reduction strategies are critically important for addressing both the overdose and HIV epidemics. The NDCS includes and emphasizes the importance of harm reduction in general and SSPs in particular.

VHA is promoting harm reduction strategies across the system, applying theory-based strategies from its award-winning approach to implementing VA's Rapid Naloxone Initiative to speed implementation. Current efforts focus on implementing SSPs which provide injection equipment supplies to people who use drugs, lowering the risk of exposure to HIV and viral hepatitis. Other SSP services include education on safe injection practices, sexually transmitted infections testing and access to tools to prevent and reduce overdoses such as fentanyl test strips and SUD treatment including low threshold buprenorphine treatment. Prior to 2024 few VHA health care facilities had a dedicated lead to plan and coordinate harm reduction initiatives, leading to critical gaps in executing harm reduction strategies. For example, the absence of a dedicated facility-level harm reduction lead creates a major obstacle to coordinating buprenorphine treatment, especially with respect to low-barrier initiation. The 2024 and 2025 budget supports and sustains funding for a dedicated harm reduction coordinator (HRC) position at every VA health care system. Having dedicated individuals helps programs to successfully implement and coordinate these services the purpose of which includes supporting Veteran engagement in SUD treatment.

In addition to these dedicated individuals, national level program management and administrative support will be sustained in the 2025 budget and is essential for activities such as coordinated acquisition and distribution of standardized sterile injection equipment and supplies for SSPs, procurement of drug test strips, design and execution of a communications and education campaign for Veterans and VHA providers and program evaluation.

Harm Reduction Coordinators (HRCs) leverage VA's infrastructure and data systems to support harm reduction efforts (for example, utilize dashboards for population health interventions), oversee implementation of broad systems level solutions (for example, clinical reminders), support establishment of an SSP and other harm reduction activities, coordinate with MH and SUD programs to improve treatment, support establishment of low barrier buprenorphine treatment for OUD and efforts to ensure maintenance of patients on buprenorphine and manage HIV PrEP medications. These efforts involve close collaborations with substance use and infectious disease clinics. Partnerships with Pharmacy Benefits Management Services is also critical, especially with Academic Detailing Services (ADS) and the Clinical Pharmacy Program Office (CPPO). The support of ADS will ensure knowledge translation services along with addressing local barriers for accessing the array of harm reduction services. The support of CPPO will ensure pharmacist disciplines are equipped with the necessary guidance and policies of practice standardization and overall professional practice.

The Department of Health and Human Services is the driver for Ending the HIV Epidemic in the U.S. (EHE) initiative with the goals of reducing newly diagnosed HIV infections by 75% by 2025 and 90% by 2030 and advancing health equity. The EHE campaign centers around identifying patients with undiagnosed HIV infection and linking them to care, as well as identifying uninfected individuals at elevated risk for HIV infection and offering them PrEP. VHA is a key agency participating in this campaign, however, its ability to execute the EHE strategy is hampered by facility-level variability in delivering harm reduction services. Establishing a dedicated harm reduction position at all VHA facilities would advance VHA's campaign to end new HIV infections among Veterans in care.

Budget Request: The 2025 SUD budget requests $264 million to support sustainment of initiatives initially funded in 2022 and with proposed sustainment through 2025 budget to comply with the ONDCP NDCS, the NCDA, and Congressional and statutory requirements. The 2025 budget includes an increase of $32.9 million above the 2024 budget request to account for by minor adjustments in original initiatives across funding lanes and organizational structures, with the most significant portion of additional costs for additional staffing to support establishment of VISN centralized screening teams as part of the MH RRTP access transformation effort. The budget request also provides continued support to expand SSP within VA and establishes a Mobile Methadone Van Pilot program. VA's 2025 SUD budget request closely aligns with the priorities outlined in the Biden-Harris Administration's Statement of Drug Policy Priorities.

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Suicide Prevention

Description	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Treatment Modality ($000):							
Suicide Diagnosis 1/	$1,479,658	$1,543,375	$1,559,477	$1,634,786	$1,707,067	$75,309	$72,281
MH care in the Emergency Room	$136,710	$243,132	$144,085	$151,043	$157,721	$6,958	$6,678
Reach Veteran in Crisis	$2,250	$2,334	$2,371	$2,486	$2,596	$115	$110
Suicide Safety Plan	$365,357	$304,731	$385,066	$403,661	$421,509	$18,595	$17,848
High Risk of Suicide	$426,693	$378,348	$449,711	$471,428	$492,272	$21,717	$20,844
MH Suicide Prevention PACT	$3,900	$3,709	$4,110	$4,309	$4,499	$199	$190
Total Treatment 1/	**$2,414,568**	**$2,475,629**	**$2,544,820**	**$2,667,713**	**$2,785,664**	**$122,893**	**$117,951**
Suicide Prevention Outreach Program:							
Veterans Crisis Line	$230,437	$300,500	$300,500	$306,683	$306,683	$6,183	$0
National Suicide Prevention Strategy Implementation	$47,471	$46,819	$46,819	$48,792	$48,792	$1,973	$0
Demonstration Projects	$11,685	$7,674	$7,674	$7,703	$7,703	$29	$0
Suicide Prevention 2.0 Initiative	$76,965	$58,213	$58,213	$58,907	$58,907	$694	$0
PREVENTS	$21	$0	$0	$0	$0	$0	$0
VA Governors Challenge Program	$0	$10,000	$10,000	$10,000	$10,000	$0	$0
Centers of Excellence (includes MIRECC and SMITREC)	$9,017	$5,993	$5,993	$6,059	$6,059	$66	$0
Local Facility and Community Outreach Activities	$678	$750	$750	$750	$750	$0	$0
Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program	$57,328	$55,583	$55,583	$54,819	$54,819	($764)	$0
Specific Purpose [Subtotal]	**$433,602**	**$485,532**	**$485,532**	**$493,713**	**$493,713**	$8,181	$0
Suicide Prevention Coordinators and Teams	$83,422	$73,262	$85,424	$88,841	$92,306	$3,417	$3,465
Total Suicide Prevention Outreach Program	**$517,024**	**$558,794**	**$570,956**	**$582,554**	**$586,019**	**$11,598**	**$3,465**

1/ A correction has been made in this table to the 2024 Budget Estimate column for medical treatment that had double counted Mental Health Care in the Emergency Room.

Authority for Action

- P.L. 116-171, *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019*
- P.L. 114-2, *Clay Hunt Suicide Prevention for American Veterans Act*
- 38 U.S.C. §1720F authorizes the comprehensive program for suicide prevention among Veterans.
- P.L. 110-110, *Joshua Omvig Veterans Suicide Prevention Act*
- Executive Order No. 13822, *Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life*, 3 C.F.R. 1513 (2018)
- P.L. 114-247, *No Veterans Crisis Line Call Should Go Unanswered Act*
- Executive Order No. 13861, *National Roadmap to Empower Veterans and End Suicide*, 84 FR 8585 (2019)

Veterans Crisis Line (VCL)

Purpose: Serves as the operational budget for VCL, which provides 24-hours per day, 7-days per week and 365-days per year suicide prevention and crisis intervention services. VCL connects Veterans and Service Members in crisis as well as their families and friends with qualified, caring VA responders through a confidential toll-free hotline, online chat, or text. VCL's budget supports operational readiness in fulfillment of the National Suicide Hotline Designation Act of 2020, which required the Federal Communications Commission (FCC) to designate 9-8-8 as the universal telephone number for the National Suicide Prevention Lifeline and the VCL. The transition to 988 was completed and activated nation-wide on July 16, 2022.

VA is proud to support the new Veterans Crisis Line number (Dial 988 then Press 1) alongside such partners as the Federal Communications Commission, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Suicide Prevention Lifeline. 988 expansion addresses the need for clarity in times of crisis, both for Veterans and non-Veterans alike. The VCL is continuing hiring, training, and onboarding through 2024 and projecting full staffing (2,311 of 2,568 FTEE for a 10% standard vacancy rate) by 2025 to ensure timely contact response.

National Suicide Prevention Program (SPP)

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

The SPP budget supports 82 full time employees and multiple suicide prevention contracts including those that focus on our communications and paid media efforts that aim to raise awareness about suicide prevention, and educate Veterans, their families, and communities about the suicide prevention resources available to them. Contracts also support work for: 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; P.L. 110-110, the *Joshua Omvig Veterans Suicide Prevention Act*, P.L. 116-214, Section 201, *Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act*; and P.L. 116-171, Section 506, the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019*.

The mission objective is to reduce Veteran suicide rates, facilitate Veteran engagement in care, and foster community and state partnerships to equip and support those who support Veterans outside of VA. In doing so, this will serve as a model for the nation in how to best address suicide as a national public health issue.

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

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

The 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 14 goals and 43 objectives included in the National Strategy 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 Centers for Disease Control (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. The 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 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.

Implementation: The SPP program budget funds FTE and contracts that support the work of SPP components operating at the VISN and facility level, as well as supporting the Suicide Prevention NOW Initiative (**SP NOW**). The **SP NOW** Plan aims to initiate quick deployment of interventions, which are deemed essential for the successful engagement of Veterans at high risk for suicide within one year's time. The five areas of focus are:1) Lethal means safety; 2) Suicide prevention in at-risk medical populations; 3) Outreach and understanding prior and non-VHA users; 4) SPP enhancements; and 5) Media campaigns.

Demonstration Projects

Purpose: Provides funding for the development 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, older Veterans, suicide risk screening and caring communications efforts, and the exploration of effective messaging, the use of artificial intelligence to aid identification and intervention and best practices for lethal means safety initiatives. These efforts are working to fill identified needs in support of the National Strategy for Preventing Veteran Suicide.

VA Suicide Prevention will continue to expand funding of demonstration projects, research, and innovation for public health approach innovations with a focus on diverse populations to better understand the unique needs and drivers of suicide risk to inform targeted interventions.

Evidence: Examples of demonstration projects for continued research and innovation include:

- The Asian American Pacific Islander (AAPI) Veteran project focuses on understanding the unique needs and drivers of suicide risk among AAPI Veterans. The American Indian/Alaskan Native (AIAN) Suicide Prevention project uses existing VA data to increase understanding of social determinants and Veterans health care use factors to inform culturally relevant and sensitive interventions for this high risk for suicide cohort of Veterans.
- Refining existing VHA clinical processes for Veterans with co-occurring homelessness and suicide risk seeks improve methods and procedures across VA to screen and identify homelessness and support with housing resources and options.
- Expanding the evidence-based LGBTQ+ focused group intervention, PRIDE in All Who Served, across the VHA enterprise to ensure access to this effective, tailored health promotion program that reduces suicide risk.
- Communicating lethal means safety messages to younger Veterans by leveraging digital platforms addresses gaps in effective messaging and evidence-based recommendations to reach younger Veterans.
- Testing scalability and sustainability of 'The Armory Project' (TAP), a partnership with firearm retailers to promote and provide out of home firearm storage during times of distress. Expanding the delivery of the evidence-based group intervention 'Project Life Force' through SP clinical telehealth hubs to reach Veterans at highest risk for suicide no matter where they reside, namely rural Veterans who may struggle to access services.
- Suicide risk identification and prevention in Reproductive Healthcare Settings addresses critical knowledge gaps to generate findings and products tailored to suicide prevention practices for women Veterans accessing reproductive care.
- Suicide Prevention among Older Veterans addresses firearm safety through the development of training videos on best ways to have firearm safety discussions with older Veterans and their family members.
- The Veteran Sponsorship Initiative+ expansion supporting High Risk Transitioning Servicemembers and Veterans (TSMV) uses a precision medicine approach to identify those TSMV at high risk for suicide and provide targeted enhanced care management during the first year of transition to civilian life. Expanding the integration of Mental Health providers will support prevention, early intervention, education, and access for at-risk Veterans in non-mental health clinic settings. Mental Health providers will continue to be hired in VHA Specialty Care Clinics identified by the research with Veterans at elevated risk for suicide including Oncology, Pain, Sleep, and Neurology clinics.
- Addressing the suicide risk of younger Veterans will be supported by a research and innovations hub at the VISN 2 Center of Excellence for Suicide Prevention. This hub will identify and pilot outreach, care coordination, and novel intervention projects focused on 18-34 y/o at-risk Veterans.
- The National Center for Veteran Financial Well-being (NCVFW) addresses the challenges of financial strain, a primary driver of suicide risk, in Veterans by ensuring that Veterans

have ready access to education, tools, and resources necessary to successfully navigate barriers to financial wellness.

Implementation: Demonstration projects are typically funded for one to three years with quarterly and annual reviews and resubmission of a project budget annually to ensure projects are adequately funded. These projects demonstrate measurable impacts for Veterans, providing further evidence and support for wider dissemination of the effort/intervention. It is the intent of the VA to take successful demonstration projects and find pathways to enhance and spread them to ensure the greatest impact for our Veterans.

Suicide Prevention 2.0 Initiative (SP 2.0 Initiative)

Purpose: SP 2.0 is moving suicide prevention beyond a one-size-fits-all model to a blended model combining community prevention strategies and evidence-based clinical strategies that will empower action at the national, regional, and local levels to reach Veterans both inside and outside VA care. To accomplish the goal of reducing suicide among all U.S. Veterans, a comprehensive approach to suicide prevention that blends community-based prevention and clinically based interventions is needed.

The Community-Based Interventions for Suicide Prevention (CBI-SP) model (Figure 1 below) aims to reach Veterans through multiple touchpoints. CBI-SP initiatives include the Governor's Challenge, Together with Veterans, and Community Engagement and Partnership for Suicide Prevention. The Governor's Challenge is a collaboration with VA and SAMHSA that brings state policy makers and leaders together to develop and implement a comprehensive suicide prevention plan. Community Engagement and Partnership for Suicide Prevention involves a comprehensive strategy to hire and train qualified Community Engagement and Partnerships Coordinators (CEPC) and Community-Based Interventions Program Managers (PM), who will collaborate at the community, regional, and state levels to support community coalition building for evidence-informed suicide prevention interventions specific to each locality's Veteran population. This model strengthens VA's focus on high-risk individuals in health care settings while embracing cross-agency collaborations and community partnerships.

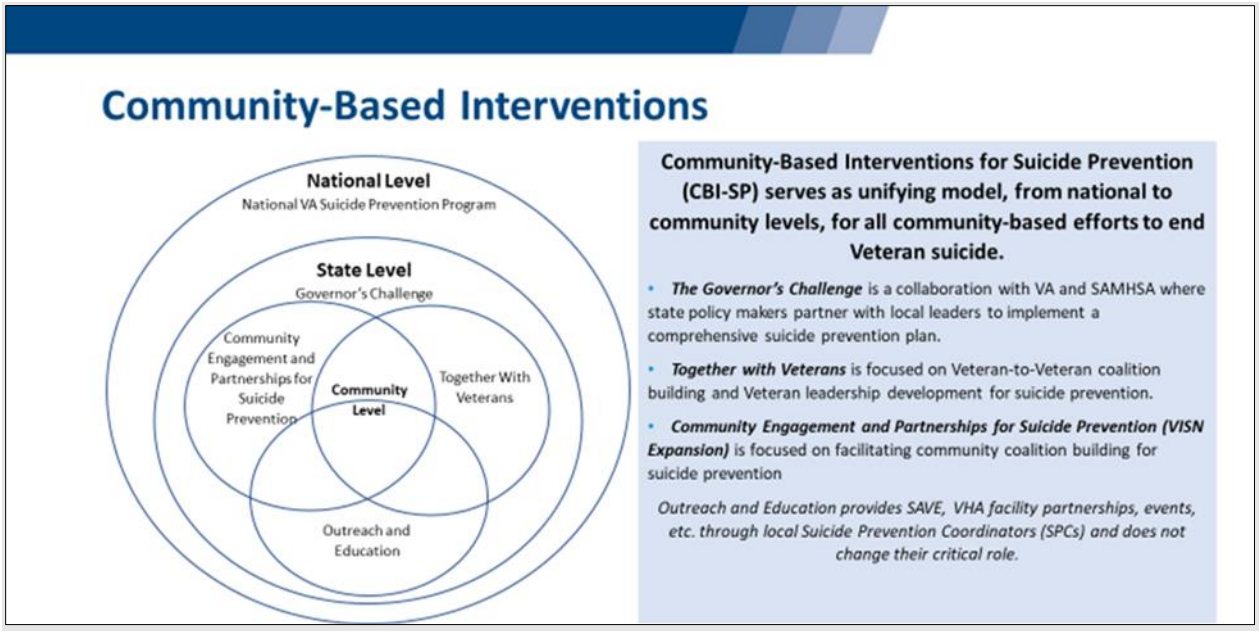

Figure 1: SP 2.0 – Community-Based Prevention

SP 2.0's Clinical Telehealth Program, in partnership with VA's Clinical Resource Hubs (CRH), has implemented a fully virtual enterprise-wide evidenced-based clinical program for suicide prevention specifically serving Veterans with a recent history of suicidal self-directed violence behaviors. Treatments provided are recommended in the 2019 VA/DoD Clinical Practice Guideline (CPG) on the Assessment and Management of Patients at Risk for Suicide Veterans have received:

1) Cognitive-Behavioral Therapy for Suicide Prevention (CBT-SP)

2) Problem-Solving Therapy for Suicide Prevention (PST-SP)

3) Dialectical Behavior Therapy (DBT), and

4) the Safety Planning Intervention (SPI).

Evidence: SP 2.0 initiative is informed by the evidence supporting suicide prevention interventions and public health approaches. The CDC, SAMHSA, and the National Action Alliance for Suicide Prevention have all moved toward a public health approach to suicide prevention. The model works to incorporate reaching Veterans, both served by VA and in the community, 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.

Community efforts promoting responsible media reporting of Veteran suicide is crucial. These efforts include accurate portrayals of Veteran suicide and mental illnesses in the entertainment industry and the safety of online content related to Veteran suicide. The Werther Effect (the negative consequences of media's portrayal of suicide) is well established and implementing recommendations for improvement for media reporting are key to reducing this effect (Ortiz & Khin, 2018; Sisask & Varnik, 2012). 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 these noted elements are informing and being incorporated into the roll out of SP 2.0.

Implementation: SP 2.0 Community-based Interventions (CBI) are being fully implemented across all 18 Veterans Integrated Services Networks (VISNs). Additionally, 50 states and five territories (including Guam, Puerto Rico, US Virgin Islands, American Samoa, and Northern Mariana Islands) in the Governor's Challenge remain engaged with technical assistance around implementation of action plans. In 2023, there were over 1,600 local coalitions, 800 of which were in the implementation phase of their work and covering more than 40% of the Veteran population - working towards ending suicide.

The approach for SP 2.0 CBI allows for us to adapt strategies and programming based on lessons learned over time and to improve upon and advance innovative community efforts while simultaneously working to enhance engagement in communities. Overall, this allows for the selection of specific unique intervention and prevention strategies relevant for local context, the testing of assumptions and workload over time and the opportunity to study what is effective in promoting suicide prevention strategies for all Americans.

For the clinical component of SP 2.0, the program has hired over 105 psychotherapists, and over 90% of therapists are trained in three or more evidence-based protocols. SP2.0 Clinical Telehealth is currently accessible in 100% of the 139 Health Care Systems in the United States. As of November 30, 2023, the program has generated over 14,500 referrals and completed over 8,000 intake assessment appointments.

Sustainment plans include re-imagining the training program models by creating independently enduring materials to ensure the continued capacity of trained SP 2.0 Clinical Telehealth therapists.

Both components of SP 2.0 have robust program evaluation underway. Program evaluation and implementation science experts designed measurement protocols that will allow for the assessment of process measures, short- and long-term outcomes over time. Unique elements of SP 2.0 utilizing both community prevention and clinical intervention strategies will be studied including such variables as:

- Increased awareness and utilization of suicide prevention resources for Veterans.
- Lowered stigma and increased willingness to seek care.

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

VA Governor's Challenge Program

The Governor's Challenge has expanded efforts into suicide mortality reviews (SMR) where funding is applied to states, territories, and tribal nations to support implementation and expansion of SMR. These groups work collaboratively to:

- Develop and implement state-wide suicide prevention practices, using a public health approach, to advance the National Strategy for Preventing Veteran Suicide and incorporate evidence-based strategies.
- Engage with city, county, territory, and state partners to enhance and align local and state-wide suicide prevention efforts.
- Understand the issues surrounding suicide prevention.
- Increase knowledge about the challenges and lessons learned in implementing best policies and practices by using state/territory-to-state/territory and community-to-community sharing.
- Implement promising, best, and evidence-based practices to prevent and reduce suicide at the local level.
- Define and measure success, including defining assignments, deadlines, and measurable outcomes to be reported.

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

Purpose: The Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP), established under P.L. 116-171 §201, enables 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 (2018-2028) and the White House strategy for Reducing Military and Veteran Suicide, this grant program assists in further implementing a public health approach that blends community-based prevention with evidence-based clinical strategies through community efforts.

Evidence: Many Veterans who die by suicide did not receive care from VA prior to their deaths. Specifically, 11 of the 17 Veterans who die daily by suicide were not seen within VHA care at least two years prior (Department of Veterans Affairs National Veteran Suicide Prevention Annual Report, 2022). 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 strengthens 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 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. Grants of up to $750,000 were awarded to organizations to 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.

The SSG Fox SPGP provides funding for local suicide prevention programs through outreach, suicide prevention services, and connection to VA and community resources. In September 2022, 80 community organizations were awarded $52.5 million in annual grants to provide suicide prevention services in 43 States, the District of Columbia, and American Samoa. Twenty-one (21) entities serve tribal lands including Navajo Nation, Cherokee Nation, Choctaw Nation, Alaskan Native tribes, and others. In 2023, grantees completed over 16,000 outreach contacts and engaged 3,191 participants. On September 20, 2023, VA awarded a second round of $52.5 million to 80 community-based organizations in 43 states, the District of Columbia, American Samoa, and Guam. Funding decisions reflect VA's authority to prioritize the distribution of grants to rural communities, Tribal lands, Territories of the United States, medically underserved areas, areas with a high number or percentage of minority Veterans or women Veterans, and areas with a high number or percentage of calls to the VCL. The full list of grantees is available at https://www.mentalhealth.va.gov/ssgfox-grants/.

Additionally, VA established a robust program evaluation design to measure short, mid- term and long-term effectiveness of the program and identify best practices after the study. There are multiple collaborations in place to assist in the implementation of this grant program. The success of the program will be summarized within two Congressionally mandated reports: an interim report summarizing grantee and program accomplishments in the first 18 months since grant awards; a final report, and an independent third-party evaluation of grantee performance and VA SSG Fox SPGP performance. Key metrics are tracked, including the number of Veterans served, since the start of grantee services and a transition to an electronic data collection tool which launched in November 2023.

Centers of Excellence

Purpose: Budget line provides ongoing operational support for the SPP from VHA Centers of Excellence and OMHSP Program Evaluation Centers. VA has 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. The CoE-SP is guided by four overarching goals that systematically drive CoE-SP activities and align with objectives outlined in the National Strategy: 1) surveillance to define the problem, 2) identification of risk/protective factors, 3) development/testing of novel interventions, and 4) implementation of evidence-informed strategies. Consistent with these objectives, the COE-SP manages VA's Behavioral Health Autopsy Program (BHAP) on behalf of OMHSP's SPP and supports data and surveillance activities, including the National Veteran Suicide Prevention Annual Reports.
- *Rocky Mountain Mental Illness Research, Education and Clinical Center (RM MIRECC):* The mission of the RM MIRECC is to study suicide to reduce suicidal ideation and behaviors in the Veteran population. The work of the RM MIRECC is focused on the implementation and evaluation of promising clinical interventions including Safety Planning in Emergency Departments (SPED) and suicide risk screening (Risk ID). In alignment with the national strategy, the RM MIRECC works to promote Veteran wellness, provide training to clinician and community providers and promote suicide prevention activities, education, and research.
- The OMHSP Program Evaluation Centers (PECs) which include the Northeast Program Evaluation Center (NEPEC), the Program Evaluation Resource Center (PERC), and the Serious Mental Illness Treatment Center (SMITREC), develop, implement and evaluate operational enhancements, conduct national program evaluations. These centers provide extensive technical, operational, and scientific support for OMHSP support suicide prevention, including service monitoring, population health assessments, measurement-based care management, and evaluation of a variety of initiatives and ongoing programs to determine utilization, quality improvement and improve effectiveness in both mental health services and suicide prevention efforts.

Examples of ongoing operational support include:

- *Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment* (REACH VET): REACH VET is a predictive model to identify those Veteran at highest risk for suicide. The program's predictive model identifies Veterans in VHA care who may benefit from clinical review and care enhancements REACH VET coordinators at local VHA facilities complete a chart review, coordinate with the Veterans treatment team, and outreach Veterans identified in the top 1% of the model. Program oversight activities are presently managed by the Suicide Prevention Program's Field Operations team. Ongoing program evaluation is conducted by SMITREC and PERC, and in conjunction with the Oak Ridge National Laboratory new social determinants of health data are being piloted to inform program enhancements.
- *Safety Planning in the Emergency Department* (SPED): SPED is an evidence-based suicide prevention intervention in which safety plans are completed with all Veterans who present to the Emergency Departments with suicidal thoughts and/or behaviors and meet the criteria for discharge home. The RM MIRECC team provides implementation support to SPED Champions nationwide, technical assistance on weekly national calls and via an email support group and tracking dashboards to inform quality improvement. *VA Suicide Risk Management (VA SRM) Consultation Program*: The RM MIRECC SRM Consultation Program team provides consultation to any clinician (in VA or the community) working with Veterans at risk for suicide utilizing the Therapeutic Risk Management of the Suicidal Patient model. This consultation program is a vehicle for dissemination of the VA/DOD Clinical Practice Guidelines (CPGs) for Suicidal Behavior.
- *Suicide Risk Identification Strategy (Risk ID)*: Risk ID is the largest population-based suicide risk screening and evaluation strategy employed by any United States healthcare system and is codified in VHA Memorandum in 2019. The RM MIRECC team supports the national implementation and evaluation of the Risk ID requirements, providing ongoing training, technical assistance, and tracking, revising and reporting of performance metrics.
- *VA's Behavioral Health Autopsy Program* (BHAP): BHAP is a multifaceted quality improvement program 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 utilizes standardized chart reviews, interviews with bereaved family members, and targeted interviews with SPCs across the nation to better understand the characteristics and contexts of Veteran suicide to enhance the care and services provided to Veterans.

- *Outreach to Facilitate Return to Care* (OFR Care): OFR Care supports VHA facility efforts to re-engage Veterans identified at high risk for suicide that have not attended an appointment in the last two years. Pilot sites outreach Veterans to offer support and access to care. Program evaluation found that OFR Care Veterans were more likely to re-engage in VHA care.

Evidence: The following examples have had a demonstrable impact on highlighting Veteran risk factors (BHAP), addressing these risk factors, and providing additional support and care (REACH VET, SPED).

REACH VET: The percent of high-risk Veterans targeted to re-engage in services resulted in an 89% success rate.

In the fourth quarter (Q4) of 2023, national performance exceeded the abovementioned metrics goals.

Metric	2023 Q4 Performance	Benchmark Target
Coordinator Accepted	100%	95%
Provider Accepted	99%	95%
Care Evaluation	99%	95%
Outreach Attempted	98%	95%
Successful Outreach*	89%	80%

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

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

SPED: In the fourth quarter (Q4) of 2023, national performance exceeded the metrics benchmark of 90% with 92% of eligible Veterans had a safety plan attempted prior to discharge from the ED/Urgent Care Center (UCC) (from baseline of 66% in May 2020). The effectiveness of SPED, described by Stanley and colleagues (2018), showed a 45% reduction in suicidal behavior.

VA SRM: Caring for Veterans at risk for suicide can be emotionally challenging. Providers can serve Veterans better when they have access to the right resources and tools and feel confident in their treatment decisions to mitigate Veterans' risk for suicide. Findings from Silva et al. (2016) illustrated that providers do not feel adequately trained nor confident in their skills to effectively intervene with suicide risk in their patients. 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 provides resources, training, and consultation to any provider, inside and outside VHA, serving Veterans at risk for suicide. SRM completes an average of 100 consults each quarter and conducts the monthly SRM Lecture Series, attended by both VHA and community providers. The SRM team conducts regular presentations to community partners and healthcare systems (e.g., Cohen Veterans Network, Triwest, Optum).

Risk ID: VA's Risk ID program requires annual suicide risk screening for all Veterans in VHA healthcare. Risk ID has been implemented in ambulatory (i.e., outpatient care) and all emergency department and urgent care settings. For Veterans who screen positive, a Comprehensive Suicide Risk Evaluation (CSRE) is required to be completed within 24 hours. At the end of 2023, 61% of Veterans received suicide risk screening when it was due and 86% of those with a positive screen received a timely CSRE. Among Veterans in ambulatory care, a positive C-SSRS screen was found to be associated with significantly increased mental health care follow-up and engagement, particularly for those who had not received any mental health care in the previous year (Bahraini et al., 2022). These findings suggest that C-SSRS screening helps identify Veterans at high risk of suicide and connect them with appropriate services.

BHAP: BHAP provides 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). Detailed findings from BHAP data are compiled on an annual basis to provide leadership and the field with actions to further suicide prevention activities. Since 2012 when BHAP data collection began, there have been more than 10,870 BHAP chart reviews completed (approximately 1,000 per year). To date, since the BHAP Family Interview Program began in 2014, there have been more than 909 family interviews completed (approximately 100 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).

Implementation:

REACH VET: The REACH VET national implementation has reached strong adherence (99-100%) across the VHA enterprise. As a result, this program has shifted from RM MIRECC implementation and evaluation to SPP maintenance and technical support. Ongoing dashboard tracking and reporting of performance continues. SPP includes REACH VET performance within the site visit reviews, providing consultation to ensure discussion to problem solve barriers and concerns in managing this program.

SPED: RM MIRECC continues implementation and evaluation of SPED, including dashboard development, tracking and weekly technical assistance calls. Tailored technical assistance is provided to underperforming facilities to collaboratively problem-solve around barriers to implementation. Common barriers among underperforming facilities include a lack of dedicated mental health staff in their Emergency Department or Urgent Care Center, challenges with completing tasks during nights and weekends, challenges associated with training rotating staff such as residents, and inadequate monitoring of information available on the SPED dashboard. Additionally, RM MIRECC continues to develop training resources to ensure that the SPED intervention is delivered in a high-quality manner. RM MIRECC has updated a national template to facilitate the development of additional SPED metrics and to improve documentation of SPED efforts.

VA 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 redesigned Rocky Mountain MIRECC/SRM website; the monthly SRM Lecture Series (offering free continuing education units for both VA and non-VA community providers and partners); the SRM Quarterly Newsletter; LinkedIn and Google search targeted advertising; and community partnerships. Within VA, SRM is regularly included in trainings and presentations. Additionally, OMHSP leadership regularly recommends use of the program when indicated. Ongoing program evaluation efforts allow the team to continually adjust to changing needs of consultees.

Risk ID: In November 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 changed the Risk ID 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 is offered and completed by VHA staff. The RM MIRECC team provides ongoing implementation support via weekly technical assistance calls and email support. Guidance documents for the field have been updated per new requirements in opioid treatment programs and are located on the internal VA SharePoint site, *Suicide Risk Identification and Management.* In partnership with SPP, monthly Risk ID metrics are sent to VISN CMHOs, and additional support is provided to underperforming sites.

BHAP: COE-SP continues 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; provide ongoing training)
- *Interview Coordination* (e.g., COE-SP trained interviewers conduct structured interviews with bereaved family members and Suicide Prevention Coordinators; provide ongoing training to enhance data quality)
- *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, VA providers, and local SPCs])
- Suicide and Non-Fatal Suicide Attempt Surveillance: The COE SP and SMITREC work in tandem to develop and conduct analyses to support VA's annual National Veteran Suicide Prevention Annual Reports. To date, VA has published seven reports, with the most recent including statistics for all Veterans and for non-Veteran U.S. adults. SMITREC and PERC coordinate regarding ongoing monitoring of site-reported non-fatal suicide attempts and overdose events.

Budget Request: VA's 2025 total budget request for Suicide Prevention is $570 million, a +$11 million increase over the 2024 budget. Primary drivers of budget increase include new FTE, increased personnel costs and contract costs, and programmatic expansions to support VA efforts in reducing Veteran Suicide.

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Women Veterans Peer Support Initiatives (including WoVen)

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations							
Women Veterans Peer Support Initiative (WoVen).....	$1,286	N/A	$1,415	$1,698	$2,000	$283	$302
**Obligations [Grand Total]..... **	**$1,286**	**N/A**	**$1,415**	**$1,698**	**$2,000**	**$283**	**$302**
Account Category:							
Medical Services	*$1,286*	*N/A*	*$1,415*	*$1,698*	*$2,000*	$283	$302
Medical Support & Compliance	$0	*$0*	*$0*	*$0*	*$0*	$0	$0
Medical Facilities	$0	*$0*	*$0*	*$0*	*$0*	$0	$0
Medical Care Total.....	*$1,286*	*N/A*	*$1,415*	*$1,698*	*$2,000*	$283	$302

[1/]Details not displayed in the 2024 Congressional Justification

Authority for Action:

- P.L. 115-182, *VA MISSION Act of 2018*, Section 506: Program on Establishment of Peer Specialists in Patient Aligned Care Team Settings Within VA Medical Centers
- P.L. 115-271, *SUPPORT Act*, Section 8051, Peer Support Counseling Program for Women Veterans
- P.L. 116-260, Title II, Division J, *Military Construction, Veterans Affairs and Related Agencies Appropriation Act of 2021*, Explanatory Justification.
- P.L. 116-315, Title V, *Deborah Sampson Act*, Section 5206, Staffing Improvement Plan for Peer Specialists of Department of Veterans Affairs Who are Women
- P.L. 117-328, Division V, *STRONG Veterans Act of 2022*, Section 401: Expansion of Peer Specialist Support Program of Department of Veterans Affairs

Purpose: More women are using VA than ever before. Over 30% of new VHA users are women and the total number of women Veterans using VA health services has more than tripled since 2001. This trajectory of rapid growth is expected to continue.

Women comprise 10% of the U.S. Veteran population and 11% of VHA Veteran users. In 2023, over half of the more than 700,000 women Veterans who used VHA care were diagnosed with at least one mental health condition, and many struggle with multiple clinically complex conditions, such as trauma, mood and eating disorders. By 2035, women will comprise 15% of the U.S. Veteran population. Due to higher rates of mental health challenges and service utilization, the rapidly growing number of women Veterans will continue to need — and use — a continuum of VHA mental health services that address their unique and diverse needs.

The peer specialist profession is a mental health care profession, not a program, within VHA and like other mental health professional disciplines is dispersed throughout VHA. The peer specialists work as fully integrated members of interdisciplinary treatment teams and deliver peer support services to Veterans. Peer specialists are Veteran employees who self-identify with a lived experience of successful recovery from a mental illness and/or substance misuse. Peer specialists are professionally trained through required peer specialist certification to effectively use their personal lived experience with recovery to inspire hope and serve as relatable role models of recovery for other Veterans. In individual and group-based meetings with Veterans, peer specialists use a host of recovery tools to help Veterans enhance healthy coping strategies and improve self-management skills over their health conditions. They support Veterans to empower themselves to address self-care, advocate for themselves, access available resources in and outside VA, reconnect with others, and to find a sense of belonging and purpose both in VA and in their communities. Examples of where peer specialists-work include outpatient, inpatient and residential mental health and substance use treatment programs, intensive community mental health recovery services, psychosocial rehabilitations recovery centers, primary care patient aligned care teams (PACT), vocational rehabilitation services, homeless programs, Veterans Justice Program and the Veterans Crisis Line's Peer Support Outreach Center.

VHA employs over 1,400 peer specialists, 20% of whom are women. The results of analyses conducted for P.L. 116-315, Section 5206 showed most VHA peer support services received by women Veterans are delivered by male peer specialists. The VHA Office of Mental Health and Suicide Prevention (OMHSP) anticipates that the peer specialist workforce and the variety of programs where peer specialists work will continue to expand in VA over time, as awareness of the peer specialist health care profession and recognition of the value that it brings to VHA health care services continue to grow. One example of an initiative that is continuing the expansion of the peer specialist workforce is implementing the STRONG Veterans Act of 2022. This requires VA to expand the hiring of peer specialists in primary care PACT over the next seven years until every VA medical center has at least two peer specialists working full-time in primary care PACT settings. This law also requires that the needs of women Veterans are specifically considered and addressed, and that women peer specialists are available in every VA primary care PACT setting to provide peer support services to women Veterans.

It is essential that all peer specialists, regardless of gender, receive the relevant and appropriate training and resources needed to optimally deliver peer support services in a manner that is sensitive to the needs and interests of women-identified Veterans.

Implementation: There is a critical need to expand VHA peer support services for women Veterans. Efforts to do so are underway and include two key strategies:

- Develop and disseminate educational resources to ensure all VHA peer specialists have the foundational knowledge needed to provide gender-sensitive peer support services to women Veterans.
- Identify, pilot, and scale up training and implementation of promising gender-specific peer specialist strategies and protocols tailored to enhance peer support services for women Veterans.

National Trainings for All Peer Specialists and Supervisors

- Women's Mental Health Peer Specialist Virtual Training Series**:** In 2021, OMHSP designed and implemented the first VA training series of its kind for peer specialists of all genders who work with women Veterans. Training topics included conditions and life experiences that affect women Veterans, such as reproductive mental health, interpersonal traumas and gender-linked stressors. Discussions incorporated strategies for working with women Veterans of mixed-gender and women-only support groups and relating to women Veterans with different/same-lived experiences. The full series included eight one-hour sessions designed and co-led by peer specialists and clinical subject matter experts.

  Each live session was attended by approximately 250 to 300 participants and 89% of participants agreed or strongly agreed that the content was useful to their practice and professional development. Each session was recorded and is now available as an on-demand continuing education training for VHA peer specialists, their supervisors, and other interested licensed clinicians.

- National Needs Assessment**:** A national quantitative and qualitative needs assessment was conducted in 2022 to shape future efforts of growth and sustainment for women Veterans' peer support services in a data-informed way. The development, implementation and interpretation of the assessment was conducted in partnership with the Veterans Integrated Service Network (VISN) 5 Mental Illness Research Education and Clinical Center (MIRECC). Participants in the quantitative survey included 311 peer specialists and 220 peer support supervisors.

  Findings were notable for an especially strong need for training in areas related to reproductive mental health, such as premenstrual, infertility, pregnancy and postpartum, pregnancy loss, perimenopause, pelvic exam anxiety, breast and gynecologic cancers, and sexual health. Among peer specialists, the proportion reporting a need for more training in these areas ranged from 54% – 75%, depending on the specific topic. Among supervisors, the proportion reporting this need ranged from 55% – 72%, depending on the specific topic.

Other topics for which high percentages of both peer specialists and supervisors identified training needs included:

- Gender-linked stressors such as caregiver burden and gender-based harassment.
- Facilitating women-only groups and supporting women when facilitating mixed-gender groups.
- Working with women Veterans when you don't have similar lived experience, or when triggered because you do have similar lived experience.

Since most peer specialists are men, it is notable that male peer specialists reported more substantial knowledge gaps than female peer specialists. For example, among male peer specialists, 83% – 89% reported knowledge gaps in various reproductive mental health topics. The qualitative portion of the needs assessment consisted of four focus groups of peer specialists. Themes emerging from these focus groups shaped a more detailed understanding of training needs, such as:

- Specific training, including practice and coaching, on how to approach sensitive topics with women Veterans.
- Specific training on how to draw on existing skills when the peer specialist does not share similar lived experiences with women Veterans.
- The need to establish and maintain a community of practice for peer specialists interested in supporting women Veterans' mental health.

Findings from this needs assessment were used to shape the curriculum of the FY 2023 VHA Peer Specialist and Peer Support Supervisor Virtual Conference, discussed below. They are also being used to develop the curriculum and format of the planned 2024 face-to-face, intensive peer specialist training in women's mental health.

- National Peer Support Services Conference: In 2023, the annual VHA Peer Specialist and Peer Support Supervisor Virtual Conference focused on the theme of women's mental health. Based on the FY 2022/23 Needs Assessment, two plenary sessions and two breakout sessions (each repeated twice) focused on women's mental health topics. Women's mental health subject matter experts joined the conference planning committee and women-related content was included in all plenary and breakout sessions when relevant.

  Preliminary results from the four-day national conference held August 21st – 24th, 2023: Daily participation rates ranged from 1,052 to 1,156 audience members. Evaluation results from the conference are pending. Each session was recorded and will be made for on-demand viewing.

- National Conference on Peer Support for Women**:** The FY 2022/2023 Needs Assessment identified a compelling need to train a cadre of peer specialists to have more in-depth knowledge of women's mental health, including reproductive mental health, gender-linked stressors, and relevant adaptions for individual peer support and peer-facilitated groups. To this end, OMHSP will design and implement a 2.5-day, in-person training for 50 peer specialists. The curriculum and training delivery modes will be derived from the needs

assessment findings. Once trained, these peer specialists will form an initial community of practice and serve as points of contact within their VISNs and facilities for other peer specialists and Veterans with gender-specific needs.

The value of this more intensive training, with a focus on reproductive mental health, is underscored by the VA/DoD Clinical Practice Guidelines for the Management of Pregnancy, which were updated August 2023. Based on rigorously reviewed evidence, one of the new recommendations is: *"We suggest offering peer support for people with perinatal depression or risk of perinatal depression to improve depressive symptoms."* From FYs 2000 through 2020, there was a more than 21-fold increase in number of pregnancies among Veterans using VHA services. Given that 57% of peer specialists, 56% of peer support supervisors, and 83% of male-identified peer specialists participating in the FY 2022/2023 needs assessment reported lacking perinatal mental health knowledge, it's crucial that VHA train peer specialists to deliver these CPG-recommended services.

Future efforts include: maintaining annual cadence of national training efforts targeting all peer specialists; repeating needs assessment at least every three years; evaluating the impact of 2024 national face-to-face conference on peer support services for women Veterans and recommend future actions based on 2024 results; fostering national community of support for peer specialists with advanced training and focus on women Veterans; and developing educational and outreach materials to raise awareness and support growth of VHA peer support services for women Veterans.

Peer Support Services For Women Veterans: VHA peer specialists are well-trained to provide a range of interventions intended to serve all Veterans. The proposed work will expand current peer support services by developing a portfolio of peer-led interventions that specifically address the needs and interests of women Veterans, including:

- WoVeN in VA: Time-limited group intervention that builds social connections among women around shared experiences and community reintegration after military separation.
- Beyond MST Together: Brief, peer-facilitated intervention to encourage psychosocial recovery from experiences of military sexual trauma (MST) through use of the Beyond MST mobile app.
- Confident and Courageous: Open group that fosters community engagement and recovery through shared activities and service.

WoVeN in VA:

- Community-Based WoVeN: WoVeN (Women Veterans Network) is a community-based organization, developed outside of VHA to create a social network of women Veterans, foster connections, and build relationships in local communities and nationally. WoVeN's core component is an eight-session series of structured group meetings to enhance wellness and build social connections. All WoVeN groups are led by two trained "peer co-leaders" (women Veteran volunteers). Since its inception in 2017, over 1,700 women Veterans have enrolled in a community-based WoVeN group. Recently published results of a voluntary survey of 669 WoVeN support group participants are extremely positive (Galovski et al., 2022). Nearly 90% of participants reported they would be "very likely" to refer another Veteran to WoVeN and 86% would participate in future WoVeN events. Among women

who attended five or more meetings, 89% reported that they enjoyed group content "quite a bit or extremely" and 79% gained "quite a bit or extreme" value from their experience. Most participants (73%) also reported that WoVeN had positively impacted two or more major life domains (e.g., social, recreational, work, family, religion, mental/physical health, and well-being). In sum, feedback on this community-based program supports the adaptation and implementation of WoVeN in VA.

- WoVeN in VA**:** A peer specialist-led adaption of the community-based WoVeN support groups. This model is designed for implementation in VA with women Veterans enrolled in VHA mental health care. Consistent with the community-based protocol, WoVeN in VA groups are designed to enhance wellness and build social connections among women Veterans. The curriculum explores shared challenges, priorities and goals, life balance and transitions, stress relief, connections, trust and esteem.
- WoVeN in VA Pilot**:** In 2021 and 2022, a team of subject matter experts developed, piloted and evaluated a standardized training and consultation model to support VA implementation. All VA medical centers were invited to apply to be selected as a pilot site. Eligibility for site selection included:
    - Two or more female peer specialists co-located at facility, grade levels GS-7 or higher.
    - Experience leading support groups.
    - Availability to completed 12-hour training and 8 weekly consultation calls.
    - Leadership/supervisor commitment to support peer specialists' completion of training requirements and to offer 8-week WoVeN in VA groups.

  Sites were selected from applicant pool with priority given to those sites with greater experience running support groups, evidence of local support to facilitate recruitment and implementation of WoVeN in VA, and geographic distribution. Two pilot cohorts (five sites per cohort) were selected, trained, and followed during implementation.

  Evaluation results of this pilot were extremely positive. The limited number of women-identified peer specialists was identified as a critical limiting factor and barrier to long-term sustainment and spread of the co-leader model in VHA.

- *Impact:* The majority of women Veterans who participated in WoVeN in VA groups indicated high satisfaction and reported feeling less isolated, more empowered and having increased self-esteem as a result of group participation. In qualitative interviews, some participants also noted that the experience had a positive impact on their view of and engagement in VA mental health services.
- *Training:* Consistent with the community-based WoVeN model, two co-leaders were trained at each site and initial pilots were implemented with two peer specialist co-leaders. Although some peer specialists wished the training afforded more time to practice, most felt the training was well done and the vast majority reported being confident regarding their abilities to facilitate WoVeN in VA Groups.
- *Consultation:* Although many peer specialists noted that they would benefit from extended consultation, both the peer specialists and the consultants found value in the consultation

model and noted that consultation sessions were valued for the extra support and guidance offered, as well as the opportunity for peer support and learning from other's experiences.

- *Implementation:* Peer specialists were largely able to get groups implemented relatively quickly, though they did note some implementation challenges, including having protected time to recruit and desire for more training dedicated to practice implementation issues (e.g., clinic setup, electronic medical record templates, etc.). Most thought WoVeN in VA was generally easy to implement and noted that they felt group participants resonated with the group structure and content.

Modifications to WoVeN in VA in 2023: Building on evaluation results of the initial pilot implementation of WoVeN in VA, in 2023 changes were made to the training, consultation and implementation and piloted in two additional cohorts. Modifications included:

- Post-training consultation extended from 3 to 6 months after completion of initial training.
- Training and WoVeN in VA model revised from co-leader to single-leader model.
- Developed and launched a train-the-trainer model to further enhance scalability.
- Application process did not change, however special consideration was again given to geographic distributions, with preference given to applicants from facilities in VISNs not previously trained.

By end of 2023, women peer specialists in 16 of 18 VISNs had completed training and WoVeN in VA groups will have been offered over 40 times. Although we have not yet completed collection and analysis of evaluation data for the single-led groups, preliminary data suggest that women Veterans who participated in single-led groups reported high satisfaction and indicated multiple significant impacts on their lives and treatment in VA, commensurate with participant evaluations of co-led WoVeN in VA groups. Although some implementation barriers persisted, in general leaders were able to recruit and engage women Veterans in single-led WoVeN in VA groups.

The shift from a co-leader to single-leader model, addition of new consultants/trainers, and successful launch of a process to train additional trainers will accelerate broader spread of this model in 2025 and beyond. Program evaluation is ongoing.

2024 Sustainment of WoVeN in VA: In 2024, two additional cohorts of WoVeN in VA will be offered. Peer specialist participants have been selected and will begin training in February 2024. Cohorts include peer specialists that will implement either as individual leads or as co-facilitators, site depending. Evaluation efforts will continue with support of ILEAD. The train-the-trainer model will also continue with one additional trainer/consultant having permanently been added to the training team.

Beyond MST Together: MST is an experience, not a diagnosis. It is associated with a wide range of physical and mental health conditions and significant healthcare needs. Survivors also are a diverse group who have a range of different reactions to the experience. Although MST affects Veterans of all genders, it disproportionately affects women and is associated with increased suicide risk.

- Beyond MST: Beyond MST is part of the National Center for PTSD's library of free, evidence-based apps for Veterans and the public. The app includes over 30 specialized

tools and other resources and features. Veterans can use the app to learn and practice coping skills and self-help approaches to healing. They can also take brief assessments in the app to track their program towards personal goals.

There have been over 20,000 downloads of Beyond MST since its release, and it has positive ratings from both iOS and Android users (ratings of 4.5 and 4.1 out of 5 respectively). Qualitative interviews during user experience testing also indicate positive feedback on the app and its look and the feel, with most users interviewed saying they would recommend it to friends/fellow Veterans.

- Beyond MST Together: Developed in partnership with the creators of the Beyond MST app, Beyond MST Together is designed for use by VHA peer specialists in their work with MST survivors. The goal of this intervention is to encourage psychosocial recovery from experiences of MST using the power of peer support services to help people use the Beyond MST self-help mobile app. With the peer specialists' support and guidance, Veterans learn to apply the tools and information in the app to their own lives to identify and achieve recovery goals, feel less alone, and overcome stigma.

  In May 2024**,** Beyond MST Together will be piloted in VA. All VA medical centers will be invited to apply. Eligibility criteria will include:

  - Peer Specialists Grade level 7 or higher with knowledge of and experience in working with those who have experienced MST.
  - Ability to recruit women Veterans with whom the intervention can be utilized.
  - Geographic diversity.

  Identified peer specialists will be invited to participate in a two-day virtual training in the intervention and begin delivering Beyond MST Together to women-identifying Veterans. The pilot will be evaluated and will focus on gathering feedback from peer specialist facilitators and Veteran users to include usability, satisfaction and barriers to uptake and implementation. Data will inform potential modifications and future dissemination efforts.

Confident and Courageous: Confident and Courageous is a recovery-oriented, peer specialist-led support group for women Veterans. In Confident and Courageous, women Veterans work together to create group activities that reflect their strengths, skills, and interests to promote self-care, care of others, community engagement, advocacy and meaningful connections and experiences. Unlike the time-limited, highly structured WoVeN in VA support groups, Confident and Courageous groups are not time-limited; group projects and pacing are flexible. By focusing on mutually designed service projects, Confident and Courageous groups serve as an enduring forum to grow connections between women Veterans while engaging in and contributing to their local communities.

Confident and Courageous was developed by VA's 2022 National Peer Specialist of the Year. The first group was implemented in 2017 at the Edward Hines, Jr. VA Hospital. Preliminary evaluation results showed a 90% participant satisfaction rate and qualitative feedback underscored the group's success in fostering a safe, supportive, recovery-promoting environment.

Subject matter experts are working with the lead developer to create a written guidebook of this promising practice for use by other peer specialists who wish to adapt the intervention for local use. The guidebook will be completed and distributed nationally in 2024.

Budget Request: The Women Veterans Peer Support Services 2025 budget request is $1.7 million, an increase of $0.3 million over the 2024 budget, to support Women Veterans Peer Support initiatives, pilots, training and educational efforts and gender-specific priorities and protocols. Year-over-year increases are driven by cost of living increases in pay and benefits.

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Pharmacy

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$10,867,650	$8,605,862	$6,931,842	$4,813,044	$6,062,175	($2,118,798)	$1,249,131
Medical Community Care (0140):	$7,283	$100,656	$7,477	$6,596	$6,430	($881)	($166)
Medical Support and Compliance (0152):	$671,354	$778,000	$741,900	$839,500	$884,500	$97,600	$45,000
Medical Facilities (0162):	$189,061	$298,400	$192,600	$198,300	$208,900	$5,700	$10,600
Discretionary Total	**$11,735,348**	**$9,782,918**	**$7,873,819**	**$5,857,440**	**$7,162,005**	**($2,016,379)**	**$1,304,565**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$2,892,523	$5,699,901	$9,000,000	$9,000,000	$3,300,099	$0
Veterans Medical Care and Health Fund (0173)	$293,896	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$886	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$1,237	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$296,019**	**$2,892,523**	**$5,699,901**	**$9,000,000**	**$9,000,000**	**$3,300,099**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$469	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$242	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$711**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$688	$0	$5,300	$23,300	$16,900	$18,000	($6,400)
Veterans Medical Care and Health Fund (0173)	$949	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$21	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,658**	**$0**	**$5,300**	**$23,300**	**$16,900**	**$18,000**	**($6,400)**
Mandatory Total	**$298,388**	**$2,892,523**	**$5,705,201**	**$9,023,300**	**$9,016,900**	**$3,318,099**	**($6,400)**
Combined Discretionary and Mandatory by Category							
Medical Services	$11,163,669	$11,498,385	$12,631,743	**$13,813,044**	**$15,062,175**	$1,181,301	$1,249,131
Medical Community Care	$7,283	$100,656	$7,477	**$6,596**	**$6,430**	($881)	($166)
Medical Support and Compliance	$672,065	$778,000	$741,900	**$839,500**	**$884,500**	$97,600	$45,000
Medical Facilities	$190,719	$298,400	$197,900	**$221,600**	**$225,800**	$23,700	$4,200
Obligations [Grand Total]	**$12,033,736**	**$12,675,441**	**$13,579,020**	**$14,880,740**	**$16,178,905**	**$1,301,720**	**$1,298,165**

Note: Pharmacy costs are now displayed separately as shown in this table to align with the data reorganization in the Medical Services chapter.

VA's use of medication therapies is a fundamental underpinning of how VA delivers health care today. VA's primary focus is on diagnosis and treatment in an ambulatory environment and home environment basis with institutional care as the modality of last resort.

Key Pharmacy Benefits Management Service (PBM) Functions:

National Formulary: The VA National Formulary (VANF) is the sole drug formulary in use in VA. The VANF contains national standardization items within selected therapeutic categories and ensures uniform availability of drug therapies across the nation. Drugs not listed on the VANF are available on a Prior Authorization (PA) basis. The VANF is an evidence-based process that places a premium on drug safety and effectiveness and has been judged as clinically and economically sound by multiple external reviewing organizations.

Consolidated Mail Outpatient Pharmacies (CMOP)- VA automated and consolidated its prescription fulfillment processes for Veteran outpatients. Prescriptions are filled and mailed to the Veteran's home. CMOPs significantly improve customer service, reduce the potential for errors and improve efficiency by filling large volumes of prescriptions faster with continually improving technologies that require less staff than would be needed at individual VA medical centers. VA currently operates seven facilities across the nation and fills approximately 85% of all outpatient prescriptions via the CMOP system.

VA Adverse Drug Event Reporting System (VA ADERS) / VA Center for Medication Safety (VAMedSAFE): VAMedSAFE conducts passive surveillance (VA ADERS), active medication safety surveillance (integrated databases) and national medication safety Medication Use Evaluations and Risk Reduction efforts for certain classes of medication and vaccines. The staff works collaboratively with the Food and Drug Administration (FDA) on surveillance with an emphasis on the safe use of medications and vaccines in the Veteran population.

VA Mobile Pharmacies: VA's four mobile pharmacies provide acute and chronic medications to Veterans and potentially other Americans affected by a natural disaster. VA's 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 that improve and transform health care through information technology. The primary initiatives are to support the Electronic Health Record (EHR) Oracle Health replacement system and innovate VistA Pharmacy applications, which will continue to be vitally important at VA Medical Centers for the next 10 years during the transition period to the new EHR.

Essential VistA pharmacy development efforts include the Advanced Medication Platform (AMPL) and Medication Order Check Healthcare Application (MOCHA) projects. AMPL Phase I is a highly interoperable, standardized, Fast Healthcare Interoperability Resources (FHIR) enabled pharmacy graphic user interface (GUI) platform that displays comprehensive clinical data (local and remote) from across the VA enterprise and enables pharmacists to build custom queues of pending medication orders directly within their workflow. AMPL Phase II for Outpatient Medication Order Processing is currently in development. The Pharmacy Clinical Informatics Office also works on MOCHA, the largest clinical decision support (CDS) application in the United States, providing order checks for drug interactions, therapeutic duplications, and dose warnings for providers and pharmacists during the entry and processing of greater than 150 million outpatient medication orders each year. MOCHA 3.0 is currently in development, with plans for the addition of Pharmacogenomic (drug/gene), hepatic, and renal order checks to the MOCHA suite of order checks. Pharmacy Clinical Informatics must assure that both EHR's incorporate information from ancillary programs and automation as expected.

Additionally, Pharmacy Clinical Informatics oversees VA's Pharmacy Product System/National Drug File Project (PPS/NDF), the largest open-source drug file in the United States. The Drug File contains over 128,000 medications and product terms, along with medication information that is provided to patients.

Clinical Pharmacy Practice Office: The Clinical Pharmacy Practice Office (CPPO) is committed to optimizing VA clinical pharmacy practice across all care settings to improve access and provide safe, quality care in a cost-effective manner while maintaining Veteran experience as a top priority. This is accomplished by ensuring all Veterans have access to comprehensive medication management (CMM) services provided by Clinical Pharmacist Practitioners (CPPs) and developing strategies to empower the pharmacy workforce to adapt to changing needs of our Veterans as part of a high reliability organization. The CPPO partners and embraces initiatives which connect our Veterans with the soonest and best care by expanding CPP care delivery in focused settings driving health equity to rural Veterans and underserved patient populations. The CPPO deploys multi-layered approaches for training and continuous professional development utilizing teleconferences, video podcasts, clinical boot camps, group coaching, and mentorship to support the clinical pharmacy workforce. Further, the CPPO has developed robust and comprehensive reports and dashboards, including productivity and impact metrics, which illustrate both the performance and quality of clinical pharmacy practice supporting the quadruple aim. The CPPO was honored nationally in 2020 by the American Society of Health-System Pharmacists (ASHP) Board of Excellence Award which recognizes the contributions to excellence in pharmacy practice across acute and ambulatory care settings. In 2023, 5,964 CPPs accounted for 52% of the pharmacist workforce. These CPPs deliver more care than ever to our Veterans, increasing access to personalized, CMM care to over 1.5 million Veterans during 4.5 million patient care visits across the continuum of care.

Pharmacy Residency Program Office: The Pharmacy Residency Program Office's (PRPO) mission is to train post-doctoral pharmacists. VA is the largest post-doctoral training program in the nation and has become the residencies-of-choice for the profession. The PRPO has won national recognition for its training programs through the American Society of Health-System Pharmacists (ASHP) Board of Excellence Award which recognizes strong influential programs nationwide. PRPO is the first program office to have an accredited virtual residency program. There are plans to expand virtual training to increase clinicians with residency training in highly specialized areas such as Neurology and Informatics. This will enable VA to have the highly trained clinical pharmacist specialists required to serve Veterans with the latest therapies and research.

Academic Detailing: Academic Detailing Services (ADS): An evidence-based knowledge-translation service provided to front-line clinical and associated staff. ADS addresses many clinical topics including, but not limited to, Suicide Prevention, Opioid Use Disorder, Alcohol Use Disorder, Tobacco Use Disorder, Chronic Obstructive Pulmonary Disease, Heart Failure, and Diabetes. Academic detailing knowledge-translation services include distillation of updated VA-DOD Clinical Practice Guidelines and the latest clinical literature into practical actions front-line clinical teams can put into immediate practice.

Academic Detailers, primarily a subgroup of clinical pharmacists, provide this service in small group or one-on-one settings to ensure the specific needs of the clinical staff are met and supportive implementation services are delivered. AD programs are overseen at the Veterans Integrated Service Network (VISN)-level and have avenues to report and address systemwide barriers with leadership at the facility and VISN-level. During 2023, there were over 27,300 outreach visits with nearly 15,650 distinct clinical staff utilizing an academic detailer workforce of less than 70 FTEE.

A majority of these visits were focused on supporting new and current providers (provider survival/new provider module), addressing opioid overdose and optimizing access to evidence-based treatments for OUD, pain and many other chronic conditions.

Patient Medication Information Management and Medication Reconciliation Initiative Office: Collaborates with program offices, the field and partner federal healthcare organizations to ensure patients and their caregivers have safe, effective, team-based, patient-driven medication reconciliation as part of a larger goal to partner with patients and their medications.

Meds by Mail Program: The PBM Meds by Mail (MbM) Program provides comprehensive outpatient mail pharmacy services and call center support to qualifying beneficiaries of VHA's Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA beneficiaries who are the dependents of permanently and totally disabled Veterans, survivors of Veterans who died from service-connected conditions while on active duty or, who at the time of death, were rated permanently and totally disabled from a service-connected condition. MbM also supports 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 Consolidated Mail Outpatient Pharmacy (CMOP) and mailed directly to the beneficiary at no cost. There are three physical MbM servicing centers: Cheyenne, WY; Dublin, GA; and Murfreesboro, TN.

Virtual Pharmacy Service Program: The PBM Virtual Pharmacy Service (VPS) Program provides outpatient pharmacy support to VAMC pharmacies to process unverified prescriptions waiting for pharmacist review. Participating VAMC pharmacies (36 including all Oracle sites) 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.

Projections for the Future: Demographic Changes - Prescription utilization tends to increase with age, though the increases seen in VHA utilization drop sharply at age 65 as enrollees become less reliant on VHA health care. Enrollees in Priorities 1a, 1b, 4 and 5 tend to have the highest utilization, while enrollees in Priorities 6 - 8 tend to have the lowest utilization. The enrollee population is projected to become older on average and to transition to higher enrollment priority levels over time. These demographic shifts will move more enrollees to ages and priorities with a

higher prescription drug demand. As enrollees gain greater access to community care, the prescription drugs associated with that care are projected to be mostly filled by VHA.

Prosthetic and Sensory Aids Services

Prosthetic and Sensory Aids Services
(dollars in thousands)

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$4,427,416	$4,571,956	$4,859,172	$5,343,218	$5,804,765	$484,046	$461,547
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	**$4,427,416**	**$4,571,956**	**$4,859,172**	**$5,343,218**	**$5,804,765**	**$484,046**	**$461,547**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$4,427,416	$4,571,956	$4,859,172	$5,343,218	$5,804,765	$484,046	$461,547
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$0	$0	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$4,427,416**	**$4,571,956**	**$4,859,172**	**$5,343,218**	**$5,804,765**	**$484,046**	**$461,547**

Authority for Action

- 38 CFR §17.150, sec. 1701(6)(F) and 1710, Program Accessibility; Existing Facilities
- 38 CFR §17.3200-3250, Prosthetic and Rehabilitative Items and Services
- 38 CFR 3.810, Service and Guide Dog Benefits
- 38 CFR 17.148, Allowance of Claims
- 38 CFR 17.149, Sensori-neural Aids
- 38 CFR 17.154, Equipment for Blind Veterans
- 38 CFR 17.155 – 159, Automobile Adaptive Equipment
- 38 CFR 17.3100 – 3130, Home Improvements and Structural Alterations

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

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

Types of Services Provided: PSAS delivers medically prescribed prosthetic and sensory aids, medical devices, equipment, 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, wheeled mobility devices, orthopedic braces and supports, eyeglasses, hearing aids, speech communication aids, cosmetic restorations, breast prostheses, wigs, home oxygen, positive airway pressure devices, ventilators, items that improve accessibility in the home and community (e.g., ramps, home modification, vehicle modifications), adaptive recreation devices, and devices surgically placed in the Veteran (e.g., implants, stents, joint replacement hardware, pacemakers, etc.). PSAS is responsible for provision of these items from clinical prescription through procurement, delivery, training, replacement, and any necessary repairs.

Recent Trends

- Since 2017, PSAS obligations have increased by 42% from $3.1 billion dollars to $4.4 billion dollars obligated in 2023 and is projected to exceed $5 billion dollars in 2024. This is due to increased Veteran utilization of PSAS, a wider variety of items and services provided to veterans, an increase in the costs of those items and services, and a higher degree of utilization of these items and services within the veteran population. Additionally, VHA data analysis processes were streamlined to improve tracking and analysis of trending and emerging PSAS items and services, and better coordinate budget projection between VHA program offices for clinical policies and services, policy analysis and forecasting, and budget.
- Since 2017, the number of unique Veterans served by PSAS has increased from 3.4 to more than 3.5 million Veterans in 2023, and the number of devices/items provided by PSAS has steadily increased from 21 to 22.7 million.
- PSAS continues to support the Veterans Community Care Program for Veterans receiving durable medical equipment (DME) and medical devices in the community by updating contract modification language for DME medical devices for Community Care Network (CCN) Contracts and through development of process flows, operational procedure guides, trainings,

and consult templates to streamline communication between community providers and VA staff.

- Since 2017, PSAS has increased national acquisition strategies by utilizing historical spend data and employing clinical requirements analysis to identify vendors best positioned to meet agency needs, awarding over 118 national contracts to multiple vendors to sustain technological advances in the commercial industry and ensure a sustained quality level of service to Veterans.
- In 2023, VA obligated $4.4 billion dollars to provide 22.7 million devices/items to more than 3.5 million Veterans, over 50% of all Veterans treated by the VHA.

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. The growth in unique Veterans receiving items and services through PSAS is significantly higher than that of the VHA patient population growth as a whole (23.7% vs. 10.6% increases, respectively, from 2013-23).
- Expand standardized note templates and event capture system procedure codes to support virtual care initiatives, increase Veteran's access to PSAS items and services, and improve care coordination and communication across clinical service lines.
- PSAS continues to collaborate with internal and external partners to support VA modernization efforts in the areas of the electronic health record, supply chain and finance/budget/procurement.
    - PSAS is working with clinical partners to design clinical ordering templates for the vast majority of PSAS devices and services. The ordering templates will standardize ordering workflows and provide a mechanism to ensure that prosthetic requests from clinicians include the comprehensive information for PSAS to fulfil the request and eliminate unnecessary delays.
    - PSAS continues to work within the Office of Electronic Health Record Modernization Supply Chain Council framework to process map current business processes that will inform business process reengineering initiatives that build upon critical needs and enhance workflow efficiencies. PSAS is developing business requirements to inform the next generation of PSAS operational systems that will integrate PSAS processes with the department's modernization initiatives to maximize customer satisfaction and activate internal controls for greater accountability.
    - PSAS manages a large specific purpose budget requiring a level of system integration with patient level activity to continue using data to manage and inform policy, improve Veteran services, and provide pathways to patient level accounting for costing and third-party billing. Continued collaboration with the VA Finance community helps ensure that PSAS budget requirements are met.
- In 2022, PSAS was authorized to procure items and services designed specifically for prevention and monitoring purposes. This is an emerging category of devices that coincide

with advancing technology and capacity to provide prevention and monitoring services outside of the traditional clinical setting.

- PSAS has developed templates, trainings, and operational guides for prosthetic items of national implementation of Community Care Network contracts to support provision of the increasing number of prosthetic items to Veterans receiving care in the community.
- Procurement and issuance procedures for prosthetic items will be improved to reduce clinical administrative burden, increase Veteran access to prosthetic items, and improve the Veteran experience by:
    - Improving inventory management practices by streamlining data system reporting and responsibilities with Supply Chain Partners for increased efficiencies.
    - Exploring prosthetic commodities to use the Denver Logistics Center to automate the ordering, shipping, of prosthetic consumable items by permitting flexibility to deliver items direct shipment to a Veteran's residence.
    - Standardizing negotiated pricing for additional prosthetic commodities utilizing national acquisition strategies to streamline distribution, re-ordering and direct shipment to a Veteran's residence.
    - Establishing a national acquisition mechanism for Veterans to receive expedited repairs to wheeled mobility devices.
    - Improving clinical efficiency and access to prosthetic supplies by streamlining procurement of implant-related critical essential items.

Prosthetic Workload

2023 Prosthetic and Sensory Aids Service Category		
Item Category	**Work Actions**	**Unique Patients**
Arms	18,714	11,974
Dialysis	7,005	3,879
DME	4,441,171	1,656,072
HISA	15,398	13,035
Implants - Bio	39,795	20,970
Implants - Nonbiologic	404,101	152,754
Legs	180,828	35,164
Orthoses/Orthotics/Shoes	1,788,571	1,055,721
Other	2,170,633	1,260,877
Oxygen	6,487,283	934,394
Restorations	10,683	6,847
Sensori-Neuro	5,465,320	2,455,140
Supplies	958,373	664,201
Wheelchairs	743,741	185,521
Grand Total	**22,731,616**	**3,547,961**

Rehabilitative Care

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$1,014,859	$901,310	$977,345	$995,138	$1,040,372	$17,793	$45,234
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$139,797	$175,900	$154,500	$174,800	$184,200	$20,300	$9,400
Medical Facilities (0162):	$188,738	$327,500	$192,300	$198,000	$208,500	$5,700	$10,500
Discretionary Total	**$1,343,394**	**$1,404,710**	**$1,324,145**	**$1,367,938**	**$1,433,072**	**$43,793**	**$65,134**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$81,830	$88,999	$84,546	$47,063	($4,453)	($37,483)
Veterans Medical Care and Health Fund (0173)	$7,369	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$113	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$7,482**	**$81,830**	**$88,999**	**$84,546**	**$47,063**	**($4,453)**	**($37,483)**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$5,025	$15,010	$0	$0	($15,010)	$0
Veterans Medical Care and Health Fund (0173)	$9,521	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$54	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$9,575**	**$5,025**	**$15,010**	**$0**	**$0**	**($15,010)**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$274	$0	$2,100	$9,200	$6,700	$7,100	($2,500)
Veterans Medical Care and Health Fund (0173)	$9,696	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$22	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$9,992**	**$0**	**$2,100**	**$9,200**	**$6,700**	**$7,100**	**($2,500)**
Mandatory Total	**$27,049**	**$86,855**	**$106,109**	**$93,746**	**$53,763**	**($12,363)**	**($39,983)**
Combined Discretionary and Mandatory by Category							
Medical Services	$1,022,341	$983,140	$1,066,344	$1,079,684	$1,087,435	$13,340	$7,751
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$149,372	$180,925	$169,510	$174,800	$184,200	$5,290	$9,400
Medical Facilities	$198,730	$327,500	$194,400	$207,200	$215,200	$12,800	$8,000
Obligations [Grand Total]	**$1,370,443**	**$1,491,565**	**$1,430,254**	**$1,461,684**	**$1,486,835**	**$31,430**	**$25,151**

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.

Blind Rehabilitation Service

$ in 1,000s		Total Obligations	Total Patients
Description	2023 Act.	$158,708	13,282
	2024 BE	$168,746	14,924
	2024 CE	$175,670	13,752
	2025 RR	$193,232	14,075
	2026 AA	$211,960	14,311
+/-	2024-2025	$17,562	323
	2025-2026	$18,728	236
+/-	2024-2025	10.0%	2.3%
	2025-2026	9.7%	1.7%

Authority for Action

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

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

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

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

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

Across all Veteran Integrated Service Networks (VISNs), BRS provides rehabilitation care through the following programs and services:

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

Recent Trends:

Innovation

- Extended reality, to include virtual reality (VR) and augmented reality can be a powerful tool that can significantly improve the quality of life, independence, and social inclusion amongst Veterans with visual impairments.
- BRS is increasing access to offer VR experiences that focus on self-care, skill building and support.
- BRS is partnering with the VA Immersive Program and Prosthetic and Sensory Aids Service to provide criteria appropriate for the provision of extended reality devices to Veterans with a visual impairment.
- Four-year Cooperative Research and Development Agreement established to explore extended reality use case pilot. VR is used to administer clinical assessments and experiences such as falls, visual acuity, guided relaxation for anxiety/adjustment to blindness.

Aging Population

- There are 62,501 Veterans with visual impairment enrolled within BRS programs throughout the continuum of care.

- BRS is not well duplicated in the private sector, leading to high reliance on VA, and limited community options.
- Approximately 80% of Veterans enrolled for BRS services are 65 years and older, which has been the fastest growing population.
- Older Veterans are more likely to have a functional disability than other older adults.
- The Blind Rehabilitation Service CoC offers treatment modalities to best meet the needs of Veterans, to include in-person, telephone and virtual care options.
- To meet unique blind rehabilitation training needs, BRS must increase the ability to serve medically complex patients within inpatient and outpatient programs.

Workforce Management

- BRS has partnered with Salus University to offer a series of three on-line courses to prepare current Blind Rehabilitation Specialists in the foundational areas of clinical and functional implications of visual impairment, as well as assessing functional low vision assessment and intervention utilizing the Visual Impairment Orientation and Mobility Professionals Scholarship Program (VIOMPSP).
- BRS has partnered with Northern Illinois University to offer one on-line preparation course for current BR Specialists in the foundational area of assistive technology utilizing the VIOMPSP.
- These courses will assist participants in meeting the certification requirements for each respective blind rehabilitation discipline.

Professional Development

- 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: Certified Low Vision Therapist (CLVT), Computer Assistive Technology Instructor Specialist (CATIS), Certified Orientation & Mobility, or Certified Vision Rehabilitation Teaching.
- VA is currently experiencing a shortage of providers in the CoC with certifications as CLVT and CATIS.
- The Visual Impairment Orientation and Mobility Professionals Scholarship Program has awarded 64 graduate training scholarships to help provide a much-needed supply of future professionals available to enter the specialty of Blind Rehabilitation.

Projections for the Future

- The VA Blind and Low Vision Rehabilitation Continuum of Care strategy is to provide enhanced care options by broadening the availability and breadth of services as Veterans needs change due to changing demographics and technological advances. Future trends include:

Innovation/Emerging Technologies

- BRS will need the ability to introduce immersive technology experiences as a modality to develop a personalized health plan based on values, individualized needs and identified goals as Veteran with a visual impairment.
- The proliferation of Artificial Intelligence has produced advances in technologies to enhance aging in place such as fall detection and providing real-time assistance preserving independence and reducing the need for the same individuals to move to assisted living and nursing homes.

Social Determinants of Health

- Identify and address social determinants that impact Veterans with visual impairments in obtaining Blind and Low Vision Rehabilitation services.
- Enhancing transportation options such as ride share for Veterans to all inpatient and outpatient appointments allowing Veterans to fully participate in their treatment plan.
- Expansion of service availability through virtual care hubs such as the Assistive Technology Virtual Hub to Veterans residing in rural and highly rural areas knowing that these locations also typically lack community-based services.

Sensory Health

- Increase services to Veterans with dual sensory impairment by providing additional training on auditory disorders.

Workforce Management

- Continue to provide scholarships for existing staff to address shortages in specific areas such as deaf-blind education and vision therapy training.
- Partner with additional universities to expand educational opportunities for staff to become certified to address workforce shortages.

Access to Care

- The demand for serving moderate and maximum assist Veterans will likely continue to increase the need for resources such as bariatric beds and overhead lifts to serve these patients at inpatient blind rehabilitation centers.
- Additional medical staffing with training to address acute inpatient rehabilitation needs and staff to address aging in place for those seeking services in their home.
- Veterans experiencing a visual impairment need to be referred for low-vision care. Per VHA Directive 1121(2), Low Vision care is provided within every VHA Eye Clinic or referred to the appropriate clinic. Of the 172 VA medical centers, approximately 109 can provide low vision optometric evaluation care. VA medical centers that have low vision optometry need to provide referrals to blind and vision rehabilitation-capable centers.

Spinal Cord Injuries and Disorders (SCI/D)

$ in 1,000s		Total Obligations	Total Patients
Description	2023 Act.	$849,591	12,979
	2024 BE	$821,609	12,435
	2024 CE	$956,627	12,941
	2025 RR	$1,081,569	12,948
	2026 AA	$1,219,994	12,930
+/-	2024-2025	$124,942	7
	2025-2026	$138,425	-18
+/-	2024-2025	13.1%	0.1%
	2025-2026	12.8%	-0.1%

Authority for Action

- P.L. 104-262, The Veterans' Health Care Eligibility Reform Act of 1996
- VHA Directive 1176(2) ("Spinal Cord Injuries and Disorders System of Care", September 30, 2019, amended February 7, 2020).

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 the Memoranda of Agreement between VA and the Department of Defense, most recently under "Memorandum of Agreement between the Department of Veterans Affairs (VA) and the DoD for Medical Treatment Provided to Active Duty Service Members (ADSM) with Spinal Cord Injury, Traumatic Brain Injury, Blindness, or Polytraumatic Injuries" and "Memorandum of Understanding between Veteran Affairs (VA) and DoD For Interagency Complex Care Coordination Requirements for Service Members and Veterans of 29 July 2014."

Types of Services Provided: The VA SCI/D System of Care is organizationally designed as a "hub-and-spokes" model in which 25 regional SCI/D Centers (hubs) provide comprehensive primary and specialty care while 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, SCI/D home care, 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 non-institutional care programs including the Bowel and Bladder program. 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 but are not limited to physicians; physician assistants; nurse practitioners; nurses; physical, occupational, recreation, and kinesiotherapy therapists; psychologists; social workers; pharmacists; dietitians; and vocational counselors.

Recent Trends:

- *Bowel & Bladder Program*

  The SCI/D National Program Office, Office of Integrated Veterans Care (IVC), Payment Operations Management (POM), and the Office of Geriatrics and Extended Care (GEC) continue to collaborate to enhance the Bowel and Bladder (B&B) Program, with the goal to improve the Veteran experience and timely payments to agency and individual providers. Recent program developments can be described in two ways, administrative and clinical processes.

  In terms of the administrative processes, the offices have made changes in response to the requirements of the MISSION Act, including changes in billing systems and consolidation of payment centers. The national standard invoice was released in May 2023 to the field, Veterans, and individuals providing care. In addition to the invoice, guidance was shared to care providers to send invoices to the National Payment Center, a notable enhancement to the prior facility/VISN processes. At the end of 2023, the Financial Services Center sunsetted the paper version of the 10091 Bowel and Bladder program Vendor File Request form. Caregivers are now required to submit this form online or by mail (they could previously submit via fax). While the online form provides additional benefits of security, faster intake for processing, the ability to track the status of the form, and improved accuracy, the new process has also been challenging for some Veterans served. In response, the SCI/D National Program Office co-hosted a Q&A session with the Financial Services Center in January 2024 to provide information to the field about the new vendor file form process as part of ongoing process improvement efforts.

  In terms of clinical standardization and processes, the SCI/D National Program Office continues to develop a new section in the IVC Field Guidebook section on the B&B Program. In the early stages of development, a National Clinical Work group was created and included SCI/D System of Care staff. Joint efforts by the SCI/D National Program Office, GEC, and IVC in the development, finalization, and roll-out of the B&B Program section of the IVC Field Guidebook continues in 2024. The SCI/D National Program Office also continues to focus on field education, with a monthly reoccurring office hour, updates to the intranet site, an active Teams Channel, program office newsletter articles, and one-on-one consultation as needed.

- *SCI/D Informatics and Analytics*

  The SCI/D Registry & Outcomes Modernization Initiative remains an important priority for the SCI/D National Program Office. The SCI/D National Program Office continues its strong partnership with the VHA Support Service Center (VSSC) in the sustainment of the VSSC SCI/D Registry which identifies Veterans SCI/D.

Of note, as part of the VHA Central Office Redesign, the Management of Information and Outcomes Coordinators previously assigned to the 25 SCI/D Centers and funded through specific purpose funds allocated by the program office were realigned to the program office. The SCI/D National Program Office provided substantial support during the transition period and continues to develop the newly formed SCI/D Informatics and Analytics team. This team takes a Veteran-centric approach to managing and reporting data related to Veterans with SCI/D. The core contributions of the SCI/D Informatics and Analytics team are to enhance SCI/D data reporting, facilitate the field's expertise with data, and to modernize SCI/D data methodologies.

To enhance SCI/D data reporting, the SCI/D Informatics and Analytics team has developed a method for the SCI/D field to request custom or ad hoc data. Since its formation, the SCI/D Informatics and Analytics team has completed more than 100 requests. Analyses of these requests are used to inform continuous development of data resources and reporting.

The SCI/D Informatics and Analytics team additionally designed and released two major education resources, a SharePoint site, and monthly office hours to support the field in the use of data. The SharePoint site has had more than 500 users since the start of 2024 and the SCI/D Informatics Office Hours meetings average 100 attendees per session.

The SCI/D Informatics and Analytics team also continues to make strides in the modernization of SCI/D data, particularly related to inpatient rehabilitation services provided at the SCI/D Centers. Modernization efforts include the development of chart-integrated data collection, standardization, field education, and improved data reporting. Modernization efforts are informed by groups of subject matter experts from the field and through collaboration with the Rehabilitation and Prosthetic Services program office.

- *SCI/D Program Evaluation*

  The SCI/D National Program Office is in its fifth and final year of a partnered Health Services Research and Development (HSR&D)-funded program evaluation project focused on SCI/D Annual Exam (AE) utilization and implementation of the Functional Mobility Assessment (FMA) tool. Direct operational impacts have included providing the field with actionable steps around enhancing SCI/D AE access and utilization, final preparation of two manuscripts for publication, and incorporating a project-generated system expanding FMA use to any SCI/D Centers that would like to use it to track mobility device-related outcomes for our Veterans.

  The program office partnered with the SCI Model Systems (SCIMS) and obtained Paralyzed Veterans of America Research Foundation funding for a post-doctoral fellow to complete a two-year evaluation titled, "Advance traumatic spinal cord injury research through data harmonization, curation, and integrative data analysis: Spinal Cord Injury Model Systems and Veterans Health Administration Spinal Cord Injury (January 1, 2023 – December 31, 2024). The project team, including a representative from the SCI/D National Program Office, presented at the American Congress of Rehabilitation Medicine (ACRM) 100th Annual

Conference in November 2023, "Comparison of demographic and health profiles between Veterans and non-Veterans living with traumatic spinal cord injury in the United States."

The SCI/D National Program Office additionally provided a co-investigator representative for a newly funded HSR&D program evaluation project titled, "Disruption of health services: The impact of COVID-19 on Veterans with SCI/D," that incorporates qualitative focus group analysis, Veteran-level characteristics and post-COVID outcomes, and identifying post-COVID changes in VHA utilization. A manuscript titled, "Veterans and provider perspectives on deferred and disrupted health services during the COVID-19 pandemic," is in final preparation. The results will be presented to the SCI/D System of Care field in 2024 national field support venues.

Several SCI/D National Program Office staff members led an operational evaluation of Whole Health utilization among Veterans on the VHA SCI/D Registry. This information was successfully published in the Journal of Spinal Cord Medicine in early 2024, titled, "Utilization of whole health services among Veterans with spinal cord injuries and disorders (SCI/D): Early insights from the VA SCI/D System of Care."

The SCI/D National Program Office, along with partners from the Center of Innovation for Complex Chronic Healthcare, presented at the International Spinal Cord Society in October 2023, on "The Veterans Health Administration Spinal Cord Injuries & Disorders Registry (VHA SCIDR): Fiscal years 1994 to 2022." This was the first international presentation of VHA SCIDR data, which is one of the three largest SCI/D data sets in North America. This project informed the international audience of the consolidation of historical VHA SCIDR data, which during the past several years, was filtered through rigorous validation and mapped onto the new, nationally standardized, automated VHA SCIDR VSSC platform.

- *Age-Friendly Health Systems (AFHS)*

  In March 2020, GEC set the aim for VHA to become the largest integrated health care system in the U.S. recognized by Institute for Healthcare Improvement (IHI) as Age-Friendly, improving the quality of care provided and enhancing the time spent with each older Veteran. Notably, this initiative is in alignment with VA's FY 2022-2028 Strategic Plan for Strategy 2.2.4: Aging, Frail and End of Life Veterans of All Ages. The SCI/D National Program Office is partnering with GEC to foster adaption of AFHS at the SCI/D Centers and to support individualized care plans centered around What Matters to the Veteran. Implementation will enable the VHA SCI/D System of Care to become the largest integrated SCI/D system of care in the world recognized by IHI as Age-Friendly.

  The SCI/D National Program Office hosted a virtual summit in January 2023 that included an introduction and discussion on AFHS. Similarly, the program office hosted a face-to-face seminar in May 2023 that featured a national GEC guest speaker who presented on this initiative. Subsequently, SCI/D National Program Office and GEC co-hosted coaching calls in June 2023 and August 2023 for SCI/D System of Care leaders. By the end of 2023, SCI/D Centers were requested to submit an action plan to incorporate AFHS principles into at least one care setting, to advance achievement of AFHS Level 1 Recognition. To date, at least 16 out of 25 SCI/D Centers have achieved at least Level 1 Recognition. Looking forward to 2024

and beyond, SCI/D Centers will be supported by the SCI/D National Program Office and GEC to move towards AFHS Level 2 Recognition for their care setting.

Projections for the Future

- *Oracle Health (formerly Cerner) Electronic Health Record*

  The transition to the Oracle Health electronic health record (EHR) system will continue over the next several years. The SCI/D National Program Office and System of Care continue a close partnership with VA Electronic Health Record Modernization (EHRM) Integration Office and Oracle Health in the development of SCI/D-specific documentation, workflows, interdisciplinary team documentation, and Veteran outcomes measures. The SCI/D National Program Office Liaison provided each facility the unique Veteran data, which supports the continuation and recognition of Veterans identified from the VSSC SCI/D Status Update and the SCI/D Registry utilization reports. Focus areas for SCI/D Oracle Health documentation include each of the major care settings, including inpatient, outpatient, SCI/D Home Care, SCI/D telehealth, and SCI/D Long Term Care, ensuring documentation follows the Veteran's lifespan throughout the SCI/D System of Care. There are also SCI/D unique challenges that are addressed in Oracle Health pathways through powerforms, quick orders, and clinical algorithms, including autonomic dysreflexia, neurogenic bladder and bowel, catastrophic disability, the SCI Pressure Ulcer Monitoring Tool, SCI/D specific Interdisciplinary Plans of Care, and IVIEW bands.

  The SCI/D National Program Office continues to provide communication, education, and informatic support to SCI/D hub and spoke teams as facilities transition, with SCI/D Oracle Health Office Hour monthly meetings, a Teams channel, and national data reports, working with VSSC programming teams to merge both CPRS and Oracle Health data and outcomes for seamless tracking and operational planning. The SCI/D National Program Office will continue to support the FHCC (VA and Department of Defense combined facilities) throughout the go-live process from CPRS to the Oracle Health EHR system, with the SCI/D National Program Office Oracle Health team and when needed, input from SCI/D subject matter experts in the field.

- *P.L. 117-135 § 105, Making Advances in Mammography and Medical Options for Veterans (MAMMO) Act - Mammography Accessibility for Paralyzed and Disabled Veterans*

  The SCI/D National Program Office is working in partnership with the Office of Diagnostics, Safe Patient Handling and Mobility, Construction and Facilities Management, Women's Health, Amputation System of Care, and Integrated Veteran Care (IVC) to lead planning and implementation of Section 105 of P. L. 117-135, *Making Advances in Mammography and Medical Options for Veterans (MAMMO) Act*, signed June 7, 2022. Section 105 addresses mammography accessibility for Veterans with SCI/D and other physical disabilities. In 2024, the Section 105 workgroup is completing analyses of facility and staff surveys to examine VA facility accessibility, infrastructure, and adherence to best practice. The SCI/D National Program Office continues to oversee the SCI/D Mammography Screening Dashboard to measure mammography screening rates for Women Veterans on the SCI/D Registry and with major limb loss. The program office is working closely with the VHA Institute for Learning, Education, and Development and the Section 105 workgroup to develop educational resources

to focus on gaps in best practices and to address barriers in physical infrastructure, communication, scheduling practices, and safe patient handling for mammography screening for women with disabilities. Dissemination and implementation activities for these resources will target both internal and external audiences.

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

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

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

Obligations by Program and Overall Average Daily Census and Per Diem

Description	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Obligations ($000)							
Institutional							
Community Nursing Home	$1,782,153	$1,529,213	$1,921,465	$2,078,128	$2,188,225	$156,663	$110,097
State Home Domiciliary	$45,278	$55,402	$56,992	$62,662	$69,085	$5,670	$6,423
State Home Nursing	$1,447,138	$1,438,784	$1,617,932	$1,745,012	$1,887,231	$127,080	$142,219
VA Community Living Centers	$5,122,366	$5,292,497	$5,380,099	$5,470,160	$5,662,369	$90,061	$192,209
Institutional Obligations [Total]	**$8,396,935**	**$8,315,896**	**$8,976,488**	**$9,355,962**	**$9,806,910**	$379,474	$450,948
Non-Institutional							
Community Adult Day Health Care	$268,731	$238,510	$294,942	$307,035	$318,358	$12,093	$11,323
Community Residential Care	$148,092	$105,825	$169,118	$170,993	$172,430	$1,875	$1,437
Home Hospice Care	$165,795	$22,739	$173,755	$179,656	$185,408	$5,901	$5,752
Home Respite Care	$245,936	$145,324	$267,463	$283,769	$299,046	$16,306	$15,277
Home Telehealth 1/	$471,015	$395,102	$501,989	$524,103	$544,667	$22,114	$20,564
Home-Based Primary Care	$1,349,563	$1,467,179	$1,485,391	$1,633,316	$1,760,908	$147,925	$127,592
Homemaker/Home Health Aide Prgs.	$2,371,292	$1,856,733	$2,623,825	$2,766,522	$2,890,368	$142,697	$123,846
Purchased Skilled Home Care	$1,541,747	$366,350	$1,708,468	$1,785,368	$1,860,573	$76,900	$75,205
Spinal Cord Injury & Disability Home Care	$18,047	$16,853	$19,044	$19,824	$20,580	$780	$756
State Home Adult Day Health Care	$2,460	$1,892	$1,836	$1,986	$2,147	$150	$161
VA Adult Day Health Care	$4,676	$8,381	$7,661	$8,026	$8,341	$365	$315
Non-Institutional Obligations [Total]	$6,587,354	$4,624,888	$7,253,492	$7,680,598	$8,062,826	$427,106	$382,228
Long-Term Services & Supports Obligations [Total]	**$14,984,289**	**$12,940,784**	**$16,229,980**	**$17,036,560**	**$17,869,736**	**$806,580**	**$833,176**
Institutional Average Daily Census							
Community Nursing Home	12,035	9,907	12,362	13,130	13,545	768	415
State Home Domiciliary	2,134	2,175	2,704	2,839	2,981	135	142
State Home Nursing	14,941	13,514	16,862	17,368	17,889	506	521
VA Community Living Centers	6,661	6,182	7,458	7,871	7,914	413	43
Institutional Average Daily Census [Total]	35,771	31,779	39,386	41,208	42,329	1,822	1,121
Institutional Per Diem							
Community Nursing Home	$405.70	$421.75	$424.68	$433.63	$442.61	$8.95	$8.98
State Home Domiciliary	$58.13	$69.58	$57.59	$60.47	$63.49	$2.88	$3.02
State Home Nursing	$265.36	$290.88	$262.16	$275.27	$289.03	$13.11	$13.76
VA Community Living Centers	$2,106.87	$2,339.12	$1,971.00	$1,904.05	$1,960.24	($66.95)	$56.19
Institutional Per Diem [Total]	$643.13	$714.98	$622.71	$622.03	$634.75	($0.68)	$12.72

1/The display for 2024 in the 2024 Congressional Justification excluded obligations for certain home telehealth modalities. These obligations have been included in all columns in this display except for the 2024 Budget Estimate.

Average Daily Census

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Nursing Home Average Daily Census, Long & Short Stay							
Community Nursing Home							
Long Stay	9,233	8,034	9,459	10,020	10,332	561	312
Short Stay	2,802	1,873	2,903	3,110	3,213	207	103
Community Nursing Home Stays [Total]	12,035	9,907	12,362	13,130	13,545	768	415
State Home Nursing							
Long Stay	14,410	13,092	16,303	16,783	17,285	480	502
Short Stay	531	423	559	585	604	26	19
State Nursing Home Stays [Total]	14,941	13,514	16,862	17,368	17,889	506	521
VA Community Living Centers							
Long Stay	5,263	5,005	5,893	6,219	6,253	326	34
Short Stay	1,398	1,177	1,565	1,652	1,661	87	9
VA Community Living Centers Stays [Total]	6,661	6,182	7,458	7,871	7,914	413	43
All Nursing Home Average Daily Census, Long & Short Stay [Grand Total]	33,637	29,603	36,682	38,369	39,348	1,687	979
Nursing Home Average Daily Census by Age							
Community Nursing Home							
< 65	1,202	986	1,246	1,335	1,379	89	44
65 to 84	8,670	6,983	8,799	9,313	9,602	514	289
> 84	2,163	1,938	2,317	2,482	2,564	165	82
Community Nursing Home Stays [Total]	12,035	9,907	12,362	13,130	13,545	768	415
State Home Nursing							
<65	674	605	822	944	1,087	122	143
65 to 84	9,203	8,007	10,487	10,412	10,443	(75)	31
> 84	5,064	4,903	5,553	6,012	6,359	459	347
State Home Nursing Stays [Total]	14,941	13,514	16,862	17,368	17,889	506	521
VA Community Living Centers							
< 65	806	775	902	952	957	50	5
65 to 84	4,766	4,347	5,405	5,704	5,735	299	31
> 84	1,089	1,059	1,151	1,215	1,222	64	7
VA Community Living Centers Stays [Total]	6,661	6,182	7,458	7,871	7,914	413	43
All Nursing Home Average Daily Census by Age [Grand Total]	33,637	29,603	36,682	38,369	39,348	1,687	979
Nursing Home Average Daily Census by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	9,687	8,137	9,929	10,524	10,853	595	329
Non-Service Connected	1,463	1,064	1,516	1,624	1,677	108	53
Service-Connected	885	706	917	982	1,015	65	33
Community Nursing Home Stays [Total]	12,035	9,907	12,362	13,130	13,545	768	415
State Home Nursing							
Priority 1A	5,116	4,235	5,381	5,629	5,817	248	188
Non-Service Connected	7,260	6,994	8,783	8,917	9,155	134	238
Service-Connected	2,565	2,286	2,698	2,822	2,917	124	95
State Home Nursing Stays [Total]	14,941	13,514	16,862	17,368	17,889	506	521
VA Community Living Centers							
Priority 1A	3,998	3,699	4,476	4,724	4,750	248	26
Non-Service Connected	1,731	1,630	1,939	2,046	2,057	107	11
Service-Connected	932	853	1,043	1,101	1,107	58	6
VA Community Living Centers Stays [Total]	6,661	6,182	7,458	7,871	7,914	413	43
All Nursing Home Stays by Priority 1A, SC & Non-SC [Total]	33,637	29,603	36,682	38,369	39,348	1,687	979

Patients Treated

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Patients Treated by Long & Short Stay							
Community Nursing Home							
Long Stay	13,547	11,516	13,973	15,246	15,725	1,273	479
Short Stay	41,307	23,723	43,853	47,096	47,950	3,243	854
Community Nursing Home Patients Trtd., [Total]	54,854	35,239	57,826	62,342	63,675	4,516	1,333
State Home Nursing							
Long Stay	18,627	16,678	21,221	23,991	26,374	2,770	2,383
Short Stay	4,343	3,506	5,040	5,632	6,143	592	511
State Home Nursing Patients Trtd., [Total]	22,970	20,184	26,261	29,623	32,517	3,362	2,894
VA Community Living Centers							
Long Stay	7,331	6,648	8,125	8,879	8,516	754	(363)
Short Stay	20,739	16,641	23,854	25,589	26,438	1,735	849
VA Community Living Centers Patients Trtd., [Total]	28,070	23,289	31,979	34,468	34,954	2,489	486
Grand Total Patients Treated by Long & Short Stay	105,894	78,711	116,066	126,433	131,146	10,367	4,713
Patients Treated by Age							
Community Nursing Home							
< 65	6,338	3,644	6,421	6,922	7,070	501	148
65 to 84	38,157	23,630	40,429	43,587	44,519	3,158	932
> 84	10,359	7,965	10,976	11,833	12,086	857	253
Community Nursing Home Stays [Total]	54,854	35,239	57,826	62,342	63,675	4,516	1,333
State Home Nursing							
< 65	940	827	1,078	1,216	1,335	138	119
65 to 84	13,894	11,723	15,883	17,916	19,666	2,033	1,750
> 84	8,136	7,634	9,300	10,491	11,516	1,191	1,025
State Home Nursing Stays [Total]	22,970	20,184	26,261	29,623	32,517	3,362	2,894
VA Community Living Centers							
< 65	3,823	3,445	4,838	5,215	5,289	377	74
65 to 84	19,236	15,641	21,532	23,207	23,534	1,675	327
> 84	5,011	4,203	5,609	6,046	6,131	437	85
VA Community Living Centers Stays [Total]	28,070	23,289	31,979	34,468	34,954	2,489	486
All Patients Treated by Age [Grand Total]	105,894	78,711	116,066	126,433	131,146	10,367	4,713
Patients Treated by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	34,192	22,785	36,045	38,859	39,690	2,814	831
Non-Service Connected	18,742	8,225	19,293	20,815	21,120	1,522	305
Service-Connected	1,920	4,229	2,488	2,668	2,865	180	197
Community Nursing Home Stays [Total]	54,854	35,239	57,826	62,342	63,675	4,516	1,333
State Home Nursing							
Priority 1A	7,685	6,224	8,786	9,911	10,879	1,125	968
Non-Service Connected	11,265	10,461	12,879	14,528	15,947	1,649	1,419
Service-Connected	4,020	3,499	4,596	5,184	5,691	588	507
State Home Nursing Stays [Total]	22,970	20,184	26,261	29,623	32,517	3,362	2,894
VA Community Living Centers							
Priority 1A	12,262	9,668	13,970	15,057	15,269	1,087	212
Non-Service Connected	10,338	8,984	11,777	12,694	12,874	917	180
Service-Connected	5,470	4,636	6,232	6,717	6,811	485	94
VA Community Living Centers Stays [Total]	28,070	23,289	31,979	34,468	34,954	2,489	486
All Patients Treated by Priority 1A, SC & Non-SC [Total]	105,894	78,711	116,066	126,433	131,146	10,367	4,713

Length of Stay

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Length of Stay by Long & Short Stay							
Community Nursing Home							
Long Stay	248.8	255.3	247.8	239.9	239.8	(7.9)	(0.1)
Short Stay	24.8	28.9	24.2	24.1	24.5	(0.1)	0.4
Community Nursing Home Length of Stay	80.1	102.9	78.2	76.9	77.6	(1.3)	0.7
State Home Nursing							
Long Stay	282.4	287.3	281.2	255.3	239.2	(25.9)	(16.1)
Short Stay	44.6	44.2	40.6	37.9	35.9	(2.7)	(2.0)
State Home Nursing Length of Stay	237.4	245.1	235.0	214.0	200.8	(21.0)	(13.2)
VA Community Living Centers							
Long Stay	262.0	275.6	265.5	255.7	268.0	(9.8)	12.3
Short Stay	24.6	25.9	24.0	23.6	22.9	(0.4)	(0.7)
VA Community Living Centers Length of Stay	86.6	97.2	85.4	83.4	82.6	(2.0)	(0.8)
Grand Total Length of Stay by Long & Short Stay	115.9	137.7	115.7	110.8	109.5	(4.9)	(1.3)
Length of Stay by Age							
Community Nursing Home							
< 65	69.2	99.0	71.0	70.4	71.2	(0.6)	0.8
65 to 84	82.9	108.2	79.7	78.0	78.7	(1.7)	0.7
> 84	76.2	89.0	77.3	76.6	77.4	(0.7)	0.8
Community Nursing Home Length of Stay [Total]	80.1	102.9	78.2	76.9	77.6	(1.3)	0.7
State Home Nursing							
< 65	261.7	267.9	279.1	283.4	297.2	4.3	13.8
65 to 84	241.8	250.0	241.7	212.1	193.8	(29.6)	(18.3)
> 84	227.2	235.1	218.5	209.2	201.5	(9.3)	(7.7)
State Home Nursing Length of Stay [Total]	237.4	245.1	235.0	214.0	200.8	(21.0)	(13.2)
VA Community Living Centers							
< 65	77.0	82.4	68.2	66.6	66.0	(1.6)	(0.6)
65 to 84	90.4	101.7	91.9	89.7	88.9	(2.2)	(0.8)
> 84	79.3	92.2	75.1	73.4	72.7	(1.7)	(0.7)
VA Community Living Centers Length of Stay [Total]	86.6	97.2	85.4	83.4	82.6	(2.0)	(0.8)
Grand Total Length of Stay by Age	115.9	137.7	115.7	110.8	109.5	(4.9)	(1.3)
Length of Stay by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	103.4	130.7	100.8	98.9	99.8	(1.9)	0.9
Non-Service Connected	28.5	47.4	28.8	28.5	29.0	(0.3)	0.5
Service-Connected	168.2	61.1	134.9	134.3	129.3	(0.6)	(5.0)
Community Nursing Home Length of Stay [Total]	80.1	102.9	78.2	76.9	77.6	(1.3)	0.7
State Home Nursing							
Priority 1A	243.0	249.1	224.2	207.3	195.2	(16.9)	(12.1)
Non-Service Connected	235.2	244.7	249.6	224.0	209.5	(25.6)	(14.5)
Service-Connected	232.9	239.1	214.9	198.7	187.1	(16.2)	(11.6)
State Home Nursing Length of Stay [Total]	237.4	245.1	235.0	214.0	200.8	(21.0)	(13.2)
VA Community Living Centers							
Priority 1A	119.0	140.1	117.3	114.5	113.5	(2.8)	(1.0)
Non-Service Connected	61.1	66.4	60.3	58.8	58.3	(1.5)	(0.5)
Service-Connected	62.2	67.3	61.3	59.8	59.3	(1.5)	(0.5)
VA Community Living Centers Length of Stay [Total]	86.6	97.2	85.4	83.4	82.6	(2.0)	(0.8)
Grand Total Length of Stay by Priority 1A, SC & Non-SC [Total]	115.9	137.7	115.7	110.8	109.5	(4.9)	(1.3)

Obligations

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Obligations by Long & Short Stay							
Community Nursing Home							
Long Stay	$1,297,859	$1,242,263	$1,399,314	$1,480,542	$1,522,864	$81,228	$42,322
Short Stay	$484,294	$286,950	$522,151	$597,586	$665,361	$75,435	$67,775
Community Nursing Home Patients Trtd., [Total]	$1,782,153	$1,529,213	$1,921,465	$2,078,128	$2,188,225	$156,663	$110,097
State Home Nursing							
Long Stay	$1,396,324	$1,386,740	$1,561,121	$1,681,916	$1,820,621	$120,795	$138,705
Short Stay	$50,814	$52,044	$56,811	$63,096	$66,610	$6,285	$3,514
State Home Nursing Patients Trtd., [Total]	$1,447,138	$1,438,784	$1,617,932	$1,745,012	$1,887,231	$127,080	$142,219
VA Community Living Centers							
Long Stay	$3,920,815	$4,309,194	$4,118,092	$4,187,027	$4,334,150	$68,935	$147,123
Short Stay	$1,201,551	$983,303	$1,262,007	$1,283,133	$1,328,219	$21,126	$45,086
VA Community Living Centers Patients Trtd., [Total]	$5,122,366	$5,292,497	$5,380,099	$5,470,160	$5,662,369	$90,061	$192,209
Grand Total Obligations by Long & Short Stay [Total]	$8,351,657	$8,260,494	$8,919,496	$9,293,300	$9,737,825	$373,804	$444,525
Obligations by Age							
Community Nursing Home							
< 65	$193,669	$169,806	$206,061	$220,160	$230,506	$14,099	$10,346
65 to 84	$1,288,911	$1,076,263	$1,413,004	$1,541,040	$1,634,606	$128,036	$93,566
> 84	$299,573	$283,144	$302,400	$316,928	$323,113	$14,528	$6,185
Community Nursing Home Obligations [Total]	$1,782,153	$1,529,213	$1,921,465	$2,078,128	$2,188,225	$156,663	$110,097
State Home Nursing							
< 65	$66,561	$67,482	$73,887	$78,170	$83,952	$4,283	$5,782
65 to 84	$902,692	$862,978	$1,053,333	$1,172,088	$1,293,445	$118,755	$121,357
> 84	$477,885	$508,324	$490,712	$494,754	$509,834	$4,042	$15,080
State Home Nursing Obligations [Total]	$1,447,138	$1,438,784	$1,617,932	$1,745,012	$1,887,231	$127,080	$142,219
VA Community Living Centers							
< 65	$635,939	$670,503	$652,076	$670,503	$694,596	$18,427	$24,093
65 to 84	$3,637,550	$3,853,680	$3,865,615	$4,031,343	$4,173,953	$165,728	$142,610
> 84	$848,877	$768,314	$862,408	$768,314	$793,820	($94,094)	$25,506
VA Community Living Centers Obligations [Total]	$5,122,366	$5,292,497	$5,380,099	$5,470,160	$5,662,369	$90,061	$192,209
Grand Total Obligations by Age	$8,351,657	$8,260,494	$8,919,496	$9,293,300	$9,737,825	$373,804	$444,525
Obligations by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	$1,419,007	$1,267,606	$1,521,207	$1,629,810	$1,702,126	$108,603	$72,315
Non-Service Connected	$227,768	$156,413	$252,115	$284,473	$310,461	$32,358	$25,989
Service-Connected	$135,378	$105,194	$148,143	$163,845	$175,638	$15,703	$11,793
Community Nursing Home Obligations [Total]	$1,782,153	$1,529,213	$1,921,465	$2,078,128	$2,188,225	$156,663	$110,097
State Home Nursing							
Priority 1A	$548,622	$501,753	$657,526	$754,997	$845,333	$97,471	$90,336
Non-Service Connected	$661,417	$699,436	$697,322	$709,195	$739,409	$11,873	$30,214
Service-Connected	$237,099	$237,595	$263,084	$280,820	$302,489	$17,736	$21,669
State Home Nursing Obligations [Total]	$1,447,138	$1,438,784	$1,617,932	$1,745,012	$1,887,231	$127,080	$142,219
VA Community Living Centers							
Priority 1A	$2,972,146	$3,042,743	$3,147,552	$3,211,960	$3,340,437	$64,408	$128,478
Non-Service Connected	$1,407,463	$1,487,341	$1,455,564	$1,463,842	$1,499,265	$8,277	$35,423
Service-Connected	$742,757	$762,413	$776,983	$794,359	$822,667	$17,376	$28,308
VA Community Living Centers Obligations [Total]	$5,122,366	$5,292,497	$5,380,099	$5,470,160	$5,662,369	$90,061	$192,209
Obligations by Priority 1A, SC & Non-SC [Total]	$8,351,657	$8,260,494	$8,919,496	$9,293,300	$9,737,825	$373,804	$444,525

Per Diems

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Per Diems by Long & Short Stay							
Community Nursing Home							
Long Stay	$385.12	$422.49	$404.19	$404.82	$403.82	$0.63	($1.00)
Short Stay	$473.53	$418.59	$491.44	$526.44	$567.35	$35.00	$40.91
Community Nursing Home Patients Trtd., [Total]	$405.70	$421.75	$424.68	$433.63	$442.61	$8.95	$8.98
State Home Nursing							
Long Stay	$265.48	$289.41	$261.63	$274.56	$288.57	$12.93	$14.01
Short Stay	$262.18	$336.16	$277.68	$295.50	$302.14	$17.82	$6.64
State Home Nursing Patients Trtd., [Total]	$265.36	$290.88	$262.16	$275.27	$289.03	$13.11	$13.76
VA Community Living Centers							
Long Stay	$2,041.03	$2,352.40	$1,909.32	$1,844.56	$1,898.99	($64.76)	$54.43
Short Stay	$2,354.74	$2,282.60	$2,203.26	$2,127.99	$2,190.82	($75.27)	$62.83
VA Community Living Centers Patients Trtd., [Total]	$2,106.87	$2,339.12	$1,971.00	$1,904.05	$1,960.24	($66.95)	$56.19
Overall Per Diem by Long & Short Stay	$680.24	$762.40	$664.36	$663.59	$678.03	($0.77)	$14.44
Per Diem by Age							
Community Nursing Home							
< 65	$441.43	$470.54	$451.85	$451.82	$457.96	($0.03)	$6.14
65 to 84	$407.30	$421.12	$438.76	$453.35	$466.40	$14.59	$13.05
> 84	$379.45	$399.18	$356.59	$349.84	$345.26	($6.75)	($4.58)
Community Nursing Home Overall Per Diem	$405.70	$421.75	$424.68	$433.63	$442.61	$8.95	$8.98
State Home Nursing							
< 65	$270.56	$304.71	$245.59	$226.87	$211.60	($18.72)	($15.27)
65 to 84	$268.73	$294.49	$274.43	$308.41	$339.34	$33.98	$30.93
> 84	$258.55	$283.28	$241.44	$225.46	$219.66	($15.98)	($5.80)
State Home Nursing Overall Per Diem	$265.36	$290.88	$262.16	$275.27	$289.03	$13.11	$13.76
VA Community Living Centers							
< 65	$2,161.66	$2,362.40	$1,975.20	$1,929.62	$1,988.51	($45.58)	$58.89
65 to 84	$2,091.04	$2,421.93	$1,954.08	$1,936.32	$1,993.98	($17.76)	$57.66
> 84	$2,135.62	$1,982.15	$2,047.18	$1,732.49	$1,779.75	($314.69)	$47.26
VA Community Living Centers Overall Per Diem	$2,106.87	$2,339.12	$1,971.00	$1,904.05	$1,960.24	($66.95)	$56.19
Overall Per Diem by Age	$680.24	$762.40	$664.36	$663.59	$678.03	($0.77)	$14.44
Per Diem by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	$401.33	$425.66	$418.60	$424.29	$429.68	$5.69	$5.39
Non-Service Connected	$426.54	$401.60	$454.38	$479.91	$507.20	$25.53	$27.29
Service-Connected	$419.09	$407.02	$441.40	$457.12	$474.09	$15.72	$16.97
Community Nursing Home Overall Per Diem	$405.70	$421.75	$424.68	$433.63	$442.61	$8.95	$8.98
State Home Nursing							
Priority 1A	$293.80	$323.69	$333.86	$367.47	$398.14	$33.61	$30.67
Non-Service Connected	$249.60	$273.25	$216.92	$217.90	$221.28	$0.98	$3.38
Service-Connected	$253.25	$284.03	$266.42	$272.63	$284.11	$6.21	$11.48
State Home Nursing Overall Per Diem	$265.36	$290.88	$262.16	$275.27	$289.03	$13.11	$13.76
VA Community Living Centers							
Priority 1A	$2,036.73	$2,247.23	$1,921.33	$1,862.80	$1,926.71	($58.53)	$63.91
Non-Service Connected	$2,227.65	$2,493.14	$2,051.03	$1,960.18	$1,996.88	($90.85)	$36.70
Service-Connected	$2,183.42	$2,443.40	$2,035.38	$1,976.68	$2,036.03	($58.70)	$59.35
VA Community Living Centers Overall Per Diem	$2,106.87	$2,339.12	$1,971.00	$1,904.05	$1,960.24	($66.95)	$56.19
Overall Per Diem for Priority 1A, SC & Non-SC	$680.24	$762.40	$664.36	$663.59	$678.03	($0.77)	$14.44

Non-Institutional Obligations and Clinic Stops/Procedures

Description	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Non-Institutional Obligations ($000)							
Community Adult Day Health Care	$268,731	$238,510	$294,942	$307,035	$318,358	$12,093	$11,323
Community Residential Care	$148,092	$105,825	$169,118	$170,993	$172,430	$1,875	$1,437
Home Hospice Care	$165,795	$22,739	$173,755	$179,656	$185,408	$5,901	$5,752
Home Respite Care	$245,936	$145,324	$267,463	$283,769	$299,046	$16,306	$15,277
Home Telehealth 1/	$471,015	$395,102	$501,989	$524,103	$544,667	$22,114	$20,564
Home-Based Primary Care	$1,349,563	$1,467,179	$1,485,391	$1,633,316	$1,760,908	$147,925	$127,592
Homemaker/Home Health Aide Prgs.	$2,371,292	$1,856,733	$2,623,825	$2,766,522	$2,890,368	$142,697	$123,846
Purchased Skilled Home Care	$1,541,747	$366,350	$1,708,468	$1,785,368	$1,860,573	$76,900	$75,205
Spinal Cord Injury & Disability Home Care	$18,047	$16,853	$19,044	$19,824	$20,580	$780	$756
State Home Adult Day Health Care	$2,460	$1,892	$1,836	$1,986	$2,147	$150	$161
VA Adult Day Health Care	$4,676	$8,381	$7,661	$8,026	$8,341	$365	$315
Non-Institutional Obligations [Total]	**$6,587,354**	**$4,624,888**	**$7,253,492**	**$7,680,598**	**$8,062,826**	**$427,106**	**$382,228**
Non-Institutional Clinic Stops/Procedures							
Community Adult Day Health Care	555,844	652,111	599,713	613,706	625,482	13,993	11,776
Community Residential Care	37,965	43,963	40,802	39,715	38,653	(1,087)	(1,062)
Home Hospice Care	727,350	551,888	739,349	739,424	739,899	75	475
Home Respite Care	30,283	35,375	32,415	33,846	35,106	1,431	1,260
Home Telehealth	751,375	672,356	761,534	770,430	777,407	8,896	6,977
Home-Based Primary Care	1,438,531	1,406,740	1,506,445	1,605,915	1,681,866	99,470	75,951
Homemaker/Home Health Aide Prgs.	16,862,873	15,440,095	17,613,901	18,398,378	18,996,921	784,477	598,543
Purchased Skilled Home Care	192,345	32,384	206,667	209,394	211,605	2,727	2,211
Spinal Cord Injury Home Care	17,443	21,401	17,508	17,658	17,796	150	138
State Adult Day Health Care	11,022	11,574	8,226	8,898	9,619	672	721
VA Adult Day Health Care	14,311	12,893	22,071	22,439	22,669	368	230
Non-Institutional Clinic Stops/Procedures [Total]	**20,639,342**	**18,880,780**	**21,548,631**	**22,459,803**	**23,157,023**	**911,172**	**697,220**
Non-Institutional Cost Per Clinic Stops/Procedures							
Community Adult Day Health Care	$483.46	$365.75	$491.81	$500.30	$508.98	$8.49	$8.68
Community Residential Care	$3,900.75	$2,407.14	$4,144.85	$4,305.50	$4,460.97	$160.65	$155.47
Home Hospice Care	$227.94	$41.20	$235.01	$242.97	$250.59	$7.96	$7.62
Home Respite Care	$8,121.26	$4,108.10	$8,251.21	$8,384.12	$8,518.37	$132.91	$134.25
Home Telehealth	$626.87	$587.64	$659.18	$680.27	$700.62	$21.09	$20.35
Home-Based Primary Care	$938.15	$1,042.96	$986.02	$1,017.06	$1,047.00	$31.04	$29.94
Homemaker/Home Health Aide Prgs.	$140.62	$120.25	$148.96	$150.37	$152.15	$1.41	$1.78
Purchased Skilled Home Care	$8,015.53	$11,312.69	$8,266.77	$8,526.36	$8,792.67	$259.59	$266.31
Spinal Cord Injury Home Care	$1,034.63	$787.49	$1,087.73	$1,122.66	$1,156.44	$34.93	$33.78
State Adult Day Health Care	$0.89	$0.65	$0.89	$0.89	$0.89	$0.00	$0.00
VA Adult Day Health Care	$326.74	$650.04	$347.11	$357.68	$367.95	$10.57	$10.27
Non-Institutional Cost Per Clinic Stops/Procedures	**$319.16**	**$244.95**	**$336.61**	**$341.97**	**$348.18**	**$5.36**	**$6.21**

1/ The display for 2024 in the 2024 Congressional Justification excluded obligations for certain home telehealth modalities. These obligations have been included in all columns in this display except for the 2024 Budget Estimate.

VA Community Living Centers Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$3,520,272	$3,022,616	$3,138,011	$3,151,325	$3,547,648	$13,314	$396,323
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$600,271	$743,900	$663,400	$750,700	$790,900	$87,300	$40,200
Medical Facilities (0162):	$832,921	$1,056,200	$848,700	$873,800	$920,300	$25,100	$46,500
Discretionary Total	**$4,953,464**	**$4,822,716**	**$4,650,111**	**$4,775,825**	**$5,258,848**	**$125,714**	**$483,023**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$418,779	$624,271	$593,035	$330,121	($31,236)	($262,914)
Veterans Medical Care and Health Fund (0173)	$51,689	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$395	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$52,084**	**$418,779**	**$624,271**	**$593,035**	**$330,121**	**($31,236)**	**($262,914)**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$50,284	$80,092	$0	$0	($80,092)	$0
Veterans Medical Care and Health Fund (0173)	$50,803	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$234	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$51,037**	**$50,284**	**$80,092**	**$0**	**$0**	**($80,092)**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$3,013	$0	$23,000	$101,300	$73,400	$78,300	($27,900)
Veterans Medical Care and Health Fund (0173)	$62,668	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$100	$718	$2,625	$0	$0	($2,625)	$0
Mandatory Obligations [Subtotal]	**$65,781**	**$718**	**$25,625**	**$101,300**	**$73,400**	**$75,675**	**($27,900)**
Mandatory Total	**$168,902**	**$469,781**	**$729,988**	**$694,335**	**$403,521**	**($35,653)**	**($290,814)**
Combined Discretionary and Mandatory by Category							
Medical Services	$3,572,356	$3,441,395	$3,762,282	$3,744,360	$3,877,769	($17,922)	$133,409
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$651,308	$794,184	$743,492	$750,700	$790,900	$7,208	$40,200
Medical Facilities	$898,702	$1,056,918	$874,325	$975,100	$993,700	$100,775	$18,600
Obligations [Grand Total]	**$5,122,366**	**$5,292,497**	**$5,380,099**	**$5,470,160**	**$5,662,369**	**$90,061**	**$192,209**

Community Residential Care Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$111,887	$65,925	$130,618	$128,493	$128,130	($2,125)	($363)
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$16,270	$13,200	$18,000	$20,400	$21,500	$2,400	$1,100
Medical Facilities (0162):	$19,800	$26,700	$20,200	$20,800	$21,900	$600	$1,100
Discretionary Total	**$147,957**	**$105,825**	**$168,818**	**$169,693**	**$171,530**	**$875**	**$1,837**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$35	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$12	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$47**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$44	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$6	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$50**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$36	$0	$300	$1,300	$900	$1,000	($400)
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$2	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$38**	**$0**	**$300**	**$1,300**	**$900**	**$1,000**	**($400)**
Mandatory Total	**$135**	**$0**	**$300**	**$1,300**	**$900**	**$1,000**	**($400)**
Combined Discretionary and Mandatory by Category							
Medical Services	$111,934	$65,925	$130,618	$128,493	$128,130	($2,125)	($363)
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$16,320	$13,200	$18,000	$20,400	$21,500	$2,400	$1,100
Medical Facilities	$19,838	$26,700	$20,500	$22,100	$22,800	$1,600	$700
Obligations [Grand Total]	**$148,092**	**$105,825**	**$169,118**	**$170,993**	**$172,430**	**$1,875**	**$1,437**

Home Telehealth Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$345,201	$209,102	$369,389	$380,203	$393,567	$10,814	$13,364
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$57,012	$63,500	$63,000	$71,300	$75,100	$8,300	$3,800
Medical Facilities (0162):	$68,048	$122,500	$69,300	$71,300	$75,100	$2,000	$3,800
Discretionary Total	**$470,261**	**$395,102**	**$501,689**	**$522,803**	**$543,767**	**$21,114**	**$20,964**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$108	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$30	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$138**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$549	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$21	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$570**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$40	$0	$300	$1,300	$900	$1,000	($400)
Veterans Medical Care and Health Fund (0173)	($2)	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$8	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$46**	**$0**	**$300**	**$1,300**	**$900**	**$1,000**	**($400)**
Mandatory Total	**$754**	**$0**	**$300**	**$1,300**	**$900**	**$1,000**	**($400)**
Combined Discretionary and Mandatory by Category							
Medical Services	$345,339	$209,102	$369,389	$380,203	$393,567	$10,814	$13,364
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$57,582	$63,500	$63,000	$71,300	$75,100	$8,300	$3,800
Medical Facilities	$68,094	$122,500	$69,600	$72,600	$76,000	$3,000	$3,400
Obligations [Grand Total]	**$471,015**	**$395,102**	**$501,989**	**$524,103**	**$544,667**	**$22,114**	**$20,564**

1/ The display for 2024 in the 2024 Congressional Justification excluded obligations for certain home telehealth modalities. These obligations have been included in all columns in this display except for the 2024 Budget Estimate.

Home Based Primary Care Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$1,008,351	$951,996	$1,089,227	$1,193,792	$1,322,767	$104,565	$128,975
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$151,585	$165,200	$167,500	$189,500	$199,700	$22,000	$10,200
Medical Facilities (0162):	$183,252	$307,700	$186,700	$192,200	$202,400	$5,500	$10,200
Discretionary Total	**$1,343,188**	**$1,424,896**	**$1,443,427**	**$1,575,492**	**$1,724,867**	**$132,065**	**$149,375**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$42,283	$36,764	$34,924	$19,441	($1,840)	($15,483)
Veterans Medical Care and Health Fund (0173)	$3,044	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$112	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$3,156**	**$42,283**	**$36,764**	**$34,924**	**$19,441**	**($1,840)**	**($15,483)**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$329	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$329**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$1,499	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$55	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,554**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$683	$0	$5,200	$22,900	$16,600	$17,700	($6,300)
Veterans Medical Care and Health Fund (0173)	$633	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$20	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,336**	**$0**	**$5,200**	**$22,900**	**$16,600**	**$17,700**	**($6,300)**
Mandatory Total	**$6,375**	**$42,283**	**$41,964**	**$57,824**	**$36,041**	**$15,860**	**($21,783)**
Combined Discretionary and Mandatory by Category							
Medical Services	$1,011,507	$994,279	$1,125,991	$1,228,716	$1,342,208	$102,725	$113,492
Medical Community Care	$329	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$153,139	$165,200	$167,500	$189,500	$199,700	$22,000	$10,200
Medical Facilities	$184,588	$307,700	$191,900	$215,100	$219,000	$23,200	$3,900
Obligations [Grand Total]	**$1,349,563**	**$1,467,179**	**$1,485,391**	**$1,633,316**	**$1,760,908**	**$147,925**	**$127,592**

Spinal Cord Injury and Disability Home Care Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$14,143	$10,753	$14,844	$14,924	$15,580	$80	$656
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$1,800	$2,100	$2,000	$2,300	$2,400	$300	$100
Medical Facilities (0162):	$2,036	$4,000	$2,100	$2,200	$2,300	$100	$100
Discretionary Total	**$17,979**	**$16,853**	**$18,944**	**$19,424**	**$20,280**	**$480**	**$856**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$53	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$2	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$55**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$1	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$12	$0	$100	$400	$300	$300	($100)
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$12**	**$0**	**$100**	**$400**	**$300**	**$300**	**($100)**
Mandatory Total	**$68**	**$0**	**$100**	**$400**	**$300**	**$300**	**($100)**
Combined Discretionary and Mandatory by Category							
Medical Services	$14,198	$10,753	$14,844	$14,924	$15,580	$80	$656
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$1,801	$2,100	$2,000	$2,300	$2,400	$300	$100
Medical Facilities	$2,048	$4,000	$2,200	$2,600	$2,600	$400	$0
Obligations [Grand Total]	**$18,047**	**$16,853**	**$19,044**	**$19,824**	**$20,580**	**$780**	**$756**

VA Adult Day Home Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$3,557	$7,581	$6,461	$6,726	$7,041	$265	$315
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$549	$400	$600	$700	$700	$100	$0
Medical Facilities (0162):	$570	$400	$600	$600	$600	$0	$0
Discretionary Total	**$4,676**	**$8,381**	**$7,661**	**$8,026**	**$8,341**	**$365**	**$315**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$3,557	$7,581	$6,461	$6,726	$7,041	$265	$315
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$549	$400	$600	$700	$700	$100	$0
Medical Facilities	$570	$400	$600	$600	$600	$0	$0
Obligations [Grand Total]	**$4,676**	**$8,381**	**$7,661**	**$8,026**	**$8,341**	**$365**	**$315**

Community Nursing Home Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$49,452	$47,787	$53,318	$57,665	$60,720	$4,347	$3,055
Medical Community Care (0140):	$1,628,649	$1,395,426	$1,755,747	$1,893,463	$1,993,705	$137,716	$100,242
Medical Support and Compliance (0152):	$99,903	$83,000	$110,400	$124,900	$131,600	$14,500	$6,700
Medical Facilities (0162):	$1,991	$3,000	$2,000	$2,100	$2,200	$100	$100
Discretionary Total	**$1,779,995**	**$1,529,213**	**$1,921,465**	**$2,078,128**	**$2,188,225**	**$156,663**	**$110,097**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$2,158	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$2,158**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$2,158**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$49,452	$47,787	$53,318	$57,665	$60,720	$4,347	$3,055
Medical Community Care	$1,630,807	$1,395,426	$1,755,747	$1,893,463	$1,993,705	$137,716	$100,242
Medical Support and Compliance	$99,903	$83,000	$110,400	$124,900	$131,600	$14,500	$6,700
Medical Facilities	$1,991	$3,000	$2,000	$2,100	$2,200	$100	$100
Obligations [Grand Total]	**$1,782,153**	**$1,529,213**	**$1,921,465**	**$2,078,128**	**$2,188,225**	**$156,663**	**$110,097**

State Nursing Home Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$0	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$1,447,114	$1,438,784	$1,617,932	$1,745,012	$1,887,231	$127,080	$142,219
Medical Support and Compliance (0152):	$0	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$24	$0	$0	$0	$0	$0	$0
Discretionary Total	**$1,447,138**	**$1,438,784**	**$1,617,932**	**$1,745,012**	**$1,887,231**	**$127,080**	**$142,219**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$0	$0	$0	$0	$0	$0	$0
Medical Community Care	$1,447,114	$1,438,784	$1,617,932	$1,745,012	$1,887,231	$127,080	$142,219
Medical Support and Compliance	$0	$0	$0	$0	$0	$0	$0
Medical Facilities	$24	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$1,447,138**	**$1,438,784**	**$1,617,932**	**$1,745,012**	**$1,887,231**	**$127,080**	**$142,219**

State Home Domiciliary

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$0	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$45,278	$55,402	$56,992	$62,662	$69,085	$5,670	$6,423
Medical Support and Compliance (0152):	$0	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$45,278**	**$55,402**	**$56,992**	**$62,662**	**$69,085**	**$5,670**	**$6,423**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$0	$0	$0	$0	$0	$0	$0
Medical Community Care	$45,278	$55,402	$56,992	$62,662	$69,085	$5,670	$6,423
Medical Support and Compliance	$0	$0	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$45,278**	**$55,402**	**$56,992**	**$62,662**	**$69,085**	**$5,670**	**$6,423**

State Home Adult Day Health Care Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$1,949	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$511	$1,892	$1,836	$1,986	$2,147	$150	$161
Medical Support and Compliance (0152):	$0	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$2,460**	**$1,892**	**$1,836**	**$1,986**	**$2,147**	**$150**	**$161**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$1,949	$0	$0	$0	$0	$0	$0
Medical Community Care	$511	$1,892	$1,836	$1,986	$2,147	$150	$161
Medical Support and Compliance	$0	$0	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$2,460**	**$1,892**	**$1,836**	**$1,986**	**$2,147**	**$150**	**$161**

Community Adult Day Health Care Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$8,356	$1,876	$9,171	$9,547	$9,899	$376	$352
Medical Community Care (0140):	$245,617	$214,434	$269,471	$279,088	$289,059	$9,617	$9,971
Medical Support and Compliance (0152):	$14,445	$21,800	$16,000	$18,100	$19,100	$2,100	$1,000
Medical Facilities (0162):	$313	$400	$300	$300	$300	$0	$0
Discretionary Total	**$268,731**	**$238,510**	**$294,942**	**$307,035**	**$318,358**	**$12,093**	**$11,323**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$8,356	$1,876	$9,171	$9,547	$9,899	$376	$352
Medical Community Care	$245,617	$214,434	$269,471	$279,088	$289,059	$9,617	$9,971
Medical Support and Compliance	$14,445	$21,800	$16,000	$18,100	$19,100	$2,100	$1,000
Medical Facilities	$313	$400	$300	$300	$300	$0	$0
Obligations [Grand Total]	**$268,731**	**$238,510**	**$294,942**	**$307,035**	**$318,358**	**$12,093**	**$11,323**

Home Hospice Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$12,671	$10,344	$5,554	$5,743	$5,927	$189	$184
Medical Community Care (0140):	$145,744	$11,195	$160,101	$164,813	$169,881	$4,712	$5,068
Medical Support and Compliance (0152):	$7,185	$1,200	$7,900	$8,900	$9,400	$1,000	$500
Medical Facilities (0162):	$195	$0	$200	$200	$200	$0	$0
Discretionary Total	**$165,795**	**$22,739**	**$173,755**	**$179,656**	**$185,408**	**$5,901**	**$5,752**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$12,671	$10,344	$5,554	$5,743	$5,927	$189	$184
Medical Community Care	$145,744	$11,195	$160,101	$164,813	$169,881	$4,712	$5,068
Medical Support and Compliance	$7,185	$1,200	$7,900	$8,900	$9,400	$1,000	$500
Medical Facilities	$195	$0	$200	$200	$200	$0	$0
Obligations [Grand Total]	**$165,795**	**$22,739**	**$173,755**	**$179,656**	**$185,408**	**$5,901**	**$5,752**

Home Respite Care Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$0	$6,942	$0	$0	$0	$0	$0
Medical Community Care (0140):	$237,493	$138,382	$267,463	$283,769	$299,046	$16,306	$15,277
Medical Support and Compliance (0152):	$8,443	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$245,936**	**$145,324**	**$267,463**	**$283,769**	**$299,046**	**$16,306**	**$15,277**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$0	$6,942	$0	$0	$0	$0	$0
Medical Community Care	$237,493	$138,382	$267,463	$283,769	$299,046	$16,306	$15,277
Medical Support and Compliance	$8,443	$0	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$245,936**	**$145,324**	**$267,463**	**$283,769**	**$299,046**	**$16,306**	**$15,277**

Homemaker/Home Health Aide Programs Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$54,224	$48,090	$59,999	$63,262	$66,094	$3,263	$2,832
Medical Community Care (0140):	$2,188,014	$1,706,943	$2,421,426	$2,542,360	$2,654,774	$120,934	$112,414
Medical Support and Compliance (0152):	$126,395	$98,000	$139,700	$158,100	$166,600	$18,400	$8,500
Medical Facilities (0162):	$2,659	$3,700	$2,700	$2,800	$2,900	$100	$100
Discretionary Total	**$2,371,292**	**$1,856,733**	**$2,623,825**	**$2,766,522**	**$2,890,368**	**$142,697**	**$123,846**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$54,224	$48,090	$59,999	$63,262	$66,094	$3,263	$2,832
Medical Community Care	$2,188,014	$1,706,943	$2,421,426	$2,542,360	$2,654,774	$120,934	$112,414
Medical Support and Compliance	$126,395	$98,000	$139,700	$158,100	$166,600	$18,400	$8,500
Medical Facilities	$2,659	$3,700	$2,700	$2,800	$2,900	$100	$100
Obligations [Grand Total]	**$2,371,292**	**$1,856,733**	**$2,623,825**	**$2,766,522**	**$2,890,368**	**$142,697**	**$123,846**

Purchased Skilled Home Care Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$43,267	$28,163	$47,946	$50,104	$52,215	$2,158	$2,111
Medical Community Care (0140):	$1,413,163	$312,487	$1,566,422	$1,628,964	$1,696,358	$62,542	$67,394
Medical Support and Compliance (0152):	$83,513	$25,000	$92,300	$104,400	$110,000	$12,100	$5,600
Medical Facilities (0162):	$1,761	$700	$1,800	$1,900	$2,000	$100	$100
Discretionary Total	**$1,541,704**	**$366,350**	**$1,708,468**	**$1,785,368**	**$1,860,573**	**$76,900**	**$75,205**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$43	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$43**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$43**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$43,267	$28,163	$47,946	$50,104	$52,215	$2,158	$2,111
Medical Community Care	$1,413,163	$312,487	$1,566,422	$1,628,964	$1,696,358	$62,542	$67,394
Medical Support and Compliance	$83,556	$25,000	$92,300	$104,400	$110,000	$12,100	$5,600
Medical Facilities	$1,761	$700	$1,800	$1,900	$2,000	$100	$100
Obligations [Grand Total]	**$1,541,747**	**$366,350**	**$1,708,468**	**$1,785,368**	**$1,860,573**	**$76,900**	**$75,205**

2023 Unique Patients using Non-Institutional Long-Term Supportive Services by Fund

FY 2023 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	393	393	393	0	0	0
Community Adult Day	5,933	5,933	5,933	23	5,910	0
Home-Based Primary	122,526	122,526	122,526	235		0
Home Respite Care	30,283	30,283	30,283	120	30,164	0
Purchased Skilled Care	192,345	192,345	192,345	1,086	192,345	0
Hospice Care	48,194	48,194	48,194	165	13,316	0
Homemaker/Home Health Aide	176,616	176,616	176,616	773	175,850	0
SCI Home Care	2,028	2,028	2,028	0	0	0
Community Residential	4,316	4,316	4,316	0	0	0
Home Telehealth	154,949	154,949	154,949	594	0	0
State Adult Day Health Care	0	191	0	0	191	0

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

LTSS Programs

Authority for Action

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

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

In 2023, the LTSS programs managed by the Office of Geriatrics and Extended Care (GEC) served 503,787 Veterans. The Veteran population served with these programs are all ages, with 71% 65-84 and 24% 85 or older.

Types of Services Provided: Long-term services and supports include facility-based programs and HCBS. There are six facility-based GEC programs: VA CLCs; CNHs; SVHs (nursing homes

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

Recent Trends: GEC honored Veterans' preferences to receive care at home by providing access to home and community-based services serving 459,286 unique Veterans in 2023 – a 11.5% increase over 2022. The increase reflected changes in care patterns and a return to more in-home visits following the COVID-19 pandemic. Geriatric Patient Aligned Care Teams (GeriPACT) experienced a 17.0% and 9.5% increase in Veteran encounters between 2021-2022 and 2022-2023, respectively. In 2003, 66,947 Veterans were enrolled in a GeriPACT, a 13.4% increase since 2021. At the end of 2023, GeriPACT was operating in 85 facilities (an increase of 2 locations compared to the end of 2022). In addition, Geriatric Evaluation Programs are in 117 facilities.

There were 186,941 Veterans who received personal care services in 2023, a 14.2% increase over 2022. Homemaker/Home Health Aide services, the largest of the non-skilled care programs, grew by 14.3% to 170,384 Veterans. Veteran Directed Care (VDC), an innovative personal care program allowing Veterans more flexibility, grew to 7,232 Veterans in 2023, a 14.8% increase over 2022. 2023 was the second year of VDC's planned expansion to all VAMCs and all U.S. territories which will be completed in 2024 as part of VA's enhancement of home and community-based services. VDC expansion is highlighted in Executive Order 14095, *Increasing Access to High-Quality Care and Supporting Caregivers*.

Palliative and Hospice Care: In 2003, seventy-nine percent of VA inpatient decedent bereaved family member respondents rated care in the last month of life on a nationwide survey as "top box" (score of "9" or "10" on a scale of zero to ten). This is highest national average of family quality ratings in more than a decade of surveying. Bereaved family survey scores have increased across the country geographically with notable increases in family perceptions of quality for deaths occurring in Acute and Intensive Care Units. As Palliative Care teams provided an increasing number of consults in both the inpatient (96,116) and outpatient settings in 2023 (47,323), these teams are delivering care and disseminating expertise to other subspecialties on caring for Veterans with serious illness. For VA inpatient settings, more deaths now occur in hospice beds than in all of Acute and Intensive Care combined.

Home Based Primary Care: Home Based Primary Care (HBPC) continues to see an increase in overall contacts and interventions from the previous years. The use of home telehealth in more than 55% of Veterans enrolled in HBPC continues to provide a strong avenue to support HBPC clinical care. HBPC programs use GIS software to improve organizational efficiencies within programs. HBPC maintains an 89% pneumococcal vaccination rate among this frail population with access limitations. National support for HBPC expansion has been provided through special funding for additional teams. This 5-year expansion effort is expected to boost HBPC growth in

support of population data and growing demand for HBPC level of care in targeted geographic locations.

HBPC is an extensively researched evidenced based program of comprehensive home care with demonstrated outcomes to cost effectively support the goal of Veterans aging in place. A recent study demonstrated that VAs HBPC program supported Veterans' end of life desires, surpassing population benchmarks. In the years studied, VA-HBPC Veterans who died at home and rates of home death with hospice increased and were higher than both benchmarks (VA patients without HBPC and Medicare non-Veterans) (Intrator et al., 2020).

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

VA continues to update information on quality in the CLC program, using the same metrics as the Centers for Medicare and Medicaid Services (CMS) use for Care Compare. As of 2023, VA had no CLCs rated with an overall one-star, compared to one CLC at the end of 2022. Results on the community nursing homes that VA contracts with are also posted on VA's public facing website.

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

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

VA is committed to ensuring 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 continues to actively monitor

COVID-19 activity and adjust guidance with the evolving COVID-19 information and the recommendations by CMS and CDC.

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

Roughly 90% of aging adults would prefer to remain at home for care versus admission to a care facility. 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.

The capacity and expenditures for LTSS (both institutional and non-institutional) are expected to increase significantly in the future. The number of VA enrollees ages 85 and older are projected to increase by 73.1% and the number of women Veteran enrollees ages 85 and older are projected to increase by 176% between 2023 and 2035. Veteran ages 85 and older have significantly higher impairments with activities of daily living and have significantly higher needs for the use of both institutional and non-institutional care. This is compounded by the projected increase between 2021 and 2031 of an almost 250% increase in the number of Veterans ages 85 and older who are Priority 1a in which the VA is Congressionally mandated to cover the cost of any needed nursing home care. The increased use of home and community-based care to allow Veterans to better age in place is also advantageous to the Veteran and the agency by attempting to prevent or delay the need for more expensive nursing home care and to meet the Veterans preferences in a Veteran centered approach.

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 6 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.

Second Year Non-Compliance with PIIA – PLTSS: Since 2018, VA has reduced improper payments and unknown payments by $11.24 billion or 76% and removed a total of seven programs from reporting requirements. In March 2023, GAO acknowledged VA's substantial reduction in improper and unknown payments using effective mitigation strategies and corrective actions (GAO-23-106285, IMPROPER PAYMENTS: Fiscal Year 2022 Estimates and Opportunities for Improvement).

Purchased Long Term Services and Supports (PLTSS) is considered a high-risk program under the Payment Integrity Information Act of 2019 (PIIA) and susceptible to significant improper and unknown payments. On June 2, 2023, the Office of the Inspector General (OIG) deemed PLTSS non-compliant with PIIA for the second consecutive year based on reporting a gross improper payment rate greater than 10 percent in fiscal years 2021 and 2022. The corrective action for moving all Community Nursing Homes care to a compliant payment method in accordance with

Federal Acquisition Regulations is currently underway and will be fully evident in Fiscal Year 2026. As a result of this corrective action and further actions outlined in the 2022 OMB Data Call on paymentaccuracy.gov, the Program Office is not requesting additional funding for PIIA compliance purposes in this budget submission.

Reference

Intrator, O., Li, J., Gillespie, S. M., Levy, C., Davis, D., Edes, T., Kinosian, B., & Karuza, J. (2020). Benchmarking Site of Death and Hospice Use: A Case Study of Veterans Cared by Department of Veterans Affairs Home-based Primary Care. *Medical care*, *58*(9), 805–814. https://doi.org/10.1097/MLR.0000000000001361

State Home Programs

State Home Per Diem Program

Authority for Action

- 38 CFR §51, *Per Diem for Nursing Home, Domiciliary, or Adult Day Health Care of Veterans in State Homes*
- 38 U.S.C. Chapter 17, *Hospital, Nursing Home, Domiciliary, and Medical Care*
  - §1741, *Criteria for Payment*
  - §1742: *Inspections of Such Homes; Restrictions on Beneficiaries*
  - §1743: *Application*
  - §1744: *Hiring and Retention of Nurses; Payments to Assist States*
  - §1745: *Nursing Home Care, Adult Day Health Care, and Medications for Veterans with Service-Connected Disabilities*

The program is administered by VHA's Geriatrics and Extended Care (GEC). Under the State Home Per Diem program (SHPD), states may provide care in a State Veterans Home (SVH) for eligible veterans in need of care in three different levels of care: nursing home care (NHC), domiciliary (DOM), and adult day health care (ADHC). Only facilities recognized by the Under Secretary for Health (USH), under 38 CFR §51.30 for NHC, 38 CFR §52.30 for ADHC or 38 CFR §51 for DOM programs. SVHs and will receive per diem payments in accordance with 38 U.S.C. 1741-1745.

Purpose: SHPD is administered by VHA's GEC. It is a grant program providing federal assistance to VA recognized SVH facilities through the provision of a percentage of the cost of construction and paying a per diem payment for care provided to eligible veterans in SVH. Admissions to SVHs are limited to eligible veterans and certain categories of veteran-related family members to include spouses and gold star parents.

SHPD supports eligible veterans with a basic rate for NHC, DOM, and ADHC. SHPD provides the prevailing rate for eligible veterans in the SVH for NHC and ADHC due to their adjudicated service-connected disability, with a service connection of 70% or greater as well as veterans in the SVH who are adjudicated as totally disabled based on individually unemployable (TDIU).

Evidence: In 2023, there were 164 SVHs, 157 recognized NHCs, 49 recognized DOMs, and 3 ADHCs with an average daily census (i.e., average daily number of patients) of approximately 19,000 veterans and 1,650 veteran spouses and gold star parents. Veteran occupancy has increased more than 5% and VA expects that 12 new State homes will open in 2024 increasing the number of frail and elderly veterans we will be paying per diem for their daily care.

Implementation Plan: VA disburses funding quarterly and applies rigorous monthly and sometimes daily monitoring and reconciliation through various tools to include the Financial Management System (FMS) and SHPD Web Application.

Budget Request: The 2025 budget request of $1.8 billion reflects a 3% increase in the average daily census (ADC) except for DOM, which reflects a 5% increase. The budget also shows a 5% increase in per diem rates to account for inflation and the historical rise in occupancy as well as the increase in occupancy experienced in 2023.

VA anticipates that 12 new SVHs will open in 2024. Additionally, the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020*, P.L. 116-315 Section 3007 relaxed domiciliary admission criteria that will be published in early 2024. The new criteria will increase the number of approved domiciliary admissions. State home occupancy increased in 2023 and is expected to continue to increase with the opening of 12 new state home facilities by 2024.

Camp Lejeune Family Member Program (CLFMP)

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$224	$725	$725	$702	$738	($23)	$36
Medical Community Care (0140):	$1,935	$3,718	$3,718	$3,904	$4,099	$186	$195
Medical Support and Compliance (0152):	$0	$3,154	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$2,159**	**$7,597**	**$4,443**	**$4,606**	**$4,837**	**$163**	**$231**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$224	$725	$725	$702	$738	($23)	$36
Medical Community Care	$1,935	$3,718	$3,718	$3,904	$4,099	$186	$195
Medical Support and Compliance	$0	$3,154	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$2,159**	**$7,597**	**$4,443**	**$4,606**	**$4,837**	**$163**	**$231**

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

CHAMPVA (Excluding Caregivers) Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$516,225	$524,735	$520,975	$570,897	$622,839	$49,922	$51,942
Medical Community Care (0140):	$1,785,271	$1,594,743	$1,907,135	$2,110,842	$2,328,825	$203,707	$217,983
Medical Support and Compliance (0152):	$0	$21,958	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$2,301,496**	**$2,141,436**	**$2,428,110**	**$2,681,739**	**$2,951,664**	**$253,629**	**$269,925**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$516,225	$524,735	$520,975	$570,897	$622,839	$49,922	$51,942
Medical Community Care	$1,785,271	$1,594,743	$1,907,135	$2,110,842	$2,328,825	$203,707	$217,983
Medical Support and Compliance	$0	$21,958	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$2,301,496**	**$2,141,436**	**$2,428,110**	**$2,681,739**	**$2,951,664**	**$253,629**	**$269,925**

Foreign Medical Programs Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$3	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$91,641	$106,883	$106,883	$127,191	$139,910	$20,308	$12,719
Medical Support and Compliance (0152):	$0	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$91,644**	**$106,883**	**$106,883**	**$127,191**	**$139,910**	**$20,308**	**$12,719**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$3	$0	$0	$0	$0	$0	$0
Medical Community Care	$91,641	$106,883	$106,883	$127,191	$139,910	$20,308	$12,719
Medical Support and Compliance	$0	$0	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$91,644**	**$106,883**	**$106,883**	**$127,191**	**$139,910**	**$20,308**	**$12,719**

Spina Bifida Program Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$32	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$81,478	$86,813	$86,813	$89,417	$93,888	$2,604	$4,471
Medical Support and Compliance (0152):	$0	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$81,510**	**$86,813**	**$86,813**	**$89,417**	**$93,888**	**$2,604**	**$4,471**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$32	$0	$0	$0	$0	$0	$0
Medical Community Care	$81,478	$86,813	$86,813	$89,417	$93,888	$2,604	$4,471
Medical Support and Compliance	$0	$0	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$81,510**	**$86,813**	**$86,813**	**$89,417**	**$93,888**	**$2,604**	**$4,471**

Children of Women Vietnam Vets Obligations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$0	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$3	$200	$4	$4	$4	$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	**$3**	**$200**	**$4**	**$4**	**$4**	**$0**	**$0**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$0	$0	$0	$0	$0	$0	$0
Medical Community Care	$3	$200	$4	$4	$4	$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**	**$200**	**$4**	**$4**	**$4**	**$0**	**$0**

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

Caregiver Support Program

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$1,655,463	$2,385,880	$2,385,880	$2,872,200	$3,456,300	$486,320	$584,100
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$20,565	$36,530	$36,530	$40,800	$43,700	$4,270	$2,900
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$1,676,028**	**$2,422,410**	**$2,422,410**	**$2,913,000**	**$3,500,000**	**$490,590**	**$587,000**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$1,655,463	$2,385,880	$2,385,880	$2,872,200	$3,456,300	$486,320	$584,100
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$20,565	$36,530	$36,530	$40,800	$43,700	$4,270	$2,900
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$1,676,028**	**$2,422,410**	**$2,422,410**	**$2,913,000**	**$3,500,000**	**$490,590**	**$587,000**

[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 funding allocations among account-level categories and among activities within each category may change in response to workload demand requirements throughout 2022 and 2023.

Authority for Action

- The Program of Comprehensive Assistance for Family Caregivers (PCAFC) and the Program of General Caregiver Support Services are authorized by 38 U.S.C. §1720G. VA Regulations pertaining to these programs are promulgated under 38 CFR Part 71.
- 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 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,* expanded Family Caregiver Program during 2-year period to include eligible pre-9/11 Veterans seriously injured in the line of duty under the Program of Comprehensive Assistance for Family Caregivers.
- Executive Order 14095 – *Increasing Access to High-Quality Care and Supporting Caregivers,* signed by President Biden on April 18, 2023, develop, and implement a pilot program to offer psychotherapy via video telehealth to Family Caregivers within PCAFC to improve their access to mental health services.

Recent Legislation and Regulatory Actions

- Beaudette v. McDonough, 34 Vet. App. 95 (2021), decided decisions rendered for PCAFC are reviewable by the Board of Veterans Appeals. Prior to this ruling, PCAFC appeals followed a clinical appeals process.
- Veteran Warriors, Inc. et al. v. Sec'y of Veterans Affairs, 29 F.4th 1320 (Fed. Cir. 2022), rejected VA's definition of the *need for supervision, protection, or instruction* in 38 CFR § 71.15 as inconsistent with the statutory text in 38 USC § 1720G(a)(2)(C)(ii-iii).

Purpose: The Caregiver Support Program (CSP) mission is to promote the health and well-being of family caregivers who care for our nation's Veterans, through education, resources, support and services. CSP is comprised of two programs: Program of General Caregiver Support Services (PGCSS) and the Program of Comprehensive Assistance for Family Caregivers (PCAFC). Both programs provide services to support and engage caregivers of Veterans as partners in care, integrating caregivers as members of the Veteran's health care team.

Caregivers eligible for participation in PGCSS are caregivers who provide personal care services to covered Veterans, meaning Veterans who are enrolled in VA health care and need personal care services because of an inability to perform one or more activities of daily living or a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury. Unlike PCAFC, there is no formal application or evaluation required to participate. PGCSS provides resources, education, and support to caregivers of all era Veterans. Support services available through PGCSS include a toll-free Caregiver Support Line (CSL), the Caregiver Peer Support Mentoring Program, Building Better Caregivers™ (BBC), Annie Caregiver Text Care Program, Resources for Enhancing All Caregivers Health (REACH) VA and Caregiver Self-Care Courses.

As part of MISSION Act of 2018, services available under PCAFC expanded to Veterans of all eras with a serious injury incurred or aggravated in the line of duty, with a service-connected disability of 70% or higher and inability to perform activities of daily living or need for supervision or protection as outlined under 38 U.S.C. 1720G. Additional resources to PCAFC Primary and Secondary Family Caregivers include caregiver training, mental health services, respite care services and patient travel reimbursement. Primary Family Caregivers may also receive a monthly stipend, health care benefits under CHAMPVA and financial and legal services.

Evidence: CSP is enhancing and expanding the types of resources provided to caregivers by funding respite liaisons at various VA medical centers (VAMC) within different Veteran Integrated Service Networks (VISNs). These liaisons specialize in increasing respite utilization

while also streamlining respite access for caregivers enrolled in CSP. This initiative is to address low utilization of respite services as well as respond to feedback obtained from caregiver listening sessions requesting increased information and access to available respite services This respite pilot has demonstrated signs of success through expanding awareness of respite care for PCAFC family caregivers, as evidenced by the notable increases in utilization. Respite increased to $46 million in 2023; an increase of $34.8 million (more than triple) the level in 2022. This reflects over 8,600 referrals in 2023 compared to 3,530 referrals in 2022. The trajectory of future utilization reflects 143% growth in 2024, with a general growth of 25% in 2025 and 15% in 2026.

CSP, in collaboration with VA's Office of Mental Health and Suicide Prevention (OMHSP) through the Clinical Resource Hubs (CRH), launched a virtual psychotherapy program to provide mental health services to Family Caregivers enrolled in the PCAFC. The nation's first virtual psychotherapy hub was piloted in Veterans Integrated Services Network (VISN) 16 and began seeing Family Caregivers on May 1, 2023. The CSP continues its efforts to recruit additional psychotherapists to expand availability of services nationwide. This effort supports Executive Order 14095 – *Increasing Access to High-Quality Care and Supporting Caregivers*, signed by President Biden on April 18, 2023, which directed the Secretary of Veteran Affairs to develop and implement a pilot program to offer psychotherapy via video telehealth to family caregivers within the PCAFC to improve their access to mental health services In 2023, CSP increased expenditures of mental health services by 129% over 2022, and as of September 30, 2023, 32 full time equivalent employees (FTE) have been hired and began providing mental health services to Family Caregivers.

Implementation Plan: During 2024, CSP will continue to execute several initiatives targeted to enhance respite utilization for caregivers. Respite care utilization has already increased due to efforts by dedicated staff in each VISN. CSP will continue to increase this pilot program to have dedicated staff at each facility to oversee respite care utilization and match services to the needs of caregivers in the program. Along with dedicated SMEs, CSP will also expand its marketing and outreach efforts to educate caregivers to respite services available to them. From 2022 to 2023, utilization of non-VA respite for family caregivers tripled, and CSP anticipates continuing to utilize respite care from community providers. CSP also leverages internal VA respite options whenever possible.

CSP began its phased approach to implementing virtual psychotherapy hubs at each VISN for the purpose of providing mental health services to Family Caregivers in 2023. CSP has developed and continues to refine a process to capture workload data to determine effectiveness of the initiative and establish strategic goals and metrics, targeted to increase access and referrals within each VISN. However, feedback from CRH and participating VISNs who are currently providing treatment identified a need for additional funding for psychotherapy services within the hubs, consistent with the increasing demand for these services. CSP has reviewed and repurposed FTE to prevent redundancy and allocate resources where needed to maximize available funding. Currently, family caregivers without access to a dedicated virtual psychotherapy hub are able to seek mental health services through their local VAMC. However, VAMCs prioritize Veteran care, so it can be difficult to provide mental health services to caregivers as well. Further, in a recent survey of Family Caregivers, 54% said they would prefer a virtual modality for mental health services, making expansion of the hubs an ideal solution. Therefore, CSP will hire an additional

34 FTE in 2024 to support telehealth services for family caregivers in all VISNs. This will increase mental health service expense by 187% over 2023 levels.

VA is currently undertaking a broad programmatic review of the PCAFC to ensure it meets the needs of Veterans and their family caregivers. While this review is underway, VA has suspended annual reassessments for participants of the PCAFC. While the current eligibility criteria are examined, VA will not discharge or decrease stipends or support to PCAFC participants and their Family Caregivers.

Budget Request: The Caregiver Support Program's 2025 budget request is for $2.9 billion, which is $491 million above the 2024 budget. The budget will growth projected by the program's actuarial model and potential program changes. PCAFC participants receive stipends, CHAMPVA, mental health services, beneficiary travel, and respite services. Additional funding will cover increased cost for PGCSS participants, to develop in person and web-based training, provide telehealth and additional technologies and hire additional FTE to assist General Caregivers in finding resources for respite and counseling services. Participation in CSP's PGCSS program has steadily grown by approximately 6% each quarter in 2023.

This budget will support:

1. Existing national program office staff and operations, including the Caregiver Support Line.
2. Existing approved VISN leads at each VISN office.
3. Existing and additional CEAT clinicians at each VISN Office.
4. Existing and additional mental health Clinical Resource Hubs at each VISN.
5. Existing and additional respite services at each VISN, facility and in the community.
6. Existing and additional field program office staff consisting of social workers, nurses, occupational therapist, and admin staff.

Veteran Family Resource Program (Formerly called the Family Coordinator Program)

The Biden-Harris Administration's *Joining Forces* mission is to support those who also serve: military and Veteran families, Caregivers and survivors.

In support of *Joining Forces*, VA is implementing the Veteran Family Resource program (VFRP) under Care Management and Social Work Services to address the needs of Veterans who often choose to place their health care on hold to prioritize the needs of their family members. For Veterans managing the care of their families, social drivers of health can significantly impact a Veteran's utilization of health care and health outcomes for both the Veteran and their family. It is imperative to make family resources accessible and easy to navigate to ensure Veteran Whole Health. VFRP aligns with these efforts, enhancing the resilience, health, and well-being of Veteran families by addressing social drivers of health challenges through connections to VA and community resources. VFRP will also ensure that Veterans and their families have access to services and resources needed to help them thrive. It is important to note that under VFRP, the Veteran will define the individuals they consider "family" within their support system. VFRP

allows for transparency of VA services and recognizes the need for a holistic approach when serving our nation's heroes. This program bolsters VHA's priorities to support Veterans, their caregivers, the family unit, and their survivors, allowing the Veteran to maintain a connection to the best, timely care.

Purpose: In 2021, VA Secretary Denis McDonough approved the implementation of a Family Coordinator Program within the VHA, Office of Patient Care Services, Care Management and Social Work Services. The Family Coordinator Program has been renamed the Veteran Family Resource program (VFRP). The program is intended to serve Veteran families with connection to services for the entire family unit (as the Veteran defines it) through information, education, and available resources to enhance the resiliency, health, and well-being of Veteran families (Strengthening America's Military Families (whitehouse.gov)). VFRP will allow Veterans and their family members to receive information on, provide connection to, and improve navigation of services and resource referrals that proactively support SDOH, such as education, skills training (e.g., workforce training, problem solving, anger management, parenting, executive functioning), food and nutritional security, and resource linkage to housing, transportation, and the digital divide. VFRP will complement existing programs, such as the Caregiver Support Program (CSP), Geriatrics and Extended Care Programs, Homeless Programs, Mental Health and Substance Use Disorder programs for family members, Women's Health, Vocational Rehabilitation, employment programs and others by addressing crucial gaps that these programs are unable to fulfill.

Evidence: In 2015, at least 6.4 million Veterans had at least one minor child in their household (Source: U.S. Veterans Eligibility Trends and Statistics, 2015 Prepared by the National Center for Veterans Analysis and Statistics). Of the 9.16 million Veterans enrolled in VA, it is anticipated that most Veterans are currently providing or will provide care for a minor child, older adult, or other vulnerable person, and will benefit from intervention and support from VFRP.

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

Establishing VFRP will ensure Veterans and family members have access to education, skills training, linkage to resources, and support related to SDOH impacting families, to include addressing the needs of children and adolescents, bereavement support, and the needs of Veterans who are in the role of caregiver of a dependent or vulnerable family member of any age. Proactively assessing the Veteran caregiver's needs provides an opportunity for earlier identification of challenges and barriers in core SDOH domains being experienced by the family unit. When families can secure food, housing, transportation, address digital divide barriers, seek support for education, and learn to access care when it is needed everyone has improved outcomes related to overall health and well-being.

Implementation Plan: VFRP will focus on community collaboration, identifying and establishing new local community partnerships to meet gaps in resources for Veterans and their families. The VFRP Steering Committee workgroups and leadership will develop a method of data collection. VFRP implementation will serve as a method of data collection to identify current gaps, mitigation strategies, and overall effectiveness of the program. Program measures to demonstrate quantifiable impacts to performance will be developed during the initial 2024 implementation and program expansion.

One National Program Manager (GS-14) and one Health System Specialist (GS-13) are needed in the national program office to develop the implementation plan of this new program, roll-out of VFRP Coordinators (VFRP-C) across the enterprise and conduct program evaluation. A steering committee with membership from VHA, VBA, and NCA is creating a strategic approach to program development.

VFRP will be implemented in a phased approach beginning in 2024, placing one VFRP-C (GS-12) in all medical centers within three Veterans Integrated Services Networks (VISNs). Based upon implementation findings and recommendations from the VFRP Steering Committee, the program is planned to expand to all medical centers within six additional VISNs in 2025 and to all remaining VA medical centers (VAMC) across VHA in 2026. Phased expansion of the program enables VHA to provide these services and broaden the scope of resources to address the critical needs of the Veteran community.

VFRP-C will be experts in family services, resources, and interventions VA has the authority to provide to both family members and Veterans in their role(s) as a member of the family. VFRP-Cs will have the ability to refer to internal and external resources and develop community level partnerships to best address the unique and varied needs of these families. Partnerships and collaborations that support the mission of VFRP will also be explored and initiated with local and national organizations as appropriate.

VFRP-Cs at VAMCs will:

- Assess the needs of the families of Veterans using evidence-based strategies;
- Build positive relationships with such families; refer Veterans to other resources (including local, State, and Federal) that support Veterans and their families;
- Develop and maintain a list of supportive services offered by the VAMC and supportive services offered at reduced or no cost by non-VA providers located in the VAMC's catchment area and
- Develop and maintain online a list of family resources that would be made available for all enrolled Veterans in the catchment area of the medical center. Implementing this program with a clinical coordinator with specific subject matter expertise is a known and successful approach with other VHA programs such as Suicide Prevention, Intimate Partner Violence Assistance, Caregiver Support, and the Post-9/11 Transition Programs.

Budget Request: The 2025 Budget requests $18.2 million to expand services from three to six VISNs. This will support improved compliance with health care appointments due to the

provision of increased access to care by identifying necessary supports to the family as defined by the Veteran.

PACT Act Sec. 705 Enhance Use Lease Authority

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Mandatory Obligations							
Medical Facilities (0162):	$45,549	$0	$41,375	$40,608	$17,280	($767)	($23,328)
Mandatory Obligations [Total]	**$45,549**	**$0**	**$41,375**	**$40,608**	**$17,280**	**($767)**	**($23,328)**

Section 705 of the Sergeant First Class Heath Robison Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act) modified VA's authority to allow the Secretary to enter into enhanced-use leases that do not adversely affect the mission of the Department or operation of facilities, programs and services of the Department in the area of the leased property and that enhance the use of the leased property by directly or indirectly benefitting Veterans or by providing supportive housing. VA will give priority to enhanced-use leases that on the leased property provide supportive housing for Veterans, provide direct services or benefits targeted to Veterans or provide services, or benefits that in that indirectly support Veterans. The funding table above reflects the VHA Medical Facilities portion of estimated obligations from the total $922 million appropriated in this section of the Act.

Readjustment Counseling

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$253,288	$287,270	$287,270	$302,568	$302,568	$15,298	$0
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$4	$13,926	$13,926	$14,297	$14,297	$371	$0
Medical Facilities (0162):	$49,690	$52,447	$52,447	$53,496	$53,496	$1,049	$0
Discretionary Total	**$302,982**	**$353,643**	**$353,643**	**$370,361**	**$370,361**	**$16,718**	**$0**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$253,288	$287,270	$287,270	$302,568	$302,568	$15,298	$0
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$4	$13,926	$13,926	$14,297	$14,297	$371	$0
Medical Facilities	$49,690	$52,447	$52,447	$53,496	$53,496	$1,049	$0
Obligations [Grand Total]	**$302,982**	**$353,643**	**$353,643**	**$370,361**	**$370,361**	**$16,718**	**$0**

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

Recent Legislation

P.L. 116-315, *The Johnny Isakson and David P. Roe, M.D. Veterans' Health Care and Benefits Improvement Act of 2020,* Section 5104: expands and makes permanent reintegration and readjustment services offered to women Veterans by providing counseling services individually or in a group retreat setting. Veterans also have the option of receiving counseling with family members or in group retreat settings where all the participants are women. In addition, Veterans may receive financial counseling and information regarding employment and other community resources. In each of fiscal years 2022 through 2025, the maximum number of individuals who receive integration and readjustment services cannot exceed 1,200 individuals. In addition, the legislation creates a two-year pilot program to assess the feasibility and advisability of providing childcare assistance to qualified Veterans during the period that such Veterans receive readjustment counseling and related health care services at a Vet Center (*P.L. 116-315 §5107(b)).*

For purposes of the pilot program, the term "qualified Veteran" would mean a Veteran who is the primary caretaker of a child or children, and either (1) receives regular readjustment counseling and related mental health services from VA; or (2) is in need of regular readjustment counseling and related mental health services from VA, and but for lack of childcare services, would receive such counseling and services from VA. The pilot program would be required in at least three Readjustment Counseling Service Regions.

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

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

P.L. 117-328, Division V, Support The Resiliency of Our Nation's Great (STRONG) Veterans Act of 2022, Section 102: Requires VA to hire an additional 50 full-time equivalent employees for Vet Centers to provide expanded mental health care to Veterans, members of the Armed Forces, and their families through outreach, community access points, outstations, and Vet Centers. Hiring must be completed by December 29, 2023. The legislation also amends eligibility for readjustment counseling in Section 1712A of Title 38 USC to include any Veteran or member of the Armed Forces pursuing a course of education using covered educational assistance benefits (P.L. 117-328 § 402). In addition, the legislation amends eligibility for mental health services, including bereavement services provided by Vet Centers to include family members of a veteran or member who died by suicide (P.L. 117-328 § 403).

P.L. 117-263, James M. Inhofe National Defense Authorization Act for Fiscal Year 2023, Section 5126: Requires VA to develop and implement a staffing model for Vet Centers; seek the periodic feedback of counseling staff related to the efficacy, impact, and composition of performance metrics for Vet Centers and standardize descriptions of position responsibilities at Vet Centers. In addition, the legislation requires that the Comptroller General of the United States submit to Congress a report on physical infrastructure and future investments with respect to Vet Centers.

Population Covered: RCS clients include Veterans (82%) and active-duty, Reserve and National Guard service members (8%), along with their families (10%), who experience challenges from deployment, combat, or other military-related trauma. Approximately 82% of clients choosing to

identify gender are male, 18% female, and less than 1% non-binary or transgender. The average age of RCS client is 54 and 62% are currently younger than 60 years.

A significant concentration of clients has served in recent combat theaters or areas of hostility with 25% serving in Iraq, 16% serving in Afghanistan and 9% serving in Desert Storm/ Desert Shield. The second largest era of clients served are Vietnam Veterans, representing 27% of those receiving Vet Center services. Another 12% have served in other areas of Combat or Hostility (not otherwise specified), 13% of those who come to RCS for services have experienced military sexual trauma, and approximately 1% of clients are provided services for bereavement care.

The RCS client population is diverse. By self-report, 59% of clients are Caucasian, 19% African American and 13% Hispanic. Approximately 2% are Asian Americans, 1.4% Pacific Islander/Hawaiian and 1.3% Alaskan Native or Native American. RCS provides services to individuals who have both honorable (89%) and other-than-honorable (11%) discharges.

Types of Services Provided: RCS consists of 303 Vet Centers, 84 Mobile Vet Centers, 22 Vet Center Outstations and 448 Community Access Points (CAPS). The number of Vet Centers and Vet Center Outstations includes new sites approved in 2023 that may not yet have workload associated with those specific locations. 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, Service members and their families.

Recent Trends: During 2023, RCS recognized decreases in the number of unique clients served and counseling visits, with decreases of 6.1% and 5.8% respectively. These decreases are correlated to the increase in vacancy rates and associated staff turnover that will be addressed through continued expansion, focused efforts to reduce vacancy rates, and continued support for staff added through implementation of the STRONG Act. During the same period of 2022 to 2023, the number of acute counseling interventions within RCS was virtually unchanged suggesting that the acuity of those seen in Vet Centers has remained consistent.

From 2022 to 2023, RCS demonstrated growth in the percentage of clients who identify as female. In 2022, 17% of all RCS clients identified as female. In 2023 this number increased to 18% of the overall clients.

RCS is continuing to see a change in its populations served by service era and eligibility. Vietnam Veterans decreased as a percentage of the RCS population served by 7% from 2022 to 2023, while Veterans serving in recent combat theaters increased by 1%. During the same timeframe, clients receiving services for military sexual trauma increased from 12,835 to 13,237, an increase of 3%.

Recognizing the need for counseling among National Guard and Reservists who are met with the challenges of deployment, RCS continues to actively reach out to National Guard and reserve component leaders to promote the availability of services to eligible service members. As of 2023, these efforts have produced a 64% increase in the number of unique clients treated under expanded eligibility in Public Laws 116-176 (implemented by RCS in May 2021) and 116-283 (legislation effective January 1, 2022).

While Vet Centers are the main service delivery sites, nearly 19% of visits are provided at Outstations, CAPs, MVCs, And other locations away from primary Vet Centers. These alternate locations allow RCS to meet the needs of Veterans and to provide greater access to services. In addition, hours of operation are adjusted to meet the needs of Veterans and to make access to RCS services convenient.

In 2023:

- RCS has provided 1.3 million counseling visits for 115,404 unique Veterans, Service members and families.
- Among the 1.3 million visits, there were 22,777 family visits, 28,374 couple visits, 462,431 group visits and 777,167 individual visits.
- The modalities of the 1.3 million visits include 324,413 phone visits, 207,854 telehealth visits and 758,482 in-person visits.
- Visits during Non-Traditional Hours totaled 109,604. (Defined as before 8:00 a.m., after 4:30 p.m., and weekends.)
- Vet Center staff provided services in 448 CAPs and 22 Outstations. Seven percent of all visits were provided in these distant locations.
- RCS staff participated in 30,982 Outreach Events, resulting in 162,291 outreach contacts.
- RCS staff in the Vet Center Call Center took 198,511 live telephone calls from Veterans, members of the Armed Forces, families, and community stakeholders.
- RCS has actively engaged with VA and Community Partners to support to emergency needs for Veterans, Service members, and their families at their time of need. RCS has provided outreach and counseling support following natural disasters (wildfires, tornadoes, and floods), mass shootings, and VA facility closures. In 2023, RCS supported 60 deployments and provided services (outreach and/or counseling) to 636 Veterans, 10 Service Members and 155 family members. Additionally, 117 civilians were referred to appropriate community agencies for additional resources and support.

- RCS completed the first phase of development and implementation of new processes to proactively identify and engage eligible Service members separating from the military to enhance outreach efforts and connection to readjustment counseling services.
- RCS coordinated with the VHA Scholarship & Clinical Education Office to award 45 scholarships authorized by the Hannon Act (P.L. 116-171, Section 502)
- RCS began recruiting and hiring 50 additional staff required under the STRONG Act (P.L. 117-328, Division V). In 2023, 25 were onboard, 5 individuals had received final offers, and 11 received tentative job offers.
- RCS Managed more than 300 leases with total obligations for the leased spaces in excess of $54.0 million dollars. Twenty new lease contracts were awarded including 1 new lease, 12 relocations, 6 renewals and 1 expansion.

Budget Request: RCS is requesting $370.4 million dollars in 2025, an increase of $16.7 million (+4.7% increase) above the 2024 Budget level. This increase includes $9.7 million for projected inflationary impacts and $7.0 million to support legislative implementation of the STRONG Veterans Act.

RCS is working to implement a component of the STRONG Veterans Act of 2022 (P.L. 117-328 § 102) requiring the addition of 50 full-time equivalent employees (FTE) in counseling staff, at a projected cost of $7.0 million in 2025.

Projections for the Future: Based on the figures provided above and the recently enacted legislation, RCS anticipates growth in demand for services. RCS will be continue 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 further refined to address potential shifts in population demand.

In 2025 and beyond RCS will:

- Continue to increase capacity to meet projected demand related to expanded eligibility for Vet Center services resulting from implementation of P.L. 116-176, Vet Center Eligibility Expansion Act and P.L. 116-283, The William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (NDAA).
- Continue the retreats for eligible Vet Center cohorts into 2025 and beyond with the addition of necessary precautions to mitigate COVID-19 related risk and continue implementation of the two-year pilot child-care assistance program to assess the feasibility and advisability of providing childcare assistance to qualified Veterans during the period that such Veterans receive readjustment counseling and related health care services at a Vet Center (P.L. 116-315 Sections 5104 & 5107 (b).
- Continue to fully implement new processes to proactively identify and engage eligible Service members separating from the military to enhance outreach efforts and connection to readjustment counseling services.

- Continue to assess levels of awareness and existing barriers to care among eligible individuals and create strategic marketing and advertising plans, including paid and organic marketing, to ensure awareness and increase utilization of Vet Center services.
- Continue to assess infrastructure needs to increase capacity and access.
- Continue efforts to expand and relocate Vet Centers that are inadequate for current staffing needs, authorized staff growth, and optimal service delivery to eligible individuals and their families as well as address infrastructure deficiencies.
- Seek the approval for the movement of CAPs to Outstations.
- Expand telemental health services (Vet Center to eligible individual's home; Vet Center to VA Medical Center when higher level care is required).
- Provide employees with training opportunities to ensure successful knowledge transfer and leadership development.
- Continue funding and support for the 50 additional positions required under the STRONG Act (P.L. 117-328, Division V).
- Continue to coordinate with VHA Scholarship & Clinical Education Office to award future scholarships authorized by the Hannon Act (P.L. 116-171, Section 502); and
- Continue to modernize the Mobile Vet Center Fleet; improve infrastructure by adding to the number of Vet Centers and/or relocations in 2025 to include, but not limited to, two additional Vet Centers and 30 projected lease awards.

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

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

With the newly enacted legislation, RCS expects continued growth and expansion of services. To meet this demand, RCS will continue to assess the need for additional staff to increase Vet Center

services and support the multi-year planned expansions and/or relocations of Vet Centers nationwide in high-demand and rural areas.

RCS has continued efforts to expand and relocate Vet Centers that were inadequate for current staffing needs, authorized staff growth, and optimal service delivery to eligible individuals and their families as well as address infrastructure deficiencies. RCS continues to improve access to readjustment counseling in communities distant from existing Vet Center services through increasing the number of Vet Centers (projected increase of two), Outstations (projected increase of five), and CAPS in Rural and Highly Rural Areas.

In ongoing consideration of continued expansion initiatives, RCS considered potential alternatives in providing Vet Center services to rural communities and newly eligible populations. Contract for fee services were considered; however, availability of contract providers, oversight and staff resource burdens associated with management of contracts and associated contract costs have shown this option to be unfeasible. Additionally, customer feedback indicates a strong preference for Veterans, active-duty Service members and their families to receive services through organic Vet Center resources and not contract providers. Finally, in relation to recently enacted legislation, statutory language is specific to Vet Center services to be provided and lays out the types of services and eligibilities that are required as result of this legislation.

RCS plans to budget at a minimum $13.0 million annually in support of Vet Center relocations and/or expansions. The Procurement Acquisition Lead Times (PALT) for procuring a new space is two to three years. Many variables can impact the procurement awards, such as viable spaces that meet our space criteria, a successful solicitation for offers, safety, security, geographic location, and environmental impacts. Leasing and construction cost vary nationwide. There are several factors that go into determining commercial building construction cost estimates including labor rates and productivity, material prices and the competitive conditions of the marketplace within a geographic region. With the recent nationwide supply chain challenges, RCS has seen a significant increase in construction cost. A competitive marketplace coupled with the increase in cost and materials are just a few challenges RCS has encountered during the solicitation process for new space.

RCS Workload

Readjustment Counseling Workload
(in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Visits.....	1,291	1,501	1,339	**1,412**	**1,489**	73	77
Uniques….....	115	119	120	**126**	**133**	6	7

Activations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations							
Medical Services (0160):	$339,859	$563,619	$411,634	$411,634	$411,634	$0	$0
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$30,618	$140,596	$94,115	$94,115	$94,115	$0	$0
Medical Facilities (0162):	$22,433	$161,034	$117,610	$117,610	$117,610	$0	$0
Obligations [Grand Total]	**$392,910**	**$865,249**	**$623,359**	**$623,359**	**$623,359**	**$0**	**$0**
Mandatory Obligations							
Veterans Medical Care and Health Fund:							
Medical Services (0173MS):	($1,622)	$0	$0	$0	$0	$0	$0
Medical Community Care (0173CC):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0173SC):	($48)	$0	$0	$0	$0	$0	$0
Medical Facilities (0173MF):	($46)	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**($1,716)**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary and Mandatory Obligations							
Medical Services (0160):	$338,237	$563,619	$411,634	$411,634	$411,634	$0	$0
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$30,570	$140,596	$94,115	$94,115	$94,115	$0	$0
Medical Facilities (0162):	$22,387	$161,034	$117,610	$117,610	$117,610	$0	$0
Obligations [Grand Total]	**$391,194**	**$865,249**	**$623,359**	**$623,359**	**$623,359**	**$0**	**$0**

Description: Facility activations provide non-recurring (equipment and supplies) and recurring (additional personnel, increases in operational) costs associated with the activation of completed construction or lease of new or replacement medical care facilities. In addition, Initial Outfitting, Transition, and Activation (IOTA) contracts are executed to supplement facility activation resources. 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 activations of new facilities and leases, which will promote better synchronization of budgetary resources with program needs.

The growth in the mid-level and prospectus level lease program requires the support of the VHA Activations Program. The 31 leases authorized in the PACT Act and subsequent years' growth in the number of leases requires an increase in activations funding. Due to the fluid nature of activations resulting from changes to project completion schedules, there may be a need to redistribute funding from one appropriation to another.

Evidence: In 2022, 60 projects received activation funding. In 2023, 62 projects received activations funding. Ninety-four projects are anticipated to require activations funding in 2024. The VHA Activations Program is expected to support more than 100 projects with activations funding in 2025 and 2026.

Implementation Plan: Implementation of the VHA Activations Program is field-based and driven by schedules developed and maintained by VA Office of Construction & Facilities Management (CFM) project managers. Execution of activations may be impacted by changes in building turn-over schedules which may affect the timing of funding needs. Close coordination with project managers will ensure funding is provided as it is required.

Costs: Program costs for implementation of the VHA Activations Program will include contracting activities to facilitate project activation, which have been included in the itemized

schedule of funding needs, as well as program level staffing costs and contract support. As the number of activations being executed increases, these costs will also increase.

Education and Training

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$2,428,037	$2,707,115	$2,766,709	$2,827,501	$2,911,806	$60,792	$84,305
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$79,231	$80,825	$90,237	$89,947	$94,737	($290)	$4,790
Medical Facilities (0162):	$110,923	$112,632	$126,331	$125,925	$132,631	($406)	$6,706
Discretionary Total	**$2,618,191**	**$2,900,572**	**$2,983,277**	**$3,043,373**	**$3,139,174**	**$60,096**	**$95,801**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$7,307	$5,678	$3,837	$4,980	$0	$1,143	($4,980)
Mandatory Obligations [Subtotal]	**$7,307**	**$5,678**	**$3,837**	**$4,980**	**$0**	**$1,143**	**($4,980)**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)							
VACAA, Section 801 (0152)	$3,543	$3,524	$3,373	$256	$0	($3,117)	($256)
Mandatory Obligations [Subtotal]	**$3,543**	**$3,524**	**$3,373**	**$256**	**$0**	**($3,117)**	**($256)**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)							
VACAA, Section 801 (0162)	$714	$2,187	$731	$0	$0	($731)	$0
Mandatory Obligations [Subtotal]	**$714**	**$2,187**	**$731**	**$0**	**$0**	**($731)**	**$0**
Mandatory Total	**$11,564**	**$11,389**	**$7,941**	**$5,236**	**$0**	**($2,705)**	**($5,236)**
Combined Discretionary and Mandatory by Category							
Medical Services	$2,435,344	$2,712,793	$2,770,546	$2,832,481	$2,911,806	$61,935	$79,325
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$82,774	$84,349	$93,610	$90,203	$94,737	($3,407)	$4,534
Medical Facilities	$111,637	$114,819	$127,062	$125,925	$132,631	($1,137)	$6,706
Obligations [Grand Total]	**$2,629,755**	**$2,911,961**	**$2,991,218**	**$3,048,609**	**$3,139,174**	**$57,391**	**$90,565**

Graduate Medical Education (GME) Trainees

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$804,325	$892,721	$892,721	$937,391	$937,391	$44,670	$0
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	**$804,325**	**$892,721**	**$892,721**	**$937,391**	**$937,391**	**$44,670**	**$0**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$7,307	$5,678	$3,837	$4,980	$0	$1,143	($4,980)
Mandatory Obligations [Subtotal]	**$7,307**	**$5,678**	**$3,837**	**$4,980**	**$0**	**$1,143**	**($4,980)**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$3,543	$3,524	$3,373	$256	$0	($3,117)	($256)
Mandatory Obligations [Subtotal]	**$3,543**	**$3,524**	**$3,373**	**$256**	**$0**	**($3,117)**	**($256)**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$714	$2,187	$731	$0	$0	($731)	$0
Mandatory Obligations [Subtotal]	**$714**	**$2,187**	**$731**	**$0**	**$0**	**($731)**	**$0**
Mandatory Total	**$11,564**	**$11,389**	**$7,941**	**$5,236**	**$0**	**($2,705)**	**($5,236)**
Combined Discretionary and Mandatory by Category							
Medical Services	$811,632	$898,399	$896,558	$942,371	$937,391	$45,813	($4,980)
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$3,543	$3,524	$3,373	$256	$0	($3,117)	($256)
Medical Facilities	$714	$2,187	$731	$0	$0	($731)	$0
Obligations [Grand Total]	**$815,889**	**$904,110**	**$900,662**	**$942,627**	**$937,391**	**$41,965**	**($5,236)**

Education and Training Non-GME Trainees

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$229,248	$285,827	$285,827	$307,048	$307,048	$21,221	$0
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$0	$374	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$229,248**	**$286,201**	**$285,827**	**$307,048**	**$307,048**	**$21,221**	**$0**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$229,248	$285,827	$285,827	$307,048	$307,048	$21,221	$0
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$0	$374	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$229,248**	**$286,201**	**$285,827**	**$307,048**	**$307,048**	**$21,221**	**$0**

Education and Training Support

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
DISCRETIONARY							
Medical Services (0160):	$1,394,464	$1,528,567	$1,588,161	$1,583,062	$1,667,367	($5,099)	$84,305
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$79,231	$80,451	$90,237	$89,947	$94,737	($290)	$4,790
Medical Facilities (0162):	$110,923	$112,632	$126,331	$125,925	$132,631	($406)	$6,706
Discretionary Total	**$1,584,618**	**$1,721,650**	**$1,804,729**	**$1,798,934**	**$1,894,735**	**($5,795)**	**$95,801**
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	$1,394,464	$1,528,567	$1,588,161	$1,583,062	$1,667,367	($5,099)	$84,305
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$79,231	$80,451	$90,237	$89,947	$94,737	($290)	$4,790
Medical Facilities	$110,923	$112,632	$126,331	$125,925	$132,631	($406)	$6,706
Obligations [Grand Total]	**$1,584,618**	**$1,721,650**	**$1,804,729**	**$1,798,934**	**$1,894,735**	**($5,795)**	**$95,801**

Authority for Action

- 38 United States Code [U.S.C.], Section 7302
- Public Law 113-146, *Veterans Access, Choice and Accountability Act of 2014* (VACAA), Section 301(b)(2)
- P.L. 114-315, *Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016*, extended the period for the increase in GME residency positions from 5 to 10 years (expiring August 7, 2024)
- P.L. 115-182, *VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018* (VA MISSION), Section 403 (extended from August 7, 2024 to August 7, 2031 through P.L. 116-159
- P.L. 117-328, *Support The Resiliency of Our Nation's Great (STRONG) Veterans Act of 2022*, Section 103

Purpose: VA administers the nation's largest education and training program for Health Professions Trainees (HPTs) through the Office of Academic Affiliations (OAA). OAA develops policy, oversees academic affiliations, allocates health professions trainee positions (HPT) and manages the budget to pay HPT salaries and benefits. OAA's responsibilities for fulfilling the mission "to educate for VA and for the Nation" are carried out in close collaboration with affiliated academic institutions across the United States, exemplifying a commitment to cultivating a skilled and knowledgeable healthcare workforce for the nation.

Evidence: Over 60 clinical disciplines are represented in VA's health professions education (HPE) programs. During the 2022-2023 academic year (AY), more than 120,000 HPTs participated in over 7,700 training programs offered through partnerships between 151 VA medical facilities and over 1,500 academic institutions. Over 20,000 trainees in VA come from Minority Serving Institutions, such as Hispanic Serving Institutions (HSIs) and Historically Black Colleges and Universities (HBCUs). Ninety six percent of the nation's medical schools, including 151 of 157 Liaison Committee on Medical Education (LCME)-accredited allopathic schools and 35 of 37 Commission on Osteopathic College Accreditation (COCA)-accredited osteopathic medical schools, are affiliated with VA. VA's HPT workforce is critical to maintaining timely Veteran access to care. VA HPE programs also play a leading role in creating the health care workforce for VA and the Nation. An estimated 70% of VA podiatrists, 75% of VA psychologists, 85% of VA optometrists and 65% of VA physicians participated in VA HPE programs prior to recruitment into staff positions.

VA data shows that registered nurses and nurse practitioners continue to be ranked as Mission-Critical Occupations. In response, OAA has implemented multiple innovative nursing education training programs aimed to address VHA and national RN and NP workforce shortages, such as a robust expansion of RN and NP residency programs, with more than 20,000 nursing HPTs completed their clinical training at VA facilities.

VA's HPE mission continues to add value for VA. HPE is a cost-effective mechanism for creating a workforce pipeline to fill critical VA and national workforce needs. VA has augmented the health care workforce in rural and under-served communities and at small and low complexity VA medical centers through establishment or expansion of existing HPE programs. Recent legislation affecting the HPE mission in VA include the following:

- The Veterans Access, Choice, and Accountability Act of 2014 (VACAA, section 301) provided VA with the ability to increase the number of graduate medical education (GME) physician residency positions by 1,500 over a ten-year period. All of the positions have been awarded; 66% were awarded in primary care (internal medicine, family medicine and geriatrics) and mental health (psychiatry and sub-specialties). A total of $119 million out of the funding provided by VACAA section 801 was allocated to this expansion, and VA anticipates obligating all of the remaining funding in 2024.
- The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Section 403 requires VA to develop and implement a pilot program to expand graduate medical education (GME) physician residency programs in covered facilities in underserved areas. Section 403 of the VA MISSION Act aims to improve access to health care through the establishment of new GME rotations or new GME residency programs at covered facilities, including those operated by VA, an Indian

Tribe or Tribal organization, the Indian Health Service (IHS), a Federally Qualified Health Center (FQHC), the U.S. Department of Defense (DoD) and others as identified by the Secretary. As required in the statute, priority will be given to covered facilities operated by IHS, Indian Tribes or Tribal organizations. MISSION established new authorities to allows VA to fund resident physician training programs outside of traditional methods for rotations at covered facilities. The pilot program funds 100 physician residents' clinical rotations in non-VA health care facilities and reimburses certain startup costs for new GME programs at covered facilities. Since 2018, OAA has focused on developing and drafting regulations for Section 403. The final rule was published in the federal register on November 13, 2023, and became effective December 13, 2023. With the final rule now published, OAA will implement the statute, beginning with a Request for Proposals (RFP) in 2024.

- The Support the Resiliency of Our Nation's Great (STRONG) Veterans Act of 2022, Section 103 mandates the addition of 250 paid mental health HPT positions within three years in the following disciplines: Psychiatry, Licensed Professional Mental Health Counselors (LPMHC), Marriage and Family Therapy (MTF) and Mental Health Nurse Practitioners (MHNP). In the first year of the expansion, VA added 108.6 mental health HPT positions with HPTs beginning training in academic year 2023-2024 (July 1, 2023). The STRONG Act exemplifies commitment to improving mental health services and promoting resiliency among our nation's veterans.

Implementation Plan: The HPE expansion stems from a critical need to address staffing shortages, particularly within mental health and nursing professions within the VA. Recognizing the urgency of this matter, the budget request is strategically tailored to support the augmentation of programs essential for addressing this issue head-on. Specifically, it will bolster initiatives like the Psychology Residency Program, Psychiatry GME Expansion, Post-Baccalaureate Registered Nurse Residency (PB-RNR), Mental Health Nurse Practitioner Residency (MH-NPR), Primary Care Nurse Practitioner Residency (PC-NPR), and other mental health occupations.

These targeted programs are designed to attract and train highly qualified nursing and mental health professionals. The goal is to equip them to fill crucial roles within the VA, ensuring that our nation's veterans receive the highest quality of care. By investing in the expansion of HPE trainee positions and directly addressing staffing shortages, the VA aims to fortify its healthcare workforce and, consequently, enhance patient outcomes. The requested budget reflects a strategic commitment to nurturing the growth and development of health professionals who play a pivotal role in delivering comprehensive and high-quality care to our Nation's veterans.

Budget Request: Excluding VACAA Section 801 funds, the requested budget for 2025 reflects a $65.9 million increase, or 5.6%, over the 2024 Budget. This increment is imperative to address the dual needs of supporting annual inflation and facilitating strategic program growth.

Of the proposed budget increases, approximately $40 million in 2025 is designated to meet the projected yearly increased costs associated with the salaries and benefits of Health Professions Trainees (HPTs). This allocation is pivotal to ensure competitive compensation and benefits for HPTs.

The remaining increased allocation, amounting to $24.3 million in 2025, will be expressly dedicated to expanding the number of trainee positions within HPE programs. This strategic expansion places a specific emphasis on disciplines such as Associated Health, Mental Health, and Nursing. The expansion is mandated by the growth requirements outlined in the MISSION and STRONG Acts, along with VA's initiative for the Mental Health Staffing Pipeline expansion. These funds are a deliberate investment to meet growing demands and strengthen VA's commitment to educational and training programs aligned with broader legislative and institutional goals.

Workload

Total HPT Funded Positions	Fiscal Year (FY)	Category	Filled Positions
2018 – 2019	2019	Actual	17,541
2019 – 2020	2020	Actual	17,422
2020 – 2021	2021	Actual	17,574
2021 – 2022	2022	Actual	17,505
2022 – 2023	2023	Actual	16,938
2023 - 2024	2024	Estimate	16,507
2024 - 2025	2025	Estimate	17,097
2025 - 2026	2026	Estimate	17,654

Food Security Office

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations							
Food Security Program	$1,117	N/A	$1,682	$16,985	$16,985	$15,303	$0
Obligations [Grand Total]	**$1,117**	**N/A**	**$1,682**	**$16,985**	**$16,985**	**$15,303**	**$0**
Account Category:							
Medical Services	*$0*	*N/A*	*$0*	*$15,000*	*$15,000*	*$15,000*	*$0*
Medical Support & Compliance	*$1,117*	*N/A*	*$1,682*	*$1,985*	*$1,985*	*$303*	*$0*
Medical Facilities	*$0*	*N/A*	*$0*	*$0*	*$0*	*$0*	*$0*
Medical Care Total	*$1,117*	*N/A*	*$1,682*	*$16,985*	*$16,985*	*$15,303*	*$0*

[1/]Details not displayed in the 2024 Congressional Justification. Funding in this table reflects funding for the VHA Food Security Office and grants authorized under the 2023 National Defense Authorization Act.

Authority for Action:

- P.L. 117-263, James M. Inhofe National Defense Authorization Act (NDAA) for FY 2023, Section 5126(f), Pilot program to award grants to eligible entities to support partnerships that address food insecurity among Veterans and family members of Veterans who receive services through Vet Centers or other facilities of the Department as determined by VA.

Purpose: The VHA Food Security Office (FSO) supports Veteran comprehensive health and wellbeing by providing resources to VA healthcare systems through partnerships, data management and research and education to support an interdisciplinary approach to ensure Veteran food security, and administration of the pilot program for food insecurity mandated by Public Law 117-263, James Inhofe NDAA for FY 2023, section 5126(f). The FSO office mission aligns with the following:

- The Biden-Harris Administration National Strategy on Hunger, Nutrition, and Health, with a goal of ending hunger and increasing healthy eating and physical activity by 2030 so fewer Americans experience diet-related diseases—while reducing related health disparities, including:
    - The White House Conference on Hunger, Nutrition and Health (White House Conference on Hunger, Nutrition and Health).
    - *Joining Forces*, a White House initiative to support families of servicemembers and Veterans, caregivers, and survivors. (Joining Forces | The *White* House).
- Government Accountability Office 2022 report *Nutrition Assistance Programs: Federal Agencies Should Improve Oversight and Better Collaborate on Efforts to Support Veterans with Food Insecurity* (GAO 22-104740) recommendations:
    - Recommendation 1 – The Under Secretary for Health should ensure that VHA monitors and evaluates the effectiveness of the Ensuring Veteran Food Insecurity Workgroup's activities, including at the VA medical center level.
    - Recommendation 3 – The Secretary of Agriculture should take steps to enhance collaboration within USDA's workgroup with VA including through a written agreement that specifically clarifies agency roles and responsibilities, articulates common outcomes, and establishes a mechanism to monitor progress, and routinely monitor and update this written agreement.
- VA Strategic Plan 2022 – 2028
    - Implementing Strategy 2.1.10: "(Nutrition and Food Services) VA identifies Veterans and transitioning Service members at-risk for food insecurity and connects them to resources, assistance programs and education to improve their health and well-being."
- Supports VHA's health care priorities to support Veterans' Whole Health and prevent Veteran suicide that are directly linked and impacted by food security activities.
    - Expanding services for Veterans without regular access to fresh, healthy food in collaboration with internal and external partners.
    - Producing a playbook to support the development facility-level food pantries/food hubs (a food hub is a food pantry on VA property that provides wrap around services by a dietitian and social worker.
    - Developing pilot grant programs that will provide grants to organizations to address food insecurity among Veterans and their families in accordance with the James Inhofe National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2023 Section 5126(f).

- Implementing a national food security data dashboard that provides the field with the number of completed food insecurity screens, the demographics of the Veterans screening positive, as well as the location of the screened Veterans.
- Hosting a Veteran food security summit for facility-level leaders throughout the VA Enterprise with a focus on building food hubs, women Veteran food security, rural health population, research on food is medicine initiatives, nutrition security and access.

Evidence: Recent research provides insight into understanding that individual subgroups have significantly higher rates of food insecurity (e.g., Veterans with mental health diagnoses, to include suicide ideation, and depression, diabetes, younger Veterans, etc.) and require specialized treatment. Interdisciplinary teams identify them through screening in Primary Care clinics and mobilizing the clinical services based on their individual needs. The scope of food insecurity is not limited to these subgroups and requires a team-based approach to care and coordinating services and complex needs.

Veteran Rates of Food Insecurity	
Male Veterans (overall)[a]	6.4%
Male Veterans (aged 50-64)[a]	12%
Male Veterans (aged 65+)[a]	4%
OEF/OIF/OND Veterans[b]	27%
Female Veterans (overall)[c]	27.6%

Note: Data from Brostow, et al. (2017)[a], Widome, et al. (2015)[b], and Narain et al. (2018)[c].

Research focused on food insecurity and suicidal ideation found that Veterans with food insecurity had nearly four times higher suicidal ideation compared to veterans not reporting food insecurity (39% vs 10%). These findings are consistent with a cross section relationship between food insecurity and suicidal ideation in Veterans. The same research also noted that Veterans with both Food Insecurity and PTSD had a nine times higher predicted probability of suicidal ideation compared to Veterans with neither risk factor pointing to the additive effect of other risk factors in addition to food insecurity in assessing suicide risk. Concluding that food insecurity is an independent risk marker for future suicidal ideations in post 9/11 Veterans (Elbogen, E.B., et al., 2023).

In 2022, the White House released its National Strategy on Hunger, Nutrition, and Health in response to the urgent, nutrition related health crisis and rising prevalence of diet related diseases. The consequences of food insecurity and diet related disease are significant, far reaching, and disproportionately impact historically underserved communities. The strategy calls for a whole of government approach, while acknowledging that the federal government alone cannot end hunger. To accelerate this work will require actions by state, Tribal, local and territory governments, academia, civil society, philanthropy, private sector and other partners. This call to action acknowledges that the current alternatives to addressing food insecurity have been inadequate for both Veterans and non-Veterans. The scope and size of addressing Veterans Food Insecurity requires a VA enterprise-level approach. The National Strategy outlines five pillars of action. The Food Security Office and the NDAA grant program addresses three of the pillars. Specifically:

- Pillar 1-Improve Food Access and affordability-End hunger by making it easier for everyone to access and afford food.
- Pillar 2-Integrate Nutrition and Health-Prioritize the role of nutrition and food security in overall health- including disease prevention and management and ensure that our health care system addresses the nutrition needs of all people.
- Pillar 5-Enhance Nutrition and Food Security Research-Improve nutrition metrics, data collection, and research to inform nutrition and food security policy, particularly on issues of equity, access and disparities.

The proposed grant program addresses Pillar 1-access to food through the agriculture program, and Pillar 2 with onsite pantry programs, medically tailored meal programs, food box delivery programs and produce prescription programs, all of which include a nutrition education requirement. Lastly Pillar 5 is addressed through the University research program that will focus on the necessary metrics to measure outcomes of each grant initiative.

Implementation Plan: FSO is fully committed to the successful implementation of the 2023 NDAA Food Insecurity pilot grant program. This is a critical initiative and represents a significant step forward in our commitment to ensure the well-being of those who have served.

The pilot program, as outlined in the 2023 NDAA, is not limited in scope to Vet Centers and extends to various facilities within the Department to comprehensively address the issue of food insecurity among our Veteran population. Through this pilot program, FSO seeks to support various initiatives including onsite food pantries, produce prescription, medically tailored grocery delivery services, medically tailored meals, and agriculture-related farming programs.

The VHA Food Security Office is diligently working on drafting the necessary regulations to effectively implement this pilot program. VA recognizes the urgency of addressing food insecurity among Veterans and their families, and our commitment to swift implementation reflects our dedication to this important cause.

In addition to managing the administration of the NDAA mandated pilot program, FSO continues to implement its core structure of partnerships, expanding external agreements with Federal agencies and nonprofit organizations to support food security initiatives. In 2023, FSO established formal partnerships with USDA and the Rockefeller Foundation. The Memorandum of Agreement (MOA) with USDA supports interagency collaboration for identification of opportunities to connect Veterans with food and nutrition assistance resources including staff education; coordination of budget and legislative proposals related to Veteran food and nutrition security; and collaboration on coordination with external stakeholders who are engaged in Veteran food and nutrition security. The partnership with the Rockefeller Foundation supports the implementation and evaluation of Food is Medicine interventions to support Veterans experiencing food insecurity. After the signing of the MOA, a Collaborative Research and Development Agreement (CRADA) was crafted, initiating the launch of VHA Fresh Connect Produce Prescription pilot in Salt Lake City, UT and Houston, TX to conduct research on the outcomes of the produce prescription pilot. Produce prescription programs include the provision of fresh fruit and vegetables in conjunction with nutrition education.

FSO continues to support its overall mission to ensure that all Veterans have equitable access to nutritious, affordable and culturally appropriate food to support Veteran whole health through data management, partnerships and using evidence-based strategies to inform health care delivery.

Budget Request: The 2025 budget requests $17.0 million for 2025. The budget request supports implementation of P.L. 117-263 §5126(f) NDAA food insecurity pilot grant program, in addition to the congressionally supported produce prescription efforts and VA food insecurity initiatives. Of the $17 million, VA anticipates awarding $15 million in grants for the food insecurity grant program.

References:

Brostow, D. P., Gunzburger, E., & Thomas, K. S. (2017). Food Insecurity among Veterans: Findings from the Health and Retirement Study. *The journal of nutrition, health & aging*, *21*(10), 1358–1364. https://doi.org/10.1007/s12603-017-0910-7.

Elbogen, E. B., Graziano, R. C., LaRue, G., Cohen, A. J., Hooshyar, D., Wagner, H. R., & Tsai, J. (2023). Food Insecurity and Suicidal Ideation: Results from a National Longitudinal Study of Military Veterans. *Archives of suicide research: official journal of the International Academy for Suicide Research*, 1–16. Advance online publication. https://doi.org/10.1080/13811118.2023.2200795

Narain, K., Bean-Mayberry, B., Washington, D. L., Canelo, I. A., Darling, J. E., & Yano, E. M. (2018). Access to Care and Health Outcomes Among Women Veterans Using Veterans Administration Health Care: Association With Food Insufficiency. *Women's health issues : official publication of the Jacobs Institute of Women's Health*, *28*(3), 267–272. https://doi.org/10.1016/j.whi.2018.01.002

Widome, R., Jensen, A., Bangerter, A., & Fu, S. S. (2015). Food insecurity among veterans of the US wars in Iraq and Afghanistan. *Public health nutrition*, *18*(5), 844–849. https://doi.org/10.1017/S136898001400072X

Health Care Professionals Educational Assistance Program

Description (Dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Obligations [Total]	**$208,228**	**$303,356**	**$303,356**	**$377,450**	**$377,450**	**$74,094**	**$0**
Education Debt Reduction Program (EDRP)	$129,059	$190,000	$190,000	$241,000	$241,000	$51,000	$0
Specialty Education Debt Reduction Program (SELRP)	$3,310	$12,000	$12,000	$12,000	$12,000	$0	$0
Employee Incentive Scholarship Program (EISP)	$3,418	$7,470	$7,470	$7,470	$7,470	$0	$0
VA National Education for Employees Program (VANEEP)	$15,001	$19,395	$19,395	$19,395	$19,395	$0	$0
Nat'l Nursing Education Initiative (NNEI)	$11,630	$19,707	$19,707	$19,707	$19,707	$0	$0
Health Professional Scholarship Program (HPSP)	$45,710	$49,700	$49,700	$69,480	$69,480	$19,780	$0
Visual Impairment Education Assistance Program (VIOMPSP)	$16	$225	$225	$225	$225	$0	$0
Administration	$84	$4,859	$4,859	$8,173	$8,173	$3,314	$0

Awards & Scholarships Description	2023 Actual	2024 Estimate	2025 Estimate	+/- 2024-2025
Education Debt Reduction Program (EDRP)	9,300	12,000	12,500	500
Specialty Education Debt Reduction Program (SELRP)	66	125	175	50
Employee Incentive Scholarship Program (EISP)	301	327	327	0
VA National Education for Employees Program (VANEEP)	377	426	426	0
Nat'l Nursing Education Initiative (NNEI)	1,583	2,021	2,021	0
Health Professional Scholarship Program (HPSP)	87	150	300	150
Visual Impairment Education Assistance Program (VIOMPSP)	3	35	35	0

Education Debt Reduction Program

Authority for Action: Health Professionals Education Assistance Program, Title 38 United States Code (U.S.C.) 7681 through 7683 codifies VHA's Education Debt Reduction Program (EDRP). EDRP was first authorized by the Veterans Programs Enhancement Act of 1998, Public Law 105-368 and implemented in 2002. The statute was amended by the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (P.L. 107-135), the Caregivers and Veterans Omnibus Health Service Act of 2010 (P.L. 111-163), the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146), the Department of Veteran Affairs Expiring Authorities Act of 2014 (P.L. 113-175). P.L. 113-146 and most recently the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 (P.L. 115-182), which increased the maximum EDRP reimbursement up to $200,000 over five years. The program allows EDRP participants to receive education debt reduction payments.

Purpose: The Education Debt Reduction Program (EDRP) serves as a critical recruitment and retention tool used by VHA medical centers to recruit and retain its most difficult-to-fill direct patient care clinical positions. As a multi-year program that reimburses participant education loan payments up to $40,000 per year–for up to five years–for an overall total of $200,000 per participant. EDRP is a principal incentive that allows VHA to remain competitive with the private sector, proving successful in both recruiting and retaining health care providers.

Evidence: EDRP has helped secure over 26,000 employees using EDRP awards since program inception. A record 3,038 new EDRP awards were approved for the 2022 application cycle, and 3,398 EDRP awards were approved during the 2023 EDRP application cycle. Registered nurses,

including advanced practice nurses, received the most EDRP awards in 2023 followed by physicians and social workers. EDRP remains a useful recruiting tool for hard-to-fill patient care providers in nationally scarce specialties.

Implementation Plan: EDRP will be used by medical centers to recruit and retain approximately 3,000 additional health care professionals annually in hard-to-fill patient care positions, while continuing to retain current program participants for the remainder of their service periods, which typically lasts five years.

Budget Request: VA requests $241 million for 2025 to recruit and retain nearly 12,500 hard-to-fill patient care provider positions, of which over 4,500 are projected to be serving in mental health occupations in support of the Mental Health Staffing Pathways effort. Average award amounts have increased along with program demand to meet VHA recruitment and retention health care provider needs. New EDRP awards averaged $77,000 in 2018 prior to the increases authorized by the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, which raised the maximum EDRP award up to $200,000 over 5 years at $40,000 per year. In comparison, EDRP awards for new participants averaged near $96,000 for 2022 and in 2023 averaged near $99,000.

In 2024, EDRP will reimburse nearly 9,000 participants and help secure over 3,000 additional clinical care providers in hard-to-fill patient care positions. For 2025, $241 million is requested to enable EDRP to reimburse nearly 12,500 participants, of which over 4,500 are projected to be serving in mental health occupations. The increase in 2025 will enable VHA to provide focused support for mental health hiring by expanding the number of mental health awards. VHA projects over 3,000 new EDRP awards in 2025. EDRP Administration costs of $2.2 million annually is needed to manage the program.

Specialty Education Loan Repayment Program

Authority for Action: Health Professionals Education Assistance Program, Title 38 United States Code (U.S.C.) 7691 through 7697 established the Specialty Education Loan Repayment Program.

Purpose: The Specialty Education Loan Repayment Program (SELRP) was authorized by Section 303 of the MISSION Act of 2018 as a loan repayment program specifically targeted to attract recent medical school graduates for VA service in exchange for a total of $160,000 (at $40,000 per year) in education loan repayment. The program will establish a pipeline of specialized providers to meet VHA's future staffing needs by offering loan repayment to medical school graduates with at least two years remaining in their residency programs, thereby allowing VHA to compete with the private sector for new graduates.

Evidence: During 2023, VA enrolled 66 new participants in SELRP. From its inception in 2021, VA has enrolled 101 new participants from the following occupational disciplines: family practice, internal medicine, anesthesiology, gastroenterology, and psychiatry physicians. Each SELRP recipient agrees to a service obligation period at a VA medical facility which helps alleviate health care workforce shortages. Upon award, recipients sign a minimum 2-year service obligation as well as a mobility agreement. Future benefits are gained in reduced recruitment costs as SELRP recipients will have obligated service agreements to fulfill.

Implementation Plan: According to the Association of American Medical Colleges, the United States faces a shortage of up to 122,000 physicians by 2032, including a critical need for specialists to treat an aging population that will increasingly live with chronic disease. The VHA currently competes against lucrative private sector offers to physicians during their residency training. It is imperative that VHA use financial incentive programs like SELRP to secure early employment commitments from physicians completing training programs. VHA currently anticipates systemwide recruitment challenges for physicians with specialized training in primary care, geriatrics, emergency medicine, gastroenterology and psychiatry. SELRP will establish a pipeline of medical students and residents to address the projected needs in the Nation's most scare specialties.

Budget Request: The 2025 budget of $12.0 million would cover the reimbursement costs for SELRP participants at a rate of $40,000 per year for each participant. In 2025, SLERP will award a minimum of 100 new awards annually while managing and funding the continuation of SLERP awards for active participants.

Employee Incentive Scholarship Program (EISP) /VA National Education for Employees Program (VANEEP)/ National Nursing Education Initiative (NNEI):

Authority for Action: Health Professionals Education Assistance Program, Title 38 United States Code (U.S.C.) 7601 through 7604 and 7671 through 7675 established the Employee Incentive Scholarship Program (EISP). EISP authorizes VA to award scholarships to employees pursuing academic degrees in clinical occupations where recruitment and retention of qualified personnel may be challenging.

Purpose: The purpose of EISP is to assist VA in meeting its need for qualified health care staff in occupations for which recruitment or retention is difficult. EISP helps VA meet its need for qualified healthcare staff by requiring scholarship recipients to complete a service obligation at a VA healthcare facility after graduation and licensure or certification. EISP awards cover tuition and related expenses such as registration, fees, and books in return for a one-to-three-year service obligation. The VA National Education for Employees Program (VANEEP) and the National Nursing Education Initiative (NNEI) are initiatives within EISP. Under VANEEP, VA facilities allow certain scholarship participants to accelerate their degree completion by attending school full-time. VANEEP provides educational funding and replacement salary to the facility to cover critical staffing needs during the participant's absence. The NNEI program is limited to funding registered nurses pursuing associate, baccalaureate, and other advanced degrees.

Evidence: The scholarships programs are vital to retaining and recruiting critical health care providers into VA's permanent workforce. As of September 30, 2023, VA has awarded 25,180 scholarships to EISP, VANEEP, and NNEI participants since the program started in 2000. During 2023, VA administered 4,845 scholarships for continuing employees and approved 1,009 new awards to EISP, VANEEP, and NNEI participants. Of the new awards, 94% supported occupations listed on the VA Office of Inspector General (OIG) determination of VHA's occupational staffing shortages.
The NNEI program is a key resource for supporting the education and retention of employees in the registered nursing occupation. A 2021 evaluation of NNEI (Rugs et al., 2021) was conducted

on 10,043 participants in 162 VA facilities from 2000-2012. At least 86.7% of NNEI participants completed the academic degree requirement. Of those who completed their degree, 97% completed the service obligation. For this cohort, 89% of individuals who completed their service obligation were still employed by VA two years later. Another evaluation was conducted in 2023 (Toyinbo et al., 2023) on 15,098 NNEI participants from 2000-2020. This evaluation concluded that at least 89% of NNEI participants completed the academic degree requirements. Consistent with the statutory intent, NNEI helps alleviate the health care workforce shortages as well as helps VA build a highly qualified nursing workforce capable of supplying the best care to Veterans.

Implementation Plan: The added EISP, VANEEP, and NNEI direct and indirect program costs would support the projected number of new mental health scholarship awards, in support of the Mental Health Staffing Pathways effort, salary support of facility level staff, and added program office staff. During 2025, VA projects to award a minimum of 1,440 employee scholarship awards, respectively. Of the 1,440 new awards, VA would allocate at least 480 new employee scholarship awards for mental health occupations. The 2025 funding would allow VA to build the health care workforce pipeline in mental health settings.

Budget Request: In alignment with the VA Fiscal Year 2022-2028 Strategic Plan and the VHA health care priority to hire faster and more competitively, VA is requesting additional funding to expand the VA employee scholarship programs in critical areas of need as defined by the VA and VHA strategic workforce plans, and the VA Office of Inspector General (OIG) determination of VHA's occupational staffing shortages. This added funding would allow VA to expand the healthcare workforce pipeline and increase the number of awards with a specific focus on mental health occupations.

For 2025, VA requests $7.4 million for EISP, $19.3 million for VANEEP, and $19.7 for NNEI.

Health Professional Scholarship Program (HPSP)

Authority for Action: Health Professionals Education Assistance Program, Title 38 United States Code (U.S.C.) 7611 through 7619 established the Health Professional Scholarship Program (HPSP).

Section 301 of the VA MISSION Act 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 the Secretary determines that the staffing shortage of physicians and dentists in the Department is less than 500.

Purpose: VA awards HPSP scholarships to applicants pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel are difficult. HPSP prioritizes applicants training in a clinical occupation commensurate with the largest staffing shortages in the VA. Increased funding for HPSP would expand the pipeline of qualified candidates to fill critical health care workforce shortage areas since the applicants awarded the scholarship must fulfill a service obligation at a VA medical facility.

Evidence: During 2023, VA awarded 610 scholarships. From the inception of HPSP in 2016, VA has awarded 1,710 scholarships to participants in the following occupational disciplines:

physicians, physician assistants, nurses, nurse practitioners, pharmacists, physical therapists, diagnostic radiological technicians, social workers, clinical psychologist, marriage and family therapist, licensed professional mental health counselors, and medical technologists. Each HPSP recipient agrees to a service obligation period at a VA medical facility which helps alleviate health care workforce shortages. Upon award of the scholarship, recipients sign a minimum 2-year service obligation as well as a mobility agreement. Additionally, HPSP enables students to gain academic credentials without additional burden of student loan debt. Future benefits are gained in reduced recruitment costs as scholarship recipients have obligated service agreements.

Implementation Plan: In 2025, HPSP will award a minimum of 250 new awards annually while managing and funding the continuation of HPSP awards for active participants.

Budget Request: The 2025 request for HPSP of $69.5 million includes $7.4 million to support the STRONG Act (50 new awards, 50 continued awards) and $11.1 million to support the Mental Health Staffing Pathways expansion. The 2025 budget will support a total of 250 new awards, 50 in support of the STRONG Act and 200 new awards in support of Mental Health Pathways.

HPSP costs are based on the average annual individual award amount of $69,500 which includes tuition charges, miscellaneous expenses, and a monthly stipend. The average annual awards are based on historical payments to schools and students. Scholarship amounts include a 3.3% average annual increase for each outyear of the program. These percentage increases are based on average rate of growth published by The College Board.

The total budget request amounts would sustain the medical student portion of HPSP as required by the VA MISSION Act of 2018, allow for the nursing selection expansion, meet the increase of mental health requirements for mental health expansion to meet both the Strong Act as well as the Mental Health Staffing Pathways initiative.

Visual Impairment Education Assistance Program (VIOMPSP)

Authority for Action: Title 38 United States Code (U.S.C.) 7501 through 7505 established the Visual Impairment and Orientation and Mobility Professionals Educational Assistance Program.

Purpose: The purpose of VIOMPSP is to increase the supply of qualified blind rehabilitation specialists for VA and the Nation. VA competes with private sector organizations and other governmental agencies for scarce health care staff. Through VIOMPSP, VA pays scholarship participant's tuition and allowable fees. Educational assistance, such as that afforded under VIOMPSP, is an excellent recruitment tool that can help VA in meeting its current and projected workforce needs for blind rehabilitation specialists and blind rehabilitation outpatient specialists for which recruitment and retention is difficult. VIOMPSP will help VA meet its need for qualified health care staff by obligating scholarship recipients to complete a service obligation at a VA health care facility after graduation and licensure or certification.

Evidence: During 2023, VA awarded 5 scholarships. From the inception of the VIOMPSP in 2015 through May 30, 2023, VA awarded 35 VIOMPSP scholarships focusing on orientation and mobility, living skills, and low vision.

Implementation Plan: VIOMPSP provides financial assistance to individuals pursuing a program of study leading to a degree or certificate in visual impairment or orientation and mobility. During 2025, VA will aggressively target students pursuing education in technology specialties to assist visually impaired Veterans.

Budget Request: The 2025 request of $225,000 will support 35 VIOMPSP participants. Each VIOMPSP scholarship recipient receives tuition, up to $15,000, for each year of a degree program, not to exceed a total of $45,000.

References:

Rugs, D., Nedd, N., Quast, T., Wang, X., Hyacinthe, M., Hall, K. S., & Powell-Cope, G. (2021). An evaluation of the Veterans Health Administration National Nursing Education Initiative. *Nursing outlook*, *69*(2), 193–201. https://doi.org/10.1016/j.outlook.2020.11.001

Toyinbo, P., Rugs, D., Nedd, N., Wang, X., Hall, K. S., Hyacinthe, M., & Cowan, L. (2023). Retention in nursing education and scholarship programs: Survival analysis of the Veterans Health Administration National Nursing Education Initiative Data. Journal of advanced nursing, 79(8), 3069–3081. https://doi.org/10.1111/jan.15655

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

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations							
Medical Services (0160):	$0	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$30,852	$38,259	$36,501	$37,924	$41,717	$1,423	$3,793
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]	**$30,852**	**$38,259**	**$36,501**	**$37,924**	**$41,717**	**$1,423**	**$3,793**

Under the authority of 25 U.S.C. § 1645(c) and 38 U.S.C. § 8153, the VA established a national interagency sharing/ reimbursement agreement with the Department of Health and Human Services/Indian Health Service (HHS/IHS) in 2012 to reimburse IHS for the provision of Direct Care Services to eligible American Indian (AI)/Alaska Native (AN) Veterans. The National Reimbursement Agreement paved the way for VA to enter into individual agreements with Tribal Health Programs (THPs) to reimburse THPs for Direct Care Services provided to eligible AI/AN Veterans. Additional details can be found in the Medical Community Care chapter.

Intimate Partner Violence Assistance Program (IPVAP)

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate 1/	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations							
Medical Services (0160):	$22,301	$35,696	$29,198	$30,101	$30,101	$903	$0
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$706	$1,183	$1,234	$1,272	$1,272	$38	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$23,007**	**$36,879**	**$30,432**	**$31,373**	**$31,373**	**$941**	**$0**

1/ 2024 Current Estimate corrects for the 2024 Budget Estimate that had double counted for implementation of the Deborah Sampson Act of 2020.

Authority for Action: VHA's 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 initially funded the program with $17.0 million in P.L. 115-141, *Military Construction, Veterans Affairs and Related Agencies Appropriations Act, 2018* and P.L. 115-244, *Energy and Water, Legislative Branch and Military Construction and Veterans Affairs Appropriation Act, 2019*. VHA Directive 1198, Intimate Partner Violence Assistance Program, was published in January 2019, requiring every VHA medical facility to implement and maintain an IPVAP to ensure that Veterans, their intimate partners and employees impacted by intimate partner violence (IPV), either experiencing or using, have access to services including prevention, education, resources, screening, assessment, intervention and/or referrals to VHA or community agencies as clinically indicated.

Purpose: VHA defines IPV as physical, verbal, emotional, psychological, stalking, and sexual abuse between intimate partners. IPV is a national health epidemic that can cause significant and long-term bio-psycho-social consequences among the Veteran population regardless of age, gender, sexual orientation or socioeconomic status. It is also significantly correlated with increased risks for other public health issues including suicide, homicide, homelessness, substance abuse, and other forms of sexual trauma including human trafficking.

VHA's IPVAP provides vital services for Veterans, their partners, caregivers and VHA staff impacted by IPV. Future program expansion is anticipated as the program continues to develop clinical programming to meet identified needs. This includes expansion of screening, assessment, safety planning and various modalities of intervention to promote safety and healthy relationships. In addition, IPVAP anticipates growth resulting from the findings of a two-year pilot (as directed in section 5304 of the *Deborah Sampson Act of 2020*, enacted as title V of the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020*, P.L 116-315) focused on expanding services for Veterans who experience sexual assault and strategically identifying underserved populations. The IPVAP also supports the VHA Human Trafficking Education and Prevention Committee which is launching a two-year pilot program at six sites through 2025. It is anticipated that identified best practices and innovations developed during the pilot will likely be supported and spread into 2026. The Committee supports the advancement of human trafficking awareness and education efforts.

Evidence: IPV and IPV-related issues are widespread and negatively impact the health and well-being of Veterans.

1. According to the Centers for Disease Control and Prevention, as many as one in three women and one in four men experience significant IPV, including sexual violence, in their lifetimes. Veterans are known to be disproportionately impacted by IPV.
2. Research highlights the intersectionality between IPV, suicidality, homicide and substance use in Veteran populations experience (Cerulli & Bossarte, 2014; Monteith, Holliday, Dichter & Hoffmire, 2022.)

3. Housing instability is highly correlated with experiences of IPV and sexual assault. Approximately 3.43% of Veterans registered for VA services enterprise-wide experienced recent homelessness. Women Veterans who experience IPV are three times more likely to experience housing insecurity. Approximately 15% of all Veterans served by the Deborah Sampson Act of 2020 section 5304 pilot are experiencing recent housing insecurity, highlighting the intersectionality between IPV and homelessness.
4. Notably, women, Veterans in rural communities, and many historically underserved populations including Veterans who identify as Native American and Alaska Native, African American and LGBTQ+ experience some of the highest rates of IPV and sexual assault.
5. In 2023 approximately 1.9 million screenings were conducted with 16,149 women and 52,643 men disclosing past year experiences of IPV. Of these, over 9,683 indicated they were at high risk for harm.

Implementation Plan: The IPVAP has been implemented nationally and continues to strengthen and expand services in response to needs identified on annual program evaluations. The national IPVAP team consists of a IPVAP National Program Manager, a Health Systems Specialist and two National Program Coordinators. In addition, the national office plans to continue to support the National *Deborah Sampson Act of 2020* section 5304 Program Manager. This position will extend through the term of the appointment to assist in the completion of the pilot project including the drafting of the CMR and subsequent actions. The term is expected to end at the end of the 2025 cycle.

To support anticipated program expansion efforts, the national office plans to add one additional program office staff member beginning in 2025 to manage the multiple initiatives to expand sexual violence programming stemming from the pilot recommendations as well as lead for the White Ribbon VA campaign and the Human Trafficking pilot project.

The national office began increasing facility-based staff in 2022 and plans to support additional growth as needed over the next few years. In 2023, IPVAP funded 11 new FTE in response to facility-based requests and justification of need. Also, as of December 2024, IPVAP executed Phase 1 of IPVAP expansion and funded 65 GS-11 clinical staff at 1a- and 1b- high complexity sites to sustain and expand access to interventions such as the Strength at Home (SAH), Recovering from IPV through Strengths and Empowerment (RISE), and Courage Group interventions. In 2025, IPVAP plans to fund existing approved facility-based staff and execute Phase 2 of IPVAP expansion funding all 1c-high complexity and all 2-medium complexity sites (estimating 44 GS-11 clinical staff) as well as continuing to review new facility-based requests with a justification of need. In 2026, IPVAP plans to fund existing approved facility-based staff and execute Phase 3 of IPVAP expansion funding all 3-low complexity sites (estimating 29 GS-11 clinical staff) as well as continuing to review new facility-based requests with a justification of need.

IPVAP launched a two-year Human Trafficking pilot program in June 2023 which will conclude in 2025. IPVAP has funded six 0.5 FTE to support this endeavor at the selected facilities through September 2025.

Budget Request: The 2025 budget request is $31.4 million. The 2025 request includes $1.3 million in Medical Support and Compliance (MSC) funding to support salaries and benefits for

the current national IPVAP team and the anticipated expansion, travel for medical center site visits and to attend mission critical meetings with key stakeholders, and national program innovations and collaborations. It also includes $30.1 million in Medical Services (MS) funding to support salaries and benefits for facility based IPVAP Coordinators, clinical staff, and IPVAP partners such as SAH, RISE and IPV-Center for Innovation, Research and Program Evaluation (IPV-CIRE).

The purpose of this funding is to support the continuation of the IPVAP across the enterprise to provide vital services for Veterans, their partners and VA staff impacted by IPV per VHA Directive 1198, Intimate Partner Violence Assistance Program. This policy requires that every facility designate and support an IPVAP Coordinator to oversee operations of a comprehensive array of programs and services to mitigate risk of IPV, known to be highly associated with suicide, homicide, homelessness, substance use and other forms of sexual trauma including human trafficking.

Continued funding is also requested to support the completion of the congressionally mandated two-year pilot program led by the IPVAP in support of P.L. 116-315, the *Johnny Isakson and David P. Roe, M.D. Veterans Healthcare and Benefits Improvement Act of 2020*. The two-year pilot was launched on October 1, 2021, and concluded on September 30, 2023. This funding will support the National Program Manager position through the term of the appointment to assist in the completion of the pilot project including the drafting of the Congressionally Mandated Report (CMR) and subsequent actions. The term is expected to end at the end of the 2025 cycle.

References:

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National Center for Posttraumatic Stress Disorder (NCPTSD)

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations							
Medical Services (0160):	$30,419	$15,001	$32,278	$15,001	$15,001	($17,277)	$0
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$11,725	$26,999	$9,564	$26,999	$26,999	$17,435	$0
Medical Facilities (0162):	$158	$0	$158	$0	$0	($158)	$0
Obligations [Grand Total]	**$42,302**	**$42,000**	**$42,000**	**$42,000**	**$42,000**	**$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, 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 Veterans through research, education and training, but without direct responsibility for patient care. NCPTSD was also mandated to serve as a resource center for information about PTSD research and education for VA and other Federal and non-Federal organizations. NCPTSD currently consists of six divisions located at VA facilities, with headquarters in White River Junction, Vermont. 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 (https://www.ptsd.va.gov), publications, online resources, as well as nationwide trainings.

Recent Trends

Research Support:

- From 2019-2023, the Center had an average of 142 competitively awarded research grants and produced an average of 363 peer-reviewed publications per year. In 2023, NCPTSD investigators led 165 funded studies (totaling $327.5 million), 35 studies were pending as of November 2023, and investigators had 435 publications.
- Established VA's National PTSD Brain Bank (NPBB) in 2014 as the first and only brain bank devoted exclusively to PTSD. The NPBB is a consortium of five VA Medical Centers and the Uniformed Services University of Health Sciences. The NPBB 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. As of November 2023, NPBB had acquired 352 frozen hemispheres (roughly divided in thirds from donors with PTSD, donors with major depression, and controls without depression or PTSD) and 352 fixed hemispheres; 235 individuals have enrolled in our antemortem donor program. To date, 22 peer-reviewed publications have been published using NPBB data. VA continues to collaborate scientifically with the Lieber Institute for Brain Development and other academic partners.

- Participated in the Million Veteran Program. Published the first evidence of genetic vulnerability to one of the hallmark symptoms of PTSD — re-experiencing traumatic events. Other biomarker studies are examining biological predictors of response to medication and device-based treatments for PTSD.
- Conducted multiple studies of treatment efficacy, efficiency and engagement of established and novel treatments for PTSD. Research has led to VA national rollouts of evidence-based psychotherapies. Recently completed data collection for a study that will be helpful for determining which psychotherapy is optimal for which patients and launched another large study that will identify optimal medications for sleep problems in Veterans with PTSD.
- Developed and validated the field's most frequently used questionnaires and structured diagnostic interviews to assess PTSD according to the revised diagnostic criteria in the 5th edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. Continued research on effective screening for military sexual trauma (MST), intimate partner violence and moral injury.
- Participated in large-scale studies of the implementation of evidence-based treatments for PTSD. Investigated barriers to implementation in outpatient and residential PTSD treatment programs. Continued a large multi-site study aimed at increasing the use of Prolonged Exposure for PTSD, one of the most effective treatments for PTSD within the military health system. Continued two multi-site trials testing modeling tools that enable clinic teams to run simulations of their workflow and decide how to best allocate their staff so more Veterans receive evidence-based treatment.
- Continued data collection, analysis, and publication on several longitudinal studies that assess the course of PTSD over time in cohorts of Veterans, furthering understanding of the prevalence, severity and genetics of PTSD in Veterans, including:
  - Continued data analyses for the Project VALOR (Veterans After-Discharge Longitudinal Registry), collecting data on a large cohort of combat exposed OEF/OIF/OND men and women Veterans to examine trajectories of PTSD symptomatology and diagnosis, the nature and extent of MST including the contribution of MST to PTSD symptoms and diagnosis and associations of PTSD, mTBI, major depressive disorder (MDD) and treatment utilization in relation to changes in suicidal behaviors. Recently collected DNA samples will be analyzed to examine genome-wide associations. In spring of 2023, investigators were recommended for large-scale funding from the Congressionally Directed Medical Research Program to continue following Project VALOR participants to assess their physical and mental well-being, post COVID pandemic.
  - Continued data collection for LIGHT, the Longitudinal Investigation of Gender, Health, and Trauma study, focuses on the impact of community violence on Veteran mental, physical and reproductive health. Questions related to COVID-19 exposure were collected

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

- Continued data collection for the National Health and Resilience in Veterans Study (NHRVS), which is examining the prevalence and correlates of a broad range of health outcomes in a large, contemporary, and nationally representative Veteran sample. Longitudinal NHRVS data collection waves since late 2020 have included measures of COVID-19 exposures and mental health responses.
- Data analysis and publication continues on Neuropsychological and Mental Outcomes of Operation Iraqi Freedom: A Longitudinal Cohort Study designed to examine the impact of Iraq combat-zone deployment on neuropsychological outcomes, including neurobehavioral and emotional functioning.
- Continued data collection for a project leveraging existing longitudinal data from a cohort of aging veterans with PTSD and collecting a third wave of data from this same cohort to examine peripheral biomarkers of accelerated cellular aging that mediate the association between traumatic stress and accelerated aging in the brain, as measured by 3-Tesla magnetic resonance spectroscopy of the prefrontal cortex and by measures of neurocognition.

- Expanded portfolio focused on PTSD and suicide. Identified biomarker of PTSD-related suicidal ideation. Awarded funding for a study of predictors of suicidal ideation among Veterans during the post-deployment transition period. Launched a study of whether PTSD treatment during inpatient hospitalization reduces risk of suicide for service members and Veterans with significant PTSD symptoms. Awarded funding to use the Military Suicide Research Consortium Common Data Elements to examine transdiagnostic phenotypes associated with self-injurious thoughts and behaviors (SITBIs) among military personnel. Recently awarded funding to evaluate the efficacy of a novel treatment to reduce the incidence and severity of SITBs in psychiatrically hospitalized active-duty military service members and adult military beneficiaries. NCPTSD researchers have recently partnered with the ARMY STARRS team to examine predictors of SITBIs among service members transitioning to civilian life. Recently received funding to establish a multisite VA suicide prevention clinical resource center focusing on establishing and promoting a precision medicine agenda for suicide prevention.
- Continued to expand the PTSD Trials Standardized Data Repository (PTSD-Repository), a database that brings together study level data from nearly randomized controlled trials (RCTs) of PTSD treatment. Updated annually, the current release includes 496 RCTs. Abstracted data elements include information on sample characteristics, study characteristics, study interventions, and outcomes (including standardized effect sizes). New in 2023 are study quality ratings for all RCTs using Cochran's Risk of Bias 2 rating system. The data are also now part of Metapsy, which provides open access to meta-analytic databases across several mental health problems (e.g., PTSD, depression, anxiety). Publicly available and free to use, the PTSD-Repository helps researchers, clinicians, Veterans and family members better understand the treatment literature.

Provider Support:

- Responded to over 2,700 requests in the PTSD Consultation Program in 2023, about one third of which were from non-VA providers who were treating Veterans. The program offers a monthly continuing education webinar on the topics that providers often ask about in consultation. Recorded webinars are available as online courses with free continuing education credits. With a continued focus on supporting providers in rural areas, the program trained 189 non-VA providers in military culture and the assessment of PTSD and suicide risk. Plans are underway to train additional non-VA providers in 2023 and 2024.
- Promoted best practices for PTSD Specialty Care within VHA through the PTSD Mentoring and Implementation Program. Initiated in 2008, the program provides administrative guidance to ensure best management and clinical practices. The PTSD Mentoring Program continued toward the goal of improving VA PTSD specialty care with an enhanced focus on helping PTSD specialty programs align with OMHSP-supported principles of care. Program activities in 2022 focused on continuation and expansion of implementation support provided to the PTSD specialty programs with focus on continuing to improve evidence-based psychotherapy "Reach" and measurement-based care (MBC). At the conclusion of FY23, the majority of PTSD Clinical Teams are high EBP reach (66%, N=78), which is a significant increase from 2020 when the data feedback was initiated (35%, N=39). MBC implementation has also demonstrated steady and significant increases during the fiscal year with majority of sites (65%, N=76) demonstrating improvements and/or maintenance their high MBC implementation rates.
- Developed an advanced online training on the administration and scoring of the Clinician Administered PTSD Scale for DSM-5 (CAPS-5). Learners work with any of three virtual patients whose presentations, back stories and responses mimic those of actual Veterans in a clinical interview. Planning is currently underway to create new courses to teach a revised version of the CAPS-5, now called the CAPS-5-R.
- Added 918 new records to the PTSDpubs database in 2023, which currently holds 68,792 indexed journal articles, technical reports and books on PTSD and traumatic stress. The NCPTSD librarians continue to expand the PTSDpubs' customized thesaurus for more precise searching, to educate researchers and providers on database best practices and to assist with literature searches, systematic reviews and other reference queries for NCPTSD researchers, the PTSD Consultation and Mentoring programs and other investigators in the field.
- Utilized the Tech into Care (TIC) initiative, which evolved out of the Practice-Based Implementation (PBI) Network, to facilitate implementation of mental health technology into care across VA. There are now 30 VA mHealth champion sites and over 1,200 VA staff trained to incorporate mental health apps into their work with Veterans. TIC offers monthly continuing education lectures, community of practice calls and informational podcast episodes. Developed and piloted Tech into Care+, a self-guided internet-based tool for supporting implementation. TIC is now piloting an improved version of the implementation tool based on feedback from the first pilot and will incorporate tracking app reach with Veterans. In April 2023, local mHealth champions attended an annual Tech into Care mHealth sustainment summit and developed action plans for continued expansion of their implementation efforts.

- Continued to supported VA's efforts to implement MBC. Collaborated with OMHSP to provide subject matter expertise to the field while implementing the requirement for MBC within all PTSD specialty programs-collect, share, act. Efforts included ongoing distribution of program MBC "collect" data throughout 2023, with plans for expanding the tracking of MBC "share & act" components in all aspects of PTSD specialty care in 2024. The PTSD Mentoring Program will continue providing direct consultation and support to low MBC implementing sites and continuing to offer data feedback quarterly to the field.
- Continued to develop and disseminate online trainings that offer free continuing education credits to VA and community providers. As of 2023, more than 100 hours of continuing education units are available to learners on topics such as assessment, common comorbidities, evidence-based treatment and provider cultural competence.

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

- Continued to lead VA efforts each June for PTSD Awareness Month with over 4.3 billion estimated interactions throughout the month. More than 60,000 people across the country participated in the 3rd annual Step Up for PTSD Virtual Walk and 101,930 individuals visited the PTSD interactive screen for PTSD Screening Day (June 27), a day set aside to encourage Veterans and other people who have experienced trauma to get screened and talk with their providers about treatment if they need it.
    - Developed and continue to update and disseminate a suite of 16 mobile apps, including self-help apps like COVID Coach and apps to support evidence-based treatments for PTSD, (Cognitive Processing Therapy, Prolonged Exposure Therapy and Cognitive Behavioral Therapy for Insomnia). These products have been downloaded over 5.6 million times across the U.S. In collaboration with the Office of Connected Care and the Veterans Crisis Line, the apps team built a safety planning module to be incorporated into NCPTSD's mobile apps; In collaboration with OMHSP, a standalone Safety Plan app was released in 2023.
    - Continued production of AboutFace, a public awareness campaign to motivate Veterans to seek treatment. Includes videos of Veterans, family members and expert clinicians. In 2023, the addition of a feature on PTSD, Race and Culture in which Veterans talk about how their identities have shaped their experiences of military life, PTSD and PTSD treatment.
    - Created new educational products for family members including infographics, animated whiteboard videos and traditional brochures. Spanish translations of many of these materials increase their reach. Recent highlights include an interactive version of the Primary Care PTSD Screen and "explainer" videos for Written Exposure Therapy and Cognitive-Behavioral Conjoint Therapy.

Projections for the Future

- Continue to explore precision medicine approaches to PTSD treatment, including through collaborations with consortia such as the Million Veteran Program and PTSD Brain Bank, and through building data repositories and patient-level meta-analytic approaches to data analysis.
- Update the PTSD Treatment Decision Aid, an interactive tool that helps patients learn about treatments for PTSD and can play a key role in shared decision-making. This major revision will create a mobile optimized version of the tool that will incorporate recommendations from the 2023 VA/DoD Clinical Practice Guideline for PTSD.
- Continue to investigate the neurobiology of PTSD to better address its identification, prevention, and treatment. An example of this work includes expanding the VA's National PTSD Brain Bank through strategic partnerships with groups that include potential donors, such as Veteran registries, Servicemember registries, and medical examiners' offices.
- Continue to develop and test novel treatments for PTSD. Examples of this work include the continued development of psychotherapeutic interventions associated with increased patient engagement, studies of psychological and pharmacological enhancers of psychotherapy effectiveness and ongoing collaboration with VA's Office of Research and Development to develop more effective medications for PTSD.
- Continue to expand our research portfolio to better understand the neurobiology, epidemiology, prevention, and treatment of suicide risk in individuals with PTSD.
- Continue to study the implementation of evidence-based treatments for PTSD. Continue to increase awareness, recognition, and understanding of PTSD and decrease barriers to seeking help.
- Continue to promote the dissemination of evidence-based care for Veterans and other trauma survivors through the PTSD Consultation and Mentoring Programs, in-person trainings, and educational products.
- Expand reach by more effectively targeting Veterans with PTSD who need care during the post-deployment transition period and Veterans who are not engaged in care at VA.
- Continued a Center-wide Diversity, Equity, and Inclusion workgroups to explore how we may expand our work studying the intersection of race and trauma, racial disparities in access to care, and differential outcomes in PTSD treatment.

National Veterans Sports Program

National Veterans Sports Program *(dollars in thousands)*							
		2024		**2025**	**2026**		
Description (dollars in thousands)	2023 Actual	Budget Estimate	Current Estimate	**Revised Request**	**Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Direct Programs (Medical Services):							
VA National Rehabilitation Adaptive Sports and Therapeutic Arts Events	$2,639	$3,000	$6,174	$3,000	$3,000	($3,174)	$0
Veteran Monthly Assistance Allowance for Disabled Veterans Training Paralympic & Olympic Sports Program	$1,993	$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	$14,500	$14,500	$14,500	$14,500	$14,500	$0	$0
Equine Therapy Grants for Adaptive Sports Programs	$1,500	$1,500	$1,500	$1,500	$1,500	$0	$0
Program Administration (Medical Support & Compliance)	$5,824	$9,414	$6,240	$9,542	$9,542	$3,302	$0
Grand Total	**$26,456**	**$30,414**	**$30,414**	**$30,542**	**$30,542**	**$128**	**$0**

Authority for Action

- 38 U.S.C. § 322 establishes the Office of National Veterans Sports Programs and Special Events
  - 38 U.S.C. § 322(d) authorizes a monthly assistance allowance for Veterans with a disability training or competing in Paralympic or Olympic sports
  - Regulation for the monthly assistance allowance 38 CFR Part 76
- 38 U.S.C. § 521A authorizes the adaptive sports programs for disabled Veterans and members of the Armed Forces
  - Regulation for the Adaptive Sports Grant Program is listed in 38 CFR Part 77

Purpose: The National Veterans Sports Programs and Special Events (NVSPSE) mission is to incorporate adaptive sports and creative arts in the lifelong rehabilitation plan of Veterans with disabilities. This service leads the nation in formalized adaptive sports medicine as a practice specialty and coordinates the growing therapeutic arts programs for Veterans. These programs encourage Veterans to lead and improve their independence, quality of life and well-being.

Populations Covered: NVSPSE primarily includes Veterans with spinal cord injuries, limb loss, traumatic brain injuries, visual impairments, multiple sclerosis, stroke, post-traumatic stress disorder, other musculoskeletal, neurological, and mental health conditions. In addition, VA staff is offered training in adaptive sports and therapeutic arts through in-person hands-on trainings and online modules for continuing education credits.

Veteran Monthly Assistance Allowance for Disabled Veterans Training in Paralympic and Olympic Sports Program: Monthly stipends are provided to emerging and elite Veteran athletes with disabilities who are actively training in a Paralympic or Olympic sport. Eligibility includes meeting the standard established by the sport national governing body or being selected as a member of the Paralympic or Olympic Team in a qualifying sport.

Grants for Adaptive Sports Programs for Disabled Veterans and Disabled Members of the Armed Forces Program: Grants are awarded to qualifying organizations to plan, develop, manage, and implement adaptive sports programs, provider training and other opportunities for 13,000+ Veterans and members of the Armed Forces with disabilities. VA awards these grants to help community organizations encourage a healthy and active lifestyle through sports and equine

therapy. Activities include Paralympic sports, equine activities, and many modern options of adaptive sports.

VA National Rehabilitation Adaptive Sports and Therapeutic Arts Rehabilitation Events: VA provides opportunities for thousands of Veterans to improve their independence, self-confidence, and quality of life through adaptive sports and therapeutic arts programs in accordance with 38 U.S.C. § 322 and 521A. The programs complement VA's rehabilitation system of care and encourage veterans with disabilities to stretch beyond perceived limitations. In service of this mission, VA directs six national rehabilitation events delivering direct patient care to Veterans eligible for VA health care. VA also provides the largest coordinated therapeutic arts program for Veterans.

Essential support from Veteran Service Organizations (VSO), corporate sponsors, individual donors and community partners helps build the foundation for the six national rehabilitation events which allows VA to extend its care beyond the clinical setting.

Held in cities across the Nation, the national rehabilitation events train hundreds of VA rehabilitation providers across more than 135 VA medical centers annually through in-person and virtual training opportunities.

- National Disabled Veterans Golf Clinic
  The National Disabled Veterans Golf Clinic (NDVGC) aims to provide an adaptive golf and rehabilitation program for veterans with visual impairments, traumatic brain injuries, limb-loss, spinal cord injuries, and other qualifying disabilities. Provision of this program serves to engage and invigorate veterans to directly improve their physical, mental, and emotional well-being. The NDVGC is a week-long adaptive golf program that is presented by the U.S. Department of Veterans Affairs and Disabled American Veterans (DAV) with the Iowa City VA Health Care System as the host VA facility. This annual event is held in Riverside, Iowa and in addition to adaptive golf veterans will be introduced to other adaptive recreational sports and wellness activities.

- National Disabled Veterans Winter Sports Clinic
  The National Disabled Veterans Winter Sports Clinic helps veterans with disabilities overcome obstacles and challenge perceived limitations. Headlined with adaptive skiing and snowboarding, the clinic serves veterans with traumatic brain injuries, spinal cord injuries, limb loss, visual impairments, and neurological conditions. VA and DAV Veterans present the clinic with local host VA Western Colorado Health Care System.

- National Veterans Creative Arts Festival
  The National Veterans Creative Arts Festival is a culmination of creative arts competitions held at VA facilities across the country. The festival showcases veteran artistry and the therapeutic benefits of art, music, dance, drama and creative writing. VA and the American Legion Auxiliary present the yearly festival which features a stage performance, writing exhibition and gallery-style showcase of artwork.

- National Veterans Golden Age Games
  The National Veterans Golden Age Games offers Veterans ages 55 and older a chance to compete in sports and learn new skills through exhibitions. Through its "Fitness for Life" motto, it demonstrates the value that sports, wellness and fitness provide to encourage senior Veterans to stay active. The National Veterans Golden Age Games is held annually and is a qualifying event for the National Senior Games.

- National Veterans Summer Sports Clinic
  The National Veterans Summer Sports Clinic introduces newly injured veterans to adaptive summer sports such as surfing, sailing, kayaking, cycling and adaptive fitness. With its hands-on instruction, the clinic complements therapy veterans receive at VA rehabilitation programs, offering an opportunity to discover new ways to gain motivation, improve independence and achieve a healthier lifestyle. It is held annually in San Diego and hosted by VA San Diego Healthcare System.

- National Veterans Wheelchair Games
  With 20+ competitions and Paralympic sports, the National Veterans Wheelchair Games inspires and empowers veterans around the globe to persevere through daily challenges. VA and Paralyzed Veterans of America present the annual event, which serves Veterans with spinal cord injuries, multiple sclerosis, limb loss, stroke, and other neurological disorders. It is the largest annual wheelchair sports rehabilitation event in the United States for Veterans with disabilities.

Evidence: NVSPSE serves thousands of Veterans and trains hundreds of VA rehabilitation providers across more than 135 VA medical centers annually. With the end of the pandemic, the national rehabilitation events and adaptive sports grant programs were able to provide opportunities for increased in-person programming. The six national rehabilitation events offered over 150% more opportunities for Veterans to join for the in-person rehabilitation event in 2023, ensuring this extension of the medical center's plan of care was meeting the intended goals for the Veteran and program. All six events plan to return to, and some are looking to exceed, pre-pandemic attendance numbers, maximizing the exposure of the rehabilitation offered through these events.

NVSPSE has also initiated efforts to utilize a multi-disciplinary sports medicine model to treatment at the national rehabilitation events. Utilization of this model has resulted in the presence of rehabilitation discipline clinics at two of the six national rehabilitation events to date. Appropriate use of this model is being further evaluated at these two events to determine what areas warrant expansion, and at the remaining four events to identify how this model can best meet the needs of the Veterans who attend these events. Addition of novel clinical services at the event maximize the Veteran's rehabilitative experience since they have the opportunity to make use of these clinical services as needed by including additional members of the rehabilitation team.

All six national rehabilitation events continue to target underserved Veteran populations, including underserved genders, races, disabilities, and geographic locations. Increased outreach and marketing efforts to reflect the diverse population has been effective. Outreach efforts will continue to reach these Veterans to include focus groups, forums and other engagements tailored

to gain feedback on program improvement and then implementing recommendations into the Veteran experience that is offered.

Leveraging sports of interest when providing rehabilitation has continued to be a priority, evident through the presence and growth of popular sports such as pickleball, especially at the sport competition based national rehabilitation events. Virtual education programs instructing on the rules and equipment, including adaptive equipment, were able to reach hundreds of VA adaptive sports medicine providers to allow them to begin engaging Veterans with this highly desirable sport. Additional hands-on training opportunities were able to focus on skill specific training, furthering the ability of these VA providers to introduce and provide this sport offering to Veterans they work with.

The adaptive sports grant program awarded nearly $16 million through a total of 91 grants to community-based adaptive sports providers in 2023. These record totals reflect a year-after-year trend which has allowed more Veterans to participate in adaptive sports activities. In addition, adaptive sports grantees have offered programming to Veterans in all 50 States, the District of Columbia, and Puerto Rico.

Implementation Plan: NVSPSE will be furthering outreach opportunities for Veterans' experiential learning and life enhancement. Continued evaluation of all programming offered by NVSPSE will focus on the diversity of Veterans served so that we can implement action plans to ensure inclusive programming that reflects the diverse general Veteran population. Continued growth of the sports medicine and multi-disciplinary model utilization at each of the national rehabilitation events will ensure each event is using a team approach to meet the varying needs of the Veterans served at the events.

Budget Request: The 2025 budget request for NVSPSE is $30.5 million. This will allow an increase in customer outreach by 5% above the level achieved in 2024 to improve compliance and satisfaction. NVSPSE has designated $16 million for the Grants for Adaptive Sports Programs for disabled Veterans and disabled members of the Armed Forces, $2 million designated for Veteran monthly assistance allowance for disabled veterans training in Paralympic and Olympic sports program, and $3 million for the six national rehabilitation events.

Neurology Centers of Excellence

Description *(dollars in thousands)*	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations							
Epilepsy Centers of Excellence	$15,093	$23,585	$23,585	$23,871	$23,871	$286	$0
Headache Centers of Excellence	$19,086	$21,476	$15,000	$22,092	$22,092	$7,092	$0
Multiple Sclerosis Centers of Excellence 1/	$4,620	N/A	$4,620	$5,300	$5,300	$680	$0
Parkinson's Disease Research, Education and Clinical Centers 1/	$10,522	N/A	$9,673	$10,200	$10,200	$527	$0
Obligations [Total]	**$49,321**	**$45,061**	**$52,878**	**$61,463**	**$61,463**	**$8,585**	**$0**
Account Category:							
Medical Services 1/	*$49,321*	*$19,983*	*$49,276*	*$57,810*	*$57,810*	*$8,534*	*$0*
Medical Support & Compliance 1/	*$0*	*$3,602*	*$3,602*	*$3,653*	*$3,653*	*$51*	*$0*
Medical Facilities 1/	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
Medical Care Total	*$49,321*	*$45,061*	*$52,878*	*$61,463*	*$61,463*	*$8,585*	*$0*

1/Details not displayed in the 2024 Congressional Justification

VA has four Centers of Excellence (CoEs) established by Congressional legislation, whose missions are to improve the health and well-being of Veterans with neurologic diseases through the integration of clinical care, education, and research.

Epilepsy Centers of Excellence

Authority for Action: P.L. 110-387 §404

Purpose: The Epilepsy Centers of Excellence (ECoE) were established to improve the health and well-being of Veterans with epilepsy and other seizure disorders through integration of clinical care, outreach, research, and education. The ECoE network comprises four regional centers and 19 VA Hospitals. The ECoE provides comprehensive epilepsy care for Veterans with seizure disorders, including those with post traumatic epilepsy. In 2023, the ECOE system of care developed designations clarifying the types of seizure care offered at individual VA Hospitals within the ECOE network, as well as expectations for outreach, and goals for participation in education and/or research. This comprehensive national system of care emphasizes interfacility care and staffing models for effective budget execution along with national collaborative work through our newly implemented governance structure.

There is an acute need to expand access to specialized epilepsy care to reach the over 438,000 Veterans with definite/probable epilepsy or seizures who received care in VA in 2023. This expansion includes electroencephalogram (EEG) testing, which is the gold standard test for diagnosing and treating epilepsy. Currently, VA access to EEG testing is insufficient. There are less than 90 functioning EEG labs nationally of which only 20 offer continuous EEG monitoring needed to establish most epilepsy and psychogenic nonepileptic seizures (PNES) diagnoses (Salinsky, et al., 2018). The 2025 budget supports the expansion of the current ECoE Tele-EEG and Tele-Epilepsy programs to extend the reach of expert VA epileptologists, neurologists who specialize in the treatment of epilepsy, to underserved areas and to medical centers with limited/no capacity to evaluate veterans with epilepsy in a timely and equitable manner. Improving access will improve quality of care, reduce discontinuity of care and improve the veteran experience. Furthermore, these programs will serve to equitably promote epilepsy subspecialty care for Veterans with PNES and DRE.

Evidence: The 2012 Institute of Medicine (IOM) report, *Epilepsy Across the Spectrum: Promoting Health and Understanding*, recommended the creation of criteria and a process of accreditation for epilepsy centers. The new VA Hospital Epilepsy Center designations, to be implemented starting in 2024, are in line with IOM's recommendations and the guidelines for specialized epilepsy centers published in the article ."*Essential services, personnel, and facilities in specialized epilepsy centers—Revised 2010 guidelines"* (Labiner, et al., 2010). Furthermore, many Veterans live in rural areas, far from VA Hospitals that provide specialized epilepsy care. Community neurology care is limited in these areas, and subspecialty epilepsy care is virtually non-existent. As a result, numerous Veterans with epileptic and non-epileptic seizures may remain undiagnosed or misdiagnosed. Mortality rates are significantly higher in Veterans with DRE compared to the general population. Better utilization of comprehensive epilepsy care, diagnostic services, and medications are each associated with reduced mortality (Haneef, et al., 2022). Lack of timely correct diagnosis leads to treatment delays, unnecessary morbidity, and increased costs due to frequent emergency department visits and hospital admissions. Time to diagnosis of PNES in Veterans was noted to be five times longer than that of civilians in one study (Salinsky, et al., 2011). Seizures dramatically impair Veteran quality of life (e.g., those with inadequately treated seizures often cannot drive or work). Consequently, the suicide rate in Veterans with seizures is double that of other Veterans - an already high-risk population (Bornovski, et al., 2021).

As a compound effect to rural need, there is a shortage of epileptologists nationally that maintain the qualifications to read and interpret EEG studies. The National Tele-EEG and Epilepsy Program (NTEEG-EP) provides the framework to regional and local VA hospitals that cannot recruit or retain this critical position by remotely reading, interpreting, and reporting the findings back to the patient's home station as well as providing expert epileptologists to consult and refer for follow-up consultation via telehealth infrastructure. The program ensures that all Veterans, regardless of their physical location, have access to diagnostic testing and field-leading experts in epilepsy care.

The ECoE can deploy epilepsy care to any Veteran via telehealth. Despite rapid expansion during the COVID-19 pandemic, access and connectivity to epilepsy specialists remains insufficient to meet needs of Veterans with seizures. This shortage has led to increased community care referrals and discontinuity of VA epilepsy care. Community care costs for hospitalizations including inpatient EEG services averaged approximately $30,000 per Veteran between FYs 2020 to 2023 for nearly 60,000 Veterans. (Source: Advanced Medical Cost Management Solution/AMCMS). Repatriating 1% to 10% of these hospitalizations by offering tele-EEG services would account for $10 to $100 million dollars annually. Utilizing tele-EEG networks would allow EEGs to be performed in remote VA hospitals or clinics and be interpreted by remote epilepsy subspecialists, deferring these costs and keeping care in the VA.

Delays in scheduling community care EEG studies, lack of raw data for review and delays returning reports to VA providers contribute to fragmented care for Veterans with epilepsy who get EEG studies via community care. Community care EEGs are often interpreted by neurologists without specialized EEG training and thus, results in lower quality studies as compared to studies interpreted by ECoE and NTEEG-EP providers. The fragmentation and lower quality of community care EEGs mean that fewer Veterans with drug resistant epilepsy get the specialized evaluations they need, such as those provided by ECoE. The expansion and optimization of

telehealth and Tele-EEG networks will improve quality of epilepsy care by expediting diagnosis and targeted treatments, reducing Veteran wait times/travel distances, and decreasing reliance on community care referrals.

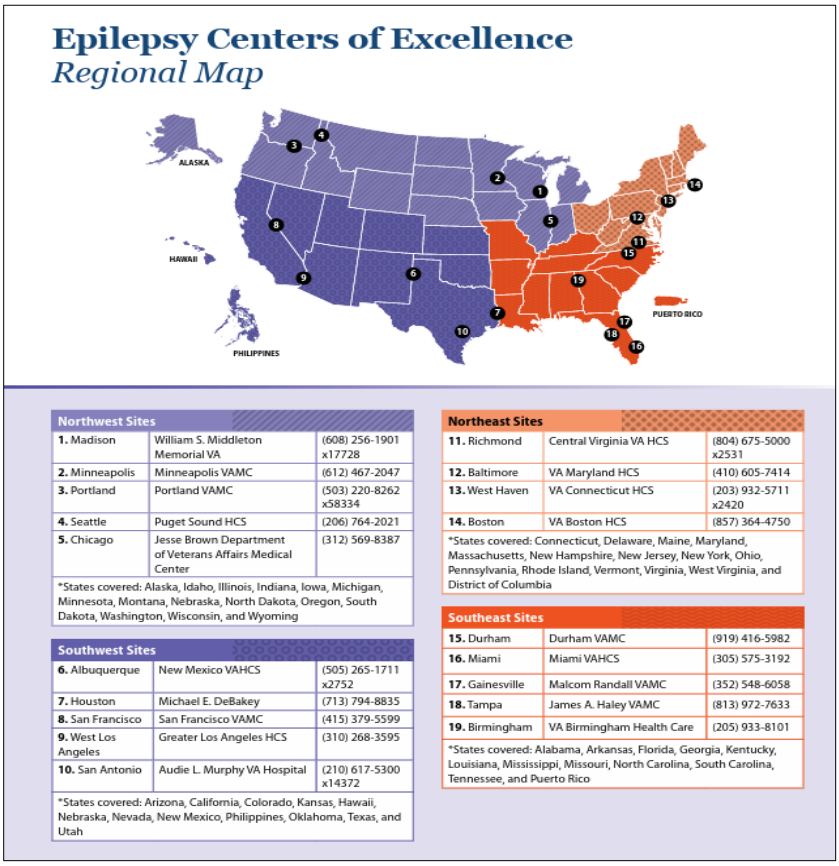
Implementation Plan: The program is currently supporting eight hubs and 24 active spoke sites. The program has almost doubled in its National Tele-EEG volume completing 93.2% more encounters in 2023 compared to the previous year. Initial projected expansion included addition of two hubs per year. NTEEG-EP received National Telehealth Hub designation in 2024 allowing both faster network expansion with consolidation of resources. This includes completion of technical EEG infrastructure and central EEG reader and monitor pools. Tele-Epilepsy clinics started in 2024 and will continue to expand to support all ECOE regions. Currently there are 25 credentialed VA Epilepsy staff supporting this effort. The 2025 Budget supports expansion of the National Tele-EEG and Epilepsy program in two phases:

- Phase 1 FY 2022 through 2025: Expansion of Store and Forward Network including administrative, clinical, and technical infrastructures.
- Phase 2 FY 2024 through 2026: Transition of Hub-Spoke to centralized National Tele-EEG and Epilepsy network. Starting Synchronous Tele-EEG support of Epilepsy Monitoring Units (EMUs) beginning in FY 2024-2025 followed by ICU/Critical Care in FYs 2025 and 2026. Start of National Tele-Epilepsy Clinics.
- Key components of the Tele-EEG/Tele-Epilepsy expansion will include:
    - Development of a Tele-Epilepsy team to complete virtual seizure evaluations nationwide. Started in NE Region with planned expansion to all ECOE regions in FYs 2024 through 2025.
    - Further development and expansion of VA central Reader Pool of epileptologists to interpret EEGs, as well as continuous EEGs to support critical care provided in VA intensive care units and emergency departments (EDs). Most of this pool of epileptologists will come from existing ECoE staff epileptologists.
    - Further development and expansion of VA Home EEG Community Care support. NTEEG-EP contracts with Stratus and Neurotech Vendors allowing interpretations and professional workload component to be completed by VA epileptologists. These vendors provide service in areas remote from all Tele-EEG connections, or in sites lacking EEG technologists. In the first half of 2024, the Tele-EEG program has pulled back the professional portion of over 90 community care studies, which expedites the continuity of care for Veterans to receive their next step in clinical care by VHA systems.
    - Development and maintenance of Tele-EEG servers or virtual storage for new Hubs and provision of EEG equipment for select new connections.
    - Development and maintenance of National EEG Repository and Synchronous Tele-EEG network by 2025. This includes creation of four National VA Servers connecting all VA recording sites.
    - Rapid EEG Technology: ECoE Pilots with Ceribell, Zeto, and Corticare are ongoing. These studies will be completed by the staff that are budged through the National Tele-

EEG Reading pool. New partnership with SimVet has produced solution to FEDRAMP problem (Ceribell). This will allow Ceribell EEG data access by VA EEG reader pool and is expected to go live by 2025.

- Implementation of VA Hospital Epilepsy Center designations beginning in 2024 through 2028. There will be a two-year transition period for existing sites to ensure infrastructure is in place for their designated level.

Figure 1 – Epilepsy Centers of Excellence, Regional Map



Northwest Sites

1. Madison	William S. Middleton Memorial VA	(608) 256-1901 x17728
2. Minneapolis	Minneapolis VAMC	(612) 467-2047
3. Portland	Portland VAMC	(503) 220-8262 x58334
4. Seattle	Puget Sound HCS	(206) 764-2021
5. Chicago	Jesse Brown Department of Veterans Affairs Medical Center	(312) 569-8387

*States covered: Alaska, Idaho, Illinois, Indiana, Iowa, Michigan, Minnesota, Montana, Nebraska, North Dakota, Oregon, South Dakota, Washington, Wisconsin, and Wyoming

Southwest Sites

6. Albuquerque	New Mexico VAHCS	(505) 265-1711 x2752
7. Houston	Michael E. DeBakey	(713) 794-8835
8. San Francisco	San Francisco VAMC	(415) 379-5599
9. West Los Angeles	Greater Los Angeles HCS	(310) 268-3595
10. San Antonio	Audie L. Murphy VA Hospital	(210) 617-5300 x14372

*States covered: Arizona, California, Colorado, Kansas, Hawaii, Nebraska, Nevada, New Mexico, Philippines, Oklahoma, Texas, and Utah

Northeast Sites

11. Richmond	Central Virginia VA HCS	(804) 675-5000 x2531
12. Baltimore	VA Maryland HCS	(410) 605-7414
13. West Haven	VA Connecticut HCS	(203) 932-5711 x2420
14. Boston	VA Boston HCS	(857) 364-4750

*States covered: Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, and District of Columbia

Southeast Sites

15. Durham	Durham VAMC	(919) 416-5982
16. Miami	Miami VAHCS	(305) 575-3192
17. Gainesville	Malcom Randall VAMC	(352) 548-6058
18. Tampa	James A. Haley VAMC	(813) 972-7633
19. Birmingham	VA Birmingham Health Care	(205) 933-8101

*States covered: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, Missouri, North Carolina, South Carolina, Tennessee, and Puerto Rico

Program implementation is feasible as demonstrated by a pilot program beginning in 2011 involving three Tele-EEG hubs (Boston, Portland, and Durham). Currently, there are eight active hubs supporting 24 active spoke sites (see Figure 1 above). An additional 15 spoke connections are in progress. Expansion will support no more than two Hubs per year on a more selective basis with an emphasis on centralizing resources. This current network supports only store-and-forward EEG for both outpatients and inpatients. The continuous (real-time synchronous) Tele-EEG monitoring to support VA critical care is feasible but requires additional staffing and connections. This will integrate with current Tele-Critical Care Program. One barrier is the challenge to recruit and retain EEG technologists, particularly in rural areas, which VHA will address using available tools.

Budget Request: The 2025 budget request for the ECOE is $23.9 million, a $286,000 increase above the 2024 request. The expansion from 8 hubs to between 10 and 12 hubs by 2026 will include new FTE, equipment, and infrastructure support. The 2025 requests reflect the resources

necessary to maintain operation of the existing ECOEs as well as: expand the staffing model for epilepsy VA Hospital designations through recruitment and retention efforts; further expand Store and Forward EEG; and offer 24/7 Tele-EEG support for all VA sites and support synchronous Tele-EEG. The increased budget will also support new FTE needed to facilitate the expansion of Store and Forward EEG and 24/7 Tele-EEG support. The budget request will also support the necessary site visits, program evaluations, and outreach needed as the ECOE program expands. The budget also supports planned integration of Rapid EEG (FY 2025) and further development of Home EEG Community Care partnerships and VA-DOD Tele-EEG collaborations.

Headache Disorders Centers of Excellence

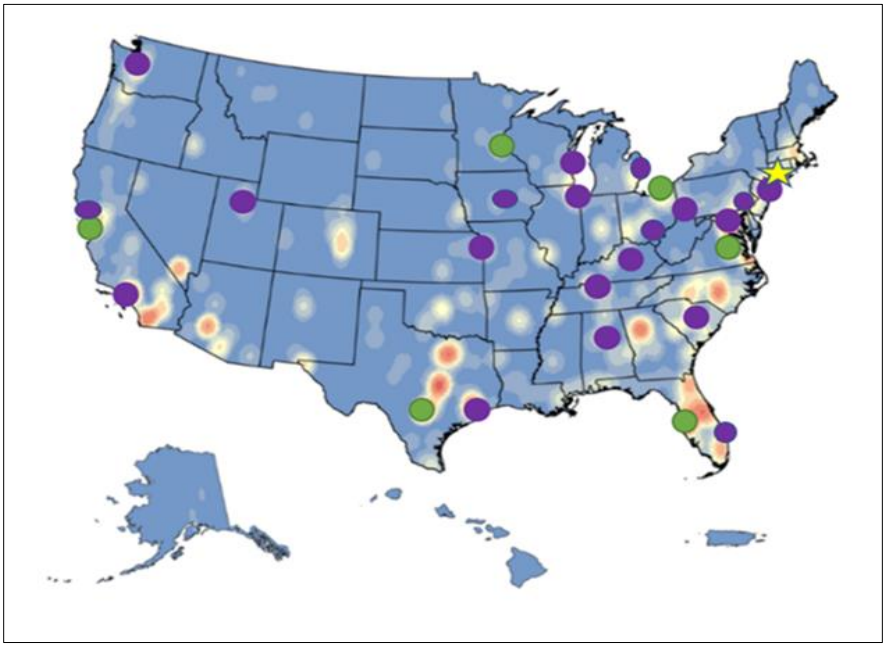
Authority for Action:

- P.L. 115-141, *Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2018* (Senate Report 115-130)
- P.L. 117-103, *Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2022 (*Joint Explanatory Statement – Division J)

Purpose: In 2018, VA was directed create a Headache Centers of Excellence (HCoE) national program to treat the pain and comorbidities common among Veterans with chronic and refractory headache associated with traumatic brain injury (TBI), chronic migraine and other disabling headache diseases. HCoEs provide access to team-based care and evidence-based therapies for headache, including pharmacotherapies, injections and infusions, and non-pharmacological options such as cognitive behavioral therapy, physical and rehabilitation modalities, and neuro-modulatory devices. The HCoE program developed interdisciplinary staffing models for headache centers, provided educational initiatives to clinicians, Veterans, and families and conducted clinical epidemiological work to understand impact of headache on Veterans and the health care system. In 2022, VA was directed to expand the HCoE program to at least 28 sites, ensure the successful recruitment and retention of healthcare providers with specialty training in headache medicine and to report on whether an association exists between open burn pit exposure and headaches.

A total of 21 HCoE sites, including 7 HCoE hub sites and 14 HCoE consortium (now referred to as "associated" sites) were established between 2018 and 2022 (Figure 2 below). This expansion allowed for at least one HCoE program located within each Veterans Integrated Service Network (VISN). In 2024, an additional seven HCoE sites will be added to the network and each of the existing HCoE associated sites will receive additional resources. This combination of expanding the total number of HCoE sites to 28 and expanding resources within all HCoE associated sites is intended to move the HCoE national program from a hub and associated site system towards a hub and spoke system, where all HCoEs are hub sites, and spokes sites refer patients to their HCoE hub.

Figure 2 – Headache Centers of Excellence, Regional Map



Expansion of the HCoE program will enhance access to interdisciplinary headache care, especially for Veterans with headaches related to military exposures and the most refractory types of headaches. The HCoE Research, Education, Evaluation, Engagement Center for Headache (RE3ACH) developed data analytic capacities to monitor and evaluate headache care and conduct an annual Veteran satisfaction survey related to headache care within VA, monitor the impact of the HCoE initiative on Care in the Community referrals for headache, and serve as the coordinating center for provider and Veteran headache educational programs. Furthermore, the RE3ACH has been investigating associations between burn pit exposure and headache, suicide and specific headache conditions, the use of pharmacological and non-pharmacological therapies (including Whole Health modalities), and the impact of the COVID-19 pandemic on headache rates and headache healthcare utilization within the HCoEs and throughout VHA.

Evidence: Between 2008 and 2023, VA provided over 10 million clinical encounters for headache care to nearly 2 million Veterans (Sico J.J., Fenton B.T., 2024). Approximately 25% of Veterans receiving headache care within VHA served in military campaigns during the Post-9/11 Global War on Terror, resulting in a notable increase in headache care utilization. In 2009, 206,000 Veterans received at least one visit for headache care; in 2022, over 459,000 Veterans received headache care, representing a more than 122% increase in the use of VHA medical care for headache management. The link between headache and TBI, especially mild TBI, is well established. 90% of Veterans experience headache after a TBI, with 50% continuing to have headaches more than a year after injury. 22% of Veterans who were exposed to open burn pits reported developing severe headaches/migraine compared to 12% of Veterans with no open burn pit exposure, according to data from the VA Airborne Hazards and Open Burn Pit Registry (AHOBPR).

In considering the current state of headache care within VA:

- Between 2009 and September 2023, use of VA for headache care has increased by 148%.
- Between 2008 and 2019, more than 20% of Veterans with a headache diagnosis accessed VA Emergency Department services for headache pain treatment (Sico, et al., 2022).
- Of Veterans living with headache disorders and receiving their care within VA, nearly 10% are Hispanic, 25% are African American, 27% are women, and nearly 30% live in a rural or highly rural areas (Sico, et al., 2022; Seng, et al., 2022).
- 66% of Veterans receiving headache care were provided the most generic headache diagnosis - Headache NOS (not otherwise specified; not otherwise specified; Sico, et al., 2022).
- Veterans with post-traumatic headache (i.e., headache attributable to TBI) have a 56% higher likelihood of having suicidal ideation or suicide attempts compared to similar Veterans (Androulakis, et al., 2021; Coffman, et al., 2022).
- The number of United Council for Neurological Subspecialty Headache Medicine-certified providers within the HCoEs increased from 1 to 19 since 2018.
- Less than 25% of Veterans receiving headache care saw a provider with headache medicine specialty training.
- Veterans receiving their headache care within VAMCs with HCoEs reported being 30% more satisfied overall with their headache care, 38% more satisfied with their headache provider and 43% more satisfied with headache care access compared to Veterans receiving their headache care within VAMCs which do not host an HCoE.
- Veterans have consistently expressed a strong preference for Whole Health as part of their headache treatment plan (Kuruvilla, et al., 2022; Lindsey, et al., 2023); since 2018, the use of Whole Health among Veterans living with headache has increased by 159%.
- Telehealth utilization for headache has increased dramatically from pre-pandemic times. Veterans have expressed a desire to continue with telehealth services for headache (Grinberg, et al., 2022); within HCoEs, 30% of all clinical encounters related to headache care were conducted via telehealth.
- To update VA and Department of Defense (DoD) providers caring for those with headache, the HCoE significantly contributed to the 2nd VA/DoD Headache CPG (Department of Veterans Affairs/Department of Defense, 2023).

Data are emerging regarding associations between open burn pit exposure, Agent Orange Exposure, and headache. In considering military exposures included in the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act of 2022):

- AHOBPR data indicates a higher rate of self-reported severe headaches/migraines among those with a greater degree of open burn pit exposure; however, there are no scientific studies to validate this potential association including those reviewed within the Long-Term Health Consequences of Exposures to Burn Pits in Iraq and Afghanistan 2011 report

by the Institute of Medicine (IOM). To address this gap, the HCOE RE3ACH used the AHOBPR to compare headache between Veterans with and without burn pit exposure. After adjusting for age, gender, race/ethnicity, branch of service and TBI history, compared to those who did not live near burn pits and had no duties associated with burn pit:

  - Compared to those with neither exposure, Veterans living near burn pits and having burn pit duties during deployment was associated with being:
    - 59% more likely to be diagnosed by a healthcare provider with a headache condition and,
    - 118% more likely to have persistent headache (i.e., diagnosed by a Department of Defense provider with new onset headache and subsequently seen by VHA for continued headache)
  - Compared to those with neither exposure, Veterans living near burn pits and <u>not</u> having burn pit duties during deployment was associated with being:
    - 14% more likely to be diagnosed by a healthcare provider with a headache condition.
    - 27% more likely to have persistent headache.

- Data from the VA Million Veteran Program (MVP) examined potential associations between military exposures and migraine, and reported that Veterans who had:
  - Agent Orange exposure are 60% more likely to have migraine compared to those not exposure to Agent Orange.
  - Chemical or biological warfare are 119% more likely to have migraine compared to those without this exposure.
  - Received the anthrax vaccine were 50% more likely to have migraine. and,
  - Taken anti-nerve agent pills were 114% more likely to have migraine.

Headache is <u>not</u> currently a presumptive service-connected condition for any military exposure noted in the PACT Act**.**

Implementation Plan: The HCoE program will expand through enhanced staffing of all existing sites to provide comprehensive, interdisciplinary headache clinical care and adding nine new HCoE sites. HCoE sites would realign in a hub (a VAMC with an HCoE) and spoke (a VAMC without an HCoE) model for headache care to facilitate referrals of Veterans with complex headache to an HCoE. All hub sites (28 in total) will develop a spoke linkage to VAMCs within their VISN to provide virtual care and create referral pathways to these centers. The greatest density of Veterans living with headache disease are found within the following VISNs, which are underrepresented within the HCoE program and have experienced the greatest growth in the use of VHA for headache care. To address this gap, the HCoE program distributed a Request for Program (RFP) process, targeting expansion of the HCoEs, especially within the following VISNs:

- VISN 7 – 184% increase from 2008 to 2023 (Columbia, South Carolina and Birmingham, Alabama both have a HCoE; Georgia does not have a HCoE).
- VISN 8 – 172% increase from 2008 to 2023 (Tampa, Florida has the only VISN 8 HCoE; Puerto Rico does not have an HCoE).
- VISN 10 – 98% increase from 2008 to 2023 (Cleveland, Ohio has the only VISN 10 HCoE; neither Indiana nor Michigan have a HCoE).
- VISN 16 – 125% increase from 2008 to 2023 (Houston, Texas has the only VISN 16 HCoE).
- VISN 17 – 281% increase from 2008 to 2023 (San Antonio, Texas has the only VISN 17 HCoE).
- VISN 21 – 156% increase from 2008 to 2023 (Nevada does not have an HCoE), and,
- VISN 22 – 179% increase from 2008 to 2023 (no HCoE in Arizona or New Mexico).

Through a competitive Request for Program (RFP) process, all VAMCs were invited to apply to become an HCoE. The 7 newly named HCoEs include the following (by VISN):

- VISN 4 – Corporal Michael J. Crescenz VAMC (Philadelphia, Pennsylvania),
- VISN 5 – Baltimore VAMC, VA Maryland Health Care System (Baltimore, Maryland),
- VISN 8 – Miami VA Healthcare System (Miami, Florida),
- VISN 10 – John D. Dingell VAMC (Detroit, Michigan) and Cincinnati VAMC (Cincinnati, Ohio),
- VISN 21 – San Francisco VA Health Care System (San Francisco, California), and,
- VISN 23 – Iowa City VA Health Care System (Iowa City, IA)

The HCoE expansion initiative is ready to implement due to the development of HCoE staffing models and dedicated national program funding. The national program funding is expected to be ongoing to support the regional nature of care provided by an HCoE site; however, some of the FTE costs are supported by the host medical facility demonstrating the shared responsibility of this initiative. Success of the HCoE is measured based on number of encounters, unique patients seen, patients seen within 14-days, percentage decrease in facility-level headache NOS diagnoses given, percentage decrease in the use of Emergency Department for headache care.

Budget Request: The 2025 budget for HCoE is $22.1 million, a +$7.1 million increase above 2024. The request reflects the resources – FTE, training, equipment, and supplies – required to maintain operation of existing HCoE sites, the expansion of the HCoE program to 28 sites based on implementation of an interdisciplinary HCoE Staffing Model (Goldman, et al., 2022), the continued increase of VHA facilities being used for headache, likely increased use of VHA given the findings of headache being associated with open burn pit exposure, Agent Orange, and other military exposures, and the national HCoE program office.

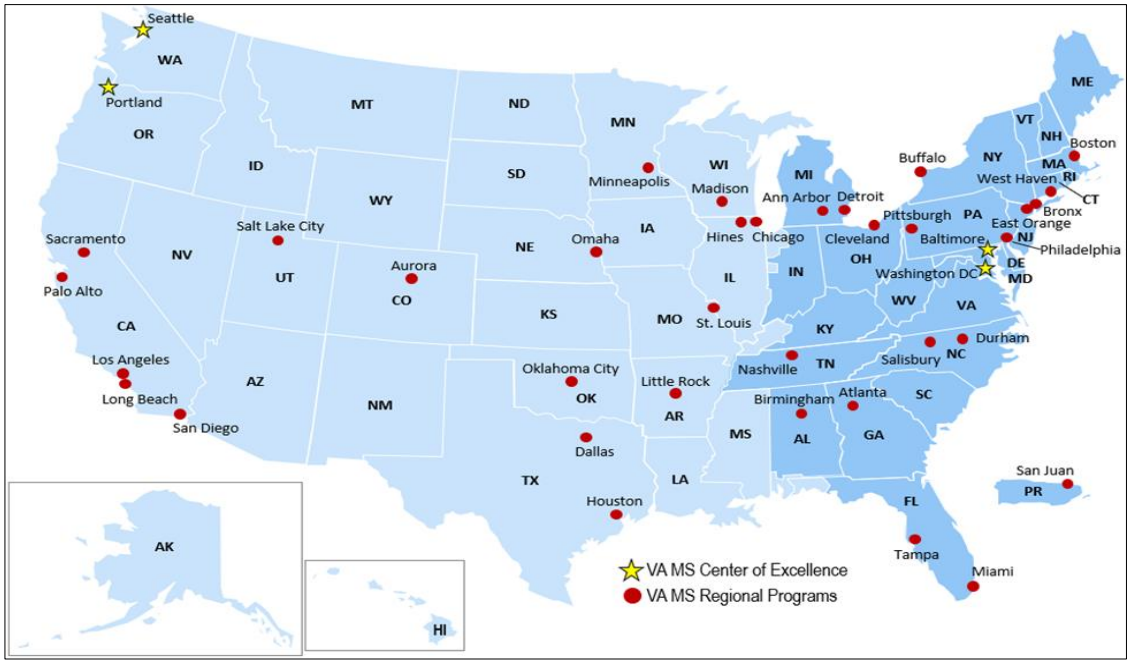
Multiple Sclerosis Centers of Excellence (MSCOE)

Authority for Action: P.L. 109-461 §209

Purpose: Established in 2003, the VA Multiple Sclerosis Centers of Excellence (MSCOEs) serve Veterans living with Multiple Sclerosis (MS), their families, and care partners by ensuring access and excellence in clinical care, education, research, and partnerships. There are two MSCOEs within VA Medical Centers (VAMCs): MSCOE East located in Baltimore, Maryland and Washington, DC serving Veteran Integrated Service Networks (VISN)s 1 to 10, and MSCOE West located in Seattle, Washington and Portland, Oregon serving VISNs 12 to 23 (Figure 3 below). These MSCOEs serve as coordinating sites across the Veterans Health Administration (VHA) were made permanent by the Veteran's Benefit Act of 2006 to serve Veterans with this disabling and often service-connected condition.

MSCOEs serve as a resource supporting 35 VAMCs to optimize the care of Veterans with MS across the nation within their home VAMCs. By partnering with Veterans, care partners, health care professionals, and other affiliates MSCOEs optimize health, activity, participation and quality of life for Veterans with MS. MSCOE missions span clinical care, education, research and informatics.

Figure 3 – Multiple Sclerosis Centers of Excellence, Regional Map



In July 2023, VHA Directive 1101.06 "Multiple Sclerosis System of Care" was recertified. It requires each of the 18 VISNs to establish at least one VA MS Regional Specialty Program (RSP) to deliver high-quality and multidisciplinary MS care. The MS RSPs will be integrated with the MSCOEs to create a hub and spoke system of care linking all VAMCs across the VHA enterprise.

Multiple sclerosis (MS) is a chronic, complex and costly disease, requiring expertise to diagnose and manage its symptoms and complications across the lifespan. MS is an inflammatory and

degenerative disease of the central nervous system with a mean age of 30 years at diagnosis and affecting nearly one million persons in the US in 2017. The condition often impacts vision, cognition, motor power, coordination and leads to impaired mobility and wheelchair dependence. MS is the most common progressive neurological condition of young adults and a common reason for discharge from the military and for service-connected disability. Veterans with MS are at risk for severe MS due to comorbid PTSD, smoking, obesity, low Vitamin D, and comorbid cardiovascular, pulmonary, and endocrine conditions.

MS is a costly chronic disease, with direct costs of prescription drugs and indirect productivity loss being important drivers. A recent study funded by the National MS Society assessed the economic burden of MS in the US during 2019 to be $85.4 billion, with a direct medical cost of $63.3 billion and indirect and nonmedical costs of $22.1 billion. Active management by MS specialists drives drug utilization toward better efficacy therapies with system-wide cost savings. MSCOE has the ability to optimize health outcomes and reduce MS health-care expenditures through its proposed expansion (see below).

Population Covered: From fiscal years (FYs) 1998 to 2023, VHA served more than 60,000 unique Veterans with MS with 20,000 actively utilizing VHA for MS care each year. MS incidence rates among the military population are among the highest in North America, particularly among Army, Navy, and Air Force branches. The numbers entering the VA Healthcare system are rising. The number of new cases (incidence per year) of MS in the military population is 10 per 100,0000. Blacks have the highest rates (12), followed by Whites (9), Hispanics (8), Asian American/Pacific Islanders (3) and Native Americans (3 The prevalence for MS in the Veteran population is also high at 178 per 100,000 population, with estimates of 384 for women and 154 for men per 100,000 population. This compares with 312 for women and 99 for men per 100,000 in the national Optum private insurance population (Wallin et al. (2019). MSCOE expects the PACT Act alone to result in an additional 600 new Veterans with MS entering VHA each year, driving the need for expansion of MS subspecialty services.

Critically, 50% of Veterans with MS live in rural areas with limited access to MS care. In 2022 driving distance to the closest MS RSP was 200 miles or more for half the VA MS population. To fill this geographic gap, the MSCOE system of care aims to expand telehealth permitting Veterans to equitably access MS specialty care regardless of location.

Types of Services Provided: The MSCOEs act as resources for the MS System of Care supporting all VAMCs in the four key MSCOE core functions of clinical care, education, research, and informatics.

- Clinical Care: MSCOEs serve as models of ideal MS interdisciplinary care. MSCOEs are tertiary referral centers providing advice on the most complex cases through interfacility consults and telehealth. MSCOE also serve as MS subject matter experts for VHA, including working closely with VA Pharmacy Benefits Management to increase access the rapidly expanding number of disease-modifying therapies on the market.
- Education Core informs clinicians, Veterans, families, and caregivers about the latest understanding of MS, its causes, and management for personalized MS treatments and symptom management.

- Research is relevant and meaningful to Veterans and their care partners spanning the breadth of basic science, clinical trials, epidemiology, and health systems research. MSCOE fosters interdisciplinary and multi-site research across the Network that inform and optimize the care of Veterans with MS.
- Informatics The Informatics core is fundamental to all MSCOE operations, allowing MSCOE to "know" Veterans with MS: to identify areas of clinical success and unmet need, to supply data for research questions, to track Veteran experience, and to facilitate insights into health care delivery and future needs.

Recent Trends: Recent accomplishments highlight the value of MSCoE:

Delivery of High-Quality MS Clinical Care:

- MSCOE Clinical Core sets national clinical standards in VA clinical documentation requiring accurate diagnosis, coding, and consideration of MS therapy. *The Clinical Core is developing templates for CPRS and Cerner to facilitate implementation of these national standards.*
- MSCOE set the VHA standard for magnetic resonance imaging (MRI) protocols for Veterans with MS. Consistent acquisition is imperative for accurate diagnosis and monitoring of MS, and comparison across facilities.
- MSCOE and VA Pharmacy Benefits Management created a disease-modifying therapy (DMT) selection and switching guidance document based on the latest clinical evidence. *MSCOE Research and Informatics Cores will evaluate the health and cost-benefits of the guidance.*
- MSCOE sets standards for telehealth utilization to provide access to MS specialty care. *Expansion of MS telehealth is the primary focus of MSCOE expansion and request inclusion in the 2025 budget.*

Educating Veterans, Care Partners, and Clinicians

- 2023 Education Core products include Veteran e-letters, Provider e-letters, provider webinars, and virtual conferences internally and with partner organizations. MSCOE trains VA advanced fellows in MS, maintains an active MSCoE.gov website, and presents at national and international academic conferences.

Veteran-Focused Research:

- MSCOE led a multi-site VA-funded study of the antioxidant lipoic acid which concluded in December 2023. Results will be published in 2024.
- MSCOE, participating in a Department of Defense multi-site clinical trial of an online intervention to combat MS fatigue, will enroll 500 Veterans with MS.
- A Delphi panel of MS providers, researchers, and Veteran stakeholders identified and prioritized MS research topics to drive Veteran-focused MS research.

Informatics Drives High-Quality Care:

- MSCOE discovered that Veterans with MS used telemedicine twice as often as Veterans without MS. *Providing rural Veterans **access** to MS specialty care through expansion of telemedicine is a focus of MSCOE proposed expansion.*

Leadership Oversight:

- MSCOE Directors contributed their expertise to recertification of VHA Directive 1101.06 "Multiple Sclerosis System of Care" published July 2023. This Directive defines the interdisciplinary team care at Regional Specialty Programs (RSPs) and expectations for ongoing education, communication, and oversight. *Time-limited financial support of MS RSPs as outlined in Projections will fulfill the requirements of the new Directive.*

Selected special 2023 project funding accomplishments:

- Veteran MS Community Care and Care Quality project: This project compared MS care quality between VHA and Community Care and used mapping to identify "hot spots" of unmet MS service needs. Veterans receive better MS care in VHA than in the community. *This study encourages expansion of VHA's MS System of Care to rural and underserved Veterans for **access** to care.*
- A medication utilization study found that the VA utilization patterns are more in line with current MS prescribing guidelines and make greater use of generic and biosimilar therapies. *Expansion of access for Veterans with MS to VA MS providers will better serve their MS needs.*

Special project funding distributed to the MSCoE Network accomplished:

- Identified Veterans receiving MS prescriptions and infusions in the community to bring back to VA care with a projected cost avoidance of >$600,000.
- Initiated the MS 344 Stop Code and entered Veterans into the MS Registry
- Supported dedicated time for the MS Coordinator to streamline infusion process, develop and implement a DMT safety monitoring project, develop a triage process to schedule multi-disciplinary care, and stand-up caregiver support groups.
- Supported MS provider time while increasing unique Veteran encounters.
- Purchased clinical testing materials to monitor Veterans with MS in the clinic.
- Supported time for MS clinicians to attend MS-related educational meetings.

Projections for the future: The MSCoE Coordinating Centers currently serve as ideal models of high-quality, multi-disciplinary, and stepped MS care delivery. MSCoE supported by VHA Directive 1101.06 will expand this same quality care to all Veterans with MS wherever they live. These new initiatives include:

1. MSCoE will deliver time-limited financial support to six Regional Programs per year to establish a total of 18 RSPs (one per VISN) over the course of three years.
2. MSCoE will establish new RSPs in areas of MS care access need.
3. MSCoE proposes incremental growth at the national level to fill vacant roles and to administratively support the RSP expansion.

Budget Request: The 2025 budget is $5.3 million, a $0.7 million increase above 2024.

Parkinson's Disease Research, Education and Clinical Centers (PADRECCs)

Authority for Action: P.L. 109-461 §209

Population Covered: According to a recent report from the Strategic Policy Evidence-based Evaluation Center (SALIENT) Quality Enhancement Research Initiative (QUERI) report (PADRECC Evaluation 2023), there were 84,644 Veterans with Parkinson's disease (PD) in the VA system in 2022, although the total number of Veterans with PD nationwide has been estimated at over 110,000. Of the Veterans identified in the SALIENT report, 58% had no Neurology/PD Specialty Care in the VA or paid for via community care. This suggests an enormous number of Veterans with PD who are not getting specialized care. In addition, the shifting demographics of the adult population place more individuals at risk for PD than ever before. A recent study revealed that at least 90,000 people are diagnosed with Parkinson's disease in the U.S. each year (Willis, et al. 2022), a 50% increase from prior annual estimates. In addition, there are multiple known and emerging military service risk factors for parkinsonism and PD, including exposure to herbicides (Ball, et al. 2019; Yi, et al. 2014), trichloroethylene (Goldman, et al. 2023), and traumatic brain injury (Gardner, et al. 2018). These service-related factors have been posited to account for up to 30% of PD cases in male servicemen (Payami, et al. 2019).

Types of Services Provided: VA supports six Parkinson's Disease Research, Education, and Clinical Centers (PADRECCs), located at the Philadelphia, Richmond, Houston, West Los Angeles, San Francisco, and Portland/Seattle VA medical centers. These Centers are not only charged with developing research programs related to PD and movement disorders including the implementation of a large-scale cooperative study of deep brain stimulation (DBS, a device-based neuromodulation treatment necessitating neurological and neurosurgical expertise), but most importantly, wide scale delivery of modern PD care as well as national education and outreach for this frequently service-connected condition. The PADRECC's mission is threefold: 1) provide comprehensive, state-of-the-art care to Veterans with PD/RD and support to their caregivers; 2) pursue research leading to improved treatment and a cure; 3) conduct outreach education programs for clinicians, Veterans, and their families. Following the original intent of the PADRECC program, Veterans continue to travel throughout the country to receive expert care and DBS as appropriate.

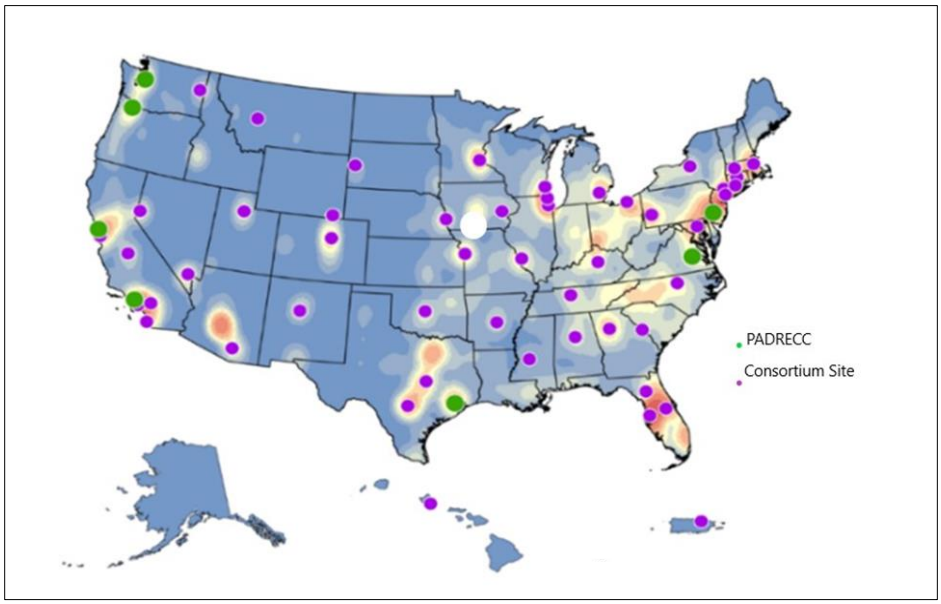
The PADRECCs have also provided countless educational programs for clinicians, Veterans, and their caregivers. In 2023, these included presentations at 38 VA support group meetings, 21 community support group meetings and 13 community patient programs. The PADRECCs also held 17 patient education programs. For healthcare providers in 2023, the PADRECCs gave 166 lectures at local, regional, national, and international conferences and symposia, trained 21 Movement Disorder Fellows, and provided clinical rotations for 165 residents, 165 medical students and 25 allied health fellows (geriatrics, psychiatry, pharmacy, etc.).

PADRECC's groundbreaking research continues to be published in scholarly journals. Through these efforts, the VA has been internationally recognized as a principal player in the field of movement disorders and has joined forces with other key organizations such as the Department of

Defense, Centers for Disease Control and Prevention, Michael J. Fox Foundation, and the Parkinson's Foundation. In 2023 the PADRECCs had 72 funded research projects (44 clinical, 8 health services, 11 epidemiology and 9 basic science), published 98 articles in scholarly publications, and presented 37 posters at national and international conferences or symposia.

The PADRECCs recognized the physical and financial hardships presented to those Veterans who travel long distances to reach expert care. In response, the PADRECCs established the National VA Parkinson's Disease Consortium Network (now known as the National VA Parkinson's Disease Network) in 2003 to provide education and training in the field of movement disorders for VHA staff, with the expectation of enhancing PD care at the local level. In 2006, the Network was broadened with the creation of the PADRECC Consortium Sites (now known as the PADRECC Associated Sites or PASs), to create a national network of movement disorder clinics that would be affiliated with, and augment the services of, the six PADRECCs. These designated PASs are staffed by fellowship trained movement disorders specialists or neurology clinicians with interest and experience in the field. The purpose of the PASs is to ensure convenient movement disorders specialty care to all veterans, regardless of locality. There are currently 56 PASs with at least one in each VISN.

Figure 4 – PADRECCs Regional Map



The National VA PD Network is a hub and spoke network of care which has been successful over the years. However, the recent SALIENT report identified several areas of high PD prevalence where a PADRECC is not present, specifically in the Midwest and Florida (see Figure 4 above). The report also illustrates the need for additional ancillary services due to the prevalence of motor and non-motor symptoms in Veteran's with PD. In addition, the increased incidence of PD as the Veteran population ages and the inclusion of PD and parkinsonism as presumed service-connected conditions for Veterans exposed to Agent Orange, moderate to severe head injury, or Trichloroethylene exposure at Camp Lejeune further solidifies the need to expand the PADRECC program. Specifically, Veterans in many parts of the country have limited access to movement disorders specialists; to PD-specific rehabilitative services; and to mental health providers trained

in the management of PD-related psychiatric symptoms.

Recent Trends: There has been increasing recognition that PD involves both motor and non-motor symptoms and that the best care requires a multi-disciplinary approach. Motor symptoms include tremor, stiffness, slowness and gait dysfunction. The most common non-motor symptoms in Veterans from the SALIENT report include falls (20.3%) depression (32.8%), PTSD (20.3%), anxiety (20.1%), dementia (31.4%), sleep disorders (40.3%), constipation (25.8%) and dysphasia (17.9%). PADRECCs have established nationally recognized indicators of quality care (Cheng et al. 2004) and have proven that specialist involvement in care and multidisciplinary care improves outcomes (Carne et al. 2005; Cheng et al. 2007). Implementation of this proposal will allow more Veterans to be treated in multidisciplinary clinics providing state-of-the-art care including movement disorder expertise, specialized rehabilitation, and tailored psychiatric interventions, chemodenervation therapy and DBS therapy.

Projections for the future: To increase access to specialized, multidisciplinary care, the PADRECC will:

1. Establish and partially fund one PADRECC in either the Midwest or Florida regions to address gaps identified in access to specialist care and DBS surgery.
2. Contribute subject matter expertise to the recertification of Directive 1420, Parkinson's Disease System of Care, which seeks to establish Regional Parkinson's and Movement Disorders Centers (RPMDCs) in every VISN. The RPMDCs will be staffed by movement disorders fellowship trained neurologists and offer specialized care such as chemodenervation therapy and deep brain stimulation adjustments. The RPMDCs will collaborate with their medical centers to ensure nursing, social work, psychiatry, physical therapy, speech therapy, occupation therapy and a clinical pharmacist is available to provide comprehensive care to Veterans with PD.
3. Explore partnership with the National Tele-Neurology Program to offer expanded telehealth services to Veterans with PD and movement disorders who live in rural areas or areas without a movement disorders specialist.
4. Collaborate with the Office of Rural Health's Parkinson's Disease Cognitive Behavioral Therapy (CBT) project providing therapy for Veterans with PD and depression and the VA Mind Brain Program to train therapists to treat functional movement disorders.

Implementation Plan: VA efforts to enhance and expand Parkinson's disease national system of care plan is as follows:

- Finalize the establishment and partial funding of one additional PADRECC that will be chosen and initiated in 2024.
- Offer development support to the RPMDCs. Explore partnership with National Tele-Neurology Program (NTNP) to expand PD and movement disorders care to Veterans in rural areas.
- Maintain the number of psychologists who are dedicated to the virtual CBT program to provide treatment for Veteran's with PD and depression.
- Working with the Veterans Experience Office, develop a survey targeted to Veterans with

movement disorders utilizing services provided at the PADRECCs, RPMDCs, other VA care and community care.

Budget Request: The PADRECC 2025 budget request is $10.2 million.

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Non-Recurring Maintenance (NRM)

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations - All Other	$2,895,164	$5,750,000	$1,776,831	$2,000,000	$2,000,000	$223,169	$0
P.L. 117-328 § 252 (EO 14507 no-year, 1124) 1/	$0	$0	$75,000	$0	$0	($75,000)	$0
P.L. 117-103 § 253 (Infrastructure no-year)	$20,567	$0	$85,871	$0	$0	($85,871)	$0
P.L. 115-244 § 248 (NRM no-year)	$80,368	$0	$58,366	$0	$0	($58,366)	$0
P.L. 115-141 § 255 (NRM no-year)	$27,652	$0	$3,932	$0	$0	($3,932)	$0
Discretionary Obligations [Subtotal]	**$3,023,751**	**$5,750,000**	**$2,000,000**	**$2,000,000**	**$2,000,000**	**$0**	**$0**
PACT Act, sec. 705	$35,359	$0	$28,415	$27,648	$7,560	($767)	($20,088)
Veterans Medical Care and Health Fund	$187,747	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	($59)	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$223,047**	**$0**	**$28,415**	**$27,648**	**$7,560**	**($767)**	**($20,088)**
Obligations [Total]	**$3,246,798**	**$5,750,000**	**$2,028,415**	**$2,027,648**	**$2,007,560**	**($767)**	**($20,088)**
Non-Add (Included Above):							
Discretionary Obligations - Base NRM	$2,255,411	$5,000,000	$1,500,000	$1,500,000	$1,500,000	$0	$0
Mandatory Obligations - Base NRM	$62,071	$0	$28,415	$27,648	$7,560	($767)	($20,088)
Discretionary Obligations - EHRM NRM	$768,340	$750,000	$500,000	$500,000	$500,000	$0	$0
Mandatory Obligations - EHRM NRM	$160,976	$0	$0	$0	$0	$0	$0
Base NRM/EHRM NRM Obligations [Subtotal]	**$3,246,798**	**$5,750,000**	**$2,028,415**	**$2,027,648**	**$2,007,560**	**($767)**	**($20,088)**

Note: The 2020 NRM actual in the above table includes additional object classes than what is displayed in the Budget Overview chapter's Obligations by Object table, such as Personnel Compensation and benefits, Other Contractual Services, Supplies and Materials and Equipment.

Non-Recurring Maintenance (NRM) funds projects to make additions, alterations and modifications to land, buildings, other structures, nonstructural improvements of land and fixed equipment. NRM can also occur when the equipment is acquired under contract and becomes permanently attached to or part of the building or structure. NRM is utilized to maintain and modernize existing campus facilities, buildings and building systems, replace existing building system components and provide for adequate future functional building system capacity. NRM can also be used for environmental remediation and abatement and building demolition. This is accomplished without constructing any new building square footage for functional program space.

Please see the Medical Facilities chapter in Volume II and various chapters in Volume IV for additional information.

Precision Oncology

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations							
Medical Services (0160):	$137,010	$195,747	$195,747	$194,987	$194,987	($760)	$0
Medical Support and Compliance (0152):	$8,524	$19,087	$19,087	$20,087	$20,087	$1,000	$0
Medical Facilities (0162):	$219	$599	$599	$359	$359	($240)	$0
Pharmacogenomics (Non-add; included in above)	$8,458	$35,616	$35,616	$35,616	$35,616	$0	$0
Obligations [Total]	**$145,753**	**$215,433**	**$215,433**	**$215,433**	**$215,433**	**$0**	**$0**

Precision Oncology and Cancer Research

(dollars in thousands)

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**
Appropriation				
Medical Care - Precision Oncology Only	$145,753	$215,433	$215,433	$215,433
Medical and Prosthetic Research - All Cancers	$81,295	$93,822	$93,822	$95,069
Medical and Prosthetic Research - Precision Oncology Only (non-add, included above)	*$34,353*	*$33,251*	*$44,810*	*$48,018*
Obligations [Total] 1/	**$227,048**	**$309,255**	**$309,255**	**$310,502**

1/Excludes OI&T

Purpose: As the largest integrated provider of cancer care in the United States, VA is committed to providing access to the best possible cancer care. The vision of the Precision Oncology Initiative is that Veterans will have access to care that is comparable to that available at the nation's leading cancer centers and as close to their homes as possible. VA's implementation is evidence-based and built on a foundation that leverages the following: oncology clinical pathways that define preferred practice; molecular diagnostic services that facilitate access to testing and the requisite expertise to use the results, and TeleOncology that delivers clinical care led by expert oncologists affiliated with National Cancer Institute (NCI)-designated cancer centers to underserved areas.

The Precision Oncology Initiative directly supports the agency priority goal to deliver timely, accessible, and high-quality benefits, care, and services to meet the unique needs of Veterans and all eligible beneficiaries by providing innovative care that is evidence-based and improves understanding of Veteran specific illnesses and injuries to develop and adopt innovative new treatments that prevent future illness and enhance Veteran outcomes. Since 2021, VA has expanded sub-specialized oncology and clinical cancer genetics services at more than 77 VA medical centers (VAMC) with the goal of 100 VA sites of care by the end of 2025.

The rapid evolution of oncology clinical practice driven by frequent scientific and medical advances necessitates the close integration of research structures and clinical services to form an oncology-learning health care system. The dual goals are to facilitate agile implementation of new clinical practices in response to new scientific discoveries and to develop new knowledge from

clinical practice. Clinical trials are often part of standard clinical care for patients with cancer and are a second area of clinical-research integration in Precision Oncology. Together, these elements form a System of Excellence for the full spectrum of care for a particular cancer type. Systems of Excellence are established for Prostate/Genitourinary Cancers, Lung Cancer and Breast and Gynecologic Cancers. In 2024, VA will continue to specifically address molecular diagnostics (tumor testing, germline testing and required enhancements of genetic counseling, and pharmacogenomics), improve upon our approach to addressing Rare Cancers, enhance the pathology and laboratory infrastructure, and enhance and grow Radiation Oncology services. In 2025, VA will add two new Radiation Oncology sites, add additional molecular testing capabilities, expand digital pathology and virtual tumor board capacity, and partner with the Department of Health and Human Services (HHS) and other federal agencies to improve cancer care through the White House Cancer Moonshot.

In 2023, an analysis completed by VA showed that in 2017, there were approximately 51,297 new cancer cases reported in VA. The most prevalent cancers identified were prostate (26%), lung/bronchus (18%), and bladder (7%), with lung cancer being the deadliest. 96.5% of these cases affected men with 3.5% affecting women Veterans. The most common cancers among women Veterans were breast cancer (31%), lung cancer (17%), and colon/rectum (7%).

VA is actively engaged in revamping our cancer registry program to improve and capture data more efficiently. VA's oncology clinical pathways and Systems of Excellence are integral to facilitating the transfer of scientific knowledge into clinical practice across the VA for Veterans with a cancer diagnosis. VA continues to expand molecular diagnostics in Precision Oncology through the National Precision Oncology Program (NPOP), addressing all three of its strategic goals. In addition to providing cutting-edge clinical tumor DNA sequencing, the program also provides germline testing for patients with cancer to guide treatment decisions and address the in-depth knowledge gained regarding patient risks of developing cancer. NPOP, targets the most frequently diagnosed and deadly cancers within VA and provides access to standardized tumor testing for all metastatic cancers across nearly every VA oncology practice site and for early-stage lung cancer. The program provides an expert consultation service to assist with interpretation of complex test results and a system-wide Molecular Oncology Tumor Board. Germline genetic testing was made available in 2023 to all patients with breast cancer, ovarian cancer, pancreatic cancer and high-risk or metastatic prostate cancer. VA continues to improve efficiency, timeliness, and utilization with the Clinical Cancer Genetics Service (CCGS). Since February 2023, CCGS has seen over 1,360 Veterans, of which 30% are rural.

In 2023, NPOP expanded to include testing for a broader range of cancer types, including rare cancers. Systematic implementation of molecular testing via clinical pathways within the electronic health record system is planned to ensure broad adoption. Also in 2023, NPOP began providing access to high-sensitivity liquid biopsy testing to detect minimal residual disease which can help patients and clinicians decide whether they can safely stop therapy or whether additional treatment is needed. To enable a true learning health care system, gathering data from VA's precision oncology efforts and the use of this data for clinical decision support will continue to be an essential driver of NPOP's efforts. To optimize resources, leverage common technologies and enhance cancer research and discovery, VA will continue to collaborate with other agencies such as the Department of Defense (DoD) and NCI under an existing collaboration named Applied

Proteogenomics Organizational Learning and Outcomes (APOLLO), with a planned expansion of VA sites. VA is also partnering with cabinet-level agencies on the White House Cancer Moonshot. In 2023, VA established an agreement with National Institute of Environmental Health Sciences (NIEHS) to conduct molecular analysis of tumor samples of Veterans with cancer who were exposed to the water at Camp Lejeune. Through the White House Cancer Moonshot, VA will address disparities in cancer care, increase access to clinical trials, improve lung cancer screening and create greater awareness and access to cancer screening.

VA continues to expand National TeleOncology (NTO) services which facilitate cutting-edge cancer care to Veterans anywhere, reducing geographic disparities. The United States, and by default VA, are facing a shortage in oncologists, geneticists, and genetic counselors (Scheuner et al., 2020). The American Society of Clinical Oncology (ASCO) anticipates a shortage of approximately 2,250 oncologists by 2025 (Yang et al., 2014) Attracting top oncologists and research talent remains a priority for VA. VA is uniquely positioned to achieve this goal through its ability to offer incentives such as: partnerships with National Cancer Institute (NCI) designated cancer centers, partnerships with academic affiliates, research opportunities and working within the largest Telehealth program in the country. Oncologists working with NTO services participate in research and innovation through these partnerships, bringing state of the art care opportunities to Veterans. In addition to areas discussed within Precision Oncology, NTO provides expertise across the spectrum of oncology care such as use of immunotherapy, chemotherapy, genetic counseling, virtual tumor boards, decentralized clinical trials, cancer care coordination, survivorship, and palliative care. Through participation in the VA National TeleOncology service, Veterans receive sub-specialized oncology care. Care is provided in disease site-specific teams that consist of a sub-specialized oncologist and an oncology certified team consisting of an advanced practice provider, registered nurse, and clinical pharmacy practitioner. In 2024, the team will expand to include a social worker and dietitian, develop additional tumor boards, expand decentralized clinical trial access, enhance breast and gynecologic care, and standardize care coordination. As of December 2023, 47% of the 51,000 patient encounters by NTO were for Veterans living in rural areas.

In 2024, VA will begin expanding access to care by implementing combined provider clinic and infusion capabilities into higher volume Community Based Outpatient Clinics (CBOCs). In addition to the Close to Me infusion model, this initiative will include an advanced practice provider and support staff. The result will be the ability to provide full-service VA care to between 50% and 70% of Veterans needing oncology and hematology services. In this clinical model, the highest risk treatments will be referred to other VA or community locations.

Evidence: Clinical pathways are standardized, evidence-based decision support tools which encompass comprehensive cancer care from diagnostics to end-of-life treatment for homogenous patient groups. Implementation of a clinical pathway has been shown to reduce unwanted variation in care and thus improve outcomes, lower costs, and reduce adverse effects and risks. VA is developing new evidence at an increasing rate with lengthy timelines for system-wide implementation resulting in variability. Clinical pathways bridge this gap by translating published evidence into treatment process maps that can be adapted to organizational expertise and preferences. Continuous assessment ensures pathways represent the most up-to-date published literature that also incorporates clinical experience and patient outcomes.

Rare cancers have been defined by the Rare Tumor Initiative at the National Institute of Health's (NIH) NCI as those affecting fewer than 200,000 total people in the U.S. or less than 40,000 annually. There are hundreds of different types of rare and less common cancers and when combined, they have a devastating impact. The number of rare cancer cases is expected to grow as precision oncology is fundamentally changing how cancers have conventionally been defined. Cancers considered common are emerging as a collection of multiple rare subtypes that share the same tissue of origin but distinct pathophysiology that can directly impact prognosis and treatment efficacy (Nogrady, 2020). As we learn more about the genomics of each cancer, it has become evident that every rare cancer subtype has unique characteristics that often require individualized treatments. Advanced genomic testing is also revealing that molecular features in certain rare cancers may be treated with drugs for more common cancers. Therefore, it is becoming evident that to better categorize cancer types for treatment decisions and to determine patient eligibility for clinical trials, molecular diagnostics will continue to play an increasingly important role in oncology clinical practice.

Pharmacogenomics (PGx) is a proactive, medication optimization strategy that can reduce adverse drug events (ADEs), improve treatment outcomes, and/or reduce costs. Every Veteran prescribed specific, high-risk medications should have PGx testing to inform their prescription therapy. Outside VA, PGx testing is becoming increasingly available to patients through expanded insurance coverage, availability through direct-to-consumer genetic testing companies, and academic and Federal research programs. In response to requests by Committees on Appropriations of both Houses of Congress in 2022 (*Public Law 117–103,* 2022), VA formed a National Pharmacogenomics Program (NPP) in 2023 to provide a coordinated approach to pharmacogenomics services for all Veterans across the system. In addition to providing clinical leadership, NPP establishes evidence-based criteria for appropriate PGx testing within VA, creates data infrastructure needed to identify Veterans eligible for PGx testing and manages PGx data for Veterans who have undergone testing. NPP is building the capability to provide PGx testing to approximately 50,000 patients annually in whom PGx is considered a high-impact and high-value intervention for the following conditions: mental health, cancer, cardiovascular, auto-immune and neurological disorders. In addition, NPP addresses the need to educate and train the workforce of providers, including pharmacists, on the appropriate ordering, interpretation and application of PGx in clinical practice; to monitor Veterans' prescriptions, medication outcomes and health care utilization over time; and to establish metrics to ensure that high-quality pharmacogenomics care is being delivered. In summary, NPP creates systems that ensure all VA facilities have the capability for providers to order clinically appropriate pharmacogenomics tests for their patients and to provide the required educational and clinical support systems to ensure that test results are appropriately applied to patient care.

As a result, VA anticipates lower ADEs among Veterans who receive PGx testing (Swen et al., 2023). Over a four-year period, nearly 1 in 10 Veterans were prescribed a medication that could have been optimized if prescribers had utilized PGx (Chanfreau-Coffinier et al., 2019). Despite current systems to ensure safe medication prescribing, ADEs occur and are tracked by VA (Moore et al., 2019). Among the most common offending medications, there are many where PGx can optimize prescriptions to prevent ADEs. The Food and Drug Administration (FDA) has evaluated evidence supporting dozens of medications influenced by PGx and concluded that there are many where there is "sufficient scientific evidence to suggest that subgroups of patients with certain

genetic variants…are likely to have altered drug metabolism, and in certain cases, differential therapeutic effects, including differences in risks of adverse events" (U.S. Food and Drug Administration (FDA)). The Clinical Pharmacogenetics Implementation Consortium (CPIC) is a NIH-supported organization that provides comprehensive evidenced-based recommendations on how best to manage patients with selected genetic variants prescribed certain medications with the goal of preventing ADEs or achieving certain therapeutic outcomes (*What is CPIC?*). To date, there are 26 medication classes where CPIC and/or FDA have concluded that moderate-to-strong evidence exists to support modification of prescription therapies based on a patient's PGx test results are likely to improve medication outcomes. CPIC guidelines are used by many U.S. medical centers implementing PGx – including VA – and many are also endorsed by the American Society of Health System Pharmacists (*Endorsed Documents*). A comprehensive review of the evidence to support using PGx test results is provided by CPIC and varies depending on the medication of interest. For some medications, there are randomized controlled trials (Hicks et al., 2020; Swen et al., 2023) for example, while others are supported by non-randomized trials (Hicks et al., 2020), retrospective studies (Deenen et al., 2016; Henricks et al., 2018) or extrapolation from known pharmacology and drug mechanisms of action (Claassens et al., 2019; Coenen et al., 2015; Greden et al., 2019; Mallal et al., 2008; Oslin et al., 2022; Pereira et al., 2020; Pirmohamed et al., 2013; Smith et al., 2019; Zhao et al., 2008). In summary, pharmacogenomic testing is an evidenced-based practice that can prevent ADEs and improve therapeutic outcomes to some of the most prescribed medications for Veterans. The scientific landscape around PGx will continue to evolve with new research, new medications, indications and testing options over time. NPP is well positioned to monitor these trends in real-time and adapt its portfolio as needed to ensure that VA is288nnovateing 288nnovateion and research findings that improve Veteran outcomes to commonly prescribed medications. The goal of NPP is to rapidly implement PGx enabling access to testing for all Veterans by creating enterprise-wide tools and resources that establish a learning health system approach supporting PGx as a routine component of clinical medicine in VA.

According to ASCO's 2020 State of the Oncology Workforce in America, only 11.6% of oncologists practice in a rural area, and 4 in 10 Americans living in rural areas with cancer report there are no cancer specialists near their home (Yang et al., 2014). With 2.7 million rural Veterans enrolled in VA and an additional 2 million rural Veterans not currently enrolled, VA must position itself to address the potential access needs for rural cancer care (Lent et al., 2023), ensuring that rural Veterans receive the same state-of-the-art care as their urban counterparts (*Rural Veterans*). VA is addressing this through expansion of its National TeleOncology services. In 2020, VA paid more than $1.2 billion in Community Care services for oncology care and is projected to meet or exceed this amount in 2021 (*Community Care Referral Dashboard*, 2023). This care includes hematology/oncology and chemotherapy/infusion services but excludes surgical oncology, radiation and benign hematology. A 2020 study using the Centers for Medicare and Medicaid Services new quality measure OP-35, to reduce potentially avoidable hospital admissions and emergency department visits among patients receiving outpatient chemotherapy, found that patients receiving chemotherapy in the VA are significantly less likely to have potentially avoidable hospitalizations than patients receiving chemotherapy through Medicare outside of the VA (Gidwani-Marszowski et al., 2020). VA believes the quality of care is better in VA because of the sub-specialized care utilizing TeleOncology and the standardized care coordination of oncology care with other VA-provided and community provided care. National TeleOncology was created to improve access to high-quality cancer care. VA created partnerships between the NTO

Hub within VA's Durham VA Health Care System (VAHCS) and VAMCs across the Nation. In addition to the launch of NTO clinics and comprehensive support though National Virtual Tumor Board and Close to Me Infusion services, several initiatives were developed to address the needs of our Veterans: Breast and Gynecologic System of Excellence, Clinical Cancer Genetics Service and Clinical Cancer Research Services.

Women are the fastest growing demographic in both military services and Veteran community. Breast cancer is the most diagnosed cancer among female Veterans, accounting for 30% of their diagnoses. Consistent with the overall VA population, the second and third most frequently occurring cancer for women Veterans are cancers of the lung/bronchus (15%) and colon/rectum (7%) (Yang et al., 2014). The Breast and Gynecologic Oncology System of Excellence (BGSoE) was founded in 2021 and is working to develop a framework for Veterans with breast and gynecologic cancers to receive state-of-the-art, guideline-adherent care, whether enrolled Veterans are receiving cancer care at the VA or the private sector. In 2022, VA developed a dashboard that tracks Veterans with these cancers across their care journey and provides navigation services to assist with care coordination. VA also began conducting virtual breast and gynecologic oncology national tumor boards with cancer providers around the country. Through the VA National TeleOncology program (NTO), the BGSoE has provided virtual care to Veterans diagnosed with breast and gynecologic cancer. The BGSoE works closely with the Office of Womens Health (OWH) to provide high-risk breast counseling for Veterans who are not diagnosed with breast cancer, but at are high risk due to several factors including family history. In 2023, VA is building the infrastructure to support oversight of end-to-end care in the system, linkages to research and clinical trials.

Increasingly, patients, providers, and policymakers have recognized the urgent need for genetic counseling and genetic testing in oncology. P.L. 117-135, *Making Advances in Mammography and Medical Options for Veterans Act*, recommends increase use of molecular testing and genetic counseling for Veterans diagnosed with breast cancer. This reflects recent community guidelines by the National Comprehensive Cancer Network which have expanded access to NGS genetic panels of hereditary predispositions to nearly all women with breast cancer (Gage et al., 2017). Some groups, such as the American Society of Breast Surgeons 2019 guidelines go even farther and recommend genetic testing for all women with breast cancer (Gage et al., 2017). NCCN guidelines exist for inherited predispositions to colon cancer, uterine cancer, ovarian cancer, pancreatic cancer, melanoma, pheochromocytoma/paraganglioma, and others. The new CCGS aims to expand access to timely genetic counseling and molecular testing for our nation's Veteran population. Since its inception in January 2023, the CCGS team has gone from serving 32 facilities to 77 facilities through NTO, underscoring the interest and need for this service nationwide.

Clinical Trials (CTs) offer high-quality medical care while advancing medical knowledge. Despite this, only 2-8% of adult patients with cancer participate in CTs, and this is less common among ethnic and racial minorities (Murthy et al., 2004; Tejeda et al., 1996; Unger et al., 2019). Other factors associated with lower CT enrollment that are applicable to VA include rurality, lower education, insufficient transportation, lower income, and/or presence of comorbidities that impact Veterans' ability to participate due to restrictive eligibility criteria (Agha et al., 2000; Meffert et al., 2019). The VA Clinical Trials Initiative will meet the challenge of low cancer CT enrollment in the VA with a two-pronged approach: (a) Cancer Trials Navigation (CTN) program and (b)

Decentralized Clinical Trials (DCTs) program. The CTN program will provide education about CTs, will perform searches for applicable CTs and will provide CT navigation to any Veteran with cancer and their VA oncology providers. In the DCT program some or all research-related activities occur at locations other than the site where the Veteran receives medical care. These activities intend to enhance equity and improve access to cancer CTs across the VA system, for all Veterans.

Implementation Plan: VA is requesting sustained funding of $215.4 million for Precision Oncology in 2025. The funding sustains health care programs in TeleOncology, Women's Oncology, Rare Cancers, Pharmacogenomics, molecular testing, clinical genetics services, and the expansion of strong practices to expand sites of care and bring Oncology services closer to Veterans. VA will also complete the lung cancer screening network, improve clinical pharmacy provider support, increase new and unique infusion efforts, ensure access to high quality sub-specialized TeleOncology care, increase and improve colorectal cancer screening, increase consistent cancer patient navigation and develop cancer navigation tools and to grow novel treatment programs which provide high quality patient care and reduce costs. The 2025 budget will allow VA to increase the number of radiotherapy sites by two and sustain breast and gynecologic, prostate, and lung cancer networks.

VA will expand upon current clinical pathways to provide the best-in-class and system-wide standardized Oncology care. Clinical pathways formally standardize oncology practice in a multi-disciplinary fashion. The clinical pathways provide decision-support to the clinical care team through technology embedded within both electronic health records systems (CPRS and Cerner). This technology also allows precision monitoring of care to facilitate systematic, real-time assessment of care in coordination with national experts. Clinical pathways designed by VA were developed and deployed for lung and prostate cancers in 2021 and kidney cancer in January 2023. In 2022, VA completed pathways for kidney, head-and-neck and salivary gland cancers and began developing breast, hematologic malignancies (plasma cell disorders and CLL/SLL) and gastrointestinal clinical pathways. VA completed pathways for diffuse large B-cell lymphoma, follicular lymphoma, colon cancer, rectal cancer and marginal zone lymphoma in 2023. By the end of 2023, VA developed 21 modern, cutting-edge clinical pathways. By the end of 2025, VA will add an additional 12 pathways. In addition to the pathways developed in 2023, VA also modified the prostate cancer clinical pathway per the Cleland Dole Act requirements and published it publicly. Clinical pathway implementation will continue to expand to additional cancer types such as skin cancer, additional rare hematologic malignancies, and brain cancer in 2024 as a tool to support the adoption of molecular testing for rare cancers and other cancer types that can benefit from precision oncology approaches. VA-developed pathways are publicly available at cancer.va.gov.

Pathways and testing directly drive results for the agency priority goal to ensure governance, systems, data and management best practices improve experiences, satisfaction, accountability and security and the area of emphasis is on the objective to inform evidence-based decisions to ensure quality outcomes and experiences. 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 increases the availability of genetic testing along with educating the oncology provider workforce in this

practice. VA's 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 U.S., there are 10 to 15 genetics professionals per 1 million residents (Hoskovec et al., 2018). TeleOncology will continue to expand the infrastructure and communications to support oncology-related genetic testing. In 2023, TeleOncology is expanding the genetic testing service to include training for field oncologists. To expand molecular diagnostics, VA will pursue additional acquisitions to cover testing for a broad range of cancer types including rare cancers. This occurs through a systematic expansion, cancer type by cancer type. For monitoring of drug response and resistance, emerging liquid biopsy methods that require repeat testing of patients during their treatment will be required. This will lead to the need for new testing partners offering best-in-class tests to cover additional sample types, cancer types, different stages of the disease and diverse molecular testing applications including diagnosis, risk prediction, prognosis and treatment monitoring. Finally, the complex data generated by Precision Oncology requires advanced informatics systems both to maximize the clinical utility of the data and to facilitate knowledge generation that can improve future care of Veterans. It is critical to ensure the learnings from a molecular test do not end with the single patient and can be used to inform the care of the next patient particularly for rare cancers where the number of patients may be small. The use of technologies such as machine learning, natural language processing, and advanced analytics will be needed within a precision oncology data platform to unveil unprecedented insights for clinical care and research. In addition to its complexity, much of the data generated requires significant storage space and analysis, for example, Binary Alignment Map (BAM) files. These files represent unique needs due to size and multidimensionality. In 2024, VA received OIT funding in support of new cancer registry software and will implement the new system by the end of 2026, nationally.

In 2019, less than 10% of eligible Veterans had received a low dose computed tomography (LDCT) for lung cancer screening (LCS). VA established the National Center for LCS (NCLCS). VA estimates that at least 1.5 million Veterans are eligible for LCS. The goal of VA's LCS program is to increase systematic, integrated, and equitable access to high-quality lung cancer screening processes for Veterans through a collaborative, interdisciplinary network. Our vision statement is that we will reduce lung cancer morbidity and mortality by leveraging a learning health care system to sustainably increase access to evidence-based lung cancer screening processes that are effective, equitable, safe, and efficient. VA will continue to improve lung cancer mortality in the future through continued quality assessment and improvement of lung cancer screening processes that take advantage of lung cancer early detection research findings. Since 2021, VA has established 110 hub-and-spoke screening sites of care and hired almost 200 LCS coordinators. VA enhanced and further developed the Lung Cancer Screening Platform (LCSP) which is a suite of electronic health record embedded tools to offer screening to patients and track them through the process. VA has also established pilot projects on smoking cessation, equitable access to screening for the homeless population, and the utilization of mobile CT. USPSTF recommends annual screening for lung cancer with LDCT's in adults aged 50-80 years who have a 20-pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery (Murthy et al., 2004). By the end of 2025, VA plans to establish quality LCS programs and adoption of the LCSP at every site across the enterprise. At least 300,000 Veterans will be assessed for LCS enrollment and

offered LDCT's. VA plans to monitor metrics and identify best practices and barriers to continue improving the success of programs across the nation. VA plans to double the number of smoking cessation programs within LCS programs. Adherence barriers will be identified, and best practices shared to increase adherence.

In 2022-2023, VA created a new National Colorectal Cancer Screening Program (NCSP) to coordinate efforts to assure that all Veterans have access to high-quality colorectal cancer screening and surveillance. To expand access to screening, VA created a Mailed Fecal Immunochemical Test (FIT) Program. FIT is a non-invasive test for colorectal cancer (CRC) screening that can be performed in the comfort of a Veterans home. A Mailed FIT Implementation Team (MFIT) published and disseminated an implementation guide throughout the enterprise. The MFIT has developed sophisticated Power BI dashboards to identify the cohort of Veterans eligible for CRC screening and facilitate the tracking of screening outcomes, from FIT orders, to results, to evaluation of abnormal screening tests with colonoscopy. VA's goal is to complete implementation of FIT across the enterprise by the end of 2025. In 2023, VA distributed 113,000 FIT kits to Veterans. To address gaps in follow-up after abnormal screening tests, a new reminder system was utilized to identify 1.6 million Veterans with prior colonoscopy in need of clear documentation of follow-up plans. This resulted in corrected screening recommendations for many tens of thousands of Veterans. Lastly, artificial intelligence computer assisted detection (CADe) devices are being evaluated with respect to their impact on colonoscopy quality. CADe has been shown to significantly increase the detection of precancerous polyps in the colon and rectum during colonoscopy. In 2022, the VA purchased 115 CADe devices and deployed them to 43 randomly selected VA facilities. Over 33,000 VA colonoscopies have already been performed at facilities outfitted with CADe devices since their deployment in late 2022. VA will complete the implementation of CADe devices nation-wide by the end of 2025.

Pharmacogenomics**:** In 2019, the VA initiated a pilot program focused on implementation of PGx testing through a partnership with Sanford Health (Sioux Falls, SD) at 30 VAMCs. In 2023, a VA NPP was formed to build on the pilot program's successes expand access enterprise-wide to PGx testing and support. As of December 2023, PGx testing is available at 103 VA health care systems with an additional 24 slated for implementation in 2024. From these sites, NPP currently supports PGx testing to approximately 20,000 of the projected 50,000 Veterans who are eligible annually. In 2023, the NPP funded 57 new full-time employees (FTE) to support PGx trained pharmacists (45 facility based, 7 VISN based, 4 nationally based). These positions will be critical for filling the clinical, educational and implementation gaps in delivering high-quality PGx care. To train these specialized pharmacists as well as the approximate 5,000 clinical pharmacy practitioners across VA, VA executed an educational contract with the University of Pittsburgh to provide the tools and materials needed to educate VA's pharmacy workforce. NPP has continued its work in implementing a series of clinical decision support systems (CDSS) in and outside the VistA electronic health record. These CDSSs assist pharmacists and prescribers so that they are aware of the availability of PGx test results, their interpretation and action they can take to mitigate negative impact of gene-drug interactions through dose modification or an alternative medication. In 2023, the NPP expanded the panel of CDSS tools available in VistA to 58 medications. Therefore, since its inception in 2019, originally as Pharmacogenomic Testing for Veterans (PHASER), NPP has gained significant experience and knowledge regarding the barriers to effective implementation of pharmacogenomics with VA.

The 2025 budget will sustain all current accomplishments and continue the expansion of PGx services so that all eligible Veterans have equal access to appropriate, evidenced-based, high-quality and high-value PGx testing. VA will continue to educate clinicians and pharmacists in the core clinical areas (primary care, mental health, cardiology and oncology) on the use of PGx with the goal of educating 50% of pharmacists in these areas in 2026 and 80% in 2027. In 2026, VA will begin to transition PGx testing externally performed to internal VA laboratories with the goal of fully transitioning from external to internal laboratories in 2027. The ability to perform PGx testing through internal VA laboratories is expected to create greater value to Veterans by not only lowering the cost of testing compared to commercial vendors but also maximizing the quality and longevity of information that can be obtained through PGx testing.

Through the TeleOncology service, VA is building clinical and research teams in partnership with NCI designated cancer centers and nation-leading academic affiliates to address breast, gynecologic and rare cancers in 2023. These multidisciplinary teams continue to provide expert sub-specialized oncology services as well as care coordination across the cancer care continuum, from diagnosis to survivorship or palliative care. They will continue their focus on ensuring quality evidence-based care is received regardless of location. This innovative cancer care coordination model is the first of its kind for these subsets of cancer within VA. As of December 2023, over 12,500 Veterans have received care through NTO; 47% of those Veterans live in rural locations. VA National TeleOncology has expanded to provide care at 77 VAMCs. NTO provides national expert consultation services including continuous management of cancer therapies through TeleOncology sub-specialists and virtual tumor boards. Funding will ensure sustainment of this state-of-art oncology care service and allow NTO to reach the goal of providing care to 100 VAMCs by the end of CY 2025.

National Virtual Tumor Boards were created to provide an option for sites to have access to multidisciplinary comprehensive disease-specific tumor boards and specialists. Since 2022 virtual tumor boards have been launched focusing on hematologic malignancies, breast and gynecologic cancer, neurooncological, thoracic cancers and cutaneous malignancies. Sessions meet regularly during the month and involve specialists from across the Nation from medical oncology, surgical oncology, radiology, pathology, radiation oncology and other teams to provide consensus recommendations for cancer management. Continuing education credit is in the process of being provided with the tumor boards. Further growth includes implementation of tumor boards for prostate cancer, rare cancers and gastrointestinal malignancies including hepatocellular carcinoma. In 2024, national virtual tumor boards will begin incorporating digital pathology in partnership with digital pathology hub VAMCs through the National Pathology and Laboratory Program Office.

The Close to Me Infusion model was created in 2021 as a solution to bring cancer treatments closer to where Veterans live. Veterans often travel long distances for cancer treatment, experience long wait times on day of treatment, pay for gas/tolls, assume lost wages, and seek care outside of VA due to not having a closer option for care. In 2022, VA sent $1.6 billion of infusion and injection cancer treatments into the community. By creating treatment clinic options at Community Based Outpatient Clinics (CBOC) and at home, the Close to Me service increases access to Veteran-centric care, reduces travel times, improves VA care continuity, and encourages high-level

treatment adherence. Treatment administration and coordination processes are reviewed by experts in sterile compounding, quality management, oncology, pharmacy, nursing, and specialty care. To date, over 500 Veterans have been treated at Close to Me infusion sites. Over $1 million in chemotherapy drug costs have been saved. Over 53,000 Veteran-drive miles have been saved. In 2023, VA is in the process of expanding to CBOCs and homes through 11 VAMCs. Expansion is expected to continue with increased VAMC CBOC and home treatment sites, the consideration of mobile units and the incorporation of remote physiologic monitoring.

Radiation Oncology: VA has 130 sites that provide medical oncology, but only 41 sites have radiation oncology facilities available. Upon last review, 45,000 dually enrolled Veterans receive radiotherapy annually and 15,000 Veterans receive radiotherapy in-house at 41 sites in the VA. The first new site in the expansion project, New Orleans, will open in 2025. There are two new sites anticipated each year in 2026 and 2027. The sites were chosen to fill a need for services identified in that area. The 2025 request would allow the continued expansion of VA's Radiation Oncology services to provide radiation oncology services to Veterans. In 2023 VA also utilized funding to upgrade outdated equipment and modernize linear accelerators and CT simulators at 5 sites so that those sites could offer state-of-the-art therapies to Veterans in their region. VA also provided funding for equipment at 50 VAMCs to ensure safety and quality in existing radiation oncology sites and improve whole health.

VA radiotherapy quality is superior in-house compared to community care based on a direct comparison of quality metrics reviewed in VHA in 2017 and what could be found in a community provided sample (Katsoulakis E. et al., 2020). A pilot project Genomic, Clinical, and Radiotherapy Information Database (GRID) to bring Radiation Oncology data into the VA Corporate Data Warehouse was completed. The next steps are to bring in retrospective data from our 41 sites and to set up real time importation of radiotherapy treatment details from current patients. VA is working closely with the Office of Community Care to coordinate bringing in treatment details on patients receiving radiotherapy in the community to ensure coordination of their care in VHA. The national program office continues to manage accreditation of all sites through the APEX accreditation program, safety and quality oversight through National Health Physics Program (NHPP), the Imaging and Radiation Oncology Core (IROC) Houston and our own radiation incident reporting and analysis system (RIRAS).

Budget Request: The 2025 Precision Oncology budget request is $215.4 million. This includes $41.3 million to increase access to Pharmacogenomic Services within the National Pharmacogenomics Program and $34.5 million to increase access to VA Radiation Oncology Therapy.

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Rural Health

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations							
Medical Services (0160):	$275,265	$305,688	$303,147	$305,688	$305,688	$2,541	$0
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$9,736	$19,459	$22,000	$19,459	$19,459	($2,541)	$0
Medical Facilities (0162):	$12,073	$12,308	$12,308	$12,308	$12,308	$0	$0
Obligations [Grand Total]	**$297,074**	**$337,455**	**$337,455**	**$337,455**	**$337,455**	**$0**	**$0**

Authority for Action: Congress established the VHA Office of Rural Health (ORH) in 2006 (38 USC § 7308) to conduct, coordinate, promote, and disseminate research on issues that affect the nearly five million Veterans who reside in rural communities. The mandate also requires ORH to develop, refine and promulgate policies, best practices, lessons learned, and innovative and successful programs. In 2008 the Veterans Rural Health Resource Centers were established by law to serve as regional field-based offices for ORH.

Purpose: To sustain programs that directly support the accomplishment of the congressionally mandated functions of ORH. These programs include but are not limited to the VHA Clinical Resource Hubs, Rural Patient Tablet Program, Tele-Critical Care Initiative, and 34 active additional Enterprise-Wide Initiatives (EWIs). ORH also operates five Veterans Rural Health Resource Centers in Portland, OR; Salt Lake City, UT; Iowa City, IA; Gainesville, FL, and White River Junction, VT. These Resource Centers are responsible for identifying, formulating, and developing best practices to enhance the delivery of health care to Veterans living in rural areas.

Evidence: In 2023, ORH furthered rural health initiative contributions to the programs named above and funded new programs in rural workforce training and continued programs for rural mental health. ORH has worked with VHA clinical and non-clinical offices to create more than 50 mature enterprise-wide initiatives that reach more than 99% of all VHA clinical sites that serve rural Veterans. ORH will continue to develop new programs through 2023 and beyond.

The 2024 ORH budget supports innovative programs in the rural space across the following clinical and vital non-clinical access program areas:

- Primary Care
- Specialty Care
- Mental Health
- Geriatrics
- Rehabilitation and Prosthetics
- Clinical Resource Hubs
- Workforce Training and Education
- Care Coordination
- Transportation

In 2023, these programs touched the lives of more than 1.3 million Veterans at more than 600 rural serving VHA sites. VHA expects to see a significant expansion of many of these programs in 2024 and 2025 as new sites are added and new rural access innovations are created.

ORH has engaged with partners across VHA program offices to project 2024 programming needs for third-year sustainment and expansion efforts of thriving innovations. ORH also worked towards the creation of long-term funding streams for the rural portion of vital initiatives such as tele-critical care, clinical resource hubs (CRHs), and the rural Veteran tablet programs. ORH had nearly $12.0 million in projected new enterprise-wide initiatives in 2024. Each ORH-funded initiative was required to have a quantitative evaluation that was overseen by VHA Central Office program offices, ORH, and the ORH Center for the Evaluation of Enterprise-Wide Initiatives (CEEWI).

CRHs have provided access to a variety of care (e.g., Primary, Mental Health, Specialty, etc.):

- In Q1/Q2 of 2023, CRHs provided over 275,000 encounters with Veterans.
- 1,000 dedicated ORH-funded FTE provide clinical care and administrative support across all 18 CRHs.
- 944 spoke sites are being served by CRH clinicians today.

During the COVID-19 pandemic, CRHs assisted in coverage of the clinical contact centers, inpatient services, and emergency departments throughout the enterprise.

The rural patient tablet program provided computer tablets to rural Veterans for delivery of telehealth care into their homes via secure internet connection. In 2023, 30,872 Veterans had 35,300 virtual video connect visits.

In 2023, ORH and Specialty Care Services (SCS) continued a five-year funding agreement to support rural tele-critical care expansion. This national tele-critical care program provided critical care to 18,264 acutely ill Veterans in 72 facilities throughout the country.

For rural workforce training and compensation, ORH collaborated with the VA Office of Academic Affiliations (OAA) to develop the Rural Interprofessional Faculty Development Initiative (RIFDI) to attract providers and improve retention by developing teaching and training skills for rural clinician/educators. In 2023, the program trained 216 clinicians at 13 rural sites.

Implementation Plan: New programs are required to submit an implementation plan that is carefully reviewed by ORH and CEEWI who then recommends improvements, where appropriate, and assesses the effectiveness of the plan at the end of the first year. Existing ORH-funded programs' implementation plans are reviewed annually by CEEWI.

ORH will engage with partners across VHA in 2025 to accurately project programming needs. ORH anticipates nearly $12.0 million in new enterprise-wide initiatives in 2025. ORH will work towards the creation of long-term funding streams for the rural portion of vital initiatives such as tele-critical care, rural Veteran tablet program, and CRHs.

CRHs are rural-serving telehealth hubs in all 18 Veterans Integrated Service Networks (VISNs) across the country and will provide primary care, mental health, specialty care, rehabilitation and extended care, surgery services, care management and social work, and diagnostic services in 2025. ORH will continue support for a significant expansion in tele-specialty care services within CRHs, to broaden access to cardiology, pulmonology, urology, dermatology, sleep medicine, endocrinology, and other specialty care services that are increasingly more difficult to access in rural areas of the United States, even from community partners. As the COVID-19 pandemic 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.

In 2025, all 18 VISN CRHs will offer primary care and mental health services to support access to care for underserved Veteran populations. This care will be delivered primarily via telehealth modalities and includes robust team-based care with nursing and clinical pharmacist practitioners. Additionally, many CRHs will provide access to numerous specialty care, surgery, and rehabilitation and extended care services.

ORH will fund the rural Veteran tablet program in 2025. ORH expects the trend of increasing virtual video connect visits 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 (VRHRCs) will continue to fulfill their congressionally mandated mission to conduct research, innovate new rural access programs, and disseminate them system wide. In 2025, these VRHRCs will continue or establish additional new rural promising practices, bringing the total number of rural promising practices in system-wide mentored implementation to at least nine. VRHRC promising practices range from training programs like rural clergy training and geriatric scholars, to clinical programs such as in-home cardiac rehabilitation, human immunodeficiency virus virtual teams, and rural implementation of comprehensive telehealth-based diabetes care. These promising rural practices operate at more than 100 sites across VHA.

The ORH VRHRC's strong innovation programs will focus on addressing gaps in rural Veterans' access to care and services and reach into program areas focused on health challenges rural Veterans face in accessing the health care. These programs include the home-based pulmonary rehabilitation (HBPR) program, which provides rural Veterans with timely, convenient access to critical specialty care services they may otherwise be unable to obtain. This 12-week program is delivered through telephone and/or video appointments and provides individualized care in: exercise prescription; nutritional counseling; medication adherence; stress management; disease and symptom management; and tobacco cessation. HBPR has served over 2,000 Veterans since the implementation of the program. HBPR is currently implemented in 27 VA facilities.

In addition, some VRHRC programs will focus on American Indian/Alaska Native (AI/AN) rural Veterans, including ORH's rural native Veteran health care navigation program. The goal of this innovative program is to reach rural AI/AN Veterans to ensure their access to VHA health care. Congress has acknowledged the contributions and impact of the ORH VRHRCs in past reports and in response ORH will continue expanding their excellent programs in the areas of research, innovation and system-wide dissemination of best practices, through 2025 and beyond.

Budget Request: The 2025 Budget requests $337.5 million, which is equal to the 2024 Budget, to sustain research on issues that affect rural Veterans while increasing our outreach to 1.32 million rural Veterans served. This is 2% above the level reached in 2024.

Supply Chain Management

Medical Care Appropriation Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Inventory Management and Access	$25,820	$104,996	$104,996	$108,146	$108,146	$3,150	$0
Medical Surgical Prime Vendor (MSPV) 2.0	$23,909	$28,337	$28,337	$29,187	$29,187	$850	$0
Defense Logistics Agency (DLA) Source Support for MSPV	$0	$0	$0	$0	$0	$0	$0
Supply Chain Master Catalog	$5,017	$5,175	$5,175	$5,333	$5,333	$158	$0
Point of Use	$0	$3,500	$6,460	$3,605	$3,605	($2,855)	$0
Clinical Decision Strategic Sourcing	$2,425	$2,595	$2,595	$2,595	$2,595	$0	$0
Grand Total	$57,171	$144,603	$147,563	$148,866	$148,866	$1,303	$0

Inventory Management and Access
(dollars in thousands)

	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	+/- 2024-2025
Medical Support and Compliance Category					
Medical Support and Compliance (0152):	$25,820	$104,996	$104,996	$108,146	$3,150
OI&T	$89,157	$136,257	$118,047	$97,810	($20,237)
Total Inventory Management and Access	$114,977	$241,253	$223,043	$205,956	($17,087)

The VA's fourth Strategic Goal is to transform business operations by modernizing systems and focusing resources more efficiently to be competitive and to provide world-class customer service to Veterans and VA employees. One focus area within this goal is Business Transformation, specifically to modernize VA's supply chain. Effective supply chain management is a major differentiator between high- and low-quality health care systems and directly influences Veteran access to care. VA's supply chain modernization priorities include deploying multiple systems and improvements to improve enterprise management and oversight of materiel to provide better support for care delivery in the field.

Inventory Management and Access

VA is replacing its 50-year-old legacy inventory management system and standalone systems for its support. With a modern inventory management system, VA would acquire the capability to support all health care logistics and support service lines of business, in a fully integrated environment, including end-to-end supply chain management inclusive of inventory management, distribution and transportation management, catalog research and purchase decision support; biomedical equipment management and maintenance; property and equipment accountability management; facility and environmental management for building service equipment and work orders; assemblage management; business analytics; and total asset visibility.

VA's COVID-19 response efforts highlighted the deficiencies with the existing, 50-year-old legacy inventory system, especially the lack of enterprise visibility of personal protective equipment. Standardization of VHA business practices across the enterprise consistent with federal and commercial best business practices will enable VA to build a lean supply chain that provides timely access to meaningful data focused on improved patient and financial outcomes.

Currently VA is assessing potential to systems for feasibility and compatibility with the other system transformations underway.

Medical/Surgical Prime Vendor (MSPV)

MSPV-Next Generation (NG) is a collection of contract vehicles that enable the VA to streamline supply chain management for an array of Medical, Surgical, Dental, Lab and Environmental Medical Supplies (EMS). The program achieves long term savings for VA medical centers by combining a "just in time" logistics approach with strategic sourcing and volume buying for Med-Surg supply needs. Item prices, prior to the application of the distribution fee, are published on the MSPV website.

MSPV-NG will transition to MSPV-Generation Z in calendar year 2024. This iteration of the acquisition vehicle will address deficiencies identified by GAO, OIG, and the Court of Federal Claims. This new contract vehicle will provide more oversight and customer centric results in the delivery of medical/surgical commodities. The increased resources will assist the healthcare facilities in resolution of issues/concerns in a more efficient manner and enhance the Veterans experience in the healthcare environment.

Defense Logistics Agency Electronic Catalog (DLA e-Cat)

VA is seeking to access to DLA contracts and suppliers to ensure VA facilities have continuous, efficient and cost-effective access to quality medical supplies. VA and DLA signed an Interagency Agreement (IAA) for VAMCs to leverage DLA's best-in-class medical logistics capabilities. VAMCs receive DLA-sourced materiel through the Electronic Catalog (ECAT) allowing the use of potential best-in-class contracts administered by DLA.

Continuing this partnership has several benefits. VA will: be able to deliver products faster and more consistently; expand the breadth and depth of medical materiel available to better support Veterans; increase opportunities for small businesses with the Federal Government; reduce operating costs; and address documented challenges the VA program has encountered. Achieving these goals will continuously improve upon VA's medical services and support over 9 million enrolled Veteran.

Clinically Driven Strategic Sourcing (CDSS)

CDSS is a commercial health care best practice that incorporates physicians and clinicians into the product sourcing process to achieve tangible results including cost reduction, improved clinical outcomes and patient safety, standardized medical-surgical products and customer satisfaction. CDSS facilitates collaboration between clinicians and logisticians throughout the value analysis and standardization process. Further, CDSS drives purchase order volume toward clinically based best-value contracts to increase VHA cost-avoidance.

CDSS supports VA's supply chain transformation and VHA's commitment to becoming a High Reliability Organization. Internal and external reports – including the Commission on Care Assessment J, Government Accountability Office (GAO) 18-34 and the Logistics Satisfaction and Time Resource Survey – highlighted procedural and structural challenges in VA's supply chain processes that increased patient care risks and clinician dissatisfaction, while decreasing cost avoidance opportunities.

Using CDSS helps reduce clinically equivalent medical supply variation used across VHA. Reducing variation decreases the time required to train clinicians on proper product use and promotes product knowledge continuity. VA clinicians benefit by having more time for patient care, which improves patient outcomes.

VA continues its strategic partnership with DoD supporting VA's obligation to ensure we provide optimum care and benefits to Veterans. VA is engaging with the clinically driven Medical Materiel Enterprise Standardization Office to understand their collaborative clinical process for medical materiel standardization, determine applicability to VA processes and develop a strategy for integration and enterprise implementation to further strengthen the CDSS program.

Supply Chain Master Catalog (SCMC)

VA's SCMC will provide VA users with visibility of all VA medical commodities, prosthetic devices (to include durable medical equipment), expendable and non-expendable equipment and non-clinical products. The SCMC is a fully searchable, online catalog available via a web interface offered to VA as a Software Service solution through the Microsoft Azure Government cloud host.

The VA SCMC harmonizes contract information from VA and other approved Federal contract offices. It is a critical element in improving product oversight, visibility and establishing enterprise best practices. Further, the SCMC is essential to providing the standard product information necessary for electronic health record (Cerner) and financial (Momentum) systems.

VA lacks standardized enterprise business rules for its cataloging efforts, which results in inconsistencies including incomplete records, duplicate records, stock-level discrepancies, incorrect dollar values, conversion factor errors and missing mandatory sources. Multiple contract systems operate across the VA and VHA that do not share product or sourcing data. These multiple siloed systems contribute to the lack of data standardization, inconsistent ordering practices and redundant contracts for identical products. For these reasons the SCMC is a critical element in product oversight, visibility and establishing enterprise best practices.

Point of Use (POU)

The POU program seeks to standardize the supply POU system at the enterprise level across medical centers while maintaining local efficiencies already realized. POUs automatically inventory, manage and store expendable medical supplies in the vicinity of patient care. POUs ensure proper supplies are available at the proper time for patient procedures. POUs optimize inventory with usage data trend analysis, on-hand inventory cost reduction and increased clinical staff focus on patient care and patient safety. The program aims to centrally standardize POU procurement, sustainment, vendor support, cybersecurity support, training and the POU implementation efforts with supply chain modernization and EHRM at the enterprise level.

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

Office of Connected Care – Telehealth Services/Connected Health

Description	2023 Actuals	2024 Budget Estimate 1/	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Treatment Modality ($000):							
Home Based Telehealth	$471,015	$453,302	$501,989	$524,103	$544,667	$22,114	$20,564
Clinic Based Telehealth	$4,451,851	$4,757,275	$5,231,664	$5,433,997	$5,837,442	$202,333	$403,445
Total Treatment 1/	**$4,922,866**	**$5,210,577**	**$5,733,653**	**$5,958,100**	**$6,382,109**	**$224,447**	**$424,009**
Connected Care Program Funding: Sustainment and Expansion							
Medical Services	$262,188	$366,446	$366,446	$396,945	$396,945	$30,499	$0
Medical Support & Compliance	$26,689	$41,615	$41,485	$42,975	$42,975	$1,490	$0
Medical Facilities	$42	$0	$130	$0	$0	($130)	$0
Sustainment and Expansion Total	**$288,919**	**$408,061**	**$408,061**	**$439,920**	**$439,920**	**$31,859**	**$0**

1/Amounts not previously displayed.

Authority for Action

- P.L. 115-182, *VA MISSION Act of 2018* and the *National Defense Authorization Act for Fiscal Year 2021*, authorize the practice of telehealth by VA health care professionals across the country irrespective of the location of the provider or the Veteran. These bills expand the Telehealth Services/Connected Health program to increase Veteran access to health care.
- *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019* authorizes VA to establish a grant program to develop telehealth access points, called Accessing Telehealth Through Local Area Stations (ATLAS)

Purpose: The Office of Connected Care and its Telehealth Services/Connected Health program is charged with delivering high-quality Veteran-centered care to optimize individual and population health, advance health care that is personalized and proactive and enhance the health care experience through virtual modalities of care.

Home- and Community-Based Services: Supports sustainment and expansion of synchronous, asynchronous and remote patient monitoring services in the home or home communities including VA Video Connect, the Veteran tablet initiative, VA Health Chat, Remote Patient Monitoring/Home Telehealth Program's equipment and services and the Accessing Telehealth Through Local Area Stations (ATLAS) pilot.

Clinic-Based Services: Supports expansion of clinical resource hubs for primary care, mental health and specialty care; expansion of targeted initiatives such at TeleDermatology, TeleEye Care, and TeleSleep medicine; and expansion of the national expert consultation services.

Hospital and Emergency Services: Supports expansion of inpatient and emergency room telehealth programs including TeleStroke Care and TeleCritical Care. It also includes the telehealth emergency management initiative.

Program Foundations: Supports 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.

Evidence: VA provided more telehealth services to more Veterans in 2023 than in any previous fiscal year while realizing increased Veteran trust (86.9%) and satisfaction (89.9%) with telehealth for the 3rd consecutive year.

Specifically, VA delivered over 11.6 million telehealth episodes of care to Veterans in 2023. This includes over 9.4 million episodes of care to Veterans in their home or other offsite locations and more than 2.9 million telehealth episodes of care to rural Veterans. Overall, VA provided telehealth services to over 2.4 million unique Veterans, representing about 40% of Veterans served in VA.

VA's patient portal continues to provide Veterans with a critical resource that facilitates education, knowledge transfer, and bidirectional communication access between Veterans and their care teams. Over 3.4 million Veterans used MyHealtheVet in 2023 and the system was used to send over 35 million secure messages.

VA continues to develop technologies to enhance Veteran access and experience. VA Health Chat, one the newest technologies to emerge, enables synchronous chat with a live agent. This capability is being implemented to offer Veterans convenient, private means to connect with VHA for scheduling, medication questions, nurse triage and urgent care. It is currently in use across 15 VISNs with a Veteran satisfaction rate >90%.

VA also continues to help Veterans bridge the digital divide through a combination of education, help desk support, and the direct provision of internet connected devices. In 2023, VA implemented 23 Virtual Health Resource Centers, which function as in-person support centers at VA facilities where Veterans can get help understanding and using VA's digital services such as mobile applications, telehealth, and MyHealtheVet. In 2023, VA's Connected Care help desk received 216,423 calls from Veterans to assist with their technology, receiving a 91% satisfaction rate from the Veterans it served. VA also completed 33,157 digital divide consults during the fiscal year and managed over 110,000 internet connected devices that it provided to Veterans who would otherwise have had insufficient technology to receive some of their VA benefits.

Implementation Plan: VA's connected care capabilities have become a vital part of VA's health care system. Telehealth, mobile health, and patient portal services are critical components of modern access and facilitators of equitable services for Veterans irrespective of their location in the country. With its 2025 budget, VA will continue to build on its success and leadership as a provider of digitally enabled care. By continuing its connected care innovations, VA will further enhance the human connections that are at the heart of health care and help more Veterans turn to VA as their health care system of choice. VA is also accelerating a transformation of health care that will provide Veterans more quality options going into the future.

Budget Request: The 2025 Budget requests $440 million in 2025 for Connected Care funding, an increase of $32 million above the 2024 Budget request. The basis for the budget increases includes the ongoing expansion and enhancement of telehealth services directly to Veteran homes (e.g., video-to-home services), goals to standardize the availability of digital services for all Veterans, expansion of regional telehealth hubs, novel access and experience innovations, and the need to sustain previous expansion efforts funded with the support of CARES Act and ARP funding.

Veterans Homelessness Programs

Description (Dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Appropriation	+/- 2024-2025	+/- 2025-2026
Homeless Veterans Treatment Costs	**$9,348,899**	**$9,522,722**	**$11,186,608**	**$12,007,323**	**$12,977,238**	$820,715	$969,915
Programs to Assist Homeless Veterans							
Permanent Housing Supportive Services							
HUD-VASH Case Management:							
HUD-VASH Case Management Base (I)	*$552,946*	*$617,618*	*$617,618*	*$661,535*	*$661,535*	$43,917	$0
HUD-VASH Case Management ARP Act (I)	*$0*	*$0*	*$0*	*$0*	*$0*	$0	$0
HUD-VASH Case Management [Subtotal]:	**$552,946**	**$617,618**	**$617,618**	**$661,535**	**$661,535**	**$43,917**	**$0**
HUD-VASH (S)	$418,026	$416,786	$428,059	$445,181	$445,181	$17,122	$0
Perm. Housing Supp. Services [Subtotal]	**$970,972**	**$1,034,404**	**$1,045,677**	**$1,106,716**	**$1,106,716**	**$61,039**	**$0**
Transitional Housing							
Grant & Per Diem:							
Grant & Per Diem Base (I)	*$256,485*	*$264,465*	*$264,465*	*$276,841*	*$276,841*	$12,376	$0
Grant & Per Diem ARP Act (I)	*$12,767*	*$0*	*$0*	*$0*	*$0*	$0	$0
Grant & Per Diem [Subtotal]:	**$269,252**	**$264,465**	**$264,465**	**$276,841**	**$276,841**	**$12,376**	**$0**
Grant & Per Diem Liaisons (I)	$40,694	$41,696	$41,696	$42,947	$42,947	$1,251	$0
Other (S)	$24,262	$20,490	$24,844	$25,838	$26,846	$994	$1,008
Health Care for Homeless Vets:							
Health Care for Homeless Base (I)	*$200,802*	*$268,457*	*$268,457*	*$283,150*	*$283,150*	$14,693	$0
Health Care for Homeless ARP Act (I)	*$9,208*	*$0*	*$0*	*$0*	*$0*	$0	$0
Health Care for Homeless Vets [Subtotal]:	**$210,010**	**$268,457**	**$268,457**	**$283,150**	**$283,150**	**$14,693**	**$0**
Transitional Housing [Subtotal]	**$544,218**	**$595,108**	**$599,462**	**$628,776**	**$629,784**	**$29,314**	**$1,008**
Prevention Services							
Supportive Svcs Low Income Vets & Families:							
Supportive Svcs Low Income Vets & Families Base (I)	*$740,436*	*$774,744*	*$774,744*	*$659,049*	*$659,049*	($115,695)	$0
Supportive Svcs Low Income Vets & Families ARP Act (I)	*$0*	*$0*	*$0*	*$0*	*$0*	$0	$0
Supportive Svcs Low Income Vets & Families [Subtotal]:	**$740,436**	**$774,744**	**$774,744**	**$659,049**	**$659,049**	**($115,695)**	**$0**
National Call Center for Homeless Veterans (I)	$15,612	$10,892	$10,892	$12,920	$12,920	$2,028	$0
Justice Outreach Homeless Prevention Base (I)	$59,449	$64,723	$64,723	$74,787	$74,787	$10,064	$0
Legal Services for Veterans (I)	$12,086	$28,056	$28,056	$48,056	$48,056	$20,000	$0
Justice Outreach Homeless Prevention ARP Act (I)	$0	$0	$0	$0	$0	$0	$0
Justice Outreach Homeless Prevention (S)	$28,123	$16,942	$28,798	$29,950	$31,118	$1,152	$1,168
Prevention Services [Subtotal]	**$855,706**	**$895,357**	**$907,213**	**$824,762**	**$825,930**	**($82,451)**	**$1,168**
Treatment							
Domiciliary Care for Homeless Vets (S)	$243,503	$241,938	$249,347	$259,321	$269,434	$9,974	$10,114
Homeless Patient Aligned Care Teams (I)	$8,199	$15,468	$15,468	$21,000	$21,000	$5,532	$0
Homeless Patient Aligned Care Teams ARP(I)	$0	$0	$0	$0	$0	$0	$0
Telephone Homeless Chronically Mental Ill (S)	$83,239	$84,616	$85,237	$88,646	$92,103	$3,409	$3,457
Treatment [Subtotal]	**$334,941**	**$342,022**	**$350,052**	**$368,967**	**$382,538**	**$18,915**	**$13,571**
Employment/Job Training							
Homeless Veterans Community Employment Prg (I)	$18,203	$20,572	$20,572	$21,772	$21,772	$1,200	$0
Homeless Veterans Community Employment ARP (I)	$0	$0	$0	$0	$0	$0	$0
Homeless. Ther. Empl., CWT & CWT/TR (S)	$217,714	$200,893	$222,939	$231,857	$240,899	$8,918	$9,042
Employment/Job Training [Subtotal]	**$235,917**	**$221,465**	**$243,511**	**$253,629**	**$262,671**	**$10,118**	**$9,042**
Administrative							
Supportive Svces Low Income Vets & Families Adm	$8,890	$11,045	$11,045	$11,476	$11,476	$431	$0
National Homeless Registry	$2,778	$5,166	$5,166	$6,352	$6,352	$1,186	$0
National Homeless Registry ARP	$0	$0	$0	$0	$0	$0	$0
National Center on Homelessness among Veterans	$0	$6,581	$6,581	$9,598	$9,598	$3,017	$0
Administrative [Subtotal]	**$11,668**	**$22,792**	**$22,792**	**$27,426**	**$27,426**	**$4,634**	**$0**
Obligations [Total]	**$2,953,422**	**$3,111,148**	**$3,168,707**	**$3,210,276**	**$3,235,065**	**$41,569**	**$24,789**
ARP Act 1/ [Total included above]	*$21,975*	*$0*	*$0*	*$0*	*$0*		
Breakout by Specific & General Purpose							
(I) Initiative Specific Purpose	$1,938,555	$2,129,483	$2,129,483	$2,129,483	$2,129,483	$0	$0
(S) Sustainment General Purpose	$1,014,867	$981,665	$1,039,224	$1,080,793	$1,105,582	$41,569	$24,789
Obligations [Total]	**$2,953,422**	**$3,111,148**	**$3,168,707**	**$3,210,276**	**$3,235,065**	$41,569	$24,789

Authority for Action: 38 U.S.C. 20

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 that pairs HUD's Housing Choice Voucher rental assistance with VA case management and supportive services for homeless Veterans. These services are designed to help homeless Veterans and their families to find and sustain permanent housing and access the health care, mental health treatment, substance use counseling, and other support necessary to help them in their recovery process and with their ability to maintain housing in the community.

Evidence: HUD-VASH subscribes to the principles of the Housing First model of care. Housing First is an evidence-based practice model that 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, ensuring that the most vulnerable Veterans are moved into housing as quickly as possible.

HUD-VASH Voucher Utilization as of September 30, 2023:

- Vouchers Allocated: 111,620
- Vouchers Under Lease: 82,522
- Vouchers Issued to Veterans Seeking Housing: 5,630
- Vouchers Reserved for Veterans: 1,604

HUD-VASH Measures of Success:

- Voucher Utilization Rate: Target 90% (Utilization as of September 30, 2023: 79.47%)
- HUD-VASH Case Manager Positions Filled: Target 90% (Positions filled as of September 2023: 85.6%)
- Unique Veterans Placed in Housing:

2021	2022	2023
14,054	13,159	16,168

- Unique Veterans Provided Case Management:

2021	2022	2023
89,714	91,404	91,270

Implementation Plan: HUD awards HUD-VASH vouchers to public housing authorities (PHAs) who self-identify to HUD their interest in receiving an allocation; these are based on geographic need. HUD announced its 2023 allocation of 1,739 new vouchers in September 2023. Additionally, HUD's Office of Native American Programs (ONAP) is considering expanding grants for the Tribal HUD-VASH Demonstration Program in 2024.

Upon HUD's publication of new HUD-VASH voucher awards and Tribal HUD-VASH grants, VA funds are distributed to the VA medical centers (VAMCs) partnering with the local PHAs or Tribally Designated Housing Authorities (TDHEs). These funds are used to provide VA or VA-contracted case management services to HUD-VASH Veterans.

Budget Request: HUD currently administers more than 111,000 HUD-VASH vouchers and Tribal HUD-VASH Demonstration Program rental subsidies. VA's HUD-VASH budget supports the full-time employee equivalent (FTE) and contract staff who provide case management and supportive services to Veterans in receipt of these subsidies. The 2025 HUD-VASH budget of $661.5 million, an increase of $44.9 million over 2024, is projected to support approximately 120,000 HUD-VASH rental subsidies anticipated to be available in 2025. The increased funding will cover both case management services for newly awarded vouchers and increased staffing and contracting costs for existing positions caused by cost-of-living adjustments, special salary rates, and other market factors. HUD-VASH currently funds more than 4,600 VA FTE nationally, in addition to approximately $70.0 million in contract services. The proposed 2025 budget will fund these existing staff and contractors as well as additional staff and services congruent with the award of new HUD-VASH vouchers in 2023 and the anticipated award of new HUD-VASH vouchers in 2024, the potential expansion of the Tribal HUD-VASH Demonstration Program and additional HUD-VASH voucher awards in 2025. The 2025 budget will also support a technical assistance contract to aid in program operations, including expanded services for aging and disabled Veterans and other special populations. Additionally, the proposed 2025 will support the increased costs associated with compliance with P.L. 116-283 §4207 of the *William M (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021*.

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 approximately 11,000 transitional housing beds nationwide. Grantee awards entitled them to receive per diem payments from VA to offset the operational costs associated with serving these Veterans. Per diem rates are statutorily tied to the State Home for domiciliary care and increase annually with inflation.

Evidence: The GPD Program has effectively served as a resource for communities to assist homeless Veterans with transitioning out of homelessness since it was first authorized in 1994. GPD fosters a partnership between VA and community-based agencies to create transitional housing resources for homeless Veterans nationwide. GPD-funded projects offer communities a way to help homeless Veterans with housing and services while assisting VAMCs by augmenting or supplementing care. Although the GPD funding request is not to support a new initiative, these funds will allow VA to continue to support this much-needed housing resource. The increase in funding will support costs associated with projected 3% inflation factor in future years to support anticipated increases in the State Home per diem rate and accounts for an increase in the maximum per diem rate from 100% to 115% of the State Home rate for domiciliary care and new provisions for minor dependents, as mandated by P.L. 116-315.

Notable numbers from FY 2023 (October 1 – September 30) related to GPD's impact include but are not limited to the following:

- VA's largest transitional housing program with approximately 12,000 beds authorized nationwide.
- Over 18,500 Veterans entered GPD transitional housing.
- Over 24,500 homeless Veterans were served by GPD transitional housing grants.
- Over 11,000 homeless Veterans exited GPD transitional housing to permanent housing.

In 2023, the following GPD transitional housing grants continued from 2022:

- **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. Approximately 350 grants to organizations to provide approximately 11,500 beds and 17 service centers.
- **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 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 41 grants to organizations were awarded to provide approximately 600 beds.
- **Case Management grant**: This is an opportunity for existing grantees providing housing retention services to formerly homeless Veterans and Veterans at risk for homelessness. Funding supports approximately 120 grants to organizations to support case managers.
- **Special Need**: VA provides funding to 16 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.

Implementation Plan: With the grants, GPD had approximately 12,000 transitional housing beds in 2023. VA establishes and tracks performance standards for all GPD grants. GPD liaisons review progress toward meeting these targets with all grantees at least quarterly. The total funding level

of $319.8 million for 2025 is projected to support more than 11,000 transitional housing beds and approximately 15 independent services centers expected to be operational in 2025.

Budget Request: GPD base budget request for 2025 is $276.8 million, a 4.6% increase over 2024. GPD base funding supports 11 FTE. Funding is primarily used to support grants and per diem payments for more than 500 active grants nationwide. The requested increase will support inflation costs and the recently modified statutory authority under P.L. 116-315 §4204 that increased per diem from 100% of the State Home rate to 115%. This change impacts approximately 10,500 of the more than 11,000 transitional housing beds expected to be operational in 2025, which will have a significant impact on the overall program budget. Additionally, P.L. 116-315 §4204, expanded the statutory authority to pay per diem for minor dependents.

Due to the expansion in the number and types of grants that the GPD Program is responsible to oversee, for example changes mandated by P.L. 117-328, Division U, the *Cleland-Dole Act*, section 310, an additional $1.0 million in Medical Support and Compliance funding is included in the request to ensure essential fiscal and programmatic oversight activities occur. Medical Support and Compliance funding supports salaries and a service-level agreement (SLA) for fiscal oversight and monitoring for all grant projects.

GPD Liaison budget request for 2025 is $42.9 million, a 3% increase over 2024 GPD liaison funding. GPD Liaisons are located at VAMCs nationwide and responsible for the oversight, monitoring and ensuring grant compliance for all active GPD grants.

Health Care for Homeless Veterans (HCHV)

Purpose: The HCHV program has effectively provided outreach services to the nation's most vulnerable Veterans and has served as a resource for communities to assist homeless Veterans with transitioning out of homelessness since it was first authorized in 1987. The central goal of all HCHV programs is to reduce homelessness among Veterans by engaging and connecting homeless Veterans with health care and other needed services. HCHV programs provide outreach, case management and HCHV Contract Residential Services (CRS) programs ensuring that homeless Veterans, especially those who are chronically homeless (many with serious mental health diagnoses and/or substance use disorders) can engage with VA and community partners that provide quality housing and services that meet the needs of these special populations. The HCHV Program is authorized by 38 U.S.C. 2031 and 38 CFR Part 63.

Evidence: During 2023, HCHV program staff provided outreach services to 23,872 Veterans, case management to over 9,659 Veterans and served more than 44,603 through Stand Downs. The HCHV Program also supported approximately 3,600 operational CRS emergency transitional housing beds with 4,541 Veterans exiting the CRS programs into permanent housing. The percentage of homeless Veterans exiting the CRS transitional housing into permanent housing was 60%. The percentage of Veterans exiting into permanent housing increased each consecutive year from 48% in 2017 to 60% in 2023. It is expected that 25,000 Veterans will need outreach services in 2024 and 27,000 Veterans in 2025.

Implementation Plan: Each VA medical center across the country implements the HCHV program at the field level and ensures continuity of services each year. HCHV staff are in place at each medical center to provide outreach services to those Veterans experiencing homelessness.

Performance standards are established and tracked for all HCHV CRS Programs. CRS liaisons review progress toward meeting these targets with all contractors at least quarterly. The 2025 budget request is projected to support four main initiatives and projects:

- HCHV outreach staff and CRS liaisons that will provide oversight to more than 3600 HCHV CRS beds (including newly established medical respite beds), which offer residential treatment for Veterans experiencing homelessness.
- Coordinated Entry Specialists, who work with local Continuums of Care to identify and coordinate services for homeless Veterans in their communities.
- Stand Down support for VAMCs.
- 33 Community Resource and Referral Centers (CRRCs), which are a collaborative effort of VA, the community, service providers and agency partners that provide an open door, one-stop hub for homeless Veterans, providing a central location to engage homeless Veterans in VA and community services.

The proposed 2025 budget will also support implementation of P.L 117-328, Division U, the Cleland-*Dole Act*, section 311. Section 311 requires VA to implement a grant specifically for homeless Veterans with substance use disorders.

In addition to the above, VA is exploring development of a new shelter-like level of care within its homeless services continuum called Safe Haven Shelter Services (SHSS). SHSS provides vulnerable unsheltered homeless Veterans with low barrier to entry safe haven shelter services, with access to healthcare, case management, peer support, meal services, a clean environment, and temporary housing assistance in a designated area on VAMC campuses. SHSS is based on an innovative practice initiated by the VA Greater Los Angeles Healthcare System (VAGLAHS) on its West LA campus called Care Treatment and Rehabilitative Services (CTRS). CTRS was designed initially as a safe and healthy shelter alternative for homeless Veterans residing in an encampment outside the medical center. CTRS participants are provided a private tiny shelter and access to VA medical and behavioral health care services, three daily meals, clean water, soap, bathrooms, showers, and weekly laundry services during their program participation. The West LA Campus site currently has 141 tiny shelters for Veterans, including ADA-accessible accommodations for those with impaired mobility. Based on the success of CTRS in Los Angeles, the continuing high numbers of unsheltered homeless Veterans nationally, and the need for low barrier safe haven settings that can provide 24/7 immediate access to shelter and services for Veterans, VA is launching a pilot effort to develop at least three new SHSS projects nationally. Using GLA's CTRS as a reference, VA estimates that each new SHSS project could cost up to $10 million to develop and operate in its first year. In subsequent years, VA estimates ongoing operational costs of approximately $4 million per project per year. Thus, VA requests a total of $30 million for the first year of this pilot project. It should be noted that these estimates assume a project of 50 tiny shelter units on a one-acre lot.

Budget Request: The 2025 budget request of $283.1 million is projected to support: HCHV outreach staff and CRS liaisons; more than 3,600 HCHV CRS beds, which offer residential treatment for Veterans experiencing homelessness; Stand Down support for VAMCs and 33 CRRCs which are a collaborative effort of VA, the community, service providers and agency partners which provide an open door, one-stop hub for homeless Veterans, providing a central

location to engage homeless Veterans in VA and community services. HCHV currently supports 918 FTE nationally, specifically 192 CRRC FTE, 725 Outreach HCHV and CRS Liaisons and Coordinated Entry Specialists. The 2025 budget request supports an additional 30 HCHV FTE, a small number of medical facilities (MF) funding (leased space for the CRRCs) in addition to Contract Residential Services beds. The 2025 budget request also includes $30 million for the SHSS initiative. The SHSS estimated cost per project is approximately $10 million per site.

Further, the 2025 budget request also includes $573,000 to support implementation of a new grant specifically for Veterans with substance use disorders mandated by section 311 of the *Cleland-Dole Act*. Estimate includes $295,000 for program staff, who will provide administrative support and oversight nationally, and $278,000 related to grant administration expenses.

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: SSVF's success has significantly contributed to decreasing the number of homeless Veterans since 2010. During SSVF's years of operation, more than 80% of Veterans and their families exited the program and are in permanent housing. Annual reports published since the inception of the SSVF program continue to demonstrate the efficiency and effectiveness of the SSVF program (https://www.va.gov/homeless/ssvf/research-library). For example, research conducted by the National Center on Homelessness Among Veterans found that for those Veterans exiting SSVF and placed in permanent housing, only 6% to 13% of families and 7% to 15% of individuals re-enter the homeless system one year after discharge from SSVF. As a point of comparison, these return rates were comparable to the 7% to 10% of Veterans in poverty who are estimated to experience homelessness on an annual basis, according to the best available data from 2012 through 2019. This is a particularly important finding as it is well-established that those who have previously been homeless are at higher risk of future homelessness. SSVF's ability to maintain these strong outcomes depends on training and support for its grantees coupled with a robust oversight program.

In 2023, 74.43% of those discharged from the SSVF program obtained permanent housing. In 2023, grant awards of $431 million from the discretionary Medical Services appropriation were awarded to non-profit organizations in all 50 states, Puerto Rico, the District of Columbia, Guam and the Virgin Islands.

SSVF innovations and services supported by the 2025 budget:

- Established in 2022, Shallow Subsidies provide two-years of continuous rental assistance (traditional SSVF rental assistance provides only 10-12 months of rental assistance in a two-year period) for Veteran families who do not need intensive clinical supports and are struggling to meet growing housing cost burdens.

- A hotel/motel emergency housing assistance can be a critical tool for those experiencing unsheltered homelessness who are unable to go into traditional shelter or emergency housing available through the community or VA. SSVF's hotel/motel assistance will continue to be utilized post-COVID as an option for this population.
- Upgraded health care supports, such as the health care navigators, offered by all SSVF grantees, help homeless and at-risk Veteran families access critically needed health and mental health resources.
- Legal Services are available for those enrolled in SSVF. For example, the eviction moratorium demonstrated the importance of policy and legal remedies in preventing homelessness.

Implementation Plan: VA publishes the SSVF notice of funding availability (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. Veteran families nationwide can access SSVF services as grantees in all 50 states, the District of Columbia, Puerto Rico, Guam and the Virgin Islands.

A NOFA was published in the Federal Register on December 5, 2023, to announce the availability of SSVF grant funding for 2025.

SSVF Grant Award Budget Request: The 2025 SSVF budget proposes a funding level of $659.0 million to support the SSVF program. 2025 funding would sustain existing SSVF grant awards including new initiatives: Shallow Subsidy, Health Care Navigation, Legal Services, and Landlord and Tenant Incentives.

SSVF Administrative Budget Request: The SSVF administrative 2025 budget request includes $11.5 million to support administrative costs, including FTE support and contract services, supporting the SSVF program.

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,"(VA, 2021) 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 provides NCCHV leadership the ability to quickly identify, understand and resolve problems within the contact and proactively implement changes for future interactions with Veterans.

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.

NCCHV is partnering with the Homeless Program Office, Veterans Benefits Administration (VBA) and Department of Defense (DoD) in a Transitioning Service Member Resource Connection (TSMRC) initiative at 30 DOD facilities, which provides information, resources and tools to Service members and their families to help prepare for the move from military to civilian life. Creating a mechanism for a warm handoff with NCCHV contact prior to leaving active-duty service ensures at-risk Service members are actively managed and connected with the appropriate VA Homeless Veteran's representative. Follow-up reviews ensure each Veteran has adequate housing prior to their first night on the street.

In 2023, NCCHV partnered with Homeless Program Office (HPO) in rolling out our first outbound call campaign in support of the Help with Employment, Agency, Risk, Transitioning and Housing (HEARTH) project. This project aimed to enhance the existing DoD to VHA transition of care process through integration of a predictive analytics model that identifies Army Veterans who are at high risk of experiencing homelessness, unemployment and/or suicidal behaviors within their first 12 months of post-military separation or retirement. NCCHV has continued the HEARTH outbound call campaign into 2024 and has currently made 724 outbound calls with a 26.03% being interested in HEARTH enrollment and 51 Veterans actively participating in the program. NCCHV intends to continue to support HPO with additional initiatives in 2025 to proactively address at risk transitioning Service members through outbound call campaigns.

Evidence: Commission on Accreditation of Rehabilitation Facilities and International Customer Management Institute Accreditation depends on the establishment and utilization of a quality monitoring program. A quality monitoring pilot conducted in 2019 showed an 8% increase in productivity for NCCHV due to coaching and monitoring to ensure social service representatives were using the correct processes. From August 2022 through August 2023 NCCHV's Average Speed of Answer has decreased by 49%, Abandonment Rate has decreased from 2.3% to 0.8% and Service Level has increased from 92% to 96%. These numbers show a direct correlation to a robust quality program and the positive impact it can have on the productivity of a call center. Text messaging is 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. NCCHV takes over 50,000 chats per year and text messaging provides another avenue of contact. Approximately 18,000 separating Service members per year without Post Transition Housing Plans are projected to receive an inbound phone call. Each new Veteran served would receive at a minimum one (1) referral and one (1) follow-up review.

Implementation: NCCHV would rely on the Health Resource Center's current Quality Monitoring Team to implement a plan specific to NCCHV. NCCHV can duplicate an already established text messaging process utilized by the VCL. NCCHV will continue collaborating with VBA, Homeless Program Office, and DoD to support the TSMRC initiative and the 30 DOD installations that have been rolled out. The 2025 budget request will support NCCHV's Quality Monitoring Pilot to mirror VCL's already-established text messaging process and its coordination efforts with the TSMRC to better assist Service members who are at risk for homelessness upon separation from the military.

Budget Request: The 2025 budget request is $12.9 million, an increase of $2.0 million for additional FTE support. NCCHV has experienced a 57% increase in call volume and 51% increase in chat volume since 2019. In 2023, there was a 29% increase in call volume compared to the same period in 2022. With this increase in demand for services, and the addition of both text capability and the nationwide TSMRC rollout, current NCCHV staffing levels will not support Veteran requirements. To support this service demand, NCCHV will require an additional 18 FTE (15 Social Service Representatives, one Management Analyst, one Supervisors, and one Quality Analysts) to support the projected workload and maintain an acceptable service level for the nation's homeless Veterans.

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 historically face heightened risks of homelessness, suicide, and other negative outcomes. Congress has recognized the value of this program by mandating the expansion of VJO field staff by 50 FTE in 2019, through P.L. 115-240, *Veterans Treatment Court Improvement Act of 2018*. Congress mandated expansion of the VJO workforce, with a focus on enhancing services to Veterans in rural and underserved areas, through section 302 of P.L. 117-328, *STRONG Veterans Act of 2022*. This request provides for the continued growth and sustainment of the program, in keeping with Congress's demonstrated intent.

Evidence: The demand for VJO services is expected to continue growing through 2025. 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 (VTC) and/or Veteran specific housing units in local jails. There are 680 VTCs and other Veteran focused courts and over 100 Veteran-specific housing units in local jails. 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.

As noted above, communities across the country continue to launch new Veteran-specific criminal justice programs – such as Veterans Treatment Courts and Veteran-specific jail housing units – and in some cases to expand the capacity of such programs that already exist. The sustained growth in demand for VJO services is evidenced by VAMCs' continued requests for additional VJO FTE to serve justice-involved Veterans in the communities they serve. Although the VJO workforce expanded significantly in 2024 (adding 86.5 FTE, a 21% increase), this expansion did not fully meet the need identified by VA medical centers, which requested an additional 68 positions beyond the 86.5 that were awarded. Given these already identified needs and the persistent, widespread interest among criminal justice agencies in developing new partnerships to serve justice-involved Veterans, we expect that facilities will also register significant demand for additional VJO capacity in 2025.

Specialists conducted outreach to justice-involved Veterans in more than 2,000 local jails and 680 VTCs and other Veteran-focused courts. These efforts allowed them to serve over 41,000 justice-involved Veterans, many of whom had significant and complex clinical needs. Fortunately, VJO specialists are highly effective at helping Veterans access VA services that are responsive to such

needs. In 2023, 94% of Veterans served by VJO specialists went on to access other VHA services. Of these Veterans:

- 65% were diagnosed with one or more mental health disorders and 67% of those with such diagnoses entered VHA mental health treatment.
- 47% were diagnosed with one or more substance use disorders and 36% of those with such diagnoses entered VHA substance use disorder treatment.

Implementation Plan: The additional funds requested for 2025 will provide ongoing support for VJO specialists and peer specialists, including those awarded in 2024, to develop and/or expand partnerships with local criminal justice agencies to facilitate justice-involved Veterans' access to VA treatments. The award and hiring processes will follow a model in place for ten years. These positions are awarded on a need basis, in response to VAMCs 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 will fill its allocated position and reports on its status in 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. VJO specialists spend significant time with criminal justice partners and traveling to distant outreach locations; therefore, their clinical workload is often lower than that of comparable staff. Thus, VAMC's historically requested additional funding to sustain locally funded positions for more than the typical three years.

Budget Request: The 2025 budget request of $74.8 million is projected to support outreach and linkage to VA services for justice-involved Veterans by approximately 505 VJO staff. This expanded VJO workforce will respond to the growth of Veteran focused interventions in local criminal justice systems, including by providing direct support to the 680 VTCs.

Legal Services for Veterans (LSV)

Purpose: LSV is a new program within the Homeless Programs Office that focuses on facilitating Veterans' access to legal services, including landlord/tenant disputes and child support arrears that can present barriers to housing stability. In addition to providing training, technical assistance, and partnership development support, the LSV program will administer two streams of grant funding to support the provision of legal services to Veterans by eligible non-VA entities.

Evidence: These new grant programs are mandated by P.L. 116-315 §4202 of the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020* and P.L. 116-283 §548 of the *William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021*. The *first ever* Legal Services for Homeless Veterans and Veterans At-Risk for Homelessness (LSV-H) Grant Program began August 1, 2023. The VA awarded 79 grants, totaling $11.5 million in funding. The awarded grantees are serving Veterans in 38 states and the District of Columbia. 100% of LSV-H grantees have implemented their programs with 86% of grantees delivering legal services to eligible Veterans in Quarter 1 of 2024.

Implementation Plan: Section 4202 of P.L. 116-315 requires VA to award grants to eligible entities for the provision of legal services to Veterans who are homeless or at risk of homelessness. Following consultation with Veteran Service Organizations and legal service providers, VA developed regulations governing this new grant program, which were published as an Interim Final

Rule on June 1, 2022. VA published a NOFO in October 2022 and awarded the first round of grants in 2023.

Section 548 of P.L. 116-283 requires VA to establish a pilot grant program within one year to assess the feasibility and advisability of awarding grants to external entities for the provision of legal services to individuals who served in the Armed Forces, regardless of the conditions of their discharge or release. Subsection (b) also requires VA to ensure at least one grant is issued in each state under the pilot program. Legal services funded by these grants must be provided at locations other than VA facilities. VA's authority to award grants under this pilot program runs for five years from the date of the program's establishment.

After consulting with external groups that currently provide legal assistance to Veterans and former Service members for issues identified in the statute (e.g., discharge upgrades, benefits assistance, and others), VA is developing regulations under which it will be able to award grants to eligible entities. As required by section 548(b), these grants will be awarded through a competitive process that ensures consideration of applicants' experience, financial capacity, and other specified qualifications.

Budget Request: The 2025 budget request of $48.1 million supports salaries for staff and wo new grant programs. The amount requested includes $21.0 million for the grant program authorized by P.L. 116-283 §548 to support the award of an estimated 140 grants to legal service providers and $23.0 million to support up to 150 grants under P.L. 116-315 §4202. Grants will cover annual salary and benefit costs for approximately one attorney position, data collection, reporting and other administrative costs associated with the grant.

Homeless Patient Aligned Care Team (HPACT)

Purpose: The HPACT program is a multi-disciplinary, population-tailored medical home designed around the unique needs and challenges homeless Veterans face both accessing and engaging in traditional 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 use 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 need to help accelerate placement into permanent housing and prevent a return to homelessness. The success of the HPACT program is based on multiple factors such as panel sizes, Veteran encounters/visits, number of Veterans served, and overall engagement in VHA. HPACT is authorized to provide health care to eligible Veterans under Title 38 U.S.C. 7302(b), Title 38 CFR Section 17.38.

The 2025 HPACT budget request supports the VA goal of *delivering timely, accessible, high-quality benefits, care and services to meet the unique needs of Veterans and all eligible beneficiaries* through the provision of additional staffing at current HPACT sites to increase the capacity of homeless Veterans served and services provided (e.g., HPACT initiatives such Mobile Medical Units and harm reduction projects) to improve quality of life for homeless Veterans. Additionally, the requested funding allows for potential growth of HPACT to new teams and/or sites to expand primary care services that are specifically tailored to Veterans experiencing

homelessness and those at risk based on the five core HPACT elements noted below, which includes increasing access to care.

The 2025 HPACT budget request supports the VA goal of *improving the trust of underserved Veteran populations* as primary care tailored specifically for homeless Veterans. HPACT consistently shows better care experiences compared to standard primary care (Kertesz et al., 2021), especially for those also experiencing serious mental illness (Gabrielian et al., 2021). In addition, homeless tailored primary care approaches, such as the HPACT model, may improve depression care for people experiencing homelessness (Jones et al., 2023). Based on the evidence, the HPACT model provides positive patient experiences that improves the trust of Veterans experiencing homelessness and highlights the need to expand services further across VHA for this vulnerable population.

Evidence: In 2012, the HPACT program began with a total of 32 pilot sites. As of 2023, there are 95 HPACT teams and providers operating at 62 VAMCs, Community Based Outpatient Clinics (CBOCs) and CRRCs across the country. HPACTs are in every VISN with over 185 full time equivalent staff serving over 23,000 Veterans annually. Veterans enrolled in HPACT show a 19% reduction in emergency department visits and a 35% reduction in inpatient hospitalizations. Veterans in HPACTs were housed in permanent housing 81 days faster than those not enrolled in a HPACT. In addition, HPACT Veterans are more likely to report positive patient care experiences related to access, communication, provider ratings and comprehensiveness of care than those enrolled in standard primary care. The benefits of HPACT and potential expansion is the program's ability to address multiple medical and social needs of Veterans in one setting and address barriers homeless Veterans face accessing and engaging in traditional primary care. These results are accomplished by incorporating five core elements that distinguish HPACT from traditional primary care models:

- Reducing barriers to care by providing open-access, walk-in care in addition to community outreach to engage those Veterans disconnected from VA services.
- 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 provide food and clothing assistance, hygiene items, showers and laundry facilities and other services on-site to meet the full spectrum of Veteran needs.
- Engaging Veterans in intensive case management that is coordinated with community agencies, partners, and other VA services for continuous care with more seamless transitions.
- 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.
- 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 issued funding for the start-up of new teams or expansion of existing teams in 2023, which launched six new HPACT sites. Additionally, 14 sites received additional HPACT staff positions with 2023 funds to support current teams and expand services

and access for Veterans experiencing homelessness. Many requested registered nurses (RN), social workers (SW), physical or occupational therapists (PT/OT) and peer support specialists to expand HPACT services further and help support the growing subpopulation of aging Veterans experiencing homelessness. The HPACT mobile medical unit (MMU) project was also launched in 2023, in which 25 MMUs were built with HPO awarded American Rescue Plan (ARP) funds and began to be distributed to HPACT programs at 25 sites across the VA system. The goal of the MMUs is for HPACT programs to provide direct medical, mental health and social services to Veterans experiencing homelessness in the community setting and help engage unsheltered Veterans in care. The 2024 budget supports the growth and increased need of the HPACT program within HPO that includes a new pilot initiative to bring the HPACT model directly to HUD-VASH Veterans. This HUD-VASH/HPACT pilot utilizes the HPACT medical home model and population tailored approach to provide in-home primary care services to Veterans actively enrolled in the HUD-VASH program. This pilot will work to address the gap of almost 23% of current HUD-VASH enrolled Veterans having no assigned primary care provider and many with high acuity medical needs as 60% are over the age of 60. The 2024 funds were awarded to support four types of positions (provider, RN care manager, LPN/LVN, MSA) at five VAMCs.

Budget Request: The total $21.0 million budget request for 2025 will support the currently funded HPACT salaries including staffing of the HUD-VASH/HPACT initiative and a GS-13 Health system specialist position in the HPACT nation program office to assist with the growing portfolio of the program. The 2025 budget is an increase of $5.5 million budget over 2024 to support 25 HPACT FTE positions (e.g., RN, SW, MD/APRN, PT/OT, peer specialist) that support the expansion and growth of the program and subsequent initiatives.

Homeless Veterans Community Employment Services (HVCES)

Purpose: HVCES provides employment services and resources to Veterans participating in VHA homeless programs to increase access to permanent housing and improve housing stability. HVCES provides direct services and coordinates 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 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 2023, approximately 5,900 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 were over 54%, which exceeds the national target of 50%. There were 13,250 newly documented, unique instances of employment for Veterans engaged in VHA homeless services. Although staff have returned to face-to-face visits with Veterans, virtual platforms are well utilized in the provision of employment services and provide increased flexibility for Veterans and greater opportunities to reach those who are not near a VA medical center.

Implementation Plan: HVCES received increased funding in 2023 to align with the greater number of Veterans served in HUD-VASH, which rose from 66,287 in 2014 to 91,154 in 2023. While not all Veterans served by VHA homeless programs are interested in employment, it is critical to provide employment assistance to all Veterans who are able to return to work to improve housing stability and help prevent returns to homelessness. While monetary benefits are a critical component of financial stability for homeless Veterans, benefits alone may not be sufficient for community integration and increased economic independence. Even part-time employment can support Veterans' housing goals. The requested funds support the vocational development specialists who provide direct employment services to homeless Veterans and develop employment opportunities and community partnerships. A model that encourages the utilization of non-VA resources provides more comprehensive services for homeless Veterans and is more cost-effective that providing only direct employment support. In 2025, 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. This will include joint trainings for staff and highlighting the impact of this partnership on employment for Veterans who have experienced homelessness. Because DOL already has targeted services for Veterans in general, and specifically for those who have experienced homelessness, this collaboration will result in Veterans being appropriately enrolled in these programs rather than being an additional cost burden to external partners. Implementation success will continue to be measured by the employment outcomes of Veterans exiting GPD programs and while in HUD-VASH case management.

Budget Request: The 2025 budget request of $21.8 million supports 210 FTE employment staff in the field at the GS-11 level. The increase of $1.2 million over 2024 will allow for up to ten new staff across locations to support VHA goals to prevent returns to homelessness and allow targeted sites to increase the reach of their services across local catchment areas, including rural locations. At the end of 2023, 10,185 Veterans were employed while in HUD-VASH case management. Providing employment services to Veterans with poor work histories, including justice involvement and psychosocial barriers, often requires more intensive services over a longer duration than would employment services for Veterans who have not experienced homelessness. Therefore, with additional staff, an estimated 500 additional Veterans will receive employment services. These new FTE will help ensure that the national HUD-VASH employment target of 50% will continue to be met or exceeded.

National Homeless Registry

Purpose: The National Homeless Registry is a comprehensive repository of Veterans who were identified as homeless or at risk for homelessness any time since October 1, 2005, along with 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 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 was secured to address this gap. The creation of this registry of Veteran data became the foundation for guiding program development and formatting research to enhance services for Veterans. Knowledge gained from these efforts augments the original registry content and adds to its ongoing development.

The National Homeless Registry supports Homeless Program Initiatives related to the expansion of ongoing efforts to support VA's mission to end Veteran homelessness, specifically related to: (1) productivity and workload capture compliance and standards, (2) VA enterprise goals related to permanent housing placement, prevention of returns to homelessness, and outreach efforts, (3) centralized technical assistance for VISN and VAMCs around homeless program policy and compliance efforts, (4) identification of service gaps and proactive engagement to reduce gaps, (5) Homeless Program performance measurement and program evaluation efforts, (6) Federal Partner, community and VA data sharing initiatives, (7) national identification and dissemination of innovative practices, (8) tracking and reporting mechanisms for homeless programs to support increased utilization, service provision, and resource allocation, (9) national support to ensure prioritization of required clinical staffing levels for VA Homeless Programs, and (10), resources for development, management and sustainment of HOMES 2.0, VA's data collection platform used by front-line homeless coordinators to manage and document outreach, assessment, referral, and engagement in homeless program services.

Implementation Plan: The registry budget supports the development and continued 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.

Budget Request: The 2025 budget request of $6.4 million will continue to support the Homeless Operations, Management and Evaluation (HOMES), management, technical assistance contracting services, staffing resources, and sustainment. Sustainment of HOMES is essential to homeless program operations, which are critical to program reporting capabilities, including VAMC level and leadership dashboards to support national initiatives, data sharing with community providers, and national/VISN/VAMC level insights to support program operations and

service provision. In addition, funding will support implementation of the legislative requirement in P.L 117-328, Division U, the *Cleland-Dole Act*, section 309 - System for Sharing and Reporting Data.

The National Center on Homelessness among Veterans (The Center)

Purpose: P.L. 114-315, The Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016, codified the National Center on Homelessness among Veterans (the Center). The Center promotes recovery-oriented care for Veterans who are homeless or at risk for homelessness. The Center conducts and supports research, assesses the effectiveness of programs, identifies, and disseminates best practices, and integrates these practices into polices, programs and services for homeless or at-risk of homelessness Veteran populations and serves as a resource center for all research and training activities carried out by VA and by other Federal and non-Federal entities with respect to Veteran homelessness. The Center operates within an integrated organizational model and is comprised of the following cores:

- Model Development & Implementation Core
- Policy/Program Integration Core
- Education & Dissemination Core
- Research & Methodology Core

Evidence: The Center works with its operational partners within VA's homeless programs and other stakeholders to identify key areas of research and program/process evaluations, educational needs, and program integration opportunities. As a result, the Center developed and/or piloted numerous housing models and interventions for Veterans who experienced homelessness or are at risk of homelessness. These programs are now VHA's homeless foundational services, including HPACTs, SSVF, Housing First, CRRCs, Low Demand Safe Haven residential, GPD transitional housing programs and the National Homeless Registry. The Center generates numerous peer-reviewed publications, trainings, and on-line resources for thousands of both VA and non-VA providers on issues related to homelessness and provides grants to the Center affiliated researchers to assist in expanding the Center's research capabilities.

Implementation Plan: Plans are underway to expand the Center's research program in 2025 by developing and evaluating new interventions (e.g., targeting housing instability, health needs and social determinants of health) in partnership with other VA program offices and universities. Additional expansion opportunities include exploring the development of programs for vulnerable Veterans at risk for homelessness, including Veterans who have recently transitioned to civilian life from military service, development of sophisticated data collection and analytic methods, the deployment of evidence-based practice training, and predictive data models to identify Veterans at-risk of evictions, disconnection from care, and negative exits from homeless programs. Data-driven enhancements of virtual care services, including services offered by the National Call Center for Homeless Veterans and Veterans Health Administration Post-9/11 Transition and Case Management, are also anticipated to be pursued.

Budget Request: The 2025 budget request for the Center is $9.6 million, an increase of $3 million over the 2024 budget request. This increase is based on the growing recognition and need to advance evidence-based policies and research-driven solutions to prevent and end homelessness

among Veterans. The 2025 budget will support the Center's FTE and contract positions needed to support the Center's work as described under implementation plan. The budget supports salaries of VHA positions that provide direct Veteran Care associated with one of the Center's model development projects, whose aims include preventing homelessness among Veterans who have recently transitioned to civilian life from military service.

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Understanding and Improving Housing and Economic Security for Veterans

The 2025 budget includes $5.8 million to implement a multi-year national evaluation focused on optimizing programs and policies to support Veteran housing and economic security consistent with VA's Supplement on Homelessness to VA's Learning Agenda. This amount will enable VHA to build and sustain data curation, analysis capacity, and implementation of evaluation findings into practice across VA. VHA will lead this evaluation in partnership with the Office of Enterprise Integration (OEI), the Veterans Benefits Administration (VBA), and the Veterans Experience Office (VEO), and evaluation protocols will be peer-reviewed by the Quality Enhancement Research Initiative (QUERI). The overall goal of this evaluation is to longitudinally assess the life experiences of Veterans to inform decisions and improvements to VA programs and policies involving long-term Veteran outcomes related to housing and economic security, including preventing and ending homelessness and receiving permanent employment or education opportunities, and, potentially, VA home loans.

This evaluation will be accomplished through the novel curation and validation of multiple sources of data representing the Veterans' life journey to better understand the risk and resilience factors

related to homelessness and housing security to better tailor programs and policies in meeting their needs. This proposed evaluation uses a novel journey mapping process that VA has adopted to address the needs of underserved, marginalized, and at-risk Veterans by using mixed methods (qualitative and quantitative data) to curate primary and secondary data on lived experiences and data trends among Veterans. The population for this evaluation is also novel in that it proposes to use Department of Defense (DOD) and State records to include a sample of Veterans who are currently not receiving VA benefits or healthcare, matched using demographic factors to those currently receiving VA benefits or services, with oversampling of Veterans who identify as underrepresented. For this combined cohort, DOD, VHA, VEO, and VBA data will be used to provide a "whole person, whole life" description of factors associated with receipt and no receipt of VA housing, educational, employment or other healthcare benefits at the population level. Using this population-based cohort, the evaluation will develop, curate and provide access to comprehensive data on Veteran housing and economic insecurity risk and resilience factors along with data on structural factors, for example, county-level housing and economic indices, and identify and disseminate findings on programs and policies that could mitigate risk factors related to housing and economic security.

Whole Health

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations 1/							
Medical Services (0160):	$60,018	$87,074	$87,074	$97,937	$97,937	$10,863	$0
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$18,989	$18,924	$18,924	$19,502	$19,502	$578	$0
Medical Facilities (0162):	$0	$1,850	$1,850	$1,850	$1,850	$0	$0
Obligations [Grand Total]	**$79,007**	**$107,848**	**$107,848**	**$119,289**	**$119,289**	**$11,441**	**$0**

[1/]Whole Health budget includes the entire $33.0 million in obligations requested for Patient Centered Care Services and Administration supporting P.L. 114-198 §933 (part of *Jason's Law*). This amount is also included in the Opioid Prevention, Treatment and Program budget shown earlier in the chapter.

Authority for Action

- Public Law 114-198 §933, *Comprehensive Addiction and Recovery Act of 2016*, signed into law July 22, 2016. Efforts are underway across VHA addressing the requirements of Comprehensive Addiction and Recovery Act (CARA), Public Law (P.L.) 114-198, Sections 932 and 933, which directed planning for, and expansion of, Complementary and Integrative Health services. The Whole Health System creates the healthcare approach that optimizes the benefits of complementary and integrative health services and self-care.
- Executive Order 13822, *Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life*, issued January 2018. It requires the Departments of Defense, Veterans Affairs, and Homeland Security, through the Assistant to the President for Domestic Policy, to develop "a joint plan that describes concrete actions to provide, to the extent consistent with the law, seamless access to mental health treatment and suicide prevention resources for transitioned uniformed services members in the year following discharge, separation, or retirement."
- Executive Order 14058, *Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government*. Specifically, the President's Management Agenda

includes *Navigating transition to civilian life*. Transforming Federal Customer Experience and Service Delivery To Rebuild Trust in Government

- House Appropriations Report 118-122 – 118th Congress (2023-2024) – Accompanies: H.R. 4366 *Consolidated Appropriations Act, 2024*. *Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2024*. The Committee recommendations includes $107,848,000 for Whole Health, as requested which is $21, 997,000 above the fiscal year 2023 enacted level. The Committee supports the Whole Health model of care and the expansion of Whole Health to all VA facilities.

Purpose: Whole Health is an approach to health care that empowers and equips people to take charge of their health and well-being and to live their life to the fullest—with a focus that goes beyond "what's the matter with you" to "what matters to you". Robust outcome evaluations demonstrating the effectiveness of the Whole Health approach (e.g., decreases in opioid use, invasive spine procedures, and stress levels, as well as increased engagement in health care, including mental health services and self-care) are outlined below.

The Whole Health System centers around supporting the Veteran to improve their overall health and well-being and serves as the "delivery system" for the Whole Health approach. It consists of three components: (1) The Pathway - where Veterans work to optimize health and well-being by defining and exploring what matters most to them and what they want for their health and well-being in partnership with Whole Health Partners, ideally peer Veterans who assist Veterans to understand the benefits of the Whole Health Approach, local Whole Health resources available for support, and assist Veterans with a self-exploration process to help them become more active participants in their health through a Personal Health Inventory and health planning process, and Whole Health Coaches, who empower Veterans to develop and achieve self-determined goals related to health and well-being as well as develop strategies for making sustainable, healthy lifestyle behavior changes and more effectively manage chronic diseases; (2) Well-being Programs - where Veterans can access evidence-based complementary and integrative health approaches including acupuncture, biofeedback, clinical hypnosis, guided imagery, massage therapy, meditation, Tai Chi, and yoga as well as education in nutrition and other areas of self-care; and (3) Whole Health Clinical Care - routine preventive and disease management care is informed by a shared understanding between the Veteran and clinician of what matters most to the Veteran. The concept of "Mission, Aspiration, and Purpose" (MAP) is the core principle around which the entire Whole Health System is organized and ensures that the focus is always on what is most important to the Veteran.

The integration of the Whole Health approach to care is advancing throughout the entire system as evidenced by locally defined Veteran Integrated Service Network (VISN) and VA Medical Centers (VAMC) Whole Health strategic objectives, tactics and actions that have been developed with and supported by the VHA's Office of Patient Centered Care and Cultural Transformation (OPCC&CT). This work is ongoing and responsive to national initiatives and enterprise goals to support Whole Health expansion and sustainment at every VAMC. Whole Health points-of-contact are available at every VAMC to aid in program expansion and connect Veterans to Whole Health services.

Evidence: In February 2020, the first stage of an evaluation of the outcomes of the Whole Health Flagship effort was completed by a team from VA QUERI. The Whole Health report (https://www.va.gov/WHOLEHEALTH/docs/EPCC_WHSevaluation_FinalReport_508.pdf) was the basis of the Congressional progress report mandated in the Comprehensive Addiction and Recovery Act of 2016, Public Law (P.L.) 114-198 legislation, which was submitted to congress March 31, 2020. Even relatively early during the Whole Health deployment at the flagships, this evaluation indicated positive results, including:

- 31% of Veterans with chronic pain at the flagships engaged in some Whole Health services;
- Opioid use among comprehensive Whole Health users decreased 38% compared with only an 11% decrease among those with no Whole Health use and
- Veterans who used Whole Health services reported:
    - Improvements in perceptions of the care received as being more patient centered,
    - Improvements in engagement in health care and self-care,
    - Improvements in engagement in life indicating improvements in mission, aspiration and purpose and
    - Improvements in perceived stress indicating improvements in overall well-being.

Continuing analysis of Veteran outcomes shows significant improvement in Veteran satisfaction, engagement with care, pain, stress, and quality of physical and mental health in those using Whole Health. In addition, users of Whole Health with back pain showed a reduction of 20-40% in downstream invasive spine procedures. Finally, Veterans with a mental health diagnosis who began using Whole Health were 2.3 times more likely to engage in evidence-based psychotherapies 12 months later when compared to those not using Whole Health.

A recent National Academies of Sciences, Engineering and Medicine (NASEM) report entitled, "Achieving Whole Health: A New Approach for Veterans and the Nation" reviewed the evidence for the Whole Health approach in depth and concluded that "Whole health is a common good that benefits everyone" that should be scaled and disseminated across the entire U.S. health care system. They found strong evidence that this initiative has been effective in improving Veterans' lives, but noted that there was still work to be done within VA to ensure access to Whole Health:

"NASEM Recommendation 2.1: National, regional, and facility VA leaders should ensure that all sites are ready to offer the Whole Health System of Care to all Veterans by ensuring that each site understands and adopts the whole health mission and vision and has the resources and services it needs to transform its care delivery approach. While VA has made tremendous advances in developing, implementing, and spreading its Whole Health System (WHS), not all VA sites have fully implemented it. All veterans should have easy access to whole health care in their community, which requires more fully scaling and spreading the WHS to all VA facilities. (National Academies of Sciences, Engineering, and Medicine, 2023, Conclusions and Recommendations."

Implementation Plan: Based on extensive experience over the past decade, it is clear that VHA is fully capable of implementing the Whole Health approach to care, including the utilization of Whole Health Coaches and Whole Health Partners. In 2023, Whole Health grew to include 29% of all Veterans receiving care through VA, with 1.8 million Veterans receiving Whole Health during 6.3 million Whole Health encounters. Tele-Whole Health-specific encounters have also grown to include 135,547 unique Veterans participating in 663,263 encounters in 2023, which is an increase of 28% unique patients and 18% of encounters over 2022. Demand has continued to grow dramatically year over year and based on participation in the most fully resourced VAMCs, we project that roughly 30-40% of Veterans will ultimately participate in the Whole Health System on a regular basis in some way. A major obstacle in growth to date has been the fact that uptake in hiring into these new roles varies widely from one VAMC to another. The goal of this proposal is to ensure that every VAMC in the country has sufficient staffing in these roles (which will vary with the size of the facility) to provide access for every Veteran who is interested in participating.

Budget Request*:* The primary goal of the proposed increase is to provide support for the hiring of Whole Health Coaches and Whole Health Partners at every VAMC. The number to be hired will vary with the size of the facility. This proposal focuses on Whole Health Coaches and Whole Health Partners because these positions are vital to accomplish the goal of "changing the conversation" with the Veteran to focus on what matters most to them. Because these positions and the goal of focusing on what matters have not been routinely incorporated into health care systems in the past, in some areas of the VHA the process of hiring these core staff has been unfamiliar to leadership and at times challenging due to competing demands. The financial support requested here will remove the primary barrier to accomplishing the goal of having these positions filled at every VAMC across the system.

This proposal will address a defined priority in the 2022 – 2028 VA Quadrennial Plan (VA Plans, Budget, Finances, and Performance), specifically STRATEGIC OBJECTIVE 2.2: (Tailored Delivery of Benefits, Care and Services Ensure Equity and Access) VA and partners will tailor the delivery of benefits and customize whole health care and services for the recipient at each phase of their life journey. It directly supports the implementation of *Strategy 2.2.2: (Whole Health) VA empowers employees to deliver high-quality whole health care that equips Veterans and supports their health and well-being by addressing what matters to them most.*

In addition, this proposal directly supports Whole Health Directive 1445, published in 2023, which establishes the Whole Health System (WHS) model of health care within the Veterans Health Administration (VHA) and outlines requirements and responsibilities for WHS implementation across Veterans Integrated Services Networks (VISNs) and Department of Veterans Affairs (VA) medical facilities. The proposal also directly supports the Under Secretary for Health's (USH) Priority to Action initiative "Support Veterans' Whole Health, their Caregivers and Survivors." Engagement with Whole Health has been shown to improve Veterans' quality of life as well as decrease the need for opioid medications for Veterans with chronic pain (Bokhour, et al., 2022). The expanded access to these services supported by this budget request will allow larger numbers of Veterans to experience these proven benefits. Because screening for and addressing social determinants of health is an essential part of the Whole Health conversation, coaches and partners are also critical to supporting the expanding effort across VHA to address this area. Finally,

coaches and partners can serve as key team members in the Primary Care/PACT setting, helping support overburdened providers and nursing staff who are experiencing growing levels of stress and burnout. These team members can help create comprehensive care plans by allowing the provider an opportunity to transition much of the education, coaching and skill-building required for good Primary Care to the coach and partner.

References:

Bokhour, B. G., Hyde, J., Kligler, B., Gelman, H., Gaj, L., Barker, A. M., Douglas, J., DeFaccio, R., Taylor, S. L., & Zeliadt, S. B. (2022). From patient outcomes to system change: Evaluating the impact of VHA's implementation of the Whole Health System of Care. *Health services research*, *57 Suppl 1*(Suppl 1), 53–65. https://doi.org/10.1111/1475-6773.13938

National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Transforming Health Care to Create Whole Health: Strategies to Assess, Scale, and Spread the Whole Person Approach to Health; Meisnere M, South-Paul J, Krist AH, editors. Achieving Whole Health: A New Approach for Veterans and the Nation. Washington (DC): National Academies Press (US); 2023 Feb 15. 8, Conclusions and Recommendations. Available from: https://www.ncbi.nlm.nih.gov/books/NBK591720/

Programs for Select Veteran Populations

This section provides narrative descriptions of selected programs that serve certain Veteran populations. The obligations shown in each table below reflect the cost of total health care services provided to each designated Veteran population. However, some programs overlap and therefore cannot be added together to determine the overall funding amount. For example, the cost of health care services provided to a female Gulf War Veteran would appear in both the Gulf War and Women Veterans Health Care funding lines.

AIDS / HIV Program

Description (*dollars in thousands*)	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary & Mandatory Obligations by Category:							
Medical Services	$1,326,762	$1,376,819	$1,423,682	$1,528,227	$1,639,542	$104,545	$111,315
Medical Community Care	$202,555	$186,275	$217,677	$234,066	$251,590	$16,389	$17,524
Medical Support and Compliance	$138,652	$136,060	$148,797	$159,762	$171,461	$10,965	$11,699
Medical Facilities	$121,514	$119,628	$130,415	$140,054	$150,359	$9,638	$10,305
Obligations [Total]	$1,789,483	$1,818,782	$1,920,571	$2,062,108	$2,212,952	$141,538	$150,844

1/The 2024 Revised Request column in the 2024 Congressional Justification interchanged the Medical Services and Medical Support and Compliance funding levels. The 2024 Budget Estimate column in this display corrects the misalignment.

Authority for Action

- 38 U.S.C. §§ 1703, 7301 and 7332
- 38 C.F.R. § 17.38

Population Covered

Overview: The scope of VHA's National HIV Program includes Veterans living with HIV (VLHIV), i.e., Veterans in VHA care with HIV infection. It also includes Veterans who are not infected but who are at increased risk of exposure to and acquisition of HIV infection through sexual transmission, injection drug use (IDU), or both.

HIV Testing: Routine HIV testing is essential for distinguishing between the subpopulations covered by VHA's National HIV Program. HIV infection is often clinically silent until it reaches an advanced stage; thus, incorporating HIV testing into routine health care allows early detection of undiagnosed infection, as well as identifying Veterans who are uninfected but are at increased risk of exposure to HIV. For both subpopulations, HIV testing saves lives, by allowing timely linkage to HIV care and initiation of anti-retroviral therapy (ART) in the former group, and initiation of ART for HIV prevention, i.e., pre-exposure prophylaxis (PrEP) in the latter group. In addition, multiple published studies have shown that individuals who are aware of their infection are less likely to transmit HIV to others and are more likely to modify behaviors likely to transmit HIV, decreasing the number of new HIV infections in the community.

VHA's policy on HIV testing is aligned with recommendations by the U.S. Preventive Services Task Force (USPSTF) and the U.S. Centers for Disease Control and Prevention (CDC), as well as the Clinical Preventive Services Guidance Statement on HIV testing issued by VHA's National

Health Promotion and Disease Prevention Program, and requires that all Veterans be offered HIV testing at least once in their lifetime as part of routine health care, with testing offered at least annually to those who have on-going risk of exposure.

At the beginning of calendar year 2022 (CY 2022), out of 6.7 million Veterans in VHA care, 3.7 million had never received a documented HIV test or a diagnosis of HIV. During CY 2022, 186,459 of these untested Veterans received HIV testing, with 259 (0.14%) testing positive for HIV. (Note: This number does not include Veterans who had previously tested negative but who were retested during CY 2022 and found to have acquired HIV infection; Including these Veterans, there were a total of 444 new HIV infections among Veterans in VA care during CY 2022.) At the end of CY 2022, 48.5% of all Veterans in VHA had been tested for HIV, an increase of 1.0% from CY 2021.

Veterans Living with HIV (VLHIV): VA is the single largest provider of HIV care in the U.S., with 31,719 VLHIV in VA care during 2022, the most recent fiscal year for which complete demographic data are available. The median age of these Veterans was 60.3 years (range, 20 y – 98 y); 36.7% were 65 years of age or older. Regarding sex (self-reported), 96.1% were men. Regarding race (self-reported), 43.4% were Black or African American and 38.7% as White. Regarding ethnicity (self-reported), 7.2% were as Hispanic or Latino. Regarding rurality, 14.1% lived in rural, highly rural, or insular island areas. Regarding period of service, 36.7% served in the Persian Gulf War era, 25.9% in the Vietnam War era and 25.9% in the post-Vietnam War era.

HIV-negative Veterans at risk: Of the 186,459 Veterans tested for HIV during CY 2022, 186,200 (99.9%) had negative test results. Data on what proportion of these uninfected Veterans are at increased risk for HIV infection are not currently available.

Organization of Care: VHA has aligned its HIV care and prevention services with the White House's National HIV/Acquired Immunodeficiency Syndrome (AIDS) Strategy (NHAS). The first NHAS was released in July 2010, with four major goals: Reducing New HIV Infections; Increasing Access to Care and Improving Health Outcomes for People Living with HIV; Reducing HIV-Related Disparities and Health Inequities; and Achieving a More Coordinated National Response to the HIV Epidemic. The NHAS was revised and updated in December 2015 and again in January 2021, focusing on the HIV Care Continuum, a population health model for HIV care defined by a sequence of essential processes of care: HIV testing; diagnosis; active linkage to and retention in care; ART initiation; and achievement of viral suppression, meaning no detectable virus present in the blood. Viral suppression prevents progression of HIV to AIDS, and blocks transmission of HIV from infected to uninfected individuals. Implementation and execution of NHAS by providers and health care organizations is assessed by measurable indicators reflecting the steps in the HIV Care Continuum.

VHA's implementation of NHAS is governed by VHA Directive 1304, *National Human Immunodeficiency Virus Program,* which sets policies for HIV care and prevention within VHA. Directive 1304 assigns primary responsibility for advising the Under Secretary for Health on VHA services related to HIV prevention, testing, diagnosis, and care to VHA's HIV, Hepatitis and Related Conditions Programs Office (HHRC), within VHA's Specialty Care Program Office

(SCPO). Under Directive 1304, HHRC is also responsible for coordinating VHA's activities in these areas.

Directive 1304 also requires that all VHA facilities:

- Designate an HIV Lead Clinician to be the principal point of contact for all HIV and HIV prevention program information.
- Offer HIV testing at least once to all Veterans in care, ensure that confirmed positive HIV test results are communicated to appropriate providers and to patients in accordance with VHA Directive 1088, *Communicating Test Results to Providers and Patients*, and ensure that Veterans with confirmed HIV-positive results are connected to HIV care as soon as possible.
- Follow guidelines and recommendations published by the U.S. Department of Health and Human Services for HIV testing, initiation, and continuation of ART in Veterans with confirmed HIV infection, PrEP, non-occupational and occupational post-exposure prophylaxis against HIV, screening for sexually transmitted infections (STIs).
- Ensure HIV reporting to state and local public health departments as required under VHA Directive 1131, Management of Infectious Diseases and Infection Prevention and Control Programs.

As one of the Federal agencies participating in formulating and implementing the NHAS, the VA utilizes the HIV Care Continuum model to assess gaps in care and for population health-based management of HIV services at the individual facility level. VA provides comprehensive HIV prevention and clinical care across the health care system from prevention of HIV to diagnosis, linkage to care, management and treatment. All FDA-approved drugs for ART are available on the VA National Formulary (VANF), as is comprehensive care management for co-morbid mental health and medical comorbidities. All VA medical centers and outpatient clinics offer HIV testing, with timely linkage to HIV-specific care for patients with newly diagnosed infection.

All VHA facilities have access to benchmark data across the VHA system at the national, VISN and facility levels on annual HIV testing rates and performance on the HIV Care Continuum. Other clinical and population health decision support resources include dashboards for population health management of VLHIV in VA care to monitor linkage to and retention in care, utilization of antiviral therapy and rates of viral suppression, point-of-care electronic clinical reminders for HIV testing and for PrEP and dashboards designed to increase PrEP uptake, particularly among Veterans identified as being at increased risk from STI screening results.

HHRC offers training and educational programs throughout the year to VHA HIV providers and holds monthly teleconferences for all HIV providers in the VHA system to discuss current issues. VHA facility HIV Lead Clinicians act as both points of contact with HHRC and as local champions of initiatives to improve access to and quality of HIV care and prevention services.

Types of Services Provided/ Methods of Care Delivery

HIV Treatment: Implementing the most current version of NHAS in VHA requires addressing high rates of medical and psychiatric co-morbidities, including mental health and substance use disorders, cardiovascular disease, renal dysfunction, and metabolic disorders among VLHIV in

VA care. VHA's National HIV Program ensures that these Veterans receive the highest quality comprehensive clinical care by timely linkage to care, initiation of ART and treatment of co-morbidities.

- Linkage to care: Of those Veterans in VA care in CY 2022 who tested positive and were alive for at least 90 days after their HIV diagnosis, 74.1% were linked to care within 30 days of their diagnosis. Note: Prior to 2016, linkage to care was defined by CDC as HIV-specific care received with 90 days of a new HIV diagnosis. The definition was revised in 2016 to receipt of HIV-specific care within 30 days of a new diagnosis. Since 2016, rates of linkage to care within 30 days have ranged from 74-87%, while rates of linkage to care within 90 days have consistently been close to or at 100%.
- Anti-retroviral therapy: Of all VLHIV in VA care in CY 2022, 85% had an ART prescription filled during that year.
- Viral suppression: Of all VLHIV in VA care in 2022, regardless of whether they had a viral load test, 70% were virally suppressed. Of those who had a viral load test in that year, 93% were virally suppressed.

HIV Prevention: VHA's HIV prevention efforts are based on recommendations by the CDC and USPSTF, and Clinical Preventive Guidance Statements issued by VHA's National Health Promotion and Disease Prevention Program. VHA's deployment of PrEP is based on FDA approval of drugs shown to be safe and effective for this indication. In 2014, VHA's Pharmacy Benefits Management Service (PBM) added PrEP to its Criteria for Use for a fixed-dose combination of emtricitabine/tenofovir that was already on the VANF for HIV treatment. VA continues to actively promote the broader use of PrEP across the VHA system by addressing local and systemic barriers to increased uptake, as well as working to increase access to nonpharmacological measures to prevent new HIV infection, such as making condoms universally available to all Veterans in VHA care.

- As of December 31, 2022, 6,028 HIV-negative Veterans in VA care were receiving PrEP, an increase of 1,004 (20%) compared to December 31, 2021, with an increase of 710 (16.5%) and an increase of 464 (12.1%) in 2020.
- These numbers do not include HIV-negative Veterans started on PrEP at VHA facilities that have deployed the Cerner EHR.

Methods of Care Delivery: Of the 31,883 VLHIV in VA care in FY 2023, 31,510 (98.8%) had an outpatient encounter at a VA facility. There were 767,340 outpatient encounters; of these, 125,456 (16.3%) were virtual (telehealth, telephone, VVC, CVT), while 1,597 (0.2%) represented Care in the Community consults.

Recent Trends

Table 1 shows recent trends in HIV diagnosis and care metrics within VHA.

Table 1. HIV diagnosis and care metrics, 2018 - 2022					
	2018	**2019**	**2020[4]**	**2021[4]**	**2022[4]**
% of Veterans in VA care ever tested for HIV[1]	43.1%[3]	43.5%[3]	46.9%[3]	47.5%[3]	48.5%
% of Veterans with new HIV diagnosis linked to care within 30 days[1]	84.6%	83.1%	77.9%	74.8%	74.1%
% of VLHIV in VA care on ART[2]	85.5%	85.8%	86.2%	84.8%	84.8%
% viral suppression among VLHIV in VA care[2]					
All VLHIV	73.5%	75.5%	72.7%	71.6%	70%
All VLHIV with VL obtained	90.6%	92.5%	92.7%	91.1%	93%

[1] Data source: HHRC Data and Analysis Group

[2] Data source: VSSC HIV Clinical Data Cube

[3] Data measured over calendar year

[4] Mann-Grandstaff VAMC data

Projections for the Future

Based on the trends over the last four years, VA projects the following:

a. HIV prevention continues to be an increasingly important focus for VHA's National HIV Program, which has developed an integrated set of strategies aimed at dramatically reducing new HIV infections among Veterans in care. These will be deployed starting in 2024 and continued through 2026, as follows:

- Initiatives to restore sustained increases in HIV testing rates in VHA, which have plateaued compared to rates of increase a decade ago. These include audit feedback to VISN and VHA facility leaders on HIV testing rates, including actionable information on intra- and inter-VISN variability; targeted outreach to low performing sites; and establishing and strengthening collaborations with VISN Specialty Care ICCs. Based on the introduction of these initiatives, VHA projects achieving an annual increase of 2 – 4% in the cumulative proportion of Veterans tested at least once for HIV between now and 2030.

- Leveraging the overlapping epidemiology of HIV infection, viral hepatitis, and STIs to implement and execute operational plans aimed at deploying a bundle of harm reduction interventions targeting transmission routes common to all of these, namely IDU and sexual transmission. Chief among these are syringe service programs (SSPs) at VHA facilities, a highly effective harm reduction intervention that provides sterile injection equipment; testing for HIV and viral hepatitis; facilitation rapid linkage to care; overdose education; linkage to counseling and treatment for substance use disorders, particularly medication-assisted therapy for opiate use disorder.

- Development and deployment of population health dashboards allowing rapid identification of candidates for viral hepatitis treatment, Veterans at increased risk for HIV infection, and candidates for behavioral interventions to decrease the risk of recurrent STIs.
- Deployment of a novel and highly transformative implementation platform, Getting to Innovation (GTI), developed by HHRC's Evaluation Group. GTI allows implementation, monitoring, and calibration of operational plans to increase HIV testing rates and PrEP uptake without the need for time-consuming and intensive involvement by implementation science experts.
- Aggressive expansion of access to PrEP through academic detailing, GTI, SSPs, and provider education campaigns, particularly among primary care providers.

b. Given current seropositivity rates and projected increases in HIV testing rates, VHA projects an increase in the number of diagnosed VLHIV in VHA care of approximately 1,000 between 2024 and 2030, an increase of approximately 3% in the number of diagnosed VLHIV in VHA care over the next 5 years.

c. Regarding VLHIV in VHA in VA care already known to have HIV, VHA projects a continuing shift away from F2F encounters in VHA infectious disease clinics over the next few years, with a corresponding increase in telehealth encounters and increasing involvement by Clinical Resource Hubs. VHA projects that the number of VLHIV in VHA care referred to Community Care will remain stable.

d. Regarding other components of the HIV Care Continuum, since 2017, the proportion of VLHIV in VHA care on ART has remained stable or increased. In alignment with NHAS, VA has an internal goal of having ART prescribed to 90% of VLHIV in care by 2030. Strategies to accomplish this include broadening deployment of HIV telehealth clinics in VHA, as well as improving rates of linkage to and retention in HIV care.

AIDS/ HIV Workload

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Unique Patients							
AIDS/HIV.....	32,835	33,103	33,240	**33,656**	**34,054**	416	398

Health Outcomes Military Exposures (HOME)
(formerly Post Deployment Health Services (PDHS))

HOME: Gulf War Program

Description (*dollars in thousands*)	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary & Mandatory Obligations by Category:							
Medical Services	$4,491,671	$5,200,954	$5,338,718	$6,284,272	$7,325,929	$945,554	$1,041,657
Medical Community Care	$1,205,189	$1,327,195	$1,434,446	$1,690,770	$1,973,534	$256,324	$282,765
Medical Support and Compliance	$705,440	$785,122	$838,763	$987,650	$1,151,722	$148,886	$164,072
Medical Facilities	$816,284	$954,739	$970,860	$1,143,540	$1,333,888	$172,680	$190,349
Obligations [Total]	$7,218,584	$8,268,010	$8,582,788	$10,106,231	$11,785,074	$1,523,443	$1,678,843

1/The 2024 Revised Request column in the 2024 Congressional Justification interchanged the Medical Services and Medical Support and Compliance funding levels. The 2024 Budget Estimate column in this display corrects the misalignment.

HOME: Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND)/Operation Inherent Resolve (OIR) Program

Description (*dollars in thousands*)	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary & Mandatory Obligations by Category:							
Medical Services	$9,173,098	$10,112,499	$10,710,300	$12,435,943	$14,330,029	$1,725,643	$1,894,086
Medical Community Care	$2,703,147	$2,898,577	$3,166,150	$3,686,379	$4,259,799	$520,229	$573,420
Medical Support and Compliance	$1,296,863	$1,382,430	$1,513,906	$1,757,668	$2,025,308	$243,761	$267,640
Medical Facilities	$1,256,793	$1,427,475	$1,465,653	$1,700,301	$1,957,783	$234,648	$257,482
Obligations [Total]	$14,429,901	$15,820,981	$16,856,009	$19,580,291	$22,572,919	$2,724,282	$2,992,628

1/The 2024 Revised Request column in the 2024 Congressional Justification interchanged the Medical Services and Medical Support and Compliance funding levels. The 2024 Budget Estimate column in this display corrects the misalignment.

HOME: Program Office

Description (*dollars in thousands*)	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary & Mandatory Obligations:							
Focus Areas:							
Environmental Health 1/	$7,275	N/A	$20,025	$20,245	$20,245	$220	$0
Airborne Hazards and Burn Pits Center of Excellence 1/	$9,400	N/A	$15,000	$15,165	$15,165	$165	$0
Epidemiology 1/	$14,600	N/A	$22,933	$23,185	$23,185	$252	$0
War Related Illness and Injury Study Center 1/	$14,812	N/A	$20,480	$20,705	$20,705	$225	$0
Toxic Embedded Fragment/Depleted Uranium 1/	$2,917	N/A	$3,500	$3,538	$3,538	$38	$0
HOME [Total]	$49,004	$81,938	$81,938	$82,838	$82,838	$900	$0
Account Category:							
Medical Services 1/	*$33,102*	*N/A*	*$63,434*	*$63,734*	*$63,734*	*$300*	*$0*
Medical Support & Compliance 1/	*$15,902*	*N/A*	*$18,504*	*$19,104*	*$19,104*	*$600*	*$0*
Medical Care Total	*$49,004*	*$81,938*	*$81,938*	*$82,838*	*$82,838*	*$900*	*$0*

1/ Details not displayed in the 2024 Congressional Justification.

Authority for Action:

Public Laws

- P.L. 91-441: directed the Department of Defense to contract with the National Academy of Sciences to conduct a comprehensive study of dangers of herbicides and the defoliation program in Vietnam. In 1978, VA began the Agent Orange Registry.

- P.L. 99-576, *Veterans' Benefits Improvement and Health Care Authorization Act of 1986*: Established the Ionizing Radiation Registry (IRR), including physical examination, medical history and baseline laboratory tests.
- P.L. 100-321, *Radiation-Exposed Veterans Compensation Act of 1988*: Authorized a list of "presumptive" diseases that qualify Veterans involved in "radiation risk activities" for compensation.
- P.L. 100-322, *Veterans Benefits and Services Act of 1988*: Specifies requirements to provide medical services, domiciliary care and nursing home care to Veterans. Provides for the confidentiality of medical records that identify persons with acquired immune deficiency syndrome (AIDS), except in specifically described circumstances and prohibits discrimination in admission to VA facilities for treatment of Veterans infected with AIDS. Also includes several administrative, personnel and reporting requirements.
- P.L. 102-4, *Agent Orange Act of 1991*: Requires VA to obtain independent scientific review of the available scientific evidence regarding associations between diseases and exposures to dioxin and other chemical compounds in herbicides.
- P.L. 105-277, *Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999*: Requires VA to determine, based on IOM reports, whether illnesses warrant a presumption of service connection and to set compensation regulations establishing such a connection for each illness.
- P.L. 105-368, *Veterans Programs Enhancement Act of 1998*: Directed VA to establish an advisory committee to help review research on the medical problems of Gulf War Veterans and submit an annual report to Congress on the results of research on the health consequences of military service in the Gulf War.
- P.L. 107-103, *Veterans Education and Benefits Expansion Act of 2001:* Expanded the definition of service-connected "qualifying chronic disability" to include "a medically unexplained chronic multi-symptom illness."
- P.L. 108-170, *Veterans Health Care, Capital Asset and Business Improvement Act of 2003*: Provided priority enrollment (Category 6) for Veterans who participated in Project 112/SHAD, allowing them to be eligible for VA health care at no cost for any illness possibly related chemical warfare agent testing.
- P.L. 108-183, *Veterans Benefits Act of o 2003*: Required VA and DoD to establish The Veterans' Advisory Board on Dose Reconstruction to audit dose reconstructions and VA claims decisions for service connection of radiogenic diseases.
- P.L. 109-417, *Pandemic and All-Hazards Preparedness Act of 2006*: requires VA to work in coordination with HHS, DHS and DoD on a national response plan for influenza.
- P.L. 117-168, *Promise to Address Comprehensive Toxics (PACT) Act of 2022* that requires VA to engage in efforts to improve the health outcomes of Veterans who were exposed to chemical, physical, environmental, and airborne hazards during their military service.

Presidential directive

- Homeland Security Presidential Directive 10 (HSPD-10) Biodefense for the 21st Century: provides a comprehensive framework for the Nation's biodefense.

Registries

- Agent Orange Registry: P.L. 102-4, 38 U.S.C. §527, 38 U.S.C. §1116, P.L. 102-585 §703 and P.L. 100-687
- Ionizing Radiation Registry: 38 U.S.C. §527, 38 U.S.C. §1116, P.L. 102-585 §703 and P. L. 100-687
- Depleted Uranium Registry: 38 U.S.C. §7301(b), P.L. 102-585 §703(b) (2)
- Gulf War Registry: P.L. 102-585, P.L. 103-446, 38 U.S.C. §1117
- Airborne Hazards and Open Burn Pits Registry: 38 U.S.C. §527, P.L. 112-260 §201; and P.L 102-585 (1992)

Types of Services Provided: Exposures to contaminants and environmental hazards during military service pose a major health concern for Veterans of all generations and cohorts. Health Outcomes Military Exposures (HOME) governs congressionally mandated programs related to environmental, occupational, and garrison exposures that may have affected U.S. Veterans and some family members during military service. These registry programs cover Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), Gulf War, Vietnam, WWII, Toxic Embedded Fragments (TEFs), Depleted Uranium (DU), and atomic Veteran's policy and activities related to the oversight of registry exams at the local Veterans health facilities.

The office conducts surveillance and studies Veterans' health and health care outcomes. Findings from these research studies inform clinical care health professionals and provide sound science for policymakers' decisions, including Department of Veterans Affairs (VA) and Congress. This research improves health care best practices and policy decisions related Veterans' benefits support. HOME subject matter experts continuously review current scientific literature and provide data to develop policy recommendations for the VA Secretary (SECVA) grounded in science regarding health outcomes for military-related exposures. HOME provides environmental health answers through a team of professionals, including a toxicologist, an environmental sciences specialist, an industrial hygienist, and a data management specialist.

HOME coordinates the work of Veterans Exposure Team (VET-HOME), VA's newest national hub for information and VA services on military environmental exposures. Its mission is to perform congressionally mandated telehealth registry evaluations for Veterans across the United States. VET-HOME will expand to provide exposure assessments and registry evaluations that support research, education, and clinical care for Veterans with military environmental exposures. The National War Related Illness and Injury Study Centers (WRIISCs) are located California, New Jersey, and Washington, D.C. In 2023, HOME established three new WRIISCs: Women's Operational Military Exposure Network (WOMEN); Complex Exposure Threats Center (CETC); Exposure- Related Care Transformation Center (EXPRT) to address gender-specific needs, response strategies to evaluate complex exposures with unknown pathology, and acceleration of implementing education and research on military exposure concerns.

Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act): This legislation carries over into subsequent years based on ongoing requirements. HOME responds to these demands and expectations of the White House, Congress, Veterans Service Organizations (VSOs), media, and Veterans as related to sections:

202, 302, 502-507, 509, 510, 604, 801, 802 and 808, with assistance to Primary Care on section 603. For example, in Section 509, HOME will establish an independent platform/website to provide public access to toxic exposure research that will help to improve private sector collaborative treatment of Veterans. This platform will require additional staff including, web masters, librarians, and health science specialists.

National WRIISC: The WRIISC is a Congressionally mandated VA program devoted to the post-deployment health concerns of Veterans, which HOME oversees. The three national programs are located within VA medical centers in Washington, DC; East Orange, New Jersey; and Palo Alto, California. These centers serve as a resource providing clinical evaluation, education, and risk communication for Veterans, their families, health care providers, and research. The WRIISC provides specialized evaluations for Veterans with difficult-to-diagnose deployment-related health concerns utilizing a multidisciplinary team with an evidence-based approach.

WRIISC-Women's Operational Military Exposure Network (WOMEN) Center: In October 2022, WOMEN was established to offer highly specialized medical expertise, which gives hope to women Veterans with post-deployment health concerns and to provide advanced clinical perspectives to VA providers. The WOMEN team coordinates a multi-symptom assessment and provides diagnostic and treatment recommendations that cross a wide spectrum of symptoms and body systems. Each Veteran receives an extensive assessment including a history and physical, neurological and mental status evaluations, occupational and environmental exposure assessments, and a psychological/neuropsychological evaluation. Other specialty services are consulted as needed to address Veterans' specific medical concerns. In addition, WOMEN offers an integrated health program with yoga, mindfulness meditation, and health coaching.

WRIISC Complex Exposure Threats Center (CETC): In October 2022, CETC was established to focus on rapid response strategies to evaluate and study the full scope of complex exposures with unknown pathology. Multifaceted and novel injuries acquired due to new technologies and environmental hazards (e.g., directed energy, chemical toxins, sub-concussive blast) require a network of experts to collect, integrate, and analyze information from a variety of sources. Such expertise cannot be statically maintained within VA alone. Thus, CETC utilizes innovative approaches in centralizing this network within the infrastructure of VA, while leveraging strong connections within other federal agencies and multiple outside institutions. Using a framework to integrate information based on strategic and tiered response units (e.g., computational models and epidemiology, research assessments and metrics, novel clinical trials, and therapeutic intervention, specialized clinical evaluation and treatment recommendations), CETC offers the best options for evaluation and intervention for those affected by new injuries or undefined conditions. This approach allows CETC to rapidly synthesize knowledge to inform evidence-based clinical care and policy for individuals impacted by emerging threats.

WRIISC–HOME Exposure-Related Care Transformation Center (EXPRT): EXPRT was formerly known as WRIISC-Research, Implementation Support, and Education (RISE). EXPRT transforms care for military exposure concerns by accelerating research into action. This program infuses the knowledge of military exposure concerns throughout the VA system through education, accelerating the implementation of education and research on military exposure concerns into care

and conducting research and systematic evaluation to determine best strategies to rapidly translate evidence into practice and improve care for military exposure concerns.

The Airborne Hazards Burn Pit Center of Excellence (AHBPCE): AHBPCE was officially recognized by Congress and the President in Public Law 115-929 as a VA Center of Excellence and was designated as the AHBPCE in May 2019.

The AHBPCE has four primary areas of responsibility:

1) Conduct clinical and translational research focusing on a range of health conditions including respiratory concerns and unexplained shortness of breath (dyspnea),
2) Develop and deliver new educational content and best practices for health care providers, Veterans, and other stakeholders,
3) Deliver specialized clinical care and consultation to Veterans with airborne hazard exposure concerns, and
4) Monitor enterprise clinical response through analysis of the VA Airborne Hazards and Open Burn Pit Registry (AHOBPR).

Karshi-Khanabad (K2) Air Base in Uzbekistan: HOME began its K2 Surveillance Program (K2SP) in 2021 to track and analyze the health outcomes of K2 Veterans. These outcomes will be compared with those of three other groups: 1) similar Veterans deployed to OEF but not K2; 2) another similar group of Veterans who never deployed to the OEF theater of operations; and 3) the general Unites States population. HOME will analyze rates of disease and deaths using data from medical records for a consistent assessment across nearly all K2 Veterans. HOME will generate reports over the next 10 years that will provide a scientifically valid assessment of the health effects that may be associated with serving at K2 and make those results available to the public.

The Individual Longitudinal Exposure Record (ILER): HOME partnered with Department of Defense (DOD) and added ILER as a key and essential component to the Electronic Health Record. ILER matches individual Service Members and Veterans with a time, place, and exposure based on authoritative records. This allows a Veteran's records to reflect specific time, place, and exposures based on authoritative records which minimizes the need for creation and maintenance of multiple self-reported registries for identifying those exposed and improve care and benefits determinations for Veterans.

Surveillance Programs: Specific military-combat exposures conduct original research to understand the effects of military service deployment on Veterans' health. The affected Veteran populations include:

- Agent Orange (AO) Veterans: Vietnam, Korean Demilitarized Zone (DMZ) at certain times and certain Thai bases and certain occupational series, certain C-123 crews, and some Blue Water Navy Veterans stationed within 12 nautical miles of the coast of Vietnam; approximately 3.1 million Veterans served in Vietnam and are presumed to have Agent Orange exposures.
- Atomic Veterans exposed to ionizing radiation (above and some below-ground tests).

- 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 DU and possible toxins in embedded fragments.
- Airborne Hazard Open Burn Pit Veterans: served in Afghanistan, Djibouti, Syria, and Uzbekistan during the Persian Gulf War, from September 19, 2001, to the present, **or** the Southwest Asia theater of operations from August 2, 1990, to the present.
- Garrison-related environmental health concerns, such as Camp Lejeune and aqueous fire-fighting foam (AFFF) exposures in garrison water supplies (per- and polyfluoroalkyl substances (PFAS)).
- K2 Veterans– possibly exposed to various hazards, including, but not limited to, fuels, DU, asbestos, and lead at a former Soviet airbase in Uzbekistan from 2001-2005.

Additionally, surveillance includes:

- Reviews of other emerging issues such as exposures to anomalous health events, directed energy, prophylactic medications, rare cancers, respiratory illness, fuels, fire-fighting foams (PFAS), directed energy (anomalous health incidents), vaccines, and concerns for intergenerational and gender issues.
- Scientific literature reviews for determination of presumptions as directed by the Military Environmental Exposure Sub-Committee (MEESC), subordinate to the VA Operations Board (VAOB) and the VA Executive Board (VAEB).

Recent Trends: Steady growth in concern for military environmental and garrison exposures and increased use of VA services for environmental health (EH) exposures, involves increasing the support for front-line clinicians to ensure military exposures are recognized and addressed using evidence based, Veteran-centric care. In support of front-line clinicians is necessary to improve Veterans' and clinicians' perception that the VA prioritizes addressing exposures concerns– patients assess the quality of their care in terms of interactions with individual clinicians.

Budget Request: The 2025 budget requests $82.8 million to fund the continued support of HOME's long-range capacity to be able to adequately respond to the demands and expectations of the groups mentioned above and most of all, to serve Veterans.

HOME Workload

		2024		**2025**	**2026**		
Description	2023 Actual	Budget Estimate	Current Estimate	**Revised Request**	**Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Unique Patients							
Gulf War	471,765	470,423	490,159	**508,711**	**527,508**	18,552	18,797
OEF/OIF/OND/OIR	1,302,977	1,313,399	1,372,422	**1,440,372**	**1,506,497**	67,950	66,125

Note: HOME workload reflects unique patients in the Gulf War Veteran Program and Veterans who served in Operation Enduring Freedom (OEF) /Operation Iraqi Freedom(OIF)/Operation New Dawn(OND)/Operation Inherent Resolve(OIR).

Traumatic Brain Injury (TBI) and Polytrauma System of Care (PSC)

*TBI: OEF/OIF/OND/OIR**

Description (*dollars in thousands*)	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary & Mandatory Obligations by Category:							
Medical Services	$216,606	$234,368	$234,196	$248,623	$264,733	$14,427	$16,110
Medical Community Care	$18,593	$29,350	$20,032	$21,195	$22,467	$1,163	$1,272
Medical Support and Compliance	$34,886	$35,956	$37,713	$40,028	$42,604	$2,315	$2,576
Medical Facilities	$43,309	$46,755	$46,827	$49,707	$52,905	$2,880	$3,198
Obligations [Total]	$313,394	$346,429	$338,768	$359,553	$382,709	$20,785	$23,156

1/The 2024 Revised Request column in the 2024 Congressional Justification interchanged the Medical Services and Medical Support and Compliance funding levels. The 2024 Budget Estimate column in this display corrects the misalignment.

*TBI: All Veteran Care***

Description (*dollars in thousands*)	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary & Mandatory Obligations by Category:							
Medical Services	$695,769	$819,997	$758,383	$826,881	$904,016	$68,498	$77,135
Medical Community Care	$132,153	$211,440	$142,724	$153,745	$165,833	$11,022	$12,087
Medical Support and Compliance	$115,465	$131,487	$125,851	$137,194	$149,959	$11,343	$12,764
Medical Facilities	$141,074	$166,594	$153,798	$167,706	$183,366	$13,908	$15,660
Obligations [Total]	$1,084,461	$1,329,518	$1,180,755	$1,285,527	$1,403,174	$104,771	$117,647

1/The 2024 Revised Request column in the 2024 Congressional Justification interchanged the Medical Services and Medical Support and Compliance funding levels. The 2024 Budget Estimate column in this display corrects the misalignment.

*Included in TBI-All Veteran Care. VA estimates the 10-year cost (2023-2032) to be $4.3 billion for TBI-OEF/OIF/OND/OIR Veteran Care.

**VA estimates the 10-year cost (2023-2032) to be $16.5 billion for TBI-All Veteran Care.

Authority for Action: Public laws (P.L.) and the United States Code governing rehabilitation provided by the Polytrauma System of Care (PSC) include:

- P.L. 104-262, *Veterans' Health Care Eligibility Reform Act of 1996,* Section 104: Requires the Department of Veterans Affairs (VA) to maintain its capacity to provide for the specialized treatment and rehabilitative needs of disabled Veterans, including those with spinal cord dysfunction, amputations, blindness, and mental illness, within distinct programs dedicated to the specialized treatment of those Veterans.
- P.L. 108-447, *Consolidated Appropriations Act, 2005*: Directs VA to ensure that Veterans with loss of limb and other very severe and lasting injuries have access to the best of both modern medicine and integrative holistic therapies for rehabilitation.
- P.L. 110-181, *National Defense Authorization Act for Fiscal Year 2008*, Section 1704(d): Directs VA to collaborate with the TBI rehabilitation research community, grantees of the National Institute of Disability and Rehabilitation Research of the Department of Education, the Defense and Veterans Brain Injury Center and other Governmental entities engaged in TBI rehabilitation.

Title 38 United States Code:

- *§1710C* – TBI: plans for rehabilitation and reintegration into the community
- *§1710D* – TBI: Comprehensive program for long-term rehabilitation
- *§1710E* – TBI: use of non-Department facilities for rehabilitation
- *§7327* – Centers for research, education and clinical activities on complex multi-trauma
- *§8111* – Sharing of DVA and DoD health care resources
- *§8153* – Sharing of health-care resources

Type of Services Provided: VA's PSC provides a full range of rehabilitation services for eligible Veterans and Active Duty Servicemembers covered by Defense Health Agency Great Lakes or TRICARE authorization, who sustained polytrauma and TBI. This includes persons with:

- TBI (whether military-related deployment related or not),
- Blast and non-blast related traumatic injuries including but not limited to amputations, musculoskeletal injuries, and open wounds,
- Other acquired brain injuries including, but not limited to, stroke, brain tumors, infection, poisoning, hypoxia, ischemia, encephalopathy, or substance abuse, as appropriate for specific cases,
- Physical, cognitive, emotional, and behavioral impairments related to the brain injury, or
- Impairments that are clinically and functionally significant and lead to activity and participation restrictions.

PSC programs are organized into a four-tier system that ensures access to the appropriate level of specialized rehabilitation care at 110 medical centers across VA. Medical rehabilitation services in PSC address the goals of recovery and community re-integration of Veterans with TBI and polytrauma including:

- Mandatory TBI Screening of all Veterans of Post-9/11 combat operations. Veterans with positive screens are referred for comprehensive evaluations by specialty providers.
- Veterans with TBI requiring rehabilitation receive an Individualized Rehabilitation and Community Reintegration (IRCR) Plan of Care documenting the physical, cognitive, mental health and vocational problems that affect the Veteran's successful community re-integration and the plan for addressing those problems. The functional status of Veterans with an IRCR Plan of Care is measured using a validated tool that allows VA providers to track changes and to provide appropriate interventions at the right time.
- The interdisciplinary teams providing services in PSC comprise specialists from physiatrists, nursing, psychology, social work, physical therapy, occupational therapy, speech-language pathology, recreational therapy, and other disciplines, as appropriate for the individual needs of the patient.
- Since 2010, the five Polytrauma Rehabilitation Centers (PRCs) have collaborated with Department of Health and Human Services' (HHS) TBI Model System Program sponsored

by the National Institute on Disability, Independent Living and Rehabilitation Research. This enables VA to benchmark outcomes against those facilities that are the gold standard for private sector rehabilitation, for which VA has demonstrated outcomes that are similar or better than the community standard.

- VA continues to demonstrate patient outcomes that are similar or better than the community standard as measured by functional improvement, discharge rates and length of stay in inpatient care. These outcomes reflect the outstanding rehabilitative care, prosthetic services, benefits and adaptive modifications to the home and automobile that help Veterans with severe disabilities overcome obstacles to achieving personal independence, positive life adjustment and opportunities in meaningful areas of life.
- PSC collaborates with specialists in the DoD, HHS, academia, and private sector to develop and deploy consensus positions and guidance on best practices such as the *VA/DoD Clinical Practice Guidelines for the Management of Mild TBI.* The Guidelines have been widely disseminated to VA rehabilitation providers through educational and training opportunities and reinforced through information technology solutions in the computerized medical record.

Recent Trends: VA 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 System of Care program budget 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.

VA is at the forefront of trends in rehabilitation care with the development of clinical services including:

- Assistive Technology Labs now in operation at 27 PSC locations to provide assessment, training, prescriptions and consultations for devices and equipment that optimize Veteran's independence and support their community participation goals.
- The Emerging Consciousness Programs at the five PRCs are unique in their dedication to improving the lives of Veterans and Service members with severe injuries and their caregivers.
- The five PRCs have implemented Intensive Evaluation and Treatment Programs to provide intensive programming for Veterans and Servicemembers with a history of multiple mild traumatic brain injuries and complex co-morbidities whose needs can't be met in traditional outpatient settings.
- PSC was the first clinical service that deployed a nationwide Telehealth System dedicated to improving access to specialized rehabilitation and care coordination. Since then, the utilization of telehealth technologies has increased exponentially, particularly in the area of in-home health. In 2023, 53.3% of patients treated in polytrauma clinic stop codes had telehealth encounters, consistent with performance in the past two years.
- 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: VA'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.

TBI Workload

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Unique Patients							
TBI-OEF/OIF/OND/OIR 1/	64,910	67,926	68,587	**71,156**	**73,767**	2,569	2,611
TBI-All Veteran Care	127,071	134,925	132,546	**138,093**	**143,970**	5,547	5,877

1/ Included in TBI-All Veteran Care.

Women Veterans Health Care

Women Veterans Health: All Care

Description (*dollars in thousands*)	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary & Mandatory Obligations by Category:							
Medical Services	$7,066,322	$7,932,843	$7,804,605	$8,529,995	$9,221,258	$725,390	$691,263
Medical Community Care	$2,320,063	$2,539,331	$2,560,878	$2,797,393	$3,022,800	$236,514	$225,407
Medical Support and Compliance	$993,559	$1,080,545	$1,097,198	$1,199,039	$1,296,107	$101,841	$97,069
Medical Facilities	$936,987	$1,079,412	$1,034,935	$1,131,258	$1,223,123	$96,323	$91,865
Obligations [Total]	$11,316,932	$12,632,131	$12,497,616	$13,657,684	$14,763,288	$1,160,068	$1,105,604

1/ The 2024 Revised Request column in the 2024 Congressional Justification interchanged the Medical Services and Medical Support and Compliance funding levels. The 2024 Budget Estimate column in this display corrects the misalignment.

Women Veterans Health: Gender-Specific Care 1/

Description (*dollars in thousands*)	2023 Actual	2024 Budget Estimate 2/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary & Mandatory Obligations by Category:							
Medical Services	$471,515	$542,088	$520,592	$586,279	$644,386	$65,687	$58,107
Medical Community Care	$226,293	$300,671	$250,284	$282,156	$310,601	$31,872	$28,445
Medical Support and Compliance	$77,968	$90,486	$86,168	$97,080	$106,793	$10,912	$9,712
Medical Facilities	$75,667	$88,925	$83,666	$94,269	$103,742	$10,604	$9,472
Obligations [Total]	$851,443	$1,022,170	$940,709	$1,059,784	$1,165,521	$119,075	$105,737

1/ Included in Women Veterans Health-All Care.
2/ The 2024 Revised Request column in the 2024 Congressional Justification interchanged the Medical Services and Medical Support and Compliance funding levels. The 2024 Budget Estimate column in this display corrects the misalignment.

Program Office Budget
(dollars in thousands)

Description (*dollars in thousands*)	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary & Mandatory Obligations:							
Women's Health Innovation and Staffing Enhancement Initiative	$95,548	$174,192	$174,192	$210,318	$210,318	$36,126	$0
Child Care	$816	$23,286	$23,286	$18,619	$18,619	($4,667)	$0
Implementation of PACT Act and MAMMO Act	$0	$32,121	$32,121	$1,106	$1,106	($31,015)	$0
Office of Women's Health Program	$15,456	$27,327	$27,327	$33,617	$33,617	$6,290	$0
Obligations [Total]	$111,820	$256,926	$256,926	$263,660	$263,660	**$6,734**	**$0**
Account Category:							
Medical Services 1/	*$102,949*	*N/A*	*$242,384*	*$231,001*	*$231,001*	*($11,383)*	*$0*
Medical Support & Compliance 1/	*$8,853*	*N/A*	*$8,741*	*$32,659*	*$32,659*	*$23,918*	*$0*
Medical Facilities 1/	*$18*	*N/A*	*$5,801*	*$0*	*$0*	*($5,801)*	*$0*
Medical Care Total	*$111,820*	*$256,926*	*$256,926*	*$263,660*	*$263,660*	*$6,734*	*$0*

1/ Details not displayed in the 2024 Congressional Justification.

Authority for Action:

P.L. 102-585, *Veterans Health Care Act of 1992*, enacted November 4, 1992, authorized the Department of Veterans Affairs (VA) to provide gender-specific services, such as Pap tests, breast examinations, mammography, and general reproductive health care to eligible women Veterans. It also provided the initial authorization (which was later made permanent and expanded in scope) to provide women Veterans with counseling for sexual trauma experienced while on active duty.

P.L. 114-223, *Continuing Appropriations and Military Construction, Veterans Affairs and Related Agencies Appropriations Act, 2017*, authorized VA to offer in-vitro fertilization (IVF) and P.L.

115-141, *Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017*, removed the expiration date for IVF services and the time limits on cryopreservation of embryos and gametes.

P.L. 116-315, *Johnny Isakson and David P. Roe M.D., Veterans Health Care and Benefits Improvement Act of 2020*, established an Office of Women's Health and provided greater opportunities for women Veterans to enhance their overall well-being by getting direct care and services related to fertility, expansion of newborn care, childcare, sexual assault and trauma, and homelessness.

P.L. 116-171, *Commander John Scott Hannon Mental Health Improvement Act of 2019*, Title VI, improved care and services for women Veterans by expanding the capabilities of the Women Veterans Call Center to include text messaging and requiring VA to provide information on services available to women Veterans.

P.L. 116-214, *Veterans COMPACT Act of 2020*, Title III required VA to complete a gap analysis of VA programs that aid women Veterans who are homeless and report on locations where women Veterans are using health care from VA.

P.L. 116-283 §764, *National Defense Authorization Act for Fiscal Year 2021,* Inclusion Of Members of Reserve Components in Mental Health Programs of Department Of Veterans Affairs.

P.L. 116-79, *Protecting Moms Who Served Act*, improved maternity care coordination and training to community maternity care providers about the unique needs of Veterans.

P.L. 117-135, *Making Advances in Mammography and Medical Options for Veterans Act (MAMMO) Act*, improves mammography services furnished by the VA.

P.L. 117-133, *Dr. Kate Hendricks Thomas Supporting Expanded Review for Veterans in Combat Environments Act (SERVICE Act)*, will help improve mammography screening to certain Veterans, based on their period and place of active service.

P.L. 117-168, *Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT Act)*, expands VA health care and benefits for Veterans exposed to burn pits and other toxic substances.

Population Covered

The women Veteran population is the fastest growing demographic within the VA and is anticipated to grow from 800,000 enrolled in 2020 to over 1.2 million by 2030. Twenty-seven percent of new enrollees as a result of the PACT Act are expected to be women. In addition to an increase in enrollment, the PACT Act includes reproductive cancer as presumptive conditions that will create a growing need for reproductive female cancer specialists. The SERVICE Act provides eligibility for breast cancer risk assessment and clinically appropriate mammograms to Veterans who have served in areas of potential toxic exposure.

Type of Services Provided
VA provides high-quality comprehensive care that includes basic preventive care, acute care and chronic disease management, reproductive health care (such as maternity and gynecology care) and treatment for all gender-specific conditions and disorders, as well as mental health care. VA provides comprehensive specialty medical and surgical services for women Veterans either on site or through care in the community. In addition, VA is providing infertility counseling and treatment and assistive reproductive technology, including in-vitro fertilization services, through the community care program.

The Office of Women's Health develops national policy and supports policy implementation of high-quality women's health care at all sites of care across VA. This includes a full spectrum of care such as primary care for acute and chronic illness, gender specific care, reproductive health care, specialty care and mental health care for women Veterans. The office also oversees initiatives associated with implementing and assessing comprehensive care such as the availability of designated women's health primary care providers at all sites of care, care coordination initiatives, provider support, informatics tools and evidence-based quality improvement initiatives. The Office of Women's Health is working to strategically fill gaps in providers, support staff, and specialty care staff to meet this demand.

The Office of Women's health supports ongoing Women's Health Mini-Residency (WHMR) trainings for VA providers. The WHMR curricula is a three-day intensive, interactive training that equips clinicians to provide high-quality gender-specific care to Women Veterans. Completing the WHMR is one pathway to becoming a designated Women's Health-Primary Care Physician (WH-PCP) and a key tool to increase access for women Veterans to receive health care.

Recent Trends
More women are choosing VA for their health care than ever before, with women accounting for over 30% of the increase in all VHA annual Veteran enrollment. The number of women Veterans using VHA services has more than tripled since 2001, growing from 159,810 to more than 600,000 as of September 2023, a trend that is expected to continue. Women Veterans have distinct health care needs and require access to gender-specific services, the increase in enrollees will require VA to significantly increase its capacity to provide gender-specific care.

The increasing number of women Veterans enrolling in VA creates a need for a trained primary care as well as VA gynecology and obstetrics workforce to provide high quality reproductive health services. The Office of Women's Health has deployed national and local training programs to train over 10,000 primary care clinicians, nurses, and emergency care clinicians. The result is basic gynecologic care (e.g., cervical cancer screening, screening for sexually transmitted disease, contraceptive care) is now readily available within the VA. However, advanced gynecologic services (e.g., gynecologic surgery, minimally invasive surgery, urogynecology, pelvic pain, complex menopause management) are still lagging.

In alignment with the White House Blueprint for Addressing the Maternal Health Crisis and in support of the *Protecting Moms Who Served Act of 2021* (Public Law 117-69), VA has expanded its Maternity Care Coordination Program to 12 full months post pregnancy. VA is committed to supporting Veteran families and improving Veterans' pregnancy and postpartum outcomes.

Maternity care coordinators connect with pregnant and post-pregnancy Veterans to monitor the delivery of care, track maternal and newborn outcomes, collaborate with VA clinicians and community providers, provide screenings for social determinants of health, mental health risk factors and health risks such as gestational diabetes and hypertensive disorders of pregnancy, and connect Veterans to vital resources.

Budget Request: The Office of Women's Health 2025 Budget request is $263.7 million, $6.7 million above the 2024 Budget, to enhance office staffing to effectively lead, manage, and oversee the national provision of health are for women Veterans. The Budget requests $33.6 million in funding to support operations of the Office of Women's Health, as displayed in the Program Office budget table.

Women Veterans Workload

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Advance Approp.	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Unique Patients								
Women Veterans Health-Gender-Specific Care 1/.....	385,897	384,426	415,485	400,513	**445,101**	**474,732**	29,616	29,631
Women Veterans Health-All Care.....	659,349	679,323	685,037	705,616	**710,824**	**736,510**	25,787	25,686

1/ Included in Women Veterans Total Unique Patients.

Women's Health Innovation and Staffing Enhancement (WHISE)

Purpose

VA is strategically enhancing services and access for women Veterans by evaluating the women's health provider and nursing staff workforce nationally and identifying potential gaps in capacity across Veterans Integrated Service Networks, including the expansion of reproductive health care workforce to provide additional services and maternity care coordination for longer time intervals to post-partum women Veterans.

Evidence

The women Veteran population is the fastest growing demographic within the VA and is anticipated to grow from 800,000 enrolled in 2020 to over 1.2 million by 2030. Health care benefits from the PACT Act are expected to increase new women enrollees by 27%. PACT Act resources also provide care for reproductive cancer as presumptive conditions that will create a need for reproductive female cancer specialists.

Expanded VHA policies for reproductive care will require additional gynecologists at all sites of care. Many of these services currently are provided through community care and shifting these services to internal providers would result in cost savings and higher quality of care for women Veterans.

Examples of key positions being evaluated are women's health primary care providers, mental health providers, gynecologists, women's health pharmacists and physical therapists. These positions will require each facility to hire additional support such as nursing staff, radiology technicians, and medical support assistants (MSAs).

WHISE has demonstrated its national impact through increasing staff by funding over 1,000 positions focused on women's health across the 18 Veterans Integrated Services Networks (VISNs). The staff funded through this initiative have directly reduced the collateral duties for Women's Health Program staff enabling them to focus on high level administrative functions. WVPMs have also reported an expansion of existing VA gender-specific clinical services leading to increased veteran satisfaction and fewer community referrals. Through collaboration with Clinical Resource Hubs (CRH), VA also used WHISE funding to support virtual services, including women's health gynecologists, pharmacists, and other specialists.

Budget Request
The WHISE 2025 Budget request is $210 million, is $36 million above the 2024 Budget request. The WHISE initiative has now supported over 1,000 women's health care positions across all 18 Veterans Integrated Service Networks. The 2025 Budget request will sustain current positions within the program and assess additional needs for women's health staffing.

Veteran Childcare Assistance Program

Authority for Action
P.L. 116-315, *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020*, §5107a Programs on Assistance for Childcare for Certain Veterans

Purpose
The Veterans Childcare Assistance Program provides a method of administering childcare assistance at each VA Medical Center (VAMC) to qualified Veterans no later than January 2026, as required by the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020*.

Evidence
The VHA Quality Enhancement Research Initiative (QUERI) surveyed 2,000 VHA enrolled Veterans with dependent children and facilitated Veteran focus groups. Data concludes 75% of surveyed Veterans experienced a barrier to finding childcare while attending a VA medical appointment. Approximately 58% of Veterans with children reported missing or canceling at least one VA medical appointment during the last twelve months specifically due to lack of childcare or childcare failure (that is planned childcare options were no longer available). Veterans who were able to attain childcare services to attend a VA medical appointment reported paying an average of $60 per episode.

The Veterans Experience Office's (VEO) Veterans Signals (VSignals) platform surveyed data from over 300,000 enrolled Veterans during the period of February 2022 to February 2023. Results suggest 4% of Veterans have at least one child in need of childcare when they attend a VA medical appointment. According to 2022 enrollment data this percentage accounts for over 350,000 enrolled Veterans.

VHA has one operational site at VA Puget Sound Health Care System's American Lake Medical Center. Operating since 2012 under a special legislative pilot authority, the center cares for an average of 3,000 Veteran dependents per year. VHA's efforts to enhance childcare services for

Veterans resonates with the President Administration's continuous endeavors to broaden access to childcare, enhance affordability, and reduce childcare-related barriers to healthcare (The White House, 2023).

Budget Request

The 2025 Budget requests $18.6 million for the Veteran Childcare Assistance Program (VCAP). VCAP is actively engaged with 42 VA Medical Centers and is making progress in developing its IT infrastructure to facilitate Direct Veterans Reimbursement and streamline overall VCAP operations. The ongoing progress underscores VCAP's dedication to providing essential childcare services for eligible Veterans. Outside of this funding level, VCAP has an identified a need for $10 million in Medical Facilities funding to support non-recurring maintenance obligations at the medical center level in 2025.

Implementation Plan

Efforts are underway to establish 10 onsite drop-in childcare centers in 2024, followed by 20 additional sites in 2025. To meet full implementation, the program will require a short menu of options for each VAMC. These options include onsite drop-in childcare services and a direct Veteran reimbursement model. The core of the program's success is ensuring all sites are operating safely, efficiently, effectively and in a manner that reflects VA's ICARE values and High Reliability Organization (HRO) journey.

The average number of unique Veterans per VA Health Care System is 56,234. VCAP prioritized onsite childcare delivery for sites with above-average enrollment. This includes 58 VAMCs and 4.9 million Veterans, with an anticipated impact of 199,225 enrolled Veterans. Based on pilot site data, onsite childcare to 58 VAMCs may result in 174,000 childcare encounters per year. A reimbursement model will further amplify this number in communities with available resources. Upon full implementation, VCAP is poised to have a profound and beneficial effect on well over one million VA appointments annually.

Reference

The White House. (2023 April 18). *FACT SHEET: Biden-Harris Administration Announces Most Sweeping Set of Executive Actions to Improve Care in History*. https://www.whitehouse.gov/briefing-room/statements-releases/2023/04/18/fact-sheet-biden-harris-administration-announces-most-sweeping-set-of-executive-actions-to-improve-care-in-history/

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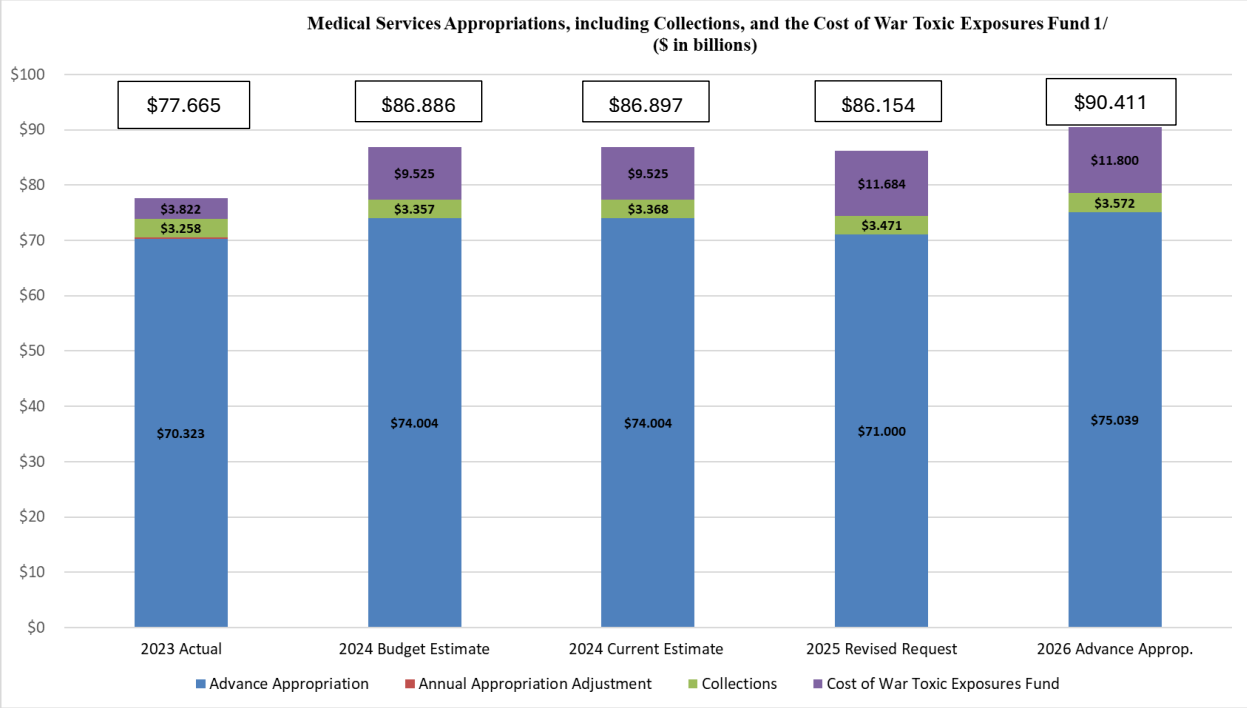
Medical Services Category

Chart: Medical Services Appropriations and Collections



1/ All columns in this chart display appropriations prior to any proposed cancelations or transfers as shown in the crosswalk tables below.

Note: A full-year 2024 appropriations Act was not enacted at the time the 2025 President's Budget was prepared. The 2024 Current Estimate assumes the 2024 President's Budget request for 2024 with updates to unobligated balances, reimbursements, transfers, and medical care collections.

Summary of the 2025 Revised Request

The Department of Veterans Affairs (VA) is maintaining the requested 2025 discretionary advance appropriation of $71.0 billion for the Medical Services account. The 2025 request also includes $11.7 billion in 2025 mandatory appropriations from the Cost of War Toxic Exposures Fund (TEF), as provided in the Fiscal Responsibility Act of 2023, and assumes a medical care collections projection of $3.5 billion. To realign funding among the four Medical Care categories to meet Veterans' projected demand for health care, VA proposes to transfer $7.3 billion from the Medical Services advance appropriation to Medical Community Care. When further combined with unobligated balances, reimbursements, and transfers to other account, the total amount of resources to be obligated in the Medical Services category in 2025 is $86.5 billion.

Summary of the 2026 Advance Appropriations Request

The 2025 budget request reflects a 2026 discretionary advance appropriation request of $75.0 billion; an allocation of $11.8 billion out of the total 2026 mandatory advance appropriation request for the TEF, as authorized in the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act); and a medical care collections projection of $3.6 billion. When combined with all other resources, the total amount of resources to be obligated in the Medical Services category in 2026 is $90.1 billion.

Appropriation Language

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; $75,039,000,000, plus reimbursements, which shall become available on October 1, 2025, and shall remain available until September 30, 2026: Provided, That, of the amount made available on October 1, 2025, under this heading, $2,000,000,000 shall remain available until September 30, 2027: Provided further, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs shall establish a priority for the provision of medical treatment for veterans who have service-connected disabilities, lower income, or have special needs: Provided further, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs shall give priority funding for the provision of basic medical benefits to veterans in enrollment priority groups 1 through 6: Provided further, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs may authorize the dispensing of prescription drugs from Veterans Health Administration facilities to enrolled veterans with privately written prescriptions based on requirements established by the Secretary: Provided further, That the implementation of the program described in the previous proviso shall incur no additional cost to the Department of Veterans Affairs: Provided further, That the Secretary of Veterans Affairs shall ensure that sufficient amounts appropriated under this heading for medical supplies and equipment are available for the acquisition of prosthetics designed specifically for female veterans: Provided further, That nothing in section 2044(e)(1) of title 38, United States Code, may be construed as limiting amounts that may be made available under this heading for fiscal years 2025 and 2026 in this or prior Acts.

Table: Medical Services Discretionary Funding Crosswalk 2023-2026

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Appropriation Medical Services (0160)							
Advance Appropriation Medical Services (0160)	$70,323,116	$74,004,000	$74,004,000	$71,000,000	$75,039,000	($3,004,000)	$4,039,000
Proposed Cancellation 1/	$0	($4,933,113)	($4,933,113)	$0	$0	$4,933,113	$0
Annual Appropriation Adjustment Medical Services (0160)	$261,000	$0	$0	$0	$0	$0	$0
Net Appropriation	**$70,584,116**	**$69,070,887**	**$69,070,887**	**$71,000,000**	**$75,039,000**	**$1,929,113**	**$4,039,000**
Transfers To:							
North Chicago Demo. Fund (0169) from Medical Services (0160)	($233,005)	($263,141)	($332,510)	($384,926)	($423,401)	($52,416)	($38,475)
DoD-VA Hlth Care Sharing Incentive Fund (0165) from Medical Services (016	($15,000)	($15,000)	($15,000)	($15,000)	($15,000)	$0	$0
Medical Community Care (0140)	$0	$0	$0	($7,307,318)	$0	($7,307,318)	$7,307,318
Transfers To [Subtotal]	($248,005)	($278,141)	($347,510)	($7,707,244)	($438,401)	($7,359,734)	$7,268,843
Transfers From:							
Medical Support & Compliance (0152)	$0	$0	$1,150,000	$0	$0	($1,150,000)	$0
Medical Community Care (0140)	$0	$0	$748,908	$0	$0	($748,908)	$0
Medical Care Collections Fund (5287)	$3,258,336	$3,356,710	$3,367,692	$3,470,595	$3,572,320	$102,903	$101,725
Transfers From [Subtotal]	$3,258,336	$3,356,710	$5,266,600	$3,470,595	$3,572,320	($1,796,005)	$101,725
Discretionary Budget Authority Total	$73,594,447	$72,149,456	$73,989,977	$66,763,351	$78,172,919	($7,226,626)	$11,409,568
Reimbursements Medical Services (0160)	$119,759	$127,577	$119,759	$119,759	$119,759	$0	$0
Unobligated Balance (SOY):							
P.L. 111-32 (H1N1 no-year)	$7	$0	$7	$7	$7	$0	$0
P.L. 110-28 (Emergency Supplemental no-year)	$136	$0	$136	$136	$136	$0	$0
No-Year (all other)	$3,130,601	$3,433,113	$2,663,890	$4,579,519	$0	$1,915,629	($4,579,519)
2-Year	$500,826	$1,500,000	$1,050,837	$2,000,000	$1,000,000	$949,163	($1,000,000)
Unobligated Balance (SOY) [Subtotal]	$3,631,570	$4,933,113	$3,714,870	$6,579,662	$1,000,143	$2,864,792	($5,579,519)
Unobligated Balance (EOY):							
P.L. 111-32 (H1N1 no-year)	($7)	$0	($7)	($7)	($7)	$0	$0
P.L. 110-28 (Emergency Supplemental no-year)	($136)	$0	($136)	($136)	($136)	$0	$0
No-Year (all other)	($2,663,890)	($2,000,000)	($4,579,519)	$0	$0	$4,579,519	$0
2-Year	($1,050,837)	($1,000,000)	($2,000,000)	($1,000,000)	($1,000,000)	$1,000,000	$0
Unobligated Balance (EOY) [Subtotal]	($3,714,870)	($3,000,000)	($6,579,662)	($1,000,143)	($1,000,143)	$5,579,519	$0
Lapse Medical Services (0160)	($851)	$0	$0	$0	$0	$0	$0
Subtotal	$73,630,055	$74,210,146	$71,244,944	$72,462,629	$78,292,678	$1,217,685	$5,830,049
Prior Year Recoveries	$106,124	$0	$0	$0	$0	$0	$0
Discretionary Obligations (0160) [Subtotal]	**$73,736,179**	**$74,210,146**	**$71,244,944**	**$72,462,629**	**$78,292,678**	**$1,217,685**	**$5,830,049**

1/ The 2024 Budget proposed a cancellation of unobligated balances of $4.933 billion. The 2024 Current Estimate assumes a rescission in this amount will be enacted.

Note: A full-year 2024 appropriations Act was not enacted at the time the 2025 President's Budget was prepared. The 2024 Current Estimate assumes the 2024 President's Budget request for 2024 with updates to unobligated balances, reimbursements, transfers, and medical care collections.

Table: Medical Services Mandatory Funding Crosswalk 2023-2026

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Veterans Medical Care and Health Fund (0173MS)							
Unobligated Balance (SOY)	$733,253	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY)	$0	$0	$0	$0	$0	$0	$0
Lapse	($55)	$0	$0	$0	$0	$0	$0
Subtotal	$733,198	$0	$0	$0	$0	$0	$0
Prior Year Recoveries	$85,362	$0	$0	$0	$0	$0	$0
Obligations, ARP Act Section 8002 (0173MS) [Total]	$818,560	$0	$0	$0	$0	$0	$0
ARP Act, sec. 8007 (0160XP)							
Unobligated Balance (SOY)	$2,847	$0	$2,850	$2,850	$2,850	$0	$0
Unobligated Balance (EOY)	($2,850)	$0	($2,850)	($2,850)	($2,850)	$0	$0
Subtotal	($3)	$0	$0	$0	$0	$0	$0
Prior Year Recoveries	$935	$0	$0	$0	$0	$0	$0
Obligations, ARP Act, sec. 8007 (0160XP) [Total]	$932	$0	$0	$0	$0	$0	$0
American Rescue Plan Act Obligations [Subtotal]	**$819,492**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Cost of War Toxic Exposures Fund							
Mandatory Appropriation	$3,822,377	$9,525,428	$9,525,428	$11,683,896	$11,800,000	$2,158,468	$116,104
Unobligated Balance (SOY)	$7,981	$0	$3,815,453	$2,346,075	$0	($1,469,378)	($2,346,075)
Realignment of Unobligated Balances	$94	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY)	($3,815,453)	($1,338,000)	($2,346,075)	$0	$0	$2,346,075	$0
Obligations, TEF [Total]	**$14,999**	**$8,187,428**	**$10,994,806**	**$14,029,971**	**$11,800,000**	**$3,035,165**	**($2,229,971)**
VACAA, sec. 801 (0160XA)							
Unobligated Balance (SOY):	$16,123	$10,658	$8,817	$4,980	$0	($3,837)	($4,980)
Unobligated Balance (EOY):	($8,817)	($4,980)	($4,980)	$0	$0	$4,980	$0
Subtotal	$7,306	$5,678	$3,837	$4,980	$0	$1,143	($4,980)
Prior Year Recoveries	$61	$0	$0	$0	$0	$0	$0
Obligations (0160XA) [Total]	**$7,367**	**$5,678**	**$3,837**	**$4,980**	**$0**	**$1,143**	**($4,980)**
Mandatory Budget Authority [Subtotal]	$3,822,377	$9,525,428	$9,525,428	$11,683,896	$11,800,000	$2,158,468	$116,104
Mandatory Obligations [Subtotal]	**$841,858**	**$8,193,106**	**$10,998,643**	**$14,034,951**	**$11,800,000**	**$3,036,308**	**($2,234,951)**

Table: Medical Services All Funding Sources Crosswalk 2023-2026

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Budget Authority [Grand Total]	$77,416,824	$81,674,884	$83,515,405	$78,447,247	$89,972,919	($5,068,158)	$11,525,672
Obligations [Grand Total]	**$74,578,037**	**$82,403,252**	**$82,243,587**	**$86,497,580**	**$90,092,678**	**$4,253,993**	**$3,595,098**
FTE							
Medical Services (0160)	282,395	293,544	297,651	290,658	290,372	(6,993)	(286)
Veterans Medical Care and Health Fund (0173MS)	2,193	0	0	0	0	0	0
Cost of War Toxic Exposures Fund (1126MS)	0	13	0	0	0	0	0
VACAA, sec. 801 (0160XA)	31	17	31	31	0	0	(31)
FTE [Total]	284,619	293,574	297,682	290,689	290,372	(6,993)	(317)

Summary of Obligations by Functional Area

The Medical Services activity display has been adjusted in the 2025 Congressional Submission to align with actuals recorded in the financial management system. To provide better visibility into the spending under this appropriation, additional detail on obligations by the following categories are reflected in the next charts.

Table: Medical Services Discretionary Obligations by Program

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Health Care Services 1/ 2/	$52,135,141	N/A	$52,553,053	$57,057,548	$58,348,159	$4,504,495	$1,290,611
Beneficiary Travel	$1,906,417	$2,668,861	$2,011,900	$2,126,009	$2,264,956	$114,109	$138,947
Caregivers Support Program 2/	$1,645,437	$2,385,880	$2,385,880	$2,872,200	$3,456,300	$486,320	$584,100
CHAMPVA (excluding Caregivers)	$503,920	$524,735	$524,735	$570,897	$622,839	$46,162	$51,942
Equipment	$1,893,811	$2,054,739	$2,128,700	$0	$2,333,973	($2,128,700)	$2,333,973
Homeless Programs and Grants 1/ 2/ 3/	$1,884,190	N/A	$2,091,021	$2,086,387	$2,086,387	($4,634)	$0
Pharmaceutical Ingredients 1/	$9,032,899	N/A	$4,439,855	$2,136,381	$3,108,124	($2,303,474)	$971,743
Prosthetic Supplies and Services 1/	$4,387,150	N/A	$4,822,530	$5,310,639	$5,769,372	$488,109	$458,733
Readjustment Counseling Service 2/	$241,090	$287,270	$287,270	$302,568	$302,568	$15,298	$0
Obligations [Subtotal]	**$73,630,055**	**$74,210,146**	**$71,244,944**	**$72,462,629**	**$78,292,678**	**$1,217,685**	**$5,830,049**
VA Prior-Year Recoveries	$106,124	$0	$0	$0	$0	$0	$0
Total Obligations	$73,736,179	$74,210,146	$71,244,944	$72,462,629	$78,292,678	$1,217,685	$5,830,049

1/ Details not displayed in the 2024 Congressional Justification.

2/ The amounts on these rows are inconsistent with the 2025 Budget Appendix estimates for 2023 Actuals, the 2024 Current Estimate, and the 2025 Revised Request. Compared to the 2025 Budget Appendix (Appendix), the obligations shown in this table for the Caregivers Support Program and Homeless Programs and Grants are lower than in the 2025 Budget Appendix as they exclude obligations in the Medical Support and Compliance category that were incorrectly included in the Medical Services program activity levels in the Appendix. The obligations shown in this table for the Readjustment Counseling Service in the 2025 Revised Request column is higher than in the Appendix. The net impact of changes made to these three rows is reflected in the Health Care Services line so that the total obligations level in all years is consistent with the Appendix.

3/ This line reflects the Medical Services portion of the Homeless Program Office Specific Purpose budget. For more information, please see the Homeless Program Table in the Medical Care chapter.

Table: Medical Services Mandatory Obligations by Program

(dollars in thousands)

Description:	2023 Actual	2024 Budget Estimate 1/	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Veterans Medical Care and Health Fund							
Health Care Services	$395,045	$0	$0	$0	$0	$0	$0
Beneficiary Travel	$13,958	$0	$0	$0	$0	$0	$0
Equipment	$3,279	$0	$0	$0	$0	$0	$0
Homeless Programs and Grants 1/ 2/	$20,375	$0	$0	$0	$0	$0	$0
Pharmaceutical Ingredients	$300,541	$0	$0	$0	$0	$0	$0
VMCHF Obligations [Subtotal]	**$733,198**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Prior Year Recoveries	$85,362	$0	$0	$0	$0	$0	$0
VMCHF Obligations [Total]	**$818,560**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
ARP Act, sec. 8007 (0160XP)							
Health Care Services	$115	$0	$0	$0	$0	$0	$0
Pharmaceutical Ingredients	($118)	$0	$0	$0	$0	$0	$0
ARP Act, sec. 8007 Obligations [Subtotal]	**($3)**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Prior Year Recoveries	$935	$0	$0	$0	$0	$0	$0
ARP Act, sec. 8007 Obligations [Total]	**$932**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Cost of War Toxic Exposures Fund (TEF)							
Health Care Services 1/	$14,999	N/A	$5,294,905	$2,800,352	$2,800,000	($2,494,553)	($352)
Equipment	$0	$0	$0	$2,229,619	$0	$2,229,619	($2,229,619)
Pharmaceutical Ingredients 1/	$0	N/A	$5,699,901	$9,000,000	$9,000,000	$3,300,099	$0
TEF Obligations [Subtotal]	**$14,999**	**$8,187,428**	**$10,994,806**	**$14,029,971**	**$11,800,000**	**$3,035,165**	**($2,229,971)**
VACAA, sec. 801							
Health Care Services 1/	$7,213	N/A	$3,837	$4,980	$0	$1,143	($4,980)
Equipment	$93	$0	$0	$0	$0	$0	$0
VACAA, sec. 801 Obligations [Subtotal]	**$7,306**	**$0**	**$3,837**	**$4,980**	**$0**	**$1,143**	**($4,980)**
Prior Year Recoveries	$61	$0	$0	$0	$0	$0	$0
VACAA, sec. 801 Obligations [Total]	**$7,367**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
MSC Obligations - Mandatory Funds [Total]	**$841,858**	**$8,187,428**	**$10,994,806**	**$14,029,971**	**$11,800,000**	**$3,035,165**	**($2,229,971)**

1/ Details not displayed in the 2024 Congressional Justification.

2/ This line reflects the Medical Services portion of the Homeless Program Office Specific Purpose budget. For more information, please see the Homeless Program Table in the Medical Care chapter.

Table: Medical Services Total Obligations by Program
(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Health Care Services 1/ 2/	$52,552,513	N/A	$57,851,795	$59,862,880	$61,148,159	$2,011,085	$1,285,279
Beneficiary Travel	$1,920,375	$2,668,861	$2,011,900	$2,126,009	$2,264,956	$114,109	$138,947
Caregivers Support Program	$1,645,437	$2,385,880	$2,385,880	$2,872,200	$3,456,300	$486,320	$584,100
CHAMPVA (excluding Caregivers)	$503,920	$524,735	$524,735	$570,897	$622,839	$46,162	$51,942
Equipment	$1,897,183	$2,054,739	$2,128,700	$2,229,619	$2,333,973	$100,919	$104,354
Homeless Programs and Grants 1/ 2/	$1,904,565	N/A	$2,091,021	$2,086,387	$2,086,387	($4,634)	$0
Pharmaceutical Ingredients 1/	$9,333,322	N/A	$10,139,756	$11,136,381	$12,108,124	$996,625	$971,743
Prosthetic Supplies and Services 1/	$4,387,150	N/A	$4,822,530	$5,310,639	$5,769,372	$488,109	$458,733
Readjustment Counseling Service	$241,090	$287,270	$287,270	$302,568	$302,568	$15,298	$0
Obligations [Subtotal]	**$74,385,555**	**$82,397,574**	**$82,243,587**	**$86,497,580**	**$90,092,678**	**$4,253,993**	**$3,595,098**
VA Prior-Year Recoveries	$192,482	$0	$0	$0	$0	$0	$0
Total Obligations	$74,578,037	$82,397,574	$82,243,587	$86,497,580	$90,092,678	$4,253,993	$3,595,098

1/ Details not displayed in the 2024 Congressional Justification.
2/ This line reflects the Homeless program office Medical Services budget and excludes Homeless program efforts funded by General Purpose. For more information, please see the Homeless Program Table in the Medical Care Chapter.

In 2025, total obligations are projected to increase by $4.3 billion above the 2024 current estimate, with four programs accounting for $4.0 billion of the increase and all other adjustments accounting for the remaining $265 million increase:

Health Care Services (+$2.0 billion). A significant portion of this increase is due to a change in the composition of FTE types and increased compensation levels due to annual pay increases and other changes, as well as anticipated changes to contracts and administrative expenses.

Pharmaceutical Ingredients (+$997 million). The estimated cost for this program is expected to increase by nearly 10% from 2024 based on expected trends.

Prosthetic Supplies and Services (+$488 million). The estimated cost for this program is expected to increase by nearly 10% from 2024 based on expected trends.

Caregivers Support Program (+$486 million). This increase is consistent with growth projected by the program's actuarial model and potential program changes.

Summary of the 2026 Advance Appropriation Request

In 2026, total obligations are projected to increase by $3.6 billion from the 2025 revised request level, with four programs accounting for $3.3 billion of the increase and all other adjustments accounting for the remaining $295 million increase:

Health Care Services (+$1.3 billion). Ongoing health care services are projected to sustain a staffing strength level consistent with the end of 2025.

Pharmaceutical Ingredients (+$971 million). The projected increase is aligned with the pharmacy component of Enrollee Health Care Projection Model's (EHCPM) projected growth between 2025 and 2026.

Caregivers Support Program (+$584 million). This increase is consistent with growth projected by the program's actuarial model and potential program changes discussed in the Medical Care chapter.

Prosthetic Supplies and Services (+$458 million). The estimated cost for this program is expected to increase based on expected trends.

Medical Services Program Funding Requirements

VA is committed to providing the best access to care for Veterans. VA continues to execute a multi-pronged strategy in 2025 that will target resources to improve Veterans' access to timely, high-quality care through strategic hiring, improved care coordination, and continued telehealth enhancements. These efforts will ensure that every eligible Veteran has a chance to access the VA health care that peer reviewed studies continue to show is better than or equal to non-VA health care.[5]

- 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.

- Telehealth Enhancements: Many Veterans prefer the convenience, timeliness and efficiency of telehealth appointments, particularly after their more widespread use during the pandemic. VA will continue to augment its clinical resource telehealth hubs with additional Primary Care, Mental Health and Clinical Pharmacy Specialists who deliver care via VA Video Connect appointments. In addition, VA will expand the development of Specialty Care telehealth hubs, providing services such as cardiology, neurology, dermatology, and inpatient intensive care unit (ICU) and stroke programs.

- Improve Veterans' Access to Same-Day Mental Health Care: Veterans are at higher risk for mental health and substance use challenges than the general population. Increasing their access to quality mental health care is the first step to closing this disparity. VA will reduce barriers to mental health access by fully implementing its Primary Care Mental Health Integration and Behavioral Health Interdisciplinary Program, which connects Veterans to same-day mental health care and improves the integration of these services into primary care settings.

Medical Services Support for VA- and Community-Provided Care

The Medical Services category provides support for both VA direct care and community care, and increases in care provided in either setting resulted in increases costs in Medical Services. This occurs in Medical Services funded activities such as beneficiary travel, pharmacy costs, and

[5] Studies show VA health care is better than or equal to non-VA health care - VA News
Majority of VA health care facilities receive 4 or 5 stars in CMS quality ratings, outperforming non-VA facilities

clinical care coordination activities. Additional detail on beneficiary travel appears in later in this chapter, while additional detail on is discussed later in this chapter; please see the Medical Care chapter for additional detail on pharmacy care.

HR Modernization

One of VHA's top priorities continues to be to improve the hiring process. Fulfilling VA's mission to provide the top-notch care that Veterans deserve is only possible with an enterprise-wide team of the best and brightest in their respective fields. To hire the best, VHA aims to have an efficient the hiring process. To retain the best, VHA must take care of its employees with competitive wages and benefits so they can focus on taking care of Veterans.

Since March 2022, VA has updated nearly 400 pay tables and increased salaries for more than 7,000 employees, due to the RAISE Act. VHA has increased inclusivity, diversity, equity, and access in VHA recruiting and established partnerships with Minority Serving Institution colleges and universities. Through authorities provided in the PACT Act, VA is implementing new hiring and retention authorities to strengthen and maintain a diverse, talented workforce with a shared mission to provide more care and more benefits to more Veterans.

The 2025 Budget builds upon these efforts and continues to support VHA's goals to onboard employees faster, accelerate training for human resources specialists, and invest in VA employees.

Providing Seamless and Coordinated Access to Care for Veterans

VA staff completed nearly than 88 million Veteran visits in 2023. Even as Veterans receive care in-person, VA continues to be at the forefront of delivering clinical care to Veterans virtually. VA provided more telehealth services to more Veterans in 2023 than in any previous fiscal year while realizing increased Veteran trust (86.9%) and satisfaction (89.9%) with telehealth for the 3rd consecutive year. This access is supplemental to care offered through our VA medical centers and Community Based Outpatient Clinics and for those eligible through VA's robust community care network. The Office of Integrated Veteran Care (IVC) oversees the design and implementation of an integrated access and care coordination model for VA and community care. VHA is working to ensure that it can reliably offer a VA option for care to any Veteran who requests it – including to Veterans who qualify for community care under the MISSION Act.

The 2025 request sustains the recent historic number of new staff to meet the workload demand as result of the PACT Act in 2025 and provides resources to ensure VA provides timely primary care and specialty care in VA facilities, and appropriate care coordination with community providers.

The following tables provide additional detail on nine distinct activities of the Medical Services account: Health Care Services, Beneficiary Travel, Caregivers Support Program, CHAMPVA (excluding Caregivers), Equipment, Homeless Programs and Grants, Pharmaceutical Ingredients, Prosthetic Supplies and Services, and Readjustment Counseling Service.

Health Care Services

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$52,135,141	N/A	$52,553,053	$57,064,548	$58,355,159	$4,511,495	$1,290,611
Mandatory Obligations	$417,372	$5,300,853	$5,298,742	$2,805,332	$2,800,000	($2,493,410)	($5,332)
Medical Services Obligations [Grand Total]	**$52,135,141**	**N/A**	**$52,553,053**	**$57,064,548**	**$58,355,159**	**$4,511,495**	**$1,290,611**

The Medical Services Health Care Services activity reflects primarily personnel and contracting costs to support the following health care activities:

- Ambulatory care (without pharmacy)
- Dental
- Inpatient
- Mental health
- Rehabilitative care
- Long term care

Medical Services FTE represents the largest share of VHA obligations by object class. They include:

- Physicians;
- Dentists;
- Registered Nurses;
- Licensed Practical Nurses (LPNs)/Licensed Vocational Nurses (LVNs)/ Nurse Assistants;
- Non-physician providers, such as podiatrists, physician assistants, psychologists, nurse practitioners, chiropractors and optometrists;
- Health Technicians/Allied Health, such as respiratory therapists, physical therapists, dietitians, social workers, radiology technologists, pharmacists, audiologist and speech pathologists, nuclear medicine technologists and laboratory aids and workers;
- Wage Board/Purchase & Hire; and
- All Other.

In 2023, VHA achieved a record hiring of 61,490 new staff, a large portion of which was in the Medical Services account, which represents growth of nearly 7.4% in 2023, while also improving retention. Due to record hiring in 2023, VA has the nationwide staffing level to accomplish the important objective of making sure that – whenever possible – all Veterans have an opportunity to receive care from a VA provider. VHA will continue to focus its hiring in key areas, such as mental health, to provide Veterans with high-quality and timely health care services and to meet Veterans' health care needs following enactment of the PACT Act.

VA's Medical Provider Recruitment & Retention Practices

As the Nation's largest integrated health care delivery system, VHA workforce challenges mirror those of the health care industry. VHA remains fully engaged in a competitive clinical recruitment

market and, therefore, faces similar challenges as our private sector counterparts. Some factors include: the growing national shortage and availability of experienced, quality candidates who possess the competencies required for the position; the salaries typically paid by private industry for similar positions; employment trends and labor-market factors that may affect the ability to recruit candidates; and other supporting factors, such as rural/highly rural locations that may be considered less desirable.

The 2025 budget continues to support VHA's Mental Health Optimization and Outpatient Staffing Enhancement and the Mental Health Staffing Pathways projects to ensure mental health programs remain adequately staffed. Through these initiatives, VHA is projecting demand for mental health services, proactively anticipating and addressing staffing gaps, and ensuring our staffing pipeline trains an interdisciplinary workforce optimal to providing the quality mental health care /Veterans deserve.

Providing world class health care is only possible with an enterprise-wide team of the best and brightest in their respective fields. VHA is focusing on improving the employee experience to ensure that care and benefits are delivered in a timely manner while also delivering positive outcomes for Veterans, their families, caregivers, and survivors. VHA is investing in its people by increasing the use of incentives for recruitment and retention, maximizing pay authorities and scheduling flexibilities, expanding scholarship opportunities, and providing more education loan repayment awards than ever before.

FTE by Type
Medical Services

Account	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary FTE							
Physicians	23,621	24,621	24,896	24,309	24,297	(587)	(12)
Dentists	1,361	1,431	1,423	1,390	1,388	(33)	(2)
Registered Nurses	69,569	72,108	73,991	72,253	72,174	(1,738)	(79)
LP Nurse/LV Nurse/Nurse Assistant	27,368	29,768	28,873	28,195	28,164	(678)	(31)
Non-Physician Providers	19,590	19,430	20,535	20,053	20,033	(482)	(20)
Health Technicians/Allied Health	85,916	88,969	90,077	87,961	87,867	(2,116)	(94)
Wage Board/Purchase & Hire	5,532	5,868	5,791	5,655	5,649	(136)	(6)
All Other	49,438	51,349	52,065	50,842	50,800	(1,223)	(42)
Discretionary Medical Service FTE [Subtotal]	**282,395**	**293,544**	**297,651**	**290,658**	**290,372**	**(6,993)**	**(286)**
Veterans Medical Care and Health Fund							
Mandatory FTE							
Physicians	182	0	0	0	0	0	0
Dentists	0	0	0	0	0	0	0
Registered Nurses	1,175	0	0	0	0	0	0
LP Nurse/LV Nurse/Nurse Assistant	238	0	0	0	0	0	0
Non-Physician Providers	45	0	0	0	0	0	0
Health Technicians/Allied Health	208	0	0	0	0	0	0
Wage Board/Purchase & Hire	5	0	0	0	0	0	0
All Other	340	0	0	0	0	0	0
VMCHF FTE [Subtotal]	**2,193**	**0**	**0**	**0**	**0**	**0**	**0**
Cost of War Toxic Exposures Fund							
Mandatory FTE							
All Other	0	13	0	0	0	0	0
American Families Plan FTE [Subtotal]	**0**	**13**	**0**	**0**	**0**	**0**	**0**
Veterans Choice Act (P.L. 113-146)							
Section 801							
Mandatory FTE							
Physicians	14	11	14	14	0	0	(14)
Dentists	0	0	0	0	0	0	0
Registered Nurses	0	0	0	0	0	0	0
LP Nurse/LV Nurse/Nurse Assistant	0	0	0	0	0	0	0
Non-Physician Providers	2	2	2	2	0	0	(2)
Health Technicians/Allied Health	2	0	2	2	0	0	(2)
Wage Board/Purchase & Hire	0	0	0	0	0	0	0
All Other	13	4	13	13	0	0	(13)
Veterans Choice Act FTE [Subtotal]	**31**	**17**	**31**	**31**	**0**	**0**	**(31)**
Total Medical Services FTE							
Physicians	23,817	24,632	24,910	24,323	24,297	(587)	(26)
Dentists	1,361	1,431	1,423	1,390	1,388	(33)	(2)
Registered Nurses	70,744	72,108	73,991	72,253	72,174	(1,738)	(79)
LP Nurse/LV Nurse/Nurse Assistant	27,606	29,768	28,873	28,195	28,164	(678)	(31)
Non-Physician Providers	19,637	19,432	20,537	20,055	20,033	(482)	(22)
Health Technicians/Allied Health	86,126	88,969	90,079	87,963	87,867	(2,116)	(96)
Wage Board/Purchase & Hire	5,537	5,868	5,791	5,655	5,649	(136)	(6)
All Other	49,791	51,366	52,078	50,855	50,800	(1,223)	(55)
Medical Services FTE [Grand Total[	**284,619**	**293,574**	**297,682**	**290,689**	**290,372**	**(6,993)**	**(317)**

Beneficiary Travel 1/

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$1,906,417	$2,668,861	$2,011,900	$2,126,009	$2,264,956	$114,109	$138,947
Mandatory Obligations (including VMCHF and TEF)	$13,958	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$1,920,375**	**$2,668,861**	**$2,011,900**	**$2,126,009**	**$2,264,956**	**$114,109**	**$138,947**

1/ This table displays obligations only in Medical Services for this activity line. A breakout of the $2.0 billion in total 2023 obligations for the Beneficiary Travel cost can be found in the Medical Care Chapter, Obligations by Object table.

	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Beneficiary Travel-Mileage	$315,049	$477,119	$330,748	$343,978	$357,737	$13,230	$13,759
Beneficiary Travel-Special Mode	$1,509,663	$2,093,781	$1,581,662	$1,678,561	$1,799,610	$96,899	$121,049
All Other Beneficiary Travel	$95,663	$97,691	$99,490	$103,470	$107,609	$3,980	$4,139
Beneficiary Travel Total	**$1,920,375**	**$2,668,591**	**$2,011,900**	**$2,126,009**	**$2,264,956**	**$114,109**	**$138,947**

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. Costs covered by the program include a per-mile rate for travel in private vehicles subject to a deductible; "special mode" (e.g., ambulance) travel in certain circumstances; and in some cases, airfare, meals and lodging.

Title 38 U.S.C, § 111, "Payments or allowances for beneficiary travel," as regulated in 38 C.F.R. §§ 70.1 – 70.50, authorizes VA to provide or reimburse to certain eligible Veterans and other beneficiaries to help obtain care or services from VA. The cost of the Beneficiary Travel program included:

- Mileage (currently $0.415), or when medically indicated, special mode (ambulance, wheelchair van, etc.) transport and common carrier (plane, train, bus, taxi, light rail, etc.) transport;
- The actual cost of bridge tolls, road and tunnel tolls, parking and authorized luggage fees when supported by a receipt; and
- The actual cost, in limited circumstances, of meals, lodging or both, not to exceed 50% of the local Federal employee rate.

Eligibility is based upon receipt of VA disability compensation service connection and/or low income (VA pension thresholds) or special administrative authority. The current BT regulations only provide authorization for BT within the States, Territories and possessions of the United States, the District of Columbia and the Commonwealth of Puerto Rico.

Caregivers Support Program

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$1,645,437	$2,385,880	$2,385,880	$2,872,200	$3,456,300	$486,320	$584,100
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$1,645,437**	**$2,385,880**	**$2,385,880**	**$2,872,200**	**$3,456,300**	**$486,320**	**$584,100**

The Medical Services category portion of the Caregiver Support Program includes respite care, stipend payments, CHAMPVA payments, and case management costs. It excludes administrative costs. For more information on the Caregivers Support Program please see the Medical Care chapter.

CHAMPVA

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$503,920	$524,735	$524,735	$570,897	$622,839	$46,162	$51,942
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$503,920**	**$524,735**	**$524,735**	**$570,897**	**$622,839**	**$46,162**	**$51,942**

The Medical Services Category portion of the CHAMPVA Program includes the pharmacy costs and the cost to VA medical center for delivering care in VA facilities. Medical Services excludes payment to providers and program administration. For more information on the CHAMPVA Program please see the Medical Care chapter.

Medical Equipment 1/

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$1,893,811	$2,054,739	$2,128,700	$0	$2,333,973	($2,128,700)	$2,333,973
Mandatory Obligations	$3,372	$0	$0	$2,229,619	$0	$2,229,619	($2,229,619)
Obligations [Grand Total]	**$1,897,183**	**$2,054,739**	**$2,128,700**	**$2,229,619**	**$2,333,973**	**$100,919**	**$104,354**

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.

Purpose

Medical equipment is a foundational element of Veteran healthcare. Some examples of lifesaving equipment include linear accelerators to provide radiation treatment for cancer; computerized tomography scanners that provide imaging to screen for lung cancer; physiologic monitoring systems that display patient vital signs in real time; anesthesia delivery systems that induce and maintain anesthesia in surgical patients; and laboratory analyzers that determine blood glucose measurements.

VA continues to deploy new medical equipment at all medical centers in response to the most critical and time-sensitive needs. Modernized medical equipment expands Veterans' access to care, provides clinical functionality that meets or exceeds community standards, enhances patient safety and mitigates information security risks.

Description
Medical equipment directly contributes to improving the Veteran experience by providing state-of-the art equipment in the VA healthcare environment. Medical equipment refresh supports VA's overarching modernization efforts by improving VHA's capabilities to provide high reliability healthcare to Veterans. Medical equipment plays a vital role in focusing VA resources more efficiently by enhancing and supporting the clinical staff through human factors design, training on technology use and systems integration. Medical equipment directly contributes to improving the service timeliness by ensuring VAMCs have the technology essential to provide medical care to Veterans.

The Assistant Under Secretary for Health for Support (AUSH-S) is responsible for national policies, standards, and guidance related to medical equipment management and safety. AUSH-S provides leadership, consultation, and expertise in technology configuration management and VHA medical equipment and clinical systems deployment, commissioning and technical sustainment and refresh. The Healthcare Technology Management Office manages this program on behalf of the AUSH-S and is accountable for program execution and oversight through coordination with Biomedical Engineering field operations managers.

Evidence
VHA's equipment inventory data was extracted from the VA's Corporate Data Warehouse (CDW) in developing projections for equipment replacement costs. This is significant as the data is based on real-time medical devices/systems currently in clinical use across VHA. The methodology used for these projections are also based on VA-adopted models for medical technology managed by VHA's Biomedical Engineering programs. Estimates were added in 2024, 2025, and 2026 for modernization related to EHR implementation.

The medical equipment used across VHA is the same equipment used in United States (U.S.) commercial healthcare. Medical Services equipment includes capitalized equipment such as diagnostic imaging equipment, radiation oncology equipment, surgical systems and intensive care monitoring systems, with a purchase price of $1 million or more; and non-capitalized equipment, such as biomedical devices, dentistry equipment, laboratory analyzers, hospital beds, scientific instruments and appliances, measuring and weighing instruments, surgical equipment and instruments and accessories that cost less than $1 million. Medical Services equipment includes clinical systems used in medical/surgical subspecialties for diagnostic interpretation, treatment planning, decision support and results reporting. Current medical equipment holdings across VHA have a value of approximately $10 billion.

VHA business process and systems re-engineering initiatives enhance clinical capabilities, patient safety, access to care and medical technology cybersecurity.

Implementation Plan

The lifecycle replacement model applied to existing VHA medical equipment drives medical equipment and health technology refresh. The model incorporates equipment lifespans based on equipment clinical utility, evolving clinical functionality and technical supportability. Equipment lifecycle management also facilitates medical technology strategic sourcing. For planning and forecasting purposes, the medical equipment portfolio is grouped by its clinical function, volume

and cost into high criticality medical equipment, high volume medical equipment, high-cost diagnostic imaging equipment, low-cost imaging equipment, high cost non-imaging equipment, sterile processing equipment, pathology/laboratory equipment, clinical systems and general biomedical equipment. VHA uses its lifecycle replacement model to identify medical equipment due for replacement for each equipment grouping by VISN and fiscal year.

Additionally, VA will upgrade or replace medical equipment and clinical systems to comply with the Oracle Cerner EHR interface requirements to correspond with medical center implementations and ensure medical device interoperability that align with clinical requirements.

Costs

The Medical Services funding level is $2.2 billion in 2025. Funding will be used to continue to address the medical equipment replacement that was deferred during the pandemic. Modernizing VHA's medical equipment, while improving its safety and cybersecurity, requires deliberate systems engineering and extensive collaboration across VA lines of business and VHA clinical programs.

Homeless Programs and Grants

		2024		**2025**	**2026**		
	2023	Budget	Current	**Revised**	**Advance**	+/-	+/-
Description (dollars in thousands)	Actual	Estimate	Estimate	**Request**	**Approp.**	2024-2025	2025-2026
Discretionary Obligations	$1,884,190	N/A	$2,091,021	$2,086,387	$2,086,387	($4,634)	$0
Mandatory Obligations	$20,375	N/A	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$1,904,565**	N/A	**$2,091,021**	**$2,086,387**	**$2,086,387**	**($4,634)**	**$0**

The Medical Services category portion of the Homeless Program centrally managed funding includes grants, case management. and other direct program costs but excludes direct administrative costs. For more information on the Homeless Program please see the Medical Care chapter.

Pharmaceutical Ingredients

		2024		**2025**	**2026**		
	2023	Budget	Current	**Revised**	**Advance**	+/-	+/-
Description (dollars in thousands)	Actual	Estimate	Estimate	**Request**	**Approp.**	2024-2025	2025-2026
Discretionary Obligations	$9,032,899	N/A	$4,439,855	$2,136,381	$3,108,124	($2,303,474)	$971,743
Mandatory Obligations	$300,423	N/A	$5,699,901	$9,000,000	$9,000,000	$3,300,099	$0
Obligations [Grand Total]	**$9,333,322**	N/A	**$10,139,756**	**$11,136,381**	**$12,108,124**	**$996,625**	**$971,743**

This category represents the cost of pharmaceutical ingredients. The Cost of War Toxic Exposures Fund is expected to be obligated on pharmacy costs beginning in 2024 due to the budget execution methodology cost reclassification method designed to minimize field-based resource allocations. VHA is projecting $5.7 billion in 2024 and $9.0 billion in 2025 from the Cost of War Toxic Exposures Fund. For more information on Pharmacy Care, please see the Medical Care chapter.

Prosthetic Supplies and Services

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$4,387,150	N/A	$4,822,530	$5,310,639	$5,769,372	$488,109	$458,733
Mandatory Obligations	$0	N/A	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$4,387,150**	N/A	**$4,822,530**	**$5,310,639**	**$5,769,372**	**$488,109**	**$458,733**

All prosthetics obligations will be in the Medical Services appropriation, whether the care is delivered by VA providers or in the community care program. 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.

Readjustment Counseling Services

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$241,090	$287,270	$287,270	$302,568	$302,568	$15,298	$0
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$241,090**	**$287,270**	**$287,270**	**$302,568**	**$302,568**	**$15,298**	**$0**

The Medical Services Category portion of Readjustment Counseling Services includes providers, contracts, and travel. For more information on Readjustment Counseling Services please see the Medical Care chapter.

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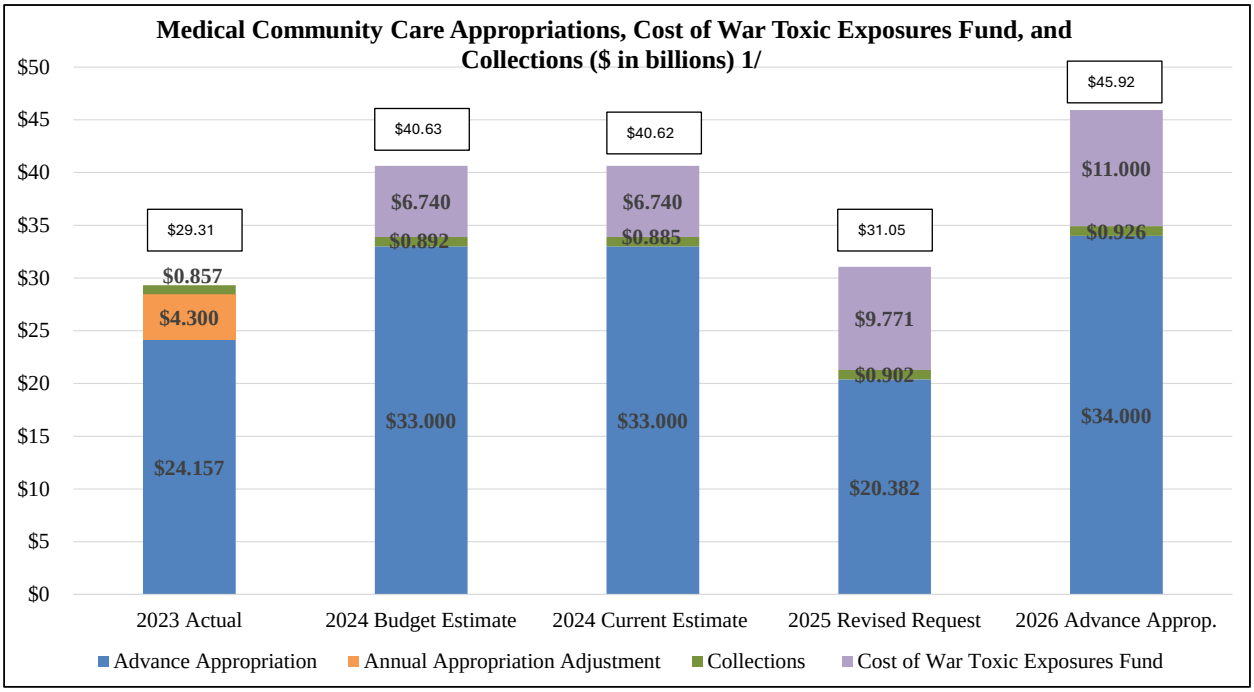
Medical Community Care Category

Chart: Medical Community Care Appropriations and Collections



1/ This table reflects appropriations prior to proposed cancellations and transfers.

Note: A full-year 2024 appropriations Act was not enacted at the time the 2025 President's Budget was prepared. The 2024 Current Estimate throughout this chapter assumes the 2024 President's Budget request for 2024 with updates to proposed transfers, unobligated balances, reimbursements, and medical care collections.

Update to the 2025 Advance Appropriations Request

The Department of Veterans Affairs (VA) is maintaining the requested 2025 discretionary advance appropriation of $20.4 billion for the Medical Community Care (MCC) account. Providing Veterans with timely access to high-quality health care is absolutely essential whether through a VA facility or community provider. 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.

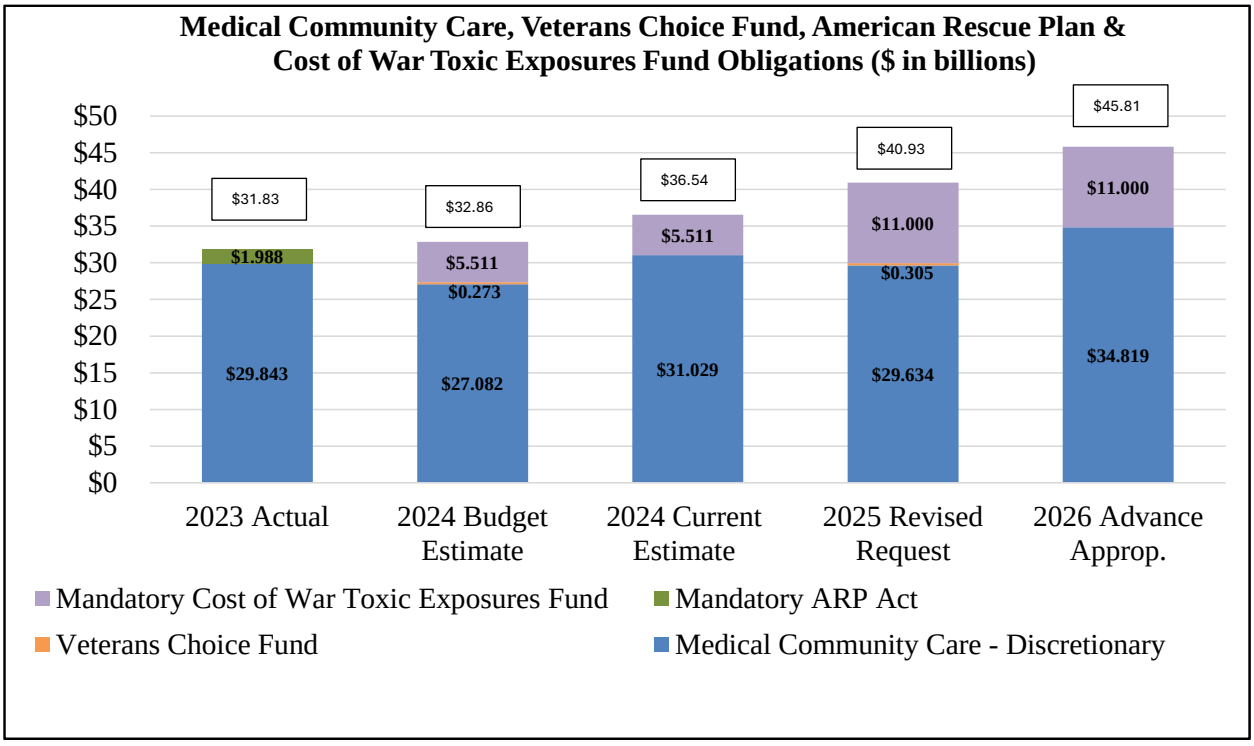
2025 Funding and 2026 Advance Appropriations Request

The Budget reflects the 2025 advance appropriation request of $20.4 billion. The Budget also includes $9.8 billion in from the 2025 mandatory appropriation to the Cost of War Toxic Exposures Fund (TEF), as enacted in the Fiscal Responsibility Act of 2023, and assumes a medical care collections projection of $902 million. To realign funding among the four Medical Care categories to meet Veterans' estimated demand for health care, VA proposes to transfer $7.3 billion from the Medical Services advance appropriation and $600 million from the Medical Facilities advance appropriation to Medical Community Care.

The 2026 advance appropriation request for Medical Community Care includes a discretionary advance appropriation of $34.0 billion; an allocation of $11.0 billion out of the total 2026 mandatory advance appropriation request for the, as authorized in the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act); and a medical care collections projection of $926 million.

When combined with unobligated balances, reimbursements, and transfers to other accounts, the total amount of resources to be obligated in the Medical Community Care category is $40.9 billion in 2025 and $45.8 billion in 2026, as detailed in the table below.

Chart: Medical Community Care Obligations



Appropriation Language

For necessary expenses for furnishing health care to individuals pursuant to chapter 17 of title 38, United States Code, at non-Department facilities, $34,000,000,000, plus reimbursements, which shall become available on October 1, 2025, and shall remain available until September 30, 2026: Provided, That, of the amount made available on October 1, 2025, under this heading, $2,000,000,000 shall remain available until September 30, 2027.

Tables: Community Care Funding Crosswalks 2023-2026

(dollars in thousands)

The following five tables show funding crosswalks for 2023 through 2026 for the VA community care program, separately by funding sources as follows:

- Medical Community Care (MCC), discretionary funding,
- Veterans Choice Fund (VCF), mandatory funding for Medical Care only,
- American Rescue Plan Act, mandatory funding,
- Cost of War Toxic Exposures Fund, mandatory funding, and
- Grand total: MCC, VCF, American Rescue Plan Act, and Cost of War Toxic Exposures Fund.

Table: Medical Community Care (0140) Discretionary Funding Crosswalk 2023-2026

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Appropriation Medical Community Care (0140)							
Advance Appropriation Medical Community Care (0140)	$24,156,659	$33,000,000	$33,000,000	$20,382,000	34,000,000	($12,618,000)	$13,618,000
Annual Appropriation Adjustment Medical Community Care (0140)	$4,300,000	$0	($1,909,069)	$0	$0	$1,909,069	$0
Appropriations Request Subtotal	$28,456,659	$33,000,000	$31,090,931	$20,382,000	$34,000,000	($10,708,931)	$13,618,000
Proposed Cancellation of Available Unobligated Balances	$0	($1,909,069)	$0	$0	$0	$0	$0
Tranfers To:							
Medical Services (0160)	$0	$0	($748,908)	$0	$0	$748,908	$0
Medical Facilities (0162)	$0	($3,919,081)	$0	$0	$0	$0	$0
North Chicago Demo. Fund (0169) from Medical Community Care (0140)	($67,500)	($70,000)	($81,000)	($93,500)	($107,000)	($12,500)	($13,500)
Transfers To [Subtotal]	($67,500)	($3,989,081)	($829,908)	($93,500)	($107,000)	($12,500)	($13,500)
Transfers From:							
Medical Services (0160)	$0	$0	$0	$7,307,318	$0	$7,307,318	($7,307,318)
Medical Support & Compliance (0152)	$1,500,000	$0	$0	$0	$0	$0	$0
Medical Facilities (0162)	$0	$0	$0	$600,000	$0	$600,000	($600,000)
Transfers From [Subtotal]	$1,500,000	$0	$0	$7,907,318	$0	$7,907,318	($7,907,318)
Collections:							
MCCF Transfer to Medical Community Care (0140)	$857,189	$892,044	$884,647	$901,747	$926,380	$17,100	$24,633
Collections [Subtotal]	$857,189	$892,044	$884,647	$901,747	$926,380	$17,100	$24,633
Budget Authority Total	**$30,746,348**	**$27,993,894**	**$31,145,670**	**$29,097,565**	**$34,819,380**	**($2,048,105)**	**$5,721,815**
Unobligated Balance (SOY):							
No-Year Medical Community Care (0140)	$155,299	$0	$182,096	$0	$0	($182,096)	$0
2-Year	$176,374	$1,909,069	$1,213,957	$1,512,724	$976,005	$298,767	($536,719)
Unobligated Balance (SOY) [Subtotal]	$331,673	$1,909,069	$1,396,053	$1,512,724	$976,005	$116,671	($536,719)
Unobligated Balance (EOY):							
No-Year Medical Community Care (0140)	($182,096)	($820,646)	$0	$0	$0	$0	$0
2-Year	($1,213,957)	($2,000,000)	($1,512,724)	($976,005)	($976,005)	$536,719	$0
Unobligated Balance (EOY) [Subtotal]	($1,396,053)	($2,820,646)	($1,512,724)	($976,005)	($976,005)	$536,719	$0
Lapse	($150)	$0	$0	$0	$0	$0	$0
Subtotal	$29,681,818	$27,082,317	$31,028,999	$29,634,284	$34,819,380	($1,394,715)	($64,453,664)
Prior Year Recoveries	$161,347	$0	$0	$0	$0	$0	$0
Obligations (0140) [Total]	**$29,843,166**	**$27,082,317**	**$31,028,999**	**$29,634,284**	**$34,819,380**	**($1,394,715)**	**$5,185,096**

Table: Veterans Choice Fund (0172) Medical Care Only Crosswalk 2023-2026

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Unobligated Balance (SOY):							
No-Year	$272,550	$272,550	$304,826	$304,826	$0	$0	($304,826)
Unobligated Balance (SOY) [Subtotal]	$272,550	$272,550	$304,826	$304,826	$0	$0	($304,826)
Unobligated Balance (EOY):							
No-Year	($304,826)	$0	($304,826)	$0	$0	$304,826	$0
Unobligated Balance (EOY) [Subtotal]	($304,826)	$0	($304,826)	$0	$0	$304,826	$0
Subtotal	($32,276)	$272,550	$0	$304,826	$0	$304,826	($304,826)
Prior Year Recoveries	$32,677	$0	$0	$0	$0	$0	$0
Obligations (0172) 1/ [Total]	**$401**	**$272,550**	**$0**	**$304,826**	**$0**	**$304,826**	**($304,826)**

1/ Excludes OI&T Obligations

Table: Medical Community Care, American Rescue Plan Act Crosswalk 2023-2026

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
UNOBLIGATED BALANCE (SOY)							
ARP Act § 8002	$1,987,643	$0	$0	$0	$0	$0	$0
ARP Act § 8007	$176	$0	$176	$176	$176	$0	$0
Unobligated Balance (SOY) [Subtotal]	**$1,987,819**	**$0**	**$176**	**$176**	**$176**	**$0**	**$0**
UNOBLIGATED BALANCE (EOY)							
ARP Act § 8002 - 3 year	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8007 - no year	($176)	$0	($176)	($176)	($176)	$0	$0
Unobligated Balance (EOY) [Subtotal]	**($176)**	**$0**	**($176)**	**($176)**	**($176)**	**$0**	**$0**
OBLIGATIONS	**$1,987,643**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Table: Medical Community Care, Cost of War Toxic Exposures Fund Crosswalk 2023-2026

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
MANDATORY APPROPRIATION							
Annual Appropriation Adjustment	$0	$6,740,264	$6,740,264	$9,770,646	$11,000,000	$3,030,382	$1,229,354
Mandatory Appropriation [Subtotal]	**$0**	**$6,740,264**	**$6,740,264**	**$9,770,646**	**$11,000,000**	**$3,030,382**	**$1,229,354**
UNOBLIGATED BALANCE (SOY)							
P.L. 118-5 (5-year, base year 2024, TEF)	$0	$0	$0	$1,229,354	$0	$1,229,354	($1,229,354)
Unobligated Balance (SOY) [Subtotal]	**$0**	**$0**	**$0**	**$1,229,354**	**$0**	**$1,229,354**	**($1,229,354)**
UNOBLIGATED BALANCE (EOY)							
P.L. 118-5 (5-year, base year 2024, TEF)	$0	($1,229,354)	($1,229,354)	$0	$0	$1,229,354	$0
Unobligated Balance (EOY) [Subtotal]	**$0**	**($1,229,354)**	**($1,229,354)**	**$0**	**$0**	**$1,229,354**	**$0**
OBLIGATIONS	**$0**	**$5,510,910**	**$5,510,910**	**$11,000,000**	**$11,000,000**	**$5,489,090**	**$0**

Table: Medical Community Care, Veterans Choice Fund (Medical Care Only), American Rescue Plan Act, Cost of War Toxic Exposures Fund Crosswalk 2023-2026

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations							
Medical Community Care (0140)	$29,843,166	$27,082,317	$31,028,999	$29,634,284	$34,819,380	($1,394,715)	$5,185,096
Discretionary Obligations [Total]	**$29,843,166**	**$27,082,317**	**$31,028,999**	**$29,634,284**	**$34,819,380**	**($1,394,715)**	**$5,185,096**
Mandatory Obligations							
Veterans Choice Act (P.L. 113-146)							
Veterans Choice Fund, Medical Care							
Administration (0172XA)	$0	$2,554	$0	$1,000	$0	$1,000	($1,000)
Medical Care (0172XB)	($32,175)	$19,321	$0	$36,056	$0	$36,056	($36,056)
Emergency Hepatitis C (0172XC)	$0	$0	$0	$0	$0	$0	$0
Emergency Community Care (0172XE)	($101)	$772	$0	$101	$0	$101	($101)
Medical Community Care (0172XG)	$0	$249,903	$0	$267,669	$0	$267,669	($267,669)
Veterans Choice Fund Prior-Year Recoveries	$32,677	$0	$0	$0	$0	$0	$0
Veterans Choice Fund [Subtotal]	**$401**	**$272,550**	**$0**	**$304,826**	**$0**	**$304,826**	**($304,826)**
American Rescue Plan (ARP) Act							
Veterans Medical Care and Health Fund							
Community Care (Section 8002) 1/	$1,987,643	$0	$0	$0	$0	$0	$0
Section 8007 - Medical Community Care	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan [Subtotal]	**$1,987,643**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
PACT Act							
Cost of War Toxic Exposures Fund	$0	$5,510,910	$5,510,910	$11,000,000	$11,000,000	$5,489,090	$0
PACT [Subtotal]	**$0**	**$5,510,910**	**$5,510,910**	**$11,000,000**	**$11,000,000**	**$5,489,090**	**$0**
Mandatory Obligations [Total]	**$1,988,044**	**$5,783,460**	**$5,510,910**	**$11,304,826**	**$11,000,000**	**$5,793,916**	**($304,826)**
Obligations [Grand Total]	**$31,831,210**	**$32,865,777**	**$36,539,909**	**$40,939,110**	**$45,819,380**	**$4,399,201**	**$4,880,270**

Tables: Community Care Obligations by Program

(dollars in thousands)

The following five tables show community care obligations by program, separately by funding sources as follows:

- Medical Community Care (MCC)
- American Rescue Plan Act (ARP)
- Cost of War Toxic Exposures Fund
- Veterans Choice Fund (VCF)
- Total MCC Category: MCC, ARP Act, Cost of War Toxic Exposures Fund, and VCF

Medical Community Care Obligations by Program

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Health Care Services:							
Ambulatory Care	$10,895,223	$11,367,959	$13,309,180	$15,144,985	$17,869,472	$1,835,805	$2,724,487
Dental Care	$1,140,709	$1,102,822	$1,333,629	$1,576,100	$1,813,024	$242,471	$236,924
Inpatient Care	$7,270,730	$6,330,838	$4,712,697	$0	$989,884	($4,712,697)	$989,884
Mental Health Care	$1,055,963	$1,112,740	$1,444,073	$1,973,128	$2,512,558	$529,055	$539,430
Prosthetics	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$7,283	$100,656	$7,477	$6,596	$6,430	($881)	($166)
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	$20,369,908	$20,015,015	$20,807,056	$18,700,809	$23,191,368	($2,106,247)	$4,490,559
Long-Term Services and Supports Community Care:							
Community Nursing Home	$1,628,649	$1,395,426	$1,755,747	$1,893,463	$1,993,705	$137,716	$100,242
Community Non-Institutional Care	$4,230,031	$2,383,441	$4,684,883	$4,898,994	$5,109,118	$214,111	$210,124
State Nursing Home	$1,447,114	$1,438,784	$1,617,932	$1,745,012	$1,887,231	$127,080	$142,219
State Home Domiciliary	$45,278	$55,402	$56,992	$62,662	$69,085	$5,670	$6,423
State Home Adult Day Care	$511	$1,892	$1,836	$1,986	$2,147	$150	$161
Community Long-Term Services and Supports [Total]	$7,351,583	$5,274,945	$8,117,390	$8,602,117	$9,061,286	$484,727	$459,169
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,958,393	$1,788,639	$2,100,835	$2,327,454	$2,562,627	$226,619	$235,173
Caregivers	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune Family	$1,935	$3,718	$3,718	$3,904	$4,099	$186	$195
Other Health Care Programs community care [Total]	$1,960,328	$1,792,357	$2,104,553	$2,331,358	$2,566,726	$226,805	$235,368
Obligations [Subtotal]	**$29,681,819**	**$27,082,317**	**$31,028,999**	**$29,634,284**	**$34,819,380**	**($1,394,715)**	**$5,185,096**
VA Prior-Year Recoveries	$161,347	$0	$0	$0	$0	$0	$0
Obligations [Total]	**$29,843,166**	**$27,082,317**	**$31,028,999**	**$29,634,284**	**$34,819,380**	**($1,394,715)**	**$5,185,096**

ARP Act Obligations by Program

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Health Care Services:							
Ambulatory Care	$3,476	$0	$0	$0	$0	$0	$0
Dental Care	$0	$0	$0	$0	$0	$0	$0
Inpatient Care	$1,774,506	$0	$0	$0	$0	$0	$0
Mental Health Care	$207,503	$0	$0	$0	$0	$0	$0
Prosthetics	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$0	$0	$0	$0	$0	$0	$0
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	$1,985,485	$0	$0	$0	$0	$0	$0
Long-Term Services and Supports Community Care:							
Community Nursing Home	$2,158	$0	$0	$0	$0	$0	$0
Community Non-Institutional Care	$0	$0	$0	$0	$0	$0	$0
State Nursing Home	$0	$0	$0	$0	$0	$0	$0
State Home Domiciliary	$0	$0	$0	$0	$0	$0	$0
State Home Adult Day Care	$0	$0	$0	$0	$0	$0	$0
Community Long-Term Services and Supports [Total]	$2,158	$0	$0	$0	$0	$0	$0
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$0	$0	$0	$0	$0	$0	$0
Caregivers	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune Family	$0	$0	$0	$0	$0	$0	$0
Other Health Care Programs community care [Total]	$0	$0	$0	$0	$0	$0	$0
Obligations [Subtotal]	**$1,987,643**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
VA Prior-Year Recoveries	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	**$1,987,643**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Cost of War Toxic Exposures Fund (TEF) Obligations by Program

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Health Care Services:							
Ambulatory Care	$0	$0	$0	$0	$0	$0	$0
Dental Care	$0	$0	$0	$0	$0	$0	$0
Inpatient Care	$0	$5,510,910	$5,510,910	$10,943,411	$11,000,000	$5,432,501	$56,589
Mental Health Care	$0	$0	$0	$56,589	$0	$56,589	($56,589)
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	$5,510,910	$5,510,910	$11,000,000	$11,000,000	$5,489,090	$0
Long-Term Services and Supports Community Care:							
Community Nursing Home	$0	$0	$0	$0	$0	$0	$0
Community Non-Institutional Care	$0	$0	$0	$0	$0	$0	$0
State Nursing Home	$0	$0	$0	$0	$0	$0	$0
State Home Domiciliary	$0	$0	$0	$0	$0	$0	$0
State Home Adult Day Care	$0	$0	$0	$0	$0	$0	$0
Community Long-Term Services and Supports [Total]	$0	$0	$0	$0	$0	$0	$0
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$0	$0	$0	$0	$0	$0	$0
Caregivers	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune Family	$0	$0	$0	$0	$0	$0	$0
Other Health Care Programs community care [Total]	$0	$0	$0	$0	$0	$0	$0
Obligations [Subtotal]	**$0**	**$5,510,910**	**$5,510,910**	**$11,000,000**	**$11,000,000**	**$5,489,090**	**$0**
VA Prior-Year Recoveries	$0	$0	$0	$0	$0	$0	$0
Total Obligations	**$0**	**$5,510,910**	**$5,510,910**	**$11,000,000**	**$11,000,000**	**$5,489,090**	**$0**

Veterans Choice Fund Obligations by Program

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Health Care Services:							
Ambulatory Care	($32,593)	$21,875	$0	$304,826	$0	$304,826	($304,826)
Dental Care	$0	$0	$0	$0	$0	$0	$0
Inpatient Care	($12)	$250,675	$0	$0	$0	$0	$0
Mental Health Care	$0	$0	$0	$0	$0	$0	$0
Prosthetics	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$0	$0	$0	$0	$0	$0	$0
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	($32,605)	$272,550	$0	$304,826	$0	$304,826	($304,826)
Long-Term Services and Supports Community Care:							
Community Nursing Home	$0	$0	$0	$0	$0	$0	$0
Community Non-Institutional Care	$329	$0	$0	$0	$0	$0	$0
State Nursing Home	$0	$0	$0	$0	$0	$0	$0
State Home Domiciliary	$0	$0	$0	$0	$0	$0	$0
State Home Adult Day Care	$0	$0	$0	$0	$0	$0	$0
Community Long-Term Services and Supports [Total]	$329	$0	$0	$0	$0	$0	$0
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$0	$0	$0	$0	$0	$0	$0
Caregivers	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune Family	$0	$0	$0	$0	$0	$0	$0
Other Health Care Programs community care [Total]	$0	$0	$0	$0	$0	$0	$0
Obligations [Subtotal]	**($32,276)**	**$272,550**	**$0**	**$304,826**	**$0**	**$304,826**	**($304,826)**
VA Prior-Year Recoveries	$32,677	$0	$0	$0	$0	$0	$0
Total Obligations	**$401**	**$272,550**	**$0**	**$304,826**	**$0**	**$304,826**	**($304,826)**

Total MCC Category Obligations by Program

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Health Care Services:							
Ambulatory Care	$10,866,106	$11,389,834	$13,309,180	$15,449,811	$17,869,472	$2,140,631	$2,419,661
Dental Care	$1,140,709	$1,102,822	$1,333,629	$1,576,100	$1,813,024	$242,471	$236,924
Inpatient Care	$9,045,224	$12,092,423	$10,223,607	$10,943,411	$11,989,884	$719,804	$1,046,473
Mental Health Care	$1,263,466	$1,112,740	$1,444,073	$2,029,717	$2,512,558	$585,644	$482,841
Prosthetics	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$7,283	$100,656	$7,477	$6,596	$6,430	($881)	($166)
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	$22,322,788	$25,798,475	$26,317,966	$30,005,635	$34,191,368	$3,687,669	$4,185,733
Long-Term Services and Supports Community Care:							
Community Nursing Home	$1,630,807	$1,395,426	$1,755,747	$1,893,463	$1,993,705	$137,716	$100,242
Community Non-Institutional Care	$4,230,360	$2,383,441	$4,684,883	$4,898,994	$5,109,118	$214,111	$210,124
State Nursing Home	$1,447,114	$1,438,784	$1,617,932	$1,745,012	$1,887,231	$127,080	$142,219
State Home Domiciliary	$45,278	$55,402	$56,992	$62,662	$69,085	$5,670	$6,423
State Home Adult Day Care	$511	$1,892	$1,836	$1,986	$2,147	$150	$161
Community Long-Term Services and Supports [Total]	$7,354,070	$5,274,945	$8,117,390	$8,602,117	$9,061,286	$484,727	$459,169
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,958,393	$1,788,639	$2,100,835	$2,327,454	$2,562,627	$226,619	$235,173
Caregivers	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune Family	$1,935	$3,718	$3,718	$3,904	$4,099	$186	$195
Other Health Care Programs community care [Total]	$1,960,328	$1,792,357	$2,104,553	$2,331,358	$2,566,726	$226,805	$235,368
Obligations [Subtotal]	**$31,637,186**	**$32,865,777**	**$36,539,909**	**$40,939,110**	**$45,819,380**	**$4,399,201**	**$4,880,270**
VA Prior-Year Recoveries	$194,024	$0	$0	$0	$0	$0	$0
Obligations [Subtotal]	$31,831,210	$32,865,777	$36,539,909	$40,939,110	$45,819,380	$4,399,201	$4,880,270
Obligations [Total]	**$31,831,210**	**$32,865,777**	**$36,539,909**	**$40,939,110**	**$45,819,380**	**$4,399,201**	**$4,880,270**

In 2025, total obligations are projected to increase by $4.4 billion above the 2024 current estimate in the following areas:

Health Care Services (+$3.7 billion). Estimates are projected to increase due to revised actuarial trends based on the most recent data, which accounts for the latest demographic trends, including impacts of the PACT Act on enrollment and utilization of VA health care, and modes of care delivery. In addition, the MISSION Act policies continue to drive increases in services available in both VA facilities and the community, particularly the use of outpatient primary, specialty, and inpatient care.

Long-Term Services and Support (+$484.7 million). Estimates are projected to increase due to the latest demographic trends and modes of care delivery. The enrollment dynamics that have a very significant impact on long-term services and support are priority level transitions and the aging of the enrollee population.

- **Other Health Care Programs (+$226.8 million).** VA-provided health service programs not projected by the Enrollee Health Care Projection Model (EHCPM) are expected to yield a net increase of $226.8 million, driven largely by Civilian Health and Medical Program (CHAMPVA) program costs.

Summary of the 2026 Advance Appropriation Request

The Medical Community Care discretionary 2026 advance appropriations request is $34.0 billion. The 2026 advance appropriations request from the Cost of War Toxic Exposures Fund for community care is $11.0 billion, which, in conjunction with the discretionary advance appropriation, ensures continuity of Veterans' health care services and sustain VA's increased capacity for care following implementation of the PACT Act.

In 2025, total obligations are projected to increase by $4.9 billion from the 2025 revised request total obligations estimate in the following areas:

Health Care Services (+$4.2 billion). Estimates are projected to increase following general healthcare trends, the PACT Act, and recent community care growth rates.

Long-Term Services and Support (+$459.2 million). Estimates are projected to increase due latest demographic trends and modes of care delivery.

- **Other Health Care Programs (+$235.4 million).** VA-provided health service programs not projected by the EHCPM are expected to yield a net increase of $235.4 million, driven largely by CHAMPVA program costs.

Medical Community Care Description

Veterans may be eligible to receive care from a community provider when VA cannot provide the care needed. This care is provided on behalf of and paid for by VA. Community care is available to Veterans based on certain conditions and eligibility requirements, and in consideration of a Veteran's specific needs and circumstances. In general, community care must be first authorized by VA before a Veteran can receive care from a community provider.

VA also provides health care to Veterans' family members and dependents through programs like CHAMPVA. Care for Veterans' family members and dependents is provided based on specific eligibility requirements, which vary by program. Additional information regarding these health care programs can be found in the "Medical Community Care Programs" section below.

In addition to funding payments for health care services to non-VA providers, the MCC category funds clinical service delivery requirements for community care. This includes care coordination and referrals, eligibility verification, and enrollment. Resources are also used to establish care network requirements such as developing contracts that serve as vehicles for VA to purchase care for Veterans from community providers as well as develop and maintain IT functions. MCC also funds short-term prescription medications for a 14-day or fewer supply filled at a non-VA pharmacy.

Some obligations related to VA's provision of community care are funded through the Medical Support and Compliance and Information Technology accounts. These accounts fund administrative expenses such as claims processing performed by the Third-Party Administrator (TPA) and the Veterans Health Administration (VHA) and software required to meet system requirements.

Medical Community Care Programs for Veterans' Family Members and Dependents

Camp Lejeune Family Member Program (CLFMP)

Authority for Action

The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154)

Population Covered

The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154) extended eligibility for VA hospital care and medical services to certain Veterans who were stationed at Camp Lejeune, North Carolina, for at least 30 days between 1957-87. Family members of such Veterans who resided, or were in utero, at Camp Lejeune for at least 30 days during that period are eligible for reimbursement of hospital care and medical services for 15 specified illnesses and conditions, and VA is the payer of last resort. Hospital care and medical services may only be furnished to family members to the extent and in the amount provided in advance in appropriations acts for such purpose. In addition, VA may only provide reimbursement for such hospital care and medical services provided to a family member after all other claims and remedies against third parties for such care and services have been exhausted. The Consolidated and Further Continuing Appropriations Act of 2015 (P.L. 113-235), signed on December 16, 2014, expanded the Camp Lejeune exposure period by changing the beginning date from January 1, 1957, to 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. Under the rule, qualified family members with at least 30 days of Camp Lejeune residency from 1957-87 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, through 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 the Camp Lejeune Family Member Program (CLFMP).

Type of Services Provided

VA Office of Integrated Veteran Care (IVC) 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 Community Assistance Panel quarterly meetings. Camp Lejeune clinicians provide subject-matter expertise to the War Related Illness and Injury Study Center. CLFMP conducts training to ensure VA employees involved in operation and administration of CLFMP are fully educated on the eligibility, enrollment and claims processes, and 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
During 2023, 497 new administrative eligibility determinations and 152 new clinical eligibility determinations were made. For comparison, 312 total administrative eligibility determinations were made in 2022 and 159 were made in 2021; 81 clinical eligibility determinations were made in 2021 and 110 were made in 2022. Administrative eligibility determinations show the family member was a dependent to an eligible Veteran during the covered period 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 1 or more of the 15 qualifying health conditions. Since the inception of the program, 3,417 family members have been found administratively eligible and 1,345 clinically eligible to receive medical reimbursement for 1 or more of the 15 approved conditions. A 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 to ensure beneficiaries understand the scope and limitations of the program.

Projections for the Future
VA will continue to promptly reimburse family members for care related to the 15 qualifying health conditions. Future goals include expanding outreach efforts to continue to educate Veterans and family members about CLFMP. The expectation is that CLFMP will experience small growth based on historical program data and the recent media attention the program has received. .

CHAMPVA and Other Dependent Programs

VA provides health care benefit administration for the beneficiaries of the following programs: CHAMPVA, Foreign Medical Program (FMP), Spina Bifida Health Care Benefits Program, and Children of Women Vietnam Veterans (CWVV). 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

- 38 U.S.C. § 1724, Hospital Care, Medical Services and Nursing Home Care Abroad
- 38 U.S.C. § 1781, Medical Care for Survivors and Dependents of Certain Veterans
- 38 U.S.C. § 1802, Spina Bifida Conditions Covered
- 38 U.S.C. § 1803, Health Care
- 38 U.S.C. § 1811, Definitions
- 38 U.S.C. § 1812, Covered Birth Defects
- 38 U.S.C. § 1813, Health Care

- 38 U.S.C. § 1821, Benefits for Children of Certain Korea Service Veterans Born with Spina Bifida
- 38 U.S.C. § 1822, Benefits for Children of Certain Thailand Service Veterans Born with Spina Bifida
- 38 U.S.C. § 5104(c), Options Following Decision by Agency of Original Jurisdiction

Population Covered

CHAMPVA

The Veterans Health Care Expansion Act of 1973 (P.L. 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 (P.L. 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 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 (IHS), and State Victims of Crime Compensation Programs.

The Veterans Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163 § 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 CHAMPVA when the primary family caregiver is not eligible for any other health care coverage (including TRICARE, Medicare, and Medicaid).

Foreign Medical Program (FMP)

FMP is a health care benefits program for U.S. 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 office does not pay for compensation and pension exams or travel.

Spina Bifida Health Care Program

Under the Department of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997 (P.L. 104-204 § 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 (P.L. 108-183 § 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 (P.L. 110-387), the program

provides reimbursement for comprehensive medical care. The Blue Water Navy Vietnam Veterans Act of 2019 (P.L. 116-23 § 1116(b)) authorizes birth children of certain Veterans who served in Thailand to be eligible for care under this program.

CWVV

Under the Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419 § 401), VA administers the CWVV program for children with certain birth defects born to women Vietnam Veterans. The CWVV program provides reimbursement only for covered birth defects.

Recent Trends

The number of enrolled beneficiaries in CHAMPVA has increased by 5.0% on an annual basis from 2015 to 2022 and increased by 14% in 2023. The number of unique users of CHAMPVA has increased by 9.7% in 2023 and served 488,688 unique beneficiaries. The CHAMPVA program expects to continue to see about a 9.7% increase in unique users in the upcoming years based off recent trends. Projections for unique users by the end of 2024 are 520,000. The ongoing implementation of the PACT Act has not yet had an impact on CHAMPVA enrollees or unique users, but it is currently projected to increase overall program utilization by 3.0%. The number of unique users of FMP went from 5,500 in 2022 to 6,410 in 2023. FMP expects to see continued growth in the number of unique users at a rate of 10.0% to 15.0% in 2024 based off historical trends. The Spina Bifida Health Care Benefits Program saw a decrease in unique users from 850 in 2022 to 818 in 2023. This represents a 5.0% decrease (29 Spina Bifida beneficiaries passed away in 2022 and 10 passed away between January and June 2023). The program expects to see a continued 3.0% decrease in unique users in the upcoming year due to recent decedent trends. Spina Bifida Program expenditures for 2023 were just over $582.7 million. Current expenditure projections for 2024 are expected to be 10.0% to 15.0% lower than 2023, as long as no extended inpatient claims are received for the remainder of the fiscal year. The ongoing implementation of the PACT Act has not had a significant impact on new Spina Bifida enrollees. The number of unique users in the CWVV program remained the same from 2022 into 2023. There was only one active participant in the program. Projected beneficiary enrollments for CWVV should remain at this level for the next year.

Indian Health Services (IHS) / Tribal Health Programs (THP) / Urban Indian Organizations (UIO) Reimbursement Agreements Program

Authority for Action

In 2012, under the authority of 25 U.S.C. § 1645(c) and 38 U.S.C. § 8153, VA established a national interagency sharing and reimbursement agreement with the Department of Health and Human Services (HHS)/IHS to reimburse IHS for the provision of direct care services to eligible American Indian (AI)/Alaska Native (AN) Veterans. VA revised the agreement with IHS in December 2023. The new agreement allows VA to reimburse IHS for additional health care services, including long-term care, home health services, and durable medical equipment. The national reimbursement agreement paved the way for VA to enter into individual agreements with THPs to reimburse THPs for direct care services provided to eligible AI/AN Veterans. In January 2022, VA expanded the program to include UIOs, as authorized in the Consolidated Appropriations Act, 2021 (P.L. 116-260 § 1113). Under these agreements, VA reimburses for

direct care services provided by IHS, THPs and UIOs to eligible AI/AN Veterans that are included in the Medical Benefits Package under 38 C.F.R. § 17.38.

VA continues to establish individual agreements with THPs and UIOs and maintains the national agreement with IHS to share resources between VA and IHS/THP/UIOs which will increase health care options for all eligible AI/AN Veterans, facilitating access to culturally sensitive care.

In 2024, VA will continue working with stakeholders to define the scope (and processes to expand the scope) of the program to reimburse IHS and THPs for eligible purchased/referred care and contracted travel tribes paid for eligible AI/AN Veterans, as authorized in the Proper and Reimbursed Care for Native Veterans Act (P.L. 116-311).

Population Covered
The population covered under the IHS/THP/UIO reimbursement agreements are eligible AI/AN Veterans. Eligible AI/AN Veterans may choose to use their tribal benefit and obtain IHS/THP/UIO care without VA preauthorization. Many of the AI/AN Veterans reside in highly rural areas where VA has limited presence. Thus, these reimbursement agreements share resources with IHS/THP/UIO facilities and allow better access to culturally sensitive care closer to home.

Type of Services Provided
Direct care services are provided at IHS or THP facilities under 38 C.F.R. § 17.38. Examples of these services are basic and preventive care, outpatient, inpatient, ambulatory surgical services, prescription drugs, and so forth. These services are provided at IHS/THP/UIO hospitals, clinics, or facilities. Purchased/referred care and contracted travel services are provided away from an IHS or THP facility but paid for by the IHS/THP facility.

Recent Trends
The 2025 estimate of $38.0 million supports an estimated 74 IHS sites under the VA-IHS National Reimbursement Agreement, 120 agreements with THPs, and 6 agreements with UIOs currently enrolled. VA anticipates providing reimbursement to more than 4,000 unique Veterans and processing over 50,000 medical claims 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 and contracted travel.

Administrative Costs Justification
The Medical Community Care category includes funding for necessary operating costs, such as contracting and administration fees, for VA's Community Care Network (CCN) contracts. VA will continue its practice to utilize Veterans Care Agreements to procure services when a provider is not available under CCN.

CCN
The request for the Medical Community Care account includes the certain costs associated with the CCN contracts. The 2023 obligations of $732.0 million was paid to a TPA and covers regions 1 through 5. Administrative costs associated with the CCN contract include:

- Per member/per month administrative fees which is the negotiated contract rate multiplied by the number of active Veterans receiving care monthly.

- Recurring costs associated with contract modifications such as, but not limited to, urgent care call center (actual per month, or fixed rate per call), reprocessing fees (per claim) and other adjustments, as needed.

- New contract modifications are one-time monetary adjustments added through the issuance of a new task order.

- Incentive/disincentives based on TPA performance.

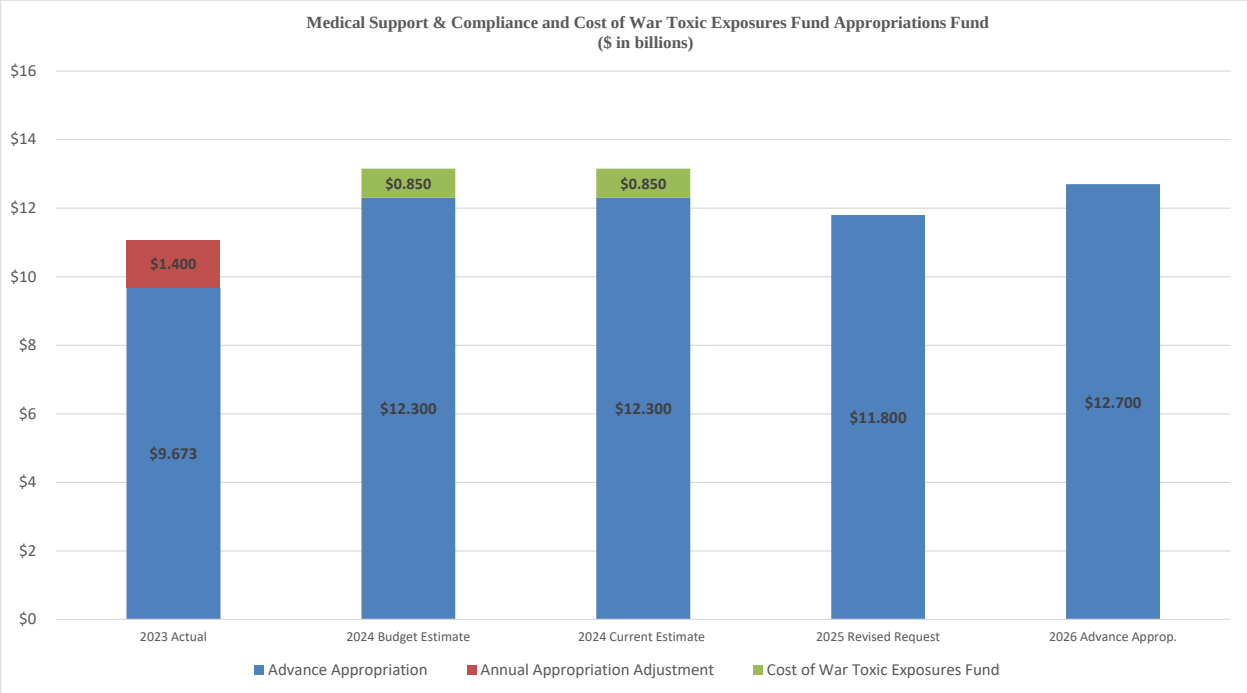
- Optional tasks not included in the original contract or additional modifications.

CHAMPVA Consolidated Mail Outpatient Pharmacy

In 2023, CHAMPVA expensed $470.1 million for prescriptions provided through the Consolidated Mail Outpatient Pharmacy. This is an increase of 11.5% from 2022. Expected annual cost increases for 2024 and 2025 are between 8.0% to 13.0% based off historical spending trends, inflation costs, and projected utilization.

Medical Support and Compliance Category

Chart: Medical Support and Compliance Appropriations [1/2/]



[1/] All columns in this chart display appropriations prior to any proposed cancellations or transfers as shown in the crosswalk tables below.

[2/] A full-year 2024 appropriations Act was not enacted at the time the Budget was prepared. The funding level in the 2024 Current Estimate column in all tables assumes the 2024 President's Budget request for 2024 with updates to unobligated balances, collections, and transfers.

Update to the 2025 Advance Appropriations Request

The Department of Veterans Affairs (VA) is maintaining the requested 2025 discretionary advance appropriation of $11.8 billion for the Medical Support and Compliance (MSC) account and assumes no funding from the Cost of War Toxic Exposures Fund (TEF) will be used for MSC in 2025. When combined with unobligated start-of-year balances, reimbursements, and transfers to other accounts, the projected 2025 obligation level in the MSC category is $12.8 billion.

The MSC budget funds expenses related to the management, security, and administration of the VA health care system. This includes VA medical center (VAMC) leadership teams and support functions, such as 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. The MSC budget also funds the

Veterans Integrated Service Network (VISN) offices, including network leadership teams, as well as expenses related to VHA Central Office programs.

2025 Funding and 2026 Advance Appropriations Request

The MSC appropriation finances the supporting structures that underlie the Veterans Health Administration's (VHA) ability to deliver high-quality health care services to Veterans and eligible beneficiaries. Approximately 63% of the 2025 total funding for this appropriation category is designated for VAMC and VISNdirect allocations. The remaining 37% of the funding is designated for VHA Central Office (VHACO) programs to support their staff as well as to allocate to VAMCs for specific tasks. This funding ensures:

- leadership teams are in place to govern,
- appropriate oversight to safeguard quality of care for Veterans is available,
- essential security services are provided,
- needed supplies and medications are ordered,
- mission-critical health care provider vacancies are filled, and
- financial services and oversight are provided, required medical equipment is procured, and patient encounters are appropriately recorded.

Appropriation Language

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.), $12,700,000,000, plus reimbursements, which shall become available on October 1, 2025, and shall remain available until September 30, 2026: Provided, That, of the amount made available on October 1, 2025, under this heading, $350,000,000 shall remain available until September 30, 2027.

The following tables display the discretionary, mandatory, and combined sources of funds.

Table: MSC Crosswalk

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Appropriation Medical Support & Compliance (0152)							
Advance Appropriation	$9,673,409	$12,300,000	$12,300,000	$11,800,000	$12,700,000	($500,000)	$900,000
Annual Appropriation Adjustment	$1,400,000	$0	$0	$0	$0	$0	$0
Net Appropriation	**$11,073,409**	**$12,300,000**	**$12,300,000**	**$11,800,000**	**$12,700,000**	**($500,000)**	**$900,000**
Tranfers To							
Medical Services (0160)	$0	$0	($1,150,000)	$0	$0	$1,150,000	$0
Medical Community Care (0140)	($1,500,000)	$0	$0	$0	$0	$0	$0
Medical Facilities (0162)	$0	($850,000)	($400,000)	$0	$0	$400,000	$0
JALFHCC (0169)	($32,144)	($33,751)	($44,887)	($42,193)	($44,302)	$2,694	($2,109)
Transfers To [Subtotal]	($1,532,144)	($883,751)	($1,594,887)	($42,193)	($44,302)	$1,552,694	($2,109)
Discretionary Budget Authority [Total]	$9,541,265	$11,416,249	$10,705,113	$11,757,807	$12,655,698	$1,052,694	$897,891
Reimbursements	$64,706	$57,424	$64,706	$64,706	$64,706	$0	$0
Unobligated Balance (SOY)							
P.L. 111-32 (H1N1 no-year)	$111	$0	$111	$111	$111	$0	$0
2-Year	$199,636	$0	$150,690	$251,010	$0	$100,320	($251,010)
Unobligated Balance (SOY) [Subtotal]	$199,747	$0	$150,801	$251,121	$111	$100,320	($251,010)
Unobligated Balance (EOY)							
P.L. 111-32 (H1N1 no-year)	($111)	$0	($111)	($111)	($111)	$0	$0
2-Year	($150,690)	$0	($251,010)	$0	$0	$251,010	$0
Unobligated Balance (EOY) [Subtotal]	($150,801)	$0	($251,121)	($111)	($111)	$251,010	$0
Lapse	($185)	$0	$0	$0	$0	$0	$0
Subtotal	$9,654,732	$11,473,673	$10,669,499	$12,073,523	$12,720,404	$1,404,024	$646,881
Prior Year Recoveries	$28	$0	$0	$0	$0	$0	$0
Discretionary Obligations (0152) [Total]	**$9,654,760**	**$11,473,673**	**$10,669,499**	**$12,073,523**	**$12,720,404**	**$1,404,024**	**$646,881**
Cost of War Toxic Exposures Fund (1126)							
Appropriation	$0	$850,000	$850,000	$0	$0	($850,000)	$0
Realignment	($94)	$0	$0	$0	$0	$0	$0
Unobligated Balance (SOY)	$26,143	$0	$26,049	$0	$0	($26,049)	$0
Unobligated Balance (EOY)	($26,049)	$0	$0	$0	$0	$0	$0
Obligations (1126) [Total]	**$0**	**$850,000**	**$876,049**	**$0**	**$0**	**($876,049)**	**$0**
Veterans Medical Care and Health Fund (0173SC)							
Unobligated Balance (SOY)	$502,305	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY)	$0	$0	$0	$0	$0	$0	$0
Lapse	($1)	$0	$0	$0	$0	$0	$0
Prior Year Recoveries	$53,382	$0	$0	$0	$0	$0	$0
Obligations (0173SC) [Total]	**$555,686**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
VACAA, sec. 801 (0152XA)							
Unobligated Balance (SOY)	$7,172	$3,780	$3,629	$256	$0	($3,373)	($256)
Unobligated Balance (EOY)	($3,629)	($256)	($256)	$0	$0	$256	$0
Subtotal	$3,543	$3,524	$3,373	$256	$0	($3,117)	($256)
Prior Year Recoveries	$0	$0	$0	$0	$0	$0	$0
Obligations (0152XA) [Total]	**$3,543**	**$3,524**	**$3,373**	**$256**	**$0**	**($3,117)**	**($256)**
Mandatory Budget Authority [Total]	$0	$850,000	$850,000	$0	$0	($850,000)	$0
Mandatory Obligations [Total]	**$559,229**	**$853,524**	**$879,422**	**$256**	**$0**	**($879,166)**	**($256)**
Budget Authority [Grand Total]	$9,541,265	$12,266,249	$11,555,113	$11,757,807	$12,655,698	$202,694	$897,891
Obligations [Grand Total]	**$10,213,989**	**$12,327,197**	**$11,548,921**	**$12,073,779**	**$12,720,404**	**$524,858**	**$646,625**
FTE							
Medical Support & Compliance (0152)	59,487	66,534	68,045	66,658	66,589	(1,387)	(69)
Cost of War Toxic Exposures Fund (1126)	0	0	0	0	0	0	0
Veterans Medical Care and Health Fund (0173SC)	3,824	0	0	0	0	0	0
VACAA, Section 801 (0152XA) 1/	27	24	27	0	0	(27)	0
FTE [Total]	**63,338**	**66,558**	**68,072**	**66,658**	**66,589**	**(1,414)**	**(69)**

Summary of Obligations by Functional Area

To provide better visibility into the spending under this appropriation, additional detail on obligations by the following categories are reflected in the following charts.

MSC Obligations by Activity - Discretionary Funds

Description: (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Annual Appropriations							
VISN & Medical Center Based:							
VAMC	$4,874,844	$5,488,977	$4,908,106	$6,112,014	$6,634,268	$1,203,909	$522,254
VISN	$1,286,778	$1,230,628	$1,403,849	$1,455,538	$1,579,909	$51,689	$124,371
VHA Central Office Based:							
Clinical Services	$158,781	$302,073	$240,572	$246,586	$246,586	$6,015	$0
Patient Care Services	$209,027	$350,995	$313,541	$321,379	$321,379	$7,839	$0
Discovery, Education and Affiliate Networks	$77,689	$175,849	$113,161	$119,191	$119,447	$6,031	$256
Operations	$169,959	$269,123	$250,284	$256,541	$256,541	$6,257	$0
Integrated Veterans Care	$407,916	$512,952	$477,045	$488,971	$488,971	$11,926	$0
Quality and Patient Safety	$169,538	$209,000	$194,370	$199,229	$199,229	$4,859	$0
Support Services	$566,543	$765,103	$711,546	$729,335	$729,335	$17,789	$0
Human Capital Management	$344,691	$437,442	$406,821	$416,992	$416,992	$10,171	$0
Health Informatics	$173,413	$213,742	$198,780	$203,750	$203,750	$4,970	$0
All Other Support and Program Offices	$1,215,553	$1,517,789	$1,451,426	$1,523,997	$1,523,997	$72,571	$0
Central Office Based Obligations [Subtotal]	**$3,493,110**	**$4,754,068**	**$4,357,545**	**$4,505,971**	**$4,506,227**	**$148,427**	**$256**
Prior Year Recoveries	$28	$0	$0	$0	$0	$0	$0
MSC Obligations - Discretionary Funds [Total]	**$9,654,760**	**$11,473,673**	**$10,669,499**	**$12,073,523**	**$12,720,404**	**$1,404,024**	**$646,881**

MSC Obligations by Activity - Mandatory Funds

Description: (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Cost of War Toxic Exposures Fund (TEF)							
VAMC	$0	$850,000	$876,049	$0	$0	($876,049)	$0
TEF Obligations [Subtotal]	**$0**	**$850,000**	**$876,049**	**$0**	**$0**	**($876,049)**	**$0**
Veterans Medical Care and Health Fund							
VAMC	$474,989	$0	$0	$0	$0	$0	$0
VISN	$47,502	$0	$0	$0	$0	$0	$0
Clinical Services	$1,600	$0	$0	$0	$0	$0	$0
Support Services	($21,834)	$0	$0	$0	$0	$0	$0
All Other Support and Program Offices	$47	$0	$0	$0	$0	$0	$0
VMCHF Obligations [Subtotal]	**$502,304**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
VACAA, sec. 801							
VAMC	$3,543	$0	$0	$0	$0	$0	$0
Discovery, Education and Affiliate Networks	$0	$3,524	$3,373	$256	$0	($3,117)	($256)
VACAA, sec. 801 Obligations [Subtotal]	**$3,543**	**$3,524**	**$3,373**	**$256**	**$0**	**($3,117)**	**($256)**
Prior Year Recoveries	$53,382	$0	$0	$0	$0	$0	$0
MSC Obligations - Mandatory Funds [Total]	**$559,229**	**$853,524**	**$879,422**	**$256**	**$0**	**($3,117)**	**($256)**

MSC Obligations by Activity - Total

Description: (dollars in thousands)	2023 Actual	2024 President's Budget	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
VISN & Medical Center Based:							
VAMC	$5,353,376	$6,338,977	$5,784,155	$6,112,014	$6,634,268	$327,860	$522,254
VISN	$1,334,280	$1,230,628	$1,403,849	$1,455,538	$1,579,909	$51,689	$124,371
VHA Central Office Based:							
Clinical Services	$160,381	$302,073	$240,572	$246,586	$246,586	$6,015	$0
Patient Care Services	$209,027	$350,995	$313,541	$321,379	$321,379	$7,839	$0
Discovery, Education and Affiliate Networks	$77,689	$179,373	$116,534	$119,447	$119,447	$2,914	$0
Operations	$169,959	$269,123	$250,284	$256,541	$256,541	$6,257	$0
Integrated Veterans Care	$407,916	$512,952	$477,045	$488,971	$488,971	$11,926	$0
Quality and Patient Safety	$169,538	$209,000	$194,370	$199,229	$199,229	$4,859	$0
Support Services	$544,709	$765,103	$711,546	$729,335	$729,335	$17,789	$0
Human Capital Management	$344,691	$437,442	$406,821	$416,992	$416,992	$10,171	$0
Health Informatics	$173,413	$213,742	$198,780	$203,750	$203,750	$4,970	$0
All Other Support and Program Offices	$1,215,600	$1,517,789	$1,451,426	$1,523,997	$1,523,997	$72,571	$0
Central Office Based Obligations [Subtotal]	**$3,472,923**	**$4,757,592**	**$4,360,918**	**$4,506,227**	**$4,506,227**	**$145,310**	**$0**
Prior Year Recoveries	$53,410	$0	$0	$0	$0	$0	$0
MSC Obligations [Total]	**$10,213,989**	**$12,327,197**	**$11,548,921**	**$12,073,779**	**$12,720,404**	**$524,858**	**$646,625**

VAMC Program

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$4,874,844	$5,488,977	$4,908,106	$6,112,014	$6,634,268	$1,203,909	$522,254
Cost of War Toxic Exposures Fund	$0	$850,000	$876,049	$0	$0	($876,049)	$0
Veterans Medical Care and Health Fund	$474,989	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$3,543	$0	$0	$0	$0	$0	$0
Mandatory Obligations	$478,532	$850,000	$876,049	$0	$0	($876,049)	$0
Obligations [Total]	$5,353,376	$6,338,977	$5,784,155	$6,112,014	$6,634,268	$327,860	$522,254

Funding in this account for VAMC-based activities supports the management, operation, oversight, security, and administration of the VA's health care system. This includes VAMC leadership teams (Director, Chief of Staff, Chief Medical Officer, and Chief Nurse), VAMC support functions (quality of care oversight, security services, legal services, billing and coding activities, acquisition, procurement, and logistics activities), human resource (HR) management, logistics and supply chain management, and fiscal management. Of the many functions required to operate VHA facilities, one essential function is revenue generation. This begins at the VAMCs and clinics with the verification of insurance and the coding of inpatient and outpatient encounters.

VISN Program

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$1,286,778	$1,230,628	$1,403,849	$1,455,538	$1,579,909	$51,689	$124,371
Veterans Medical Care and Health Fund	$47,502	$0	$0	$0	$0	$0	$0
Obligations [Total]	$1,334,280	$1,230,628	$1,403,849	$1,455,538	$1,579,909	$51,689	$124,371

These funds provide the necessary resources for the VISN offices that provide regional support, management, and oversight to the VAMCs, clinics, and other field activities within their regions. This includes but is not limited to network leadership teams (Network Director, Deputy Network Director, Chief Financial Officer, Chief Medical Officer, and Chief Information Officer) and clinical and administrative functional leads, which are centrally located to provide leadership to those programs within each VISN. Each VISN office is responsible for coordinating the delivery of health care to Veterans by leveraging and integrating operations at all VA health care facilities within the VISN.

Clinical Services

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$158,781	$302,073	$240,572	$246,586	$246,586	$6,015	$0
Veterans Medical Care and Health Fund	$1,600	$0	$0	$0	$0	$0	$0
Obligations [Total]	$160,381	$302,073	$240,572	$246,586	$246,586	$6,015	$0

The Office of the Assistant Under Secretary for Health (AUSH) for Clinical Services (CS) and the Chief Medical Officer 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 AUSH for Dentistry, the Deputy Dental Program Director, and staff assigned under the directorates of Dental Operations, Dental Informatics and Analytics, Dental Laboratory Operations, Homeless Veterans Dental Program, Dental Education, Dental Research, Oral Health Quality Group, and Dental Administration.

Diagnostics
Diagnostic Services uses MSC funds to fund staff payroll, travel, contract services at VHACO, and field-based medical support staff. The funds are used to establish national policy and provide clinical operational oversight and enforcement functions. Additionally, these funds are used for national contracts providing services for accreditation, inspections, licenses to operate, proficiency assessments, education and training, agreements, program analytics, and data management and reporting. The MSC funds are used to promote Veteran access to services, safety initiatives, quality improvement, and communication for clinical standards of practice.

Homeless
The VHA Homeless Programs Office provides direct support to eight Homeless Programs Initiatives:

1. Department of Housing and Urban Development (HUD)/VA Supported Housing is 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,

2. Health Care for Homeless Veterans provides contract residential services, outreach, and case management to Veterans who are homeless or at-risk of homelessness,
3. Veterans Justice Outreach aims to prevent homelessness and avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans,
4. Homeless Veterans Community Employment Services assists Veterans with accessing employment opportunities to support their housing needs, improve the quality of their lives, and assist in their community reintegration efforts,
5. Grant and Per Diem (GPD) program awards grants to community-based agencies to create transitional housing programs and offer per diem payment to GPD funded organizations,
6. Supportive Services for Veteran and Families program provides supportive services to homeless and at-risk Veteran families,
7. Veterans National Homeless Registry maintains a comprehensive repository of Veterans who have been identified as homeless or at risk for homelessness.
8. Homeless Patient Aligned Care Teams: provides multidisciplinary, population tailored medical homes designed around the unique needs and distinct challenges homeless Veterans face, both accessing and engaging in health care.

The remaining support is for 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 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, in addition to 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, National Center for Posttraumatic Stress Disorder (PTSD), VA's Center of Excellence in research and education on PTSD, and other public-facing resources. Please see the Mental Health and Suicide Prevention sections in the Medical Care chapter for more information.

National Electronic Health Records Modernization Supplemental Staffing Unit
The National Electronic Health Records (EHR) Modernization (EHRM) Supplemental Staffing Unit (NESSU) uses MSC funds in its mission to develop and oversee aspects of the enterprise-wide NESSU staff deployment plan in conjunction with VISNs and VAMCs as they implement EHRM. This includes overseeing hiring and onboarding of staff to include centralized credentialing, overseeing aspects of training and provisioning for staff, establishing Telehealth Service Agreements with every deployment site, aspects of time keeping and travel requirements, management of telehealth equipment, negotiating formal Memorandums of Agreement, and coordinating NESSU staff resources with Clinical Resource Hubs.

Primary Care and Disability and Medical Assessment
The National Primary Care Office provides national oversight and monitoring of primary care delivery and develops policies and programs to direct clinical operations and research and educational program activities. The office facilitates the delivery of quality oriented, efficient, timely, safe, and effective primary care within VHA facilities.

The Office of Disability and Medical Assessment is also aligned under the National Primary Care Office, whereby it provides executive leadership to VHA's disability programs worldwide, including both the traditional Compensation and Pension (CP) and the Integrated Disability Evaluation System Programs. These responsibilities include securing and executing funding, quality performance improvement, clinician certification and training, providing analytics support, and development of national CP policy.

Specialty Care
Specialty Care Services uses MSC funds to fund VHACO and field-based medical administrative staff that support field-based clinical operations and policy work. The support is salary, travel, and all other needs for national contracts that are administrative in nature (such as licensing agreements, inspections, program analyses work, and the collection, review, and reporting of data). The national programs' assigned work is not for clinical care but involves clinical administrative staff and clinical operations.

Spinal Cord Injuries and Disorders
The Spinal Cord Injuries and Disorders (SCI/D) national program office uses MSC funding to support salary expenses, travel, education and conferences for staff, and printing expenses. In addition, the MSC funding also supports contracts for Long Term Care Institute surveys, Universal Stakeholder Participation and Experience Questionnaire customer satisfaction surveys, Data Programmer and SCI/D Nurse Staffing Analysis.

Surgery
The National Surgery Office (NSO) uses the annual budgeted MSC funds to ensure and support the optimal delivery of surgical services to promote, preserve and restore the health of the Veteran in accordance with generally accepted standards of medical practice through an established quality improvement program and monitoring of surgical quality improvement activities at the national, regional, and local level. The NSO establishes and maintains VHA surgical policy related to the delivery of surgical and transplant services by VHA Surgical Programs. The NSO also provides

stewardship for surgical data for research purposes and oversight of funds for the delivery of transplant and related services.

Patient Care Services

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$209,027	$350,995	$313,541	$321,379	$321,379	$7,839	$0
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$209,027	$350,995	$313,541	$321,379	$321,379	$7,839	$0

The Office of Patient Care Services (PCS) leads VHA in delivering the highest quality Veteran-centric care, supporting health and wellbeing through leveraging technology, and providing clinical services across the continuum of care. The AUSH/PCS also serves as the Chief Nursing Officer (CNO). The CNO is the Senior Advisor to the Under Secretary for Health (USH) and to key VHA and Department officials on all matters relating to VA nursing and the delivery of PCS. The CNO collaborates inter-professionally to enhance and support evidence-based professional practice, workforce research and education, and the VA nursing workforce to strengthen leadership and teamwork to provide quality patient-driven care for the Nation's Veterans.

Office of Nursing Services

The Office of Nursing Services (ONS) serves as the primary consultant to the AUSH/PCS on all matters relating to nursing and the delivery of patient care. ONS is responsible for the planning and formulation of national policies and activities that impact all nursing staff in the delivery of health care within the VA. ONS collaborates inter-professionally to enhance and support evidence-based professional practice, workforce research, education, and the VA nursing workforce to strengthen leadership and teamwork to provide quality patient driven care for the Nation's Veterans. ONS utilizes MSC funds to support and fund salaries, travel, and training for the implementation of the VHA Nursing Workforce Strategic Plan.

Caregiver Support Program

The Caregiver Support Program (CSP) mission is to promote the health and well-being of family caregivers, who care for the Nation's Veterans, through education, resources, support, and services. Please see the CSP section in the Medical Care chapter for more information.

Care Management and Social Work Services

Care Management and Social Work Services (CMSW) leads implementation and equitable access to person-centered interventions, care coordination, military health care transitions, and clinical services that integrate health wellness and social determinants of health for all Veterans, Service members, their families, caregivers, and survivors. As the Nation's largest employer and training organization for social workers, CMSW is an innovator in social work professional practice, advocator for equal access to care and resources and promoter for social justice. This is achieved through the coordination of care, services and benefits afforded to Veterans and their loved ones by VA programs and collaboration with community partners.

CMSW develops policy and provides oversight of the National Social Work Program, VA Fisher House and Family Hospitality Program, Intimate Partner Violence Assistance Program, Post-9/11 Military2VA Case Management Program, VA Liaisons Program, Survivors Assistance and Memorial Support, the Veteran Family Resource Program, and several initiatives aligned to the service such as guardianship or human trafficking, Social Work Patient Aligned Care Teams and Care Coordination and Integrated Case Management in collaboration with ONS. CMSW also provides clinical practice oversight to facility-based master's prepared social workers in the delivery of holistic care. MSC funds are used for program office salaries, travel, and contracts which support CMSW clinical programming, supportive services, and other Veteran-centric initiatives.

Connected Care
The Office of Connected Care focuses on delivering health information technology (IT) solutions that increase Veterans' access to care and support Veterans' participation in their own health care. Connected Care works collaboratively to standardize and promote the use of virtual and digital health products and their interfaces and development tools. This includes driving the growth and adoption of technologies that help Veterans communicate with their VA care teams and coordinate, track, and manage their health care. These technology and health solutions are delivered through Connected Care Programs including VA Telehealth Services, My HealtheVet and VA Mobile and Virtual Health Resource Centers. MSC funds are used to support and fund salaries, travel, training, and services for the implementation of Connected Care's Strategic Plan, in addition to supporting the field to meet strategic plan standards.

Geriatrics and Extended Care
This program provides national guidance on the long-term services and support for geriatric Veterans and those requiring extended care. This includes facility-based programs, home- and community-based, purchased care programs and data analytics, quality improvement and research support. Geriatrics and Extended Care (GEC) manages the Community Living Center and State Veterans Homes (SVH) Surveys, SVH Per Diem and Construction Grant Programs, Community Nursing Homes and Purchased Long-term Services and Support, Medical Foster Homes, and Home-Based Primary Care. GEC also provides support for the Veteran Community Partnerships, Geriatric Research and Education Centers, Palliative and Hospice Care and other aging initiatives. MSC funds are used for program office salaries and contracts to support these quality surveys and other Veteran-centric programs.

Patient Centered Care and Cultural Transformation
The mission of the Office of Patient Centered Care and Cultural Transformation is to transform VA to a Whole Health System of care to support the health and well-being of Veterans and VA employees. Whole Health incorporates peer support, access to complementary and integrative health approaches, health coaching, and a Whole Health approach to clinical care into the Veteran experience. Please see the Whole Health section in the Medical Care chapter for more information.

Pharmacy Benefits Management Services
Pharmacy Benefits Management Services utilizes MSC funds for several programs throughout the country to provide organizational and clinical leadership to VHA pharmacies, as well as support to other health care providers to facilitate the highest quality care to Veterans by ensuring safe,

effective, and medically necessary management of medications. This is accomplished by creating a practice environment that fosters education, professional development, progressive practice initiatives, and innovative technologies to ensure consistent, accurate, and reliable medication distribution and information systems.

Physician Assistant Services
The Executive Director of Physician Assistant (PA) Services advises the VA and facility-based clinical leadership of all matters relating to the employment and effective utilization of PAs in VHA. Responsibilities include policy development, consultation on the PA role in various settings and capacities, recruitment strategies, credentialing requirements and ongoing educational needs, Congressional inquiries, constituent and external organization, coordination and collaboration with external Federal and state regulatory agencies and local and national organizations, succession planning, monitoring trending data, academic preparation for qualified professionals, and current community practice patterns. The program office has oversight of the VA PA residencies and PA Veteran scholarship programs.

Population Health
Population Health aims to transform VHA into a system that assists Veterans and their families to achieve their health goals through primary prevention and accessible, evidence-based, equitable, and high value Veteran-centric interactions. The office has oversight for the following programs:

- Office of Rural Health,
- Health Outcomes Military Exposures Office,
- Office of Health Equity: identifies disparities experienced by diverse groups of Veterans, develops quality improvement tools to help VA facilities reduce disparities through the Equity Guided Improvement Strategy and partners with stakeholders to share equity knowledge and best practices,
- Lesbian, Gay, Bisexual, Transgender, Queer, and Other Identities Health Program: oversees policy, training, education, consultation, and implementation of best clinical practices to reduce health disparities in sexual and gender minority Veterans,
- National Center for Health Promotion and Disease Prevention: provides programs, resources, training, and guidance to promote health promotion, disease prevention, and health education for Veterans through resources such as the Veterans Health Library,
- National Public Health Program Office: leads public health activities, surveillance, and investigations for high consequence infections through the VA National Public Health Reference, and has oversight for the policy for VHA's All Hazards Emergency Cache Program,
- Health Solutions: deploys and refines electronic medical record solutions to monitor and optimize health care delivery.

Rehabilitation and Prosthetic Services
Rehabilitation and Prosthetic Services oversees program and policy development for medical rehabilitation services for VHA, coordinating the provision of the full continuum of medical

rehabilitative and prosthetic services to promote the health, independence, and quality of life for Veterans with disabilities. This office administers program and policy development for 8 national programs with 11 different rehabilitation disciplines (Physical Medicine and Rehabilitation, Blind Rehabilitation, Chiropractic Care, Audiology and Speech Pathology, Recreation and Creative Arts Therapy, Orthotic, Prosthetic and Ped-orthic Clinical Services, Prosthetics and Sensory Aids, and the National Veterans Sports Program and Special Events). Specialized programs administered by this office include the Polytrauma/Traumatic Brain Injury System of Care, Amputation System of Care, Driver Rehabilitation Training, and Advanced Technology Labs. The office aligns clinical expertise, clinical and practice guidance, and specialized procurement resources to provide comprehensive rehabilitation, prosthetic, and orthotic services across the VHA health care system in the most economical and timely manner.

Office of Sterile Processing
The Office of Sterile Processing (OSP) is dedicated to the success of Sterile Processing Services (SPS) across VHA, serving as leaders and consultative experts regarding Reusable Medical Devices through collaboration with VA and external partners. OSP sets policy and provides critical guidance, oversight, data analysis, education, and support to VHA SPS staff nationwide.

Discovery, Education and Affiliate Networks

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$77,689	$175,849	$113,161	$119,191	$119,447	$6,031	$256
VACAA, sec. 801	$0	$3,524	$3,373	$256	$0	($3,117)	($256)
Obligations [Total]	$77,689	$179,373	$116,534	$119,447	$119,447	$2,914	$0

The Office of Discovery, Education and Affiliate Networks (DEAN) ensures that Veterans have access to the most innovative health care solutions by promoting medical research initiatives, training health care professions, and developing community partnerships. DEAN is responsible for managing education and training programs for health profession students and residents to enhance the quality of care provided to Veteran patients as required by 38 U.S.C. § 7302; applying basic, translational, clinical, health services and rehabilitative research to apply scientific knowledge to develop effective care solutions for Veterans; and providing innovative project management of the design, evaluation, and diffusion of new processes that facilitate health care innovations in the field to better serve Veterans.

Academic Affiliations
As one of four statutory missions of VA, the Office of Academic Affiliations (OAA) utilizes its MSC funding to support the statutory mission of health professions education (HPE) as outlined in 38 U.SC. § 7302. OAA's effective execution of MSC funding in support of this mission contributes substantially to VA's ability to deliver cost-effective, high-quality patient care for Veterans and has a major impact on the health care workforce in VA. OAA's MSC funding supports OAA staff salaries and travel, funding for mission critical conferences and committees (for example, National Academic Affiliations Council, National Designated Education Officer Conference, and Request for Proposal Review Committees), funding for National Coordinating

Centers for VA-based advanced fellowships, and fees and payments for accreditation of VA-based HPE Programs.

National Artificial Intelligence Institute (NAII)
The Budget supports the National Artificial Intelligence Institute (NAII) and VHA's strategic investment to begin leveraging artificial intelligence (AI) to enhance VHA's capacity to meet current and future executive mandates, improve the health care experience of Veterans, and deliver more efficient and effective care. The value of AI to VHA is in fostering a technologically advanced, competitive hiring landscape and in ensuring the provision of swift, high-quality, trustworthy health care. The AI strategy positions VHA as a leader in scaling AI responsibly, setting a benchmark in healthcare innovation, and ultimately, in honoring our commitment to those who have served. While artificial intelligence (AI) is not new, it is evolving quickly. In recent years, the use of artificial intelligence technology has been shown to improve both administrative and clinical care delivery. At the current time, integrating this technology (for example, machine learning, computer vision, and natural language processing) with existing VHA business processes and health care delivery has continued to improve efficiencies, scale solutions, and transform how the VHA operates and serves our Veterans.

National Center for Health Care Advancement and Partnerships
The National Center for Health Care Advancement and Partnerships (HAP) utilizes its MSC funding to accomplish VHA's mission to honor America's Veterans by supporting the field to cultivate public private partnerships (P3) and explore emerging therapies when other treatments have not been successful. HAP supports small scale health care advancement initiatives that enable staff in the field to implement impactful partnership projects aligned with HAP's pillars and VA/VHA strategic plan. Examples of healthcare advancement initiatives supported by HAP include the Veteran Sponsor Partnership Network, which supports VHA partnerships with organizations that pair Service members with peer sponsors to support Veterans through the military-to-civilian transition, and Stellate Ganglion Block for Veterans with PTSD. HAP further disseminates P3 best practices across VHA at the national, state, and community level. HAP hosts the annual VHA National Community Partnership Challenge to recognize exemplary P3 that enhance the health and well-being of Veterans and their communities.

Office of Health Care Innovation and Learning
The Office of Health Care Innovation and Learning (HIL) utilizes MSC funding to support the VA's mission to honor America's Veterans by bringing innovative health care solutions to Veterans. OHIL brings together the VHA Innovation Ecosystem, the Simulation Learning, Evaluation, Assessment and Research Network, the Center for Care and Payment Innovation, the Office of Advanced Manufacturing, and the Strategic Initiatives Lab. Through these core programs, HIL advances VHA health care delivery and service by supporting VA facilities engaged in identifying and scaling innovation, supporting the training and ongoing competency maintenance (including life-saving skills such as CPR) for VHA staff, developing and deploying Veteran and VA-specific training and education experiences in both virtual reality and augmented reality, providing novel treatment to Veterans through virtual and augmented reality applications, and by exploring novel care and payment pathways that will lead to higher value by maximizing quality care per unit costs.

Research and Development
The Office of Research and Development supports the Research mission by utilizing its MSC funding for salary support and sustainment of the Medicare Data Merge initiative at the Edward Hines Jr. VAMC located in Hines, Illinois. The VA Information Resource Center in Hines, Illinois 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.

Operations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$169,959	$269,123	$250,284	$256,541	$256,541	$6,257	$0
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$169,959	$269,123	$250,284	$256,541	$256,541	$6,257	$0

The Office of the AUSH for Operations (AUSHO) is responsible for overseeing the delivery of health care services. The Office of the AUSHO provides oversight for 18 VISNs, 172 VAMCs, and over 1,000 outpatient sites of care.

Center for Development and Civic Engagement
The Center for Development and Civic Engagement's MSC funding is used to facilitate the strategic integration of volunteers, donations, and community partners for the purpose of enhancing care and benefits for America's Veterans.

Office of Emergency Management
Funding supports the VHA enterprise through the integration of emergency management programs, functions and supporting activities to prevent, protect, mitigate, respond, and recover from all hazards. The Office of Emergency Management provides support in the form of personnel, finances, materials, and processes during these five overlapping phases of internal and external disasters and military contingencies.

Health Care Operations Center
These funds support the centralized management and support of operations across the VHA enterprise. This includes daily operational support to and management of the VISNs, routine monitoring and analytics of operational, quality, and productivity metrics, and implementation of enterprise-wide initiatives. The Health Care Operations Center (HOC) provides rapid, near real-time information and analyses to support senior leader decision-making and problem-solving, while also improving VHA's ability to provide Veterans timely access to the highest quality care.

HOC provides daily operational and analytical support for the management of VHA operations nationwide, including managing the daily VHA senior leadership briefing, providing daily operational support and oversight for the 18 VISNs, and providing real-time facilitation for enterprise-wide deployments. Additionally, HOC also provides support and consultation to other AUSH offices on data development, analysis, and presentation, in addition to reporting of issue

briefs, responding to request for information, Freedom of Information Act (FOIA) requests, Congressional inquiries, and media questions across the entire breadth of VHA activities.

Member Services
Member Service's (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: enrolls eligible Veterans who apply for VA health care in addition to providing other enrollment and related services,
- Health Resource Center: assists Veterans in understanding and obtaining benefits,
- Veterans Transportation Program: helps alleviate the costs of travel to medical appointments for eligible Veterans,
- Pharmacy Services: assists Veterans with management of prescription issues and copayments through the Pharmacy Customer Care and Clinical Pharmacy Resources efforts, respectively.

MSC funds are used to support multiple Veteran-facing initiatives within these national programs as well as supporting administrative offices and staff.

Integrated Veteran Care

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$407,916	$512,952	$477,045	$488,971	$488,971	$11,926	$0
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$407,916	$512,952	$477,045	$488,971	$488,971	$11,926	$0

IVC was established in 2022 by the VHA USH. IVC creates a more seamless and coordinated experience for any Veteran who accesses the VHA system, within VHA or the community. IVC positions VHA for better coordination and resource alignment, while also offering streamlined and simplified access processes for the field and for Veterans.

IVC is a matrixed organization structure that allows for increased collaboration across functional areas. Four organizational functions will coordinate across IVC to create seamless, integrated Veteran access to care.

Access Transformation
Access Transformation (AT) guides VHA's processes, roles, and practices to provide Veterans with access to timely, appropriate, quality health care, whether within the direct care system, virtual care system, or in the community. AT is responsible for:

- Ensuring modernization of Clinical Contact Centers across the enterprise, with coordinated collaboration between program offices focused on virtual care delivery to provide seamless virtual care to Veterans,

- Leading and coordinating technological innovations to support integrated access and care management for VISNs and VAMC staff.

Integrated Optimization
Integrated Optimization (IO) collaborates with VAMC, VISN, regional, and national program office leadership to address challenges and opportunities for optimizing Veterans' access to health care within the direct care system or in the community. IO is responsible for:

- Collaborating with Integrated Field Operations and Group Practice Managers in developing and implementing access policies, processes, and improvements for direct and community care (the team simplifies scheduling processes and minimizes scheduling errors by working in collaboration with technology and innovation to ensure the best technology is available and its utilization is well understood),
- Supporting a comprehensive set of projects and initiatives for managing referral management, care coordination, and improving the Veteran experience,
- Delivering comprehensive engagement and support across all VAMCs in the enterprise enabling sites to provide value-based, Veteran-centric health care timely and equitably,
- Facilitating VISN, VAMC, and VHA program office collaboration, mentorship, and education on IVC access initiatives, enabling Veterans to receive timelier patient-centered care that is equitable, high-quality, and value-driven within VHA and the community.

Integrated External Networks
Integrated External Networks (IEN) leads, develops, and administers contracts and networks for community care for Veterans and their beneficiaries. IEN is responsible for:

- Ensuring community care programs provide services and customer support to Veterans and family members eligible for community care using Veteran Care Agreements and Third-Party Administrators across the country and US territories,
- Developing and overseeing contracts for Veteran health care services, working to ensure that network providers provide timely, high-quality care for Veterans that integrates with VA-coordinated lifetime care management,
- Provide education, outreach, and customer support to providers, Veterans, and their beneficiaries,
- Monitor, measure, and report on providers' quality, safety, access performance, and health outcomes to ensure community care provides high quality, Veteran-centric health services for our Veterans.

Integrated Informatics and Analytics
Integrated Informatics and Analytics (IIA) provides the tools and support for leadership to make data-driven decisions on access investments or partnerships as appropriate for the market. IIA is responsible for:

- Collecting, analyzing, and integrating both internal direct care and external network data to provide stakeholders actionable information for investment, resource, program, and operational management decisions,
- Championing and coordinating data analytics for purchased care network population health efforts, to provide comparability to VHA population health efforts,
- Enabling users to apply a value-based measurement framework to assist and measure goals, metrics, and key performance indicators,
- Establishing a trusted source of data to deliver consistent, high-quality data, drive predictive and prescriptive modeling, and advance IVC's analytics and modeling capabilities.

Quality and Patient Safety

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$169,538	$209,000	$194,370	$199,229	$199,229	$4,859	$0
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$169,538	$209,000	$194,370	$199,229	$199,229	$4,859	$0

The Office of Quality and Patient Safety provides oversight, expertise, and support to advance the highest standards of care, innovation, responsible stewardship, and ethical practice within the VA health care system.

National Center for Patient Safety
The National Center for Patient Safety (NCPS) develops, leads, and oversees activities and programs that drive the improvement of patient safety throughout VHA. The primary mission of NCPS is to advance a culture of patient safety to prevent harm. The NCPS establishes policy and provides oversight for the VHA National Patient Safety Program, including the development of guidance and measurement to mitigate Veteran harm. Additionally, NCPS is responsible for:

- maintaining a database for patient safety events and root cause analysis reports,
- curriculum delivery for post-graduate patient safety educational programs,
- promoting the VHA HRO Journey to Zero Harm through clinical team and just culture training,
- oversight and administration of the Patient Safety Centers of Inquiry to advance patient safety science,
- evaluation of health care solutions, technology and innovations from a patient safety and value-based perspective and oversight of the VHA Alerts and Recall Program for Medical Products, Drugs and Food.

The Optimizing Health Care Value Program provides evaluation of VHA-wide clinical and business processes and initiatives. Utilization Management provides consultative guidance,

standardized resources, and targeted education to determine medical necessity of inpatient Veteran health care through application of evidenced based criteria.

Analytics and Performance Integration
The Office of Analytics and Performance Integration's (API) mission delivers innovative and authoritative performance measurement, analytic and reporting tools and capabilities throughout VHA to enhance the value and quality of care for Veterans. API utilizes its MSC funding for staff salaries, travel, and education to enable the entire VHA health system use data to drive high value and Veteran-centric care through seven program areas including:

- Center for Strategic Analytic Reporting: develops the Strategic Analytics for Improvement and Learning report to measure, evaluate, and benchmark quality and efficiency at VA medical facilities, in addition to utilizing data from the CMS for comparisons to the private sector,
- Inpatient Evaluation Center: produces innovative products focused on tracking and improving the outcomes of hospitalized Veterans,
- Office of Productivity, Efficiency, and Staffing: dedicated to enhancing VHA health care effectiveness using standard industry practices and external practice benchmarks for monitoring and improving clinical productivity and effectiveness.

Additionally, API supports legislative requirements such as the Survey of Health Care Experiences of Patients to measure patient experiences in the VA and the External Peer Review Program contract, managed by Performance Measurement to operate a system of external review of identified medical records in alignment with external comparators to assess the quality of VHA inpatient and outpatient care.

Quality Management
The Office of Quality Management (OQM) supports the ongoing assessment and improvement of health care outcomes and health care delivery processes. OQM program offices help ensure VHA is hiring qualified providers, identifying, and utilizing evidence-based practices, screening for deviations from standards of care to identify areas for continuous process improvement and ensuring facilities remain in a continuous state of readiness and compliance with industry standards. In addition, OQM actively participates in the continuous efforts of a learning organization both as a system, and through individual development, by providing education, training, and competency build for quality professionals across the VHA, further enhancing data knowledge and use, leadership skills, and quality competencies. OQM programs working to achieve these goals include External Accreditation Services and Programs, the National Improvement Office, the Evidenced-Based Practice Program, Credentialing and Privileging, the office of Medical-Legal Risk Management, and the High Reliability Enterprise Support Team.

Support Services

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$566,543	$765,103	$711,546	$729,335	$729,335	$17,789	$0
Veterans Medical Care and Health Fund	($21,834)	$0	$0	$0	$0	$0	$0
Obligations [Total]	$544,709	$765,103	$711,546	$729,335	$729,335	$17,789	$0

The Office of the AUSH for Support provides facilities, engineering, equipment, occupational safety and health, procurement and logistics support services, expertise, and program oversight to enable effective and efficient medical facility operations, clinical services, and patient care services.

Health Care Environment and Facilities Programs
Health Care Environment and Facilities Programs uses MSC funds to provide oversight in the areas of capital asset management, health care engineering, environmental management, and occupational safety and health across the VHA enterprise in support of medical facility infrastructure. Each of these specialty areas works together to ensure operational compliance with codes, standards, regulations, statutes, and executive orders. MSC funds directly support the salaries and training requirements of VISN level Green Environmental Management Systems Program Managers and Energy Engineers.

Health Care Technology Management
The Office of Health Care Technology Management is responsible for national policies, standards, and guidance related to medical equipment management to assure safe, available, and innovative technology across VHA. Additionally, this office uses MSC funds to employ Biomedical Engineers and Biomedical Equipment Support Specialists to provide oversight to Biomedical Engineering Programs across VHA field operations regarding the commissioning, technical sustainment, and systematic technical refresh of medical equipment used across VHA. Please see the Medical Equipment Section in the Medical Services chapter for more information.

Procurement and Logistics Office
The Procurement and Logistics Office uses MSC funds to recruit and retain the best qualified acquisition workforce to provide support to all of VHA in purchasing high-quality, cost-effective health care products and services for all facilities, provide world class logistics and acquisition services to VHA's integrated health care system and medical facilities, and develops, implements, and oversees policies and processes compliant with all applicable laws and regulations. Additionally, this office uses MSC funds to employ subject matter experts to oversee logistics plans, policies, and operations and provide oversight for the planning, clinically driven strategic sourcing, deployment, sustainment, and disposition for VHA equipment assets. Please see the Medical Equipment Section in the Medical Services chapter for more information.

Veterans Canteen Service
Since 1946 Veterans Canteen Service (VCS) has been serving America's Veterans, caregivers, family members, visitors, and volunteers as the commercial retail, café, and coffee shop service across 200 VAMCs, and facilities as a self-sustaining entity with one mission: providing comfort and wellbeing. VCS is an integral part of the VA community, driven to be efficient, innovative,

and customer focused, giving back to Veterans with support for rehabilitation events, homelessness programs, suicide prevention, and emergency support during natural disasters. VCS does not use MSC funds. Please see the VCS Revolving Fund section in the Revolving and Trust Activities chapter for more information.

VA Logistics Redesign
VA's supply chain modernization priorities include deploying multiple systems and improvements to improve enterprise management and oversight of materiel to provide better support for care delivery in the field. Please see the Supply Chain Management section in the Medical Care chapter for more information.

Human Capital Management

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$344,691	$437,442	$406,821	$416,992	$416,992	$10,171	$0
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$344,691	$437,442	$406,821	$416,992	$416,992	$10,171	$0

The Office of Human Capital Management (HCM) is committed to achieving individual and organizational high performance for VHA workforce to serve the Nation's Veterans. HCM supports the human capital needs of VHA employees and health professions trainees. HCM provides guidance, information, and consultation to VHACO components, VHA health care facilities, VISNs, and external entities such as health professional organizations, Congress, and other Federal agencies. HCM oversees VHA's succession and workforce planning, identifies and monitors talent needs and trends within the organization, and links succession planning and business strategies, presenting VHA with the opportunity to reach long-term goals and achieve human capital objectives. To drive change and the long-term development of people and culture to address future challenges as VA continues its modernization transformation, HCM conducts a Department-wide assessment of organizational health annually, providing data analytics and action planning consultation to ensure results are used to improve the workplace. MSC funds support additional HCM functions including administrative, financial, and logistical oversight for all VHA headquarters program offices and staff.

Institute for Learning, Education and Development
The Institute for Learning, Education and Development (ILEAD), merged from Employee Education System and Health Care Talent Leadership Institute in 2023, provides employee learning, education, and development opportunities and solutions to VHA's workforce. The ILEAD transformation goal is to create a learning community of practice through continuous engagement, provide training solutions and services that empower the advancement of VHA's high performing workforce and enable VHA learners to deliver exceptional care to Veterans.

ILEAD partners with VA, VHA program offices, VISNs, and medical facilities to provide quality workforce education and training to improve outcomes in Veteran clinical care, health care operations, and administration. VHA employees rely upon ILEAD for high-quality, impactful education, and training support. ILEAD continues to serve as a managing partner for the Federal Health Care Training Partnership, consisting of agencies (including the Department of Defense)

that collaborate and share continuing medical education training programs among partner organizations with a clinical and public health training mission. ILEAD shares, at no cost to the learner, continuing medical education and continuing education in the health professions training programs on the VHA Training Finder Real Time Affiliate Integrated Network (TRAIN). A service of Public Health Foundation, TRAIN operates through collaborative partnerships with state and Federal agencies, local and national organizations, and educational institutions. MSC funds support overhead costs associated with maintaining the program and administrative support costs for training, travel, equipment, and supplies.

ILEAD is responsible for linking talent planning and talent development processes and programs into a single system characterized by informed, structured, ongoing, and deliberate processes to identify, develop, and leverage the leadership talents of the VHA workforce. The result is a cadre of ready, willing, diverse, and capable leaders to step into VHA's most demanding roles. ILEAD promotes and manages leadership programs and developmental opportunities that maximize the acquisition of leadership and health care leadership competencies through growth activities that are 70% experiential (for example, activities, details, assignments, and committees), 20% exposure (for example, coaching, mentoring, and shadowing) and 10% traditional didactic training. ILEAD oversees VHA leadership succession planning, identifies, and monitors talent needs and trends within the organization, and links succession planning and business strategies to present VHA with the opportunity to reach long-term goals and achieve human capital objectives.

National Center for Organization Development

The National Center for Organization Development (NCOD) collaborates with leaders throughout VA enabling them to create a highly engaged workforce to increase the long-term growth and performance of the VA. NCOD administers, analyzes, and presents results of the annual All Employee Survey to leaders and assists with action planning across VA. NCOD conducts consultative engagements designed to support services and workgroups by working with individual leaders virtually and in person. NCOD provides services designed to strengthen executive leadership teams to better overcome challenges and grow their organizations together. NCOD offers 360° assessments as well as executive coaching to current and developing leaders within the organization and conducts the VA Internal Coach Training Program to build a broader cadre of skilled, qualified coaches who support highly valued, impactful leadership coaching and who become eligible for the International Coaching Federation credential.

NCOD reaches out to leaders at sites considered at-risk related to employee engagement, offering foundation approaches aimed at improving the work environment for employees. NCOD oversees VA Voices, which is designed to engage employees and promote collaboration to achieve the shared mission of serving Veterans. The aim is twofold: to engage employees and to create an organizational climate that sustains engagement over time. NCOD has developed several programs, services and resources focused on engagement to support leaders in creating a workplace where employees want to work and where 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
Workforce Management and Consulting (WMC) provides VHA-wide leadership for workforce operations and administration management through strategic human capital planning, senior executive recruitment, performance and advisory services, labor management and labor relations, and training and career development. WMC ensures the recruitment and retention of a highly skilled, motivated, and effective workforce and provides advice and assistance to VHA leadership on HR issues. WMC provides full-service HR operations for VA employees (including VHACO, specific VA staff office organizations, and OIT) and serves as the delegated examining unit for all VHA. WMC also provides personnel security and credentialing oversight to VISNs and VAMCs through issuance of policy, technical guidance, and consultative services focused on establishing consistency in suitability and credentialing related practices. MSC funds support essential HR staff salaries, human capital recruitment and retention programs, such as employee scholarship programs, and critical HR contracts and services supporting VHA employees nationwide.

Health Informatics

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$173,413	$213,742	$198,780	$203,750	$203,750	$4,970	$0
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$173,413	$213,742	$198,780	$203,750	$203,750	$4,970	$0

Office of Health Informatics (OHI) oversees the collection, exchange, and use of EHR data, optimizes the current EHR to promote evidence-based decision making and patient centered care, and delivers health IT solutions that increase Veteran access to care, and supports participation in their health care by:

- ensuring that health care information systems are implemented in a manner that meets the requirements of VHA users, including EHRM,
- enhancing heath information exchanges with Federal and private partners,
- providing national policy and guidance to VHA on matters related to health informatics, FOIA, privacy, health information management, records management, and library personnel nationwide,
- facilitating sound decision making for development, acquisition, and maintenance of health IT investments through business requirements, IT strategy and priorities, and investment analysis,
- developing, delivering, and implementing virtual and digital technologies that help Veterans communicate with their VA care teams, and coordinate, track, and manage their health care, and
- partnering with VHA programs and VA's OIT to deploy enterprise applications and databases to support strategic goals and objectives for VHA.

Program Support Operations
Program Support Operations, manages the business functions for OHI, providing guidance and support in such areas as planning and strategy, budget, HR, and contracting.

Clinical Informatics and Data Management Office
Clinical Informatics and Data Management Office's (CIDMO) mission is to advance the enterprise standards of care and experience for Veterans and clinical staff through information and process management. CIDMO partners with program offices, OIT, and the field to derive clinical value from technologies and improve the user experience. The office accomplishes this work though application of technical expertise including process engineering, human factors engineering, terminology, knowledge representation, system design, and computer-science-based analytical methods. CIDMO products usually have four components: re-engineered clinical processes, encoded clinical logic, new or configured software, and change management. CIDMO provides products for use in direct patient care. The rest of its work is focused on the safe operation and use of IT, developing and piloting foundational methods of information management including national standards, providing technical consultations to other offices, improving the management and competencies of the informatics workforce, coordinating high-return collaborations with other Federal agencies and health care systems, and cooperatively managing applications and technical platforms such as those for data, clinical decision support, and interoperability. Nearly all CIDMO activities are designed to support EHRM with dual benefit to Veterans Health Information Systems and Technology Architecture sites.

Health Information Governance
Health Information Governance (HIG) represents VA on national and international health care policy initiatives regarding Veterans' data. HIG serves as VHAs subject matter and policy expert regarding privacy, health care security, and data contained in Veterans' EHR and in national data systems. The office provides compliance monitoring, management of national data systems, and knowledge-based library services. The office develops and implements policy and regulations in accordance with FOIA, Privacy Act, title 38, United States Code confidentiality statutes, and Health Insurance Portability and Accountability Act privacy rule. HIG provides national guidance, policy, and training to VHA field-based professionals on health information management, library, privacy, FOIA, records management, identity management, and health care security topics.

Strategic Investment Management
Strategic Investment Management (SIM) was established to support the business' health IT needs by facilitating business transformation, informing change management efforts, and providing the information that leaders need to make sound decisions. SIM adds value by informing decision making and driving business transformation. SIM is composed of three organizational services:

1. Business Architecture Services bridges the gap between VHA capabilities and stakeholders by establishing a common language to describe the business of health care delivery. Additionally, this service identifies, classifies, and models health business strategies, functions, processes, and information to allow executives and portfolio managers to make better and more informed decisions regarding health care transformation and IT solution development, acquisition, and configuration,
2. Investment Governance Services provides oversight of budget planning activities relative to VHA IT needs, coordinates IT governance functions within VHA, and provides VHA liaison to VA-wide IT governance,

3. Requirements Development and Management Services collaborates with VHA program offices, VHA field staff, subject matter experts, and stakeholders to gather, document, analyze, validate, and communicate requirements supporting clinical and business needs which drives traceability towards an enterprise standard. This ensures VHA's IT needs are documented in a manner that is crucial to improving existing IT systems and in the acquisition of modern technology.

Office of Nursing Informatics
Office of Nursing Informatics (ONI) supports nurses throughout the care continuum to link science, technology, and the use of EHR, tools, and processes to improve health. ONI ensures providers can access knowledge that reflects the best evidence of care practices to help lead to the desired outcomes in care delivery and operational performance. ONI measures outcomes based on what nurses caring for Veterans are experiencing, and what solutions mean to Veterans.

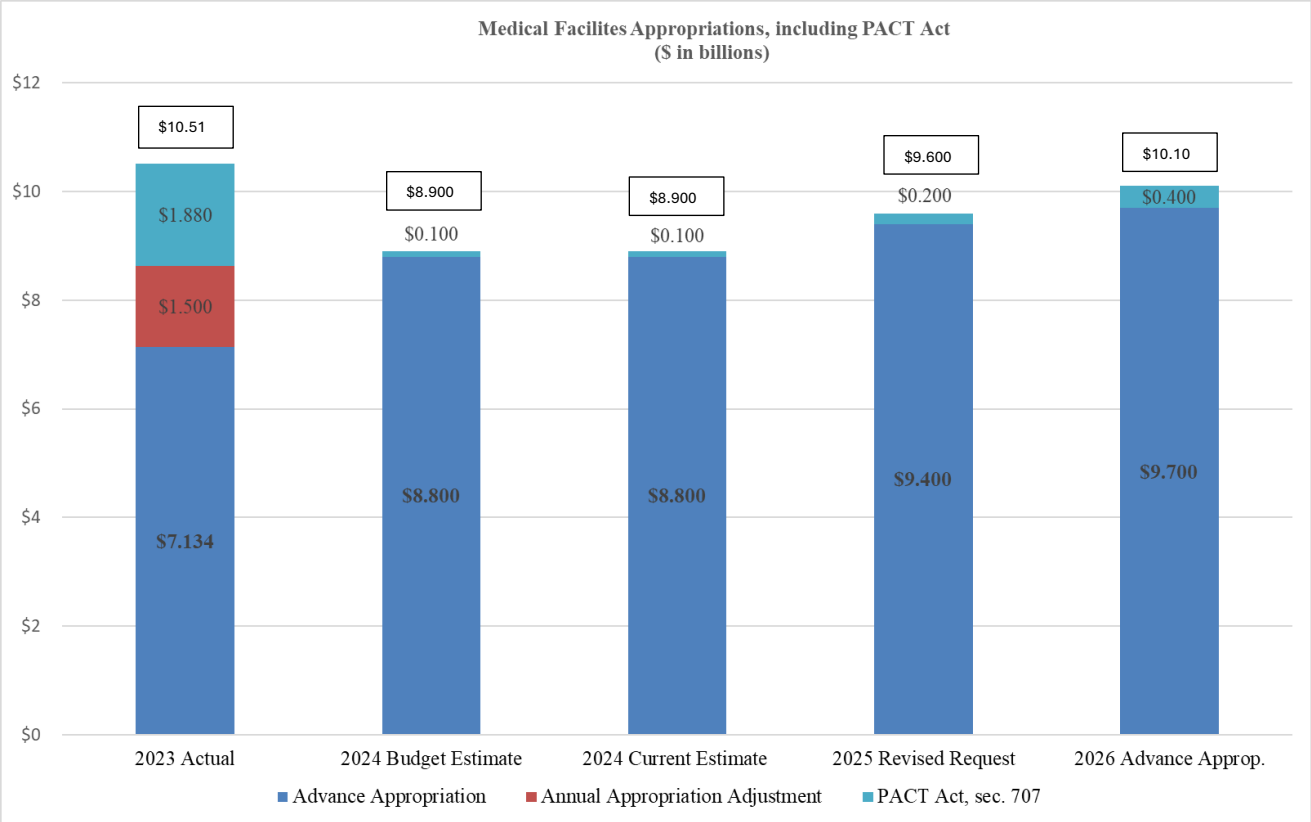
All-Other Support and Program Offices

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations	$1,215,553	$1,517,789	$1,451,426	$1,523,997	$1,523,997	$72,571	$0
Veterans Medical Care and Health Fund	$47	$0	$0	$0	$0	$0	$0
Obligations [Total]	$1,215,600	$1,517,789	$1,451,426	$1,523,997	$1,523,997	$72,571	$0

The VHA program offices in this line include Patient Advocacy, Readjustment Counseling, Women's Health, Health Care Transformation, Finance, Strategy, Oversight, Risk and Ethics, Chief of Staff, Office of the Deputy USH, and Office of the USH.

Section G: Medical Facilities Category

Chart: Medical Facilities Appropriations [1/ 2/]



[1/] All columns in this chart display appropriations prior to any proposed cancellations or transfers as shown in the crosswalk tables below.

[2/] A full-year 2024 appropriations Act was not enacted at the time the Budget was prepared. The funding level in the 2024 Current Estimate column in all tables assumes the 2024 President's Budget request for 2024 with updates to unobligated balances, collections, reimbursements, and transfers.

The following tables display the discretionary, mandatory, and combined sources of funds for the Medical Facilities category.

Table: Medical Facilities Discretionary Crosswalk, 2023-2026

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Appropriation Medical Facilities (0162)							
Advance Appropriation	$7,133,816	$8,800,000	$8,800,000	$9,400,000	$9,700,000	$600,000	$300,000
Proposed Cancellation 1/	$0	($250,515)	($250,515)	$0	$0	$250,515	$0
Annual Appropriation Adjustment	$1,500,000	$0	$0	$0	$0	$0	$0
Appropriations Request [Subtotal]	**$8,633,816**	**$8,549,485**	**$8,549,485**	**$9,400,000**	**$9,700,000**	**$850,515**	**$300,000**
Transfers To							
Medical Community Care (0140)	$0	$0	$0	($600,000)	$0	($600,000)	$600,000
JALFHCC (0169)	($142,715)	($55,452)	($75,452)	($66,021)	($69,322)	$9,431	($3,301)
Transfers To [Subtotal]	($142,715)	($55,452)	($75,452)	($666,021)	($69,322)	($590,569)	$596,699
Transfers From							
Medical Community Care (0140)	$0	$3,919,081	$0	$0	$0	$0	$0
Medical Support & Compliance (0152)	$0	$850,000	$400,000	$0	$0	($400,000)	$0
Transfers From [Subtotal]	$0	$4,769,081	$400,000	$0	$0	($400,000)	$0
Proposed Cancellation from Transferred Advance Appropriations	$0	($4,769,081)	$0	$0	$0	$0	$0
Reappropriation of the Transferred Cancelled Funds with a 5-Year Period of Availability	$0	$4,769,081	$0	$0	$0	$0	$0
Budget Authority [Total]	$8,491,101	$13,263,114	$8,874,033	$8,733,979	$9,630,678	($140,054)	$896,699
Reimbursements	$16,571	$18,609	$16,571	$16,571	$16,571	$0	$0
Unobligated Balance (SOY)							
P.L. 117-328 § 252 (EO 14507 no-year, 1124XN) 2/	$75,000	$0	$75,000	$0	$0	($75,000)	$0
P.L. 117-103 § 253 (Infrastructure no-year)	$108,824	$0	$85,871	$0	$0	($85,871)	$0
P.L. 115-244 § 248 (NRM no-year)	$139,162	$0	$58,366	$0	$0	($58,366)	$0
P.L. 115-141 § 255 (NRM no-year)	$30,667	$0	$3,932	$0	$0	($3,932)	$0
P.L. 111-32 (H1N1 no-year)	$5	$0	$5	$5	$5	$0	$0
P.L. 110-28 (Emergency Supplemental no-year)	$5,800	$0	$5,800	$5,800	$5,800	$0	$0
No-Year (all other)	$10,861	$0	$8,252	$8,252	$8,252	$0	$0
2-Year	$315,248	$250,515	$267,385	$409,235	$0	$141,850	($409,235)
Unobligated Balance (SOY) [Subtotal]	$685,567	$250,515	$504,611	$423,292	$14,057	($81,319)	($409,235)
Unobligated Balance (EOY)							
P.L. 117-328 § 252 (EO 14507 no-year, 1124XN) 2/	($75,000)	$0	$0	$0	$0	$0	$0
P.L. 117-103 § 253 (Infrastructure no-year)	($85,871)	$0	$0	$0	$0	$0	$0
P.L. 115-244 § 248 (NRM no-year)	($58,366)	$0	$0	$0	$0	$0	$0
P.L. 115-141 § 255 (NRM no-year)	($3,932)	$0	$0	$0	$0	$0	$0
P.L. 111-32 (H1N1 no-year)	($5)	$0	($5)	($5)	($5)	$0	$0
P.L. 110-28 (Emergency Supplemental no-year)	($5,800)	$0	($5,800)	($5,800)	($5,800)	$0	$0
No-Year (all other)	($8,252)	$0	($8,252)	($8,252)	($8,252)	$0	$0
2-Year	($267,385)	$0	($409,235)	$0	$0	$409,235	$0
Unobligated Balance (EOY) [Subtotal]	($504,611)	$0	($423,292)	($14,057)	($14,057)	$409,235	$0
Lapse	($45)	$0	$0	$0	$0	$0	$0
Subtotal	$8,688,583	$13,532,238	$8,971,923	$9,159,785	$9,647,249	$187,862	$487,464
Prior Year Recoveries	$21,358	$0	$0	$0	$0	$0	$0
Discretionary Obligations (0162) [Total]	**$8,709,941**	**$13,532,238**	**$8,971,923**	**$9,159,785**	**$9,647,249**	**$187,862**	**$487,464**
Discretionary Budget Authority	$8,491,101	$13,263,114	$8,874,033	$8,733,979	$9,630,678	($140,054)	$896,699
Discretionary Obligations [Total]	**$8,709,941**	**$13,532,238**	**$8,971,923**	**$9,159,785**	**$9,647,249**	**$187,862**	**$487,464**

1/ The 2024 Budget proposed a cancellation of unobligated balances of $250.515 million. The 2024 Current Estimate assumes a rescission in this amount will be enacted.

2/ P.L. 117-328 sec. 252 provided that of the unobligated balances available in fiscal year 2023 in the "Recurring Expenses Transformational Fund" (RETF), $75,000,000 be for the deployment, upgrade, or installation of infrastructure or equipment to support goals established in Executive Order 145057. This use of the RETF is reflected in the Medical Facilities category as its execution is consistent with Non-Recurring Maintenance in VHA.

Table: Medical Facilities Mandatory Crosswalk, 2023-2026

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
PACT Act, sec. 705 (0162XU)							
Mandatory Appropriations	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (SOY)	$275,205	$275,205	$229,656	$188,281	$147,673	($41,375)	($40,608)
Unobligated Balance (EOY)	($229,656)	($275,205)	($188,281)	($147,673)	($130,393)	$40,608	$17,280
Obligations PACT Act, sec. 705 (0162XU) [Total]	**$45,549**	**$0**	**$41,375**	**$40,608**	**$17,280**	**($767)**	**($23,328)**
PACT Act, sec. 707 (0162XL)							
Mandatory Appropriations	$1,880,000	$100,000	$100,000	$200,000	$400,000	$100,000	$200,000
Unobligated Balance (SOY) (base year 2023)	$0	$1,829,719	$1,855,998	$1,772,407	$982,218	($83,591)	($790,189)
Unobligated Balance (SOY) (base year 2024+)	$0	$0	$0	$0	$181,631	$0	$181,631
Unobligated Balance (EOY) (base year 2023) 1/	($1,855,998)	($1,142,995)	($1,772,407)	($982,218)	($977,947)	$790,189	$4,271
Unobligated Balance (EOY) (base year 2024+)	$0		$0	($181,631)	$0	($181,631)	$181,631
Obligations PACT Act, sec. 707 (0162XL) [Total]	**$24,002**	**$786,724**	**$183,591**	**$808,558**	**$585,902**	**$624,967**	**($222,656)**
Veterans Medical Care and Health Fund (0173MF)							
Unobligated Balance (SOY)	$772,056	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY)	$0	$0	$0	$0	$0	$0	$0
Lapse	($13)	$0	$0	$0	$0	$0	$0
Subtotal	$772,043	$0	$0	$0	$0	$0	$0
Prior Year Recoveries	$43,711	$0	$0	$0	$0	$0	$0
Obligations (0173MF) [Total]	**$815,754**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
VACAA, sec. 801 (0162XA)							
Unobligated Balance (SOY)	$10,884	$3,791	$10,394	$0	$0	($10,394)	$0
Unobligated Balance (EOY)	($10,394)	$0	$0	$0	$0	$0	$0
Subtotal	$490	$3,791	$10,394	$0	$0	($10,394)	$0
Prior Year Recoveries	$568	$0	$0	$0	$0	$0	$0
Obligations (0162XA) [Total]	**$1,058**	**$3,791**	**$10,394**	**$0**	**$0**	**($10,394)**	**$0**
Mandatory Budget Authority	$1,880,000	$100,000	$100,000	$200,000	$400,000	$100,000	$200,000
Mandatory Obligations [Total]	**$886,363**	**$790,515**	**$235,360**	**$849,166**	**$603,182**	**$613,806**	**($245,984)**

1/ The 2024 Congressional Justification did not display estimated balances separately by base year.

Table: Medical Facilities Discretionary & Mandatory Total and FTE, 2023-2026

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Revised Request	2026 Advance Approp.	+/- 2024-2025	+/- 2025-2026
Discretionary and Mandatory Budget Authority [Grand Total]	$10,371,101	$13,363,114	$8,974,033	$8,933,979	$10,030,678	($40,054)	$1,096,699
Discretionary and Mandatory Obligations [Grand Total]	**$9,596,304**	**$14,322,753**	**$9,207,283**	**$10,008,951**	**$10,250,431**	**$801,668**	**$241,480**
FTE							
Medical Facilities (0162)	21,586	26,501	26,855	25,839	25,790	(1,016)	(49)
Veterans Medical Care and Health Fund (0173MF)	4,453	0	0	0	0	0	0
VACAA, Section 801 (0162XA)	1	0	1	0	0	(1)	0
FTE [Total]	**26,040**	**26,501**	**26,856**	**25,839**	**25,790**	**(1,017)**	**(49)**

Summary of 2025 Revised Request

The Department of Veterans Affairs (VA) is maintaining the requested 2025 discretionary advance appropriation of $9.4 billion for the Medical Facilities account and proposes a $600 million transfer to Medical Community Care based on revised estimates for each account. Mandatory appropriations were provided in Title VII of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act):

- Section 705 appropriated $922.0 million in fiscal year 2022 for the Department's enhanced-use lease program to be available until expended. The Department allocated $275.2 million of this funding to the Medical Facilities account and $40.6 million is projected to obligated from this funding source in 2025.

- Section 707 appropriated $5.5 billion in fiscal years 2023-2031 of which $1.9 billion was appropriated in 2023, $100 million in 2024, and $200 million will be made available in 2025. Section 707 also makes available $400 million in 2026, $450 million in 2027, $600 million in 2028, $610 million in 2029, $620 million in 2030, and $650 million in 2031. These funds are available until expended for major medical facility leases, and the $1.9 billion appropriated in 2023 is specifically for the leases authorized by section 702 of the PACT Act; $808.6 million is projected to be obligated in 2025.

When these resources are combined with available transfers, reimbursements and other net unobligated balances, Medical Facilities will meet the projected 2025 obligation level of $9.2 billion, as detailed in the tables below.

Table: Medical Facilities Discretionary Obligations by Program
(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Program (0162)							
Engineering & Environmental Management	$828,304	$1,245,577	$1,085,293	$1,105,447	$1,173,010	$20,154	$67,563
Engineering Service	$1,166,345	$1,444,823	$1,480,139	$1,444,496	$1,532,780	($35,643)	$88,284
Ground Maintenance & Fire Protection	$132,761	$178,197	$171,802	$175,341	$186,057	$3,539	$10,716
Leases	$1,084,283	$1,515,753	$1,253,995	$1,460,843	$1,600,000	$206,848	$139,157
Non-Recurring Maintenance	$3,023,751	$5,750,000	$1,925,000	$2,000,000	$2,000,000	$75,000	$0
Operating Equipment Maintenance & Repair	$449,857	$503,971	$550,481	$551,727	$585,447	$1,246	$33,720
Other Facilities Operation Support	$40,987	$73,802	$44,329	$50,438	$53,521	$6,109	$3,083
Plant Operation	$964,600	$1,274,587	$1,161,171	$1,131,489	$1,200,643	($29,682)	$69,154
Recurring Maintenance & Repair	$556,192	$945,454	$694,325	$682,518	$724,232	($11,807)	$41,714
Textile Care Processing & Maintenance	$223,290	$294,247	$267,007	$300,808	$319,193	$33,801	$18,385
Transportation	$218,213	$305,827	$263,381	$256,678	$272,366	($6,703)	$15,688
Obligations Before Prior Year Recoveries (0162)	$8,688,583	$13,532,238	$8,896,923	$9,159,785	$9,647,249	$262,862	$487,464
Prior Year Recoveries	$21,358	$0	$0	$0	$0	$0	$0
Obligations After Prior Year Recoveries [Subtotal]	**$8,709,941**	**$13,532,238**	**$8,896,923**	**$9,159,785**	**$9,647,249**	**$262,862**	**$487,464**
Discretionary Program (1124XN) - Recurring Expenses Transformational Fund							
Non-Recurring Maintenance (Base)	$0	$0	$75,000	$0	$0	($75,000)	$0
RETF Obligations Before Prior Year Recoveries [Subtotal]	**$0**	**$0**	**$75,000**	**$0**	**$0**	**($75,000)**	**$0**
Prior Year Recoveries	$0	$0	$0	$0	$0	$0	$0
Obligations After Prior Year Recoveries [Subtotal]	**$0**	**$0**	**$75,000**	**$0**	**$0**	**($75,000)**	**$0**
Discretionary Obligations [Total] (0162)	**$8,709,941**	**$13,532,238**	**$8,971,923**	**$9,159,785**	**$9,647,249**	**$187,862**	**$487,464**

Table: Medical Facilities Mandatory Obligations by Program

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Mandatory Program (0162) - PACT Act, Sec 705							
Engineering & Environmental Management	$10,190	$0	$12,960	$12,960	$9,720	$0	($3,240)
Non-Recurring Maintenance	$35,359	$0	$28,415	$27,648	$7,560	($767)	($20,088)
Obligations PACT Act, sec. 705	$45,549	$0	$41,375	$40,608	$17,280	($767)	($23,328)
Mandatory Program (0162) - PACT Act, Sec 707							
Engineering & Environmental Management	$0	$0	$28,683	$5,642	$0		
Leases	$24,002	$786,724	$154,908	$802,916	$585,902	$648,008	($217,014)
Obligations PACT Act, sec. 707	$24,002	$786,724	$183,591	$808,558	$585,902	$648,008	($217,014)
Mandatory Program (0173MF) - Veterans Medical Care and Health Fund							
Engineering & Environmental Management	$140,876	$0	$0	$0	$0	$0	$0
Engineering Service	$157,571	$0	$0	$0	$0	$0	$0
Ground Maintenance & Fire Protection	$20,758	$0	$0	$0	$0	$0	$0
Leases	$45,320	$0	$0	$0	$0	$0	$0
Non-Recurring Maintenance	$187,747	$0	$0	$0	$0	$0	$0
Operating Equipment Maintenance & Repair	$41,143	$0	$0	$0	$0	$0	$0
Other Facilities Operation Support	($2,396)	$0	$0	$0	$0	$0	$0
Plant Operation	$71,724	$0	$0	$0	$0	$0	$0
Recurring Maintenance & Repair	$78,484	$0	$0	$0	$0	$0	$0
Textile Care Processing & Maintenance	$14,360	$0	$0	$0	$0	$0	$0
Transportation	$16,456	$0	$0	$0	$0	$0	$0
Obligations Before Prior Year Recoveries [Subtotal]	$772,043	$0	$0	$0	$0	$0	$0
Prior Year Recoveries	$43,711	$0	$0	$0	$0	$0	$0
Obligations After Prior Year Recoveries [Subtotal]	$815,754	$0	$0	$0	$0	$0	$0
Mandatory Program (0162) -VACAA Sec. 801							
Engineering & Environmental Management	$334	$539	$7,278	$0	$0	($7,278)	$0
Leases	$0	$3,252	$0	$0	$0	$0	$0
Non-Recurring Maintenance	($59)	$0	$0	$0	$0	$0	$0
Operating Equipment Maintenance & Repair	$4	$0	$0	$0	$0	$0	$0
Other Facilities Operation Support	$143	$0	$3,116	$0	$0	($3,116)	$0
Plant Operation	$16	$0	$0	$0	$0	$0	$0
Recurring Maintenance & Repair	$30	$0	$0	$0	$0	$0	$0
Textile Care Processing & Maintenance	$22	$0	$0	$0	$0	$0	$0
Obligations Before Prior Year Recoveries [Subtotal]	**$490**	**$3,791**	**$10,394**	**$0**	**$0**	**($10,394)**	**$0**
Prior Year Recoveries	$568	$0	$0	$0	$0	$0	$0
Obligations After Prior Year Recoveries [Subtotal]	**$1,058**	**$3,791**	**$10,394**	**$0**	**$0**	**($10,394)**	**$0**
Mandatory Obligations [Total] (0162)	**$886,363**	**$790,515**	**$235,360**	**$849,166**	**$603,182**	**$636,847**	**($240,342)**

Table: Medical Facilities Total Obligations by Program
(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Program:							
Engineering & Environmental Management	$979,704	$1,246,116	$1,134,214	$1,124,049	$1,182,730	($10,165)	$58,681
Engineering Service	$1,323,916	$1,444,823	$1,480,139	$1,444,496	$1,532,780	($35,643)	$88,284
Ground Maintenance & Fire Protection	$153,519	$178,197	$171,802	$175,341	$186,057	$3,539	$10,716
Leases	$1,153,605	$2,305,729	$1,408,903	$2,263,759	$2,185,902	$854,856	($77,857)
Non-Recurring Maintenance 1/	$3,246,798	$5,750,000	$2,028,415	$2,027,648	$2,007,560	($767)	($20,088)
Operating Equipment Maintenance & Repair	$491,004	$503,971	$550,481	$551,727	$585,447	$1,246	$33,720
Other Facilities Operation Support	$38,734	$73,802	$47,445	$50,438	$53,521	$2,993	$3,083
Plant Operation	$1,036,340	$1,274,587	$1,161,171	$1,131,489	$1,200,643	($29,682)	$69,154
Recurring Maintenance & Repair	$634,706	$945,454	$694,325	$682,518	$724,232	($11,807)	$41,714
Textile Care Processing & Maintenance	$237,672	$294,247	$267,007	$300,808	$319,193	$33,801	$18,385
Transportation	$234,669	$305,827	$263,381	$256,678	$272,366	($6,703)	$15,688
Obligations Before Prior Year Recoveries (0162)	$9,530,667	$14,322,753	$9,207,283	$10,008,951	$10,250,431	$801,668	$241,480
Prior Year Recoveries	$65,637	$0	$0	$0	$0	$0	$0
Obligations Total After Prior Year Recoveries (0162)	**$9,596,304**	**$14,322,753**	**$9,207,283**	**$10,008,951**	**$10,250,431**	$801,668	$241,480

[1/] The 2023 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 2025, total obligations are projected to increase by $802 million above the 2024 current estimate in the following areas:

Leases (+$854.9 million). Leases are projected to increase, largely influenced by the major leases authorized by section 702 of the PACT Act.

All Other Increases (+$41.6 million). This amount covers the projected increased cost of textile care processing, Ground Maintenance & Fire Protection, Operating Equipment Maintenance & Repair, and Other Facilities Operation Support.

All Decreases (-$94.8 million). Engineering & Environmental Management, Engineering Service, Non-Recurring Maintenance, Plant Operation, Recurring Maintenance & Repair, and Transportation are projected to decrease.

Summary of the 2026 Advance Appropriation Request

The Medical Facilities discretionary advance appropriations request is $9.7 billion, an increase of $300 million from the 2025 discretionary advance appropriations request. The 2026 request ensures continuity of Veterans' health care services. In 2026, total obligations are projected to increase by $487.5 million from the 2025 revised request level in the following areas:

Leases (-$77.9 million). Leases are projected to decrease largely because of the projected PACT Act Sec. 707 spend plan which decreases from $802.9 million in 2025 to $585.9 million in 2026. Leasing needs will be reassessed as part of the 2026 President's Budget.

Non-Recurring Maintenance (-$20.1 million). NRM is projected to decrease as a result of year-to-year changes in the PACT Act Sec. 705 spend plan while discretionary NRM is expected to remain at the $2.0 billion level. NRM needs will be reassessed as part of the 2026 President's Budget.

All Other Increases (+$339.4 million). This amount covers the projected increased costs for engineering, operations, textile care processing, transportation, maintenance, and repairs.

Medical Facilities Program Funding Requirements

The Medical Facilities appropriation supports the operation and maintenance of VA hospitals, CBOCs, community living centers, domiciliary facilities, Vet Centers, and the health care corporate offices. The appropriation also supports the administrative expenses of planning, designing, and executing construction or renovation projects at these facilities. As of September 30, 2023, VHA operates a portfolio of approximately 5,593 owned buildings with a total of 153.1 million square feet of space on 16,025 acres of land. The portfolio also includes 1,714 leases with a total of 23.1 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.

When VA's discretionary appropriation, mandatory appropriation, and cancellation and transfer requests are combined with available reimbursements and other net unobligated balances, Medical Facilities will meet the projected 2026 obligation level of $10.3 billion, as detailed in the tables below.

The sections that follow detail the operations of each of the account's 11 programs.

Engineering and Environmental Management Services

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations [Subtotal]	**$828,304**	**$1,245,577**	**$1,085,293**	**$1,105,447**	**$1,173,010**	**$20,154**	**$67,563**
PACT Act, sec. 705	$10,190	$0	$12,960	$12,960	$9,720	$0	($3,240)
PACT Act, sec. 707, sec. 702	$0	$0	$0	$0	$0	$0	$0
PACT Act, sec. 707, non sec. 702	$0	$0	$28,683	$5,642	$0	($23,041)	($5,642)
Veterans Medical Care and Health Fund	$140,876	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$334	$539	$7,278	$0	$0	($7,278)	$0
Mandatory Obligations [Subtotal]	**$151,400**	**$539**	**$48,921**	**$18,602**	**$9,720**	**($30,319)**	**($8,882)**
Obligations [Total]	**$979,704**	**$1,246,116**	**$1,134,214**	**$1,124,049**	**$1,182,730**	**($10,165)**	**$58,681**

Engineering and Environmental Management Services are associated with personal services and other costs associated with the oversight and management of engineering activities; fire and safety engineering activities; project engineers, resident engineers, drafters, technicians, construction inspectors and clerical employees and all supplies and materials needed for preparation of specifications and drawings and contractual service cost for recurring projects; fleet, green, and energy managers for related studies and activities.

Engineering Service

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations [Subtotal]	**$1,166,345**	**$1,444,823**	**$1,480,139**	**$1,444,496**	**$1,532,780**	**($35,643)**	**$88,284**
Veterans Medical Care and Health Fund	$157,571	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$157,571**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$1,323,916**	**$1,444,823**	**$1,480,139**	**$1,444,496**	**$1,532,780**	**($35,643)**	**$88,284**

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)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations [Subtotal]	**$132,761**	**$178,197**	**$171,802**	**$175,341**	**$186,057**	**$3,539**	**$10,716**
Veterans Medical Care and Health Fund	$20,758	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$20,758**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$153,519**	**$178,197**	**$171,802**	**$175,341**	**$186,057**	**$3,539**	**$10,716**

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)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations [Subtotal]	**$1,084,283**	**$1,515,753**	**$1,253,995**	**$1,460,843**	**$1,600,000**	**$206,848**	**$139,157**
PACT Act, sec. 707, sec. 702	$24,002	$786,724	$83,591	$790,189	$4,271	$706,598	($785,918)
PACT Act, sec. 707, non sec. 702	$0	$0	$71,317	$12,727	$581,631	($58,590)	$568,904
Veterans Medical Care and Health Fund	$45,320	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$0	$3,252	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$69,322**	**$789,976**	**$154,908**	**$802,916**	**$585,902**	**$648,008**	**($217,014)**
Obligations [Total]	**$1,153,605**	**$2,305,729**	**$1,408,903**	**$2,263,759**	**$2,185,902**	**$854,856**	**($77,857)**

Leases can have many functions, including clinical space for CBOCs; administrative workspace for Veterans' support; research; and warehouses for storage of supplies and equipment, all in direct or indirect support of the operational needs of the local medical center. Leases complement the portfolio of VA-owned medical facilities and provide additional flexibility in providing services to Veterans in the right place and at the right time.

The 2025 request seeks Congressional Committee approval for nine major leases. The new VA's Strategic Capital Investment Planning (SCIP) major lease request consists of four new leases and five replacement leases in 2025. See Volume 4 for additional detail.

VA uses both in-house Lease Contracting Officers and the General Services Administration (GSA) to procure medical facility space and administrative space for VA use. When VA procures the lease, it is through a delegation that is granted on a lease-by-lease basis by GSA. These leases are critical to meeting Veterans' needs by allowing VA to operate clinics or other necessary services close to Veteran populations while maintaining flexibility, so these points of service can be relocated or resized on a regular basis due to shifting demographic trends.

Non-Recurring Maintenance (NRM)

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations - All Other	$2,895,164	$5,750,000	$1,776,831	$2,000,000	$2,000,000	$223,169	$0
P.L. 117-328 § 252 (EO 14507 no-year, 1124) 1/	$0	$0	$75,000	$0	$0	($75,000)	$0
P.L. 117-103 § 253 (Infrastructure no-year)	$20,567	$0	$85,871	$0	$0	($85,871)	$0
P.L. 115-244 § 248 (NRM no-year)	$80,368	$0	$58,366	$0	$0	($58,366)	$0
P.L. 115-141 § 255 (NRM no-year)	$27,652	$0	$3,932	$0	$0	($3,932)	$0
Discretionary Obligations [Subtotal]	**$3,023,751**	**$5,750,000**	**$2,000,000**	**$2,000,000**	**$2,000,000**	**$0**	**$0**
PACT Act, sec. 705	$35,359	$0	$28,415	$27,648	$7,560	($767)	($20,088)
Veterans Medical Care and Health Fund	$187,747	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	($59)	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$223,047**	**$0**	**$28,415**	**$27,648**	**$7,560**	**($767)**	**($20,088)**
Obligations [Total]	**$3,246,798**	**$5,750,000**	**$2,028,415**	**$2,027,648**	**$2,007,560**	**($767)**	**($20,088)**
Non-Add (Included Above):							
Discretionary Obligations - Base NRM	$2,255,411	$5,000,000	$1,500,000	$1,500,000	$1,500,000	$0	$0
Mandatory Obligations - Base NRM	$62,071	$0	$28,415	$27,648	$7,560	($767)	($20,088)
Discretionary Obligations - EHRM NRM	$768,340	$750,000	$500,000	$500,000	$500,000	$0	$0
Mandatory Obligations - EHRM NRM	$160,976	$0	$0	$0	$0	$0	$0
Base NRM/EHRM NRM Obligations [Subtotal]	**$3,246,798**	**$5,750,000**	**$2,028,415**	**$2,027,648**	**$2,007,560**	**($767)**	**($20,088)**

Note: The 2023 NRM actual in the above table includes additional object classes than what is displayed in the Budget Overview chapter's Obligations by Object table, such as Personnel Compensation and benefits, Other Contractual Services, Supplies & Materials and Equipment.

1/ P.L. 117-328, the Consolidated Appropriations Act, 2023 made $75 million in the Recurring Expenses Transformational Fund (RETF) available for NRM.

Non-recurring maintenance program funds additions, alterations and modifications to land, buildings, other structures, nonstructural improvements of land, and fixed equipment (when the equipment is acquired under contract and becomes permanently attached to or part of the building or structure) to maintain and modernize existing campus facilities, buildings and building systems; replace existing building system components; provide for adequate future functional building system capacity without constructing any new building square footage for functional program space; and/or provide for environmental remediation and abatement; and building demolition.

VHA uses the NRM program as its primary means of addressing its most pressing infrastructure needs as identified by Facility Condition Assessments. These assessments are performed at each facility every three years and highlight a building's most pressing and mission-critical repair and maintenance needs. VHA specifically supports research and development infrastructure projects by ensuring that the Office of Research and Development is involved in the identification of gaps to support the SCIP process. This inclusion ensures a research focus for mitigation within a ten-year window of identified research infrastructure deficiencies.

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 $30 million, as adjusted in the *National Defense Authorization Act for Fiscal Year 2024, P.L. 108-136*). 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 2025 and 2026 advance appropriation requests support continued implementation of EHRM with $500 million in each of 2025 and 2026 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. VHA obligated $989 million in EHRM NRM projects in 2023.

The types of "building systems" permitted for NRM infrastructure projects consist of the following: building thermal and moisture protection; doors and windows; interior finishes only directly related with building system work; conveyance and transport systems; fire suppression; plumbing; heating, ventilation and air conditioning; electrical systems; communication systems; safety and security systems; utility systems, boiler plants, chiller plants, water filtration and treatment plants, cogeneration plants, central energy plants, elevator towers, connecting corridors, and stairwells.

Clinical Specific Initiative Projects:

Clinical Specific Initiative (CSI) projects are emergent projects that cannot be planned due to dynamic health care environments. Associated funding for these projects is distributed to the VISNs at the beginning of each year to obligate towards existing clinical building space and address workload gaps, or support access. 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)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations [Subtotal]	**$449,857**	**$503,971**	**$550,481**	**$551,727**	**$585,447**	**$1,246**	**$33,720**
Veterans Medical Care and Health Fund	$41,143	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$4	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	$41,147	$0	$0	$0	$0	$0	$0
Obligations [Total]	**$491,004**	**$503,971**	**$550,481**	**$551,727**	**$585,447**	**$1,246**	**$33,720**

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)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations [Subtotal]	**$40,987**	**$73,802**	**$44,329**	**$50,438**	**$53,521**	**$6,109**	**$3,083**
Veterans Medical Care and Health Fund	($2,396)	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$143	$0	$3,116	$0	$0	($3,116)	$0
Mandatory Obligations [Subtotal]	**($2,253)**	**$0**	**$3,116**	**$0**	**$0**	**($3,116)**	**$0**
Obligations [Total]	**$38,734**	**$73,802**	**$47,445**	**$50,438**	**$53,521**	**$2,993**	**$3,083**

This function includes other costs associated with inpatient and outpatient providers and miscellaneous benefits and services.

Plant Operations

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations [Subtotal]	**$964,600**	**$1,274,587**	**$1,161,171**	**$1,131,489**	**$1,200,643**	**($29,682)**	**$69,154**
Veterans Medical Care and Health Fund	$71,724	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$16	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$71,740**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$1,036,340**	**$1,274,587**	**$1,161,171**	**$1,131,489**	**$1,200,643**	**($29,682)**	**$69,154**

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)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations [Subtotal]	**$556,192**	**$945,454**	**$694,325**	**$682,518**	**$724,232**	**($11,807)**	**$41,714**
Veterans Medical Care and Health Fund	$78,484	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$30	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$78,514**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$634,706**	**$945,454**	**$694,325**	**$682,518**	**$724,232**	**($11,807)**	**$41,714**

Recurring Maintenance and Repair services encompass all projects where the minor improvement is below $25,000, such as maintenance service contracts, routine repair of facilities, and the upkeep of land. Examples include painting interior and exterior walls, the repair of water leaks in pipes and roofs and the replacement of light bulbs, carpet, ceiling, and floor tiles.

Textile Care Processing and Management

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations [Subtotal]	**$223,290**	**$294,247**	**$267,007**	**$300,808**	**$319,193**	**$33,801**	**$18,385**
Veterans Medical Care and Health Fund	$14,360	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$22	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$14,382**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$237,672**	**$294,247**	**$267,007**	**$300,808**	**$319,193**	**$33,801**	**$18,385**

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)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	**2025 Revised Request**	**2026 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Discretionary Obligations [Subtotal]	**$218,213**	**$305,827**	**$263,381**	**$256,678**	**$272,366**	**($6,703)**	**$15,688**
Veterans Medical Care and Health Fund	$16,456	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$16,456**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$234,669**	**$305,827**	**$263,381**	**$256,678**	**$272,366**	**($6,703)**	**$15,688**

Transportation Services include the costs to operate facilities' motor vehicles, including the purchase and operation of VA vans and buses, facility maintenance vehicles, and the clinical motor vehicle pool operations.

Actuarial Model Projections

Models Used to Inform the Budget Request

The Department of Veterans Affairs (VA) uses three actuarial models to support formulation of the majority of the VA health care budget, to conduct strategic and capital planning, and to assess the impact of potential policies and changes in a dynamic health care environment. The three actuarial models are the VA Enrollee Health Care Projection Model (EHCPM), the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) Model, and the Program of Comprehensive Assistance for Family Caregivers (PCAFC) Model.

Activities and programs that are not projected by any of these three models are called "non-modeled" and can change from year to year. In general, they include non-recurring maintenance (NRM), community care network contract administration, state-based long-term services and supports programs (LTSS), readjustment counseling, recently enacted programs, some components of CHAMPVA programs (Camp Lejeune family member program, spina bifida, foreign medical program, children of women Vietnam Veterans), and some components for the PCAFC program (caregiver travel, VA oversight, administrative salaries, and contracts).

VA Enrollee Health Care Projection Model

The VA EHCPM supports approximately 89% 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 2023 EHCPM (Base Year 2022) was used to build the 2025 and 2026 Medical Care budget request. The 2023 EHCPM was updated using workload through FY 2022 to reflect information on the enrollee population and their utilization of VHA health care. In addition, the 2023 EHCPM includes a calibration to available high-level FY 2023 workload and expenditure data. See additional details in the section "Impact of the 2023 EHCPM Update."

The expenditure basis used to build the EHCPM projections includes the Medical Services, Medical Community Care, Medical Support & Compliance, and Medical Facilities appropriations, but excludes non-recurring maintenance. The projections include all care provided in VA facilities (direct care) or paid for by VA (community care).

Key Drivers of Growth in Projected Resource Requirements

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

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

The Sergeant First Class (SFC) Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act became Public Law No 117-168 in August of 2022, expanding benefits for Veterans exposed to certain toxins in the course of their military service, with a focus on Gulf War era Veterans as well as new groups of Vietnam Veterans who were exposed to Agent Orange. The 2023 EHCPM projects enrollment and utilization for Title I, which changes enrollment eligibility timelines, and Titles III and IV, which expand eligibility based on conditions presumed to be associated with hazardous exposures. VA accounted for interaction between Titles I, III, and IV, to remove "double-counting" impacts on the estimates. All other PACT Act-associated costs were evaluated separately.

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 2023 EHCPM incorporated the actual experience and projected impact of the MISSION Act, including changes to eligibility to receive care in the community based on geographic access standards (including grandfathered Veterans Choice and Accountability (Choice) Act of 2014 enrollees), best medical interest provision, wait time standards, and urgent and emergency care benefits.

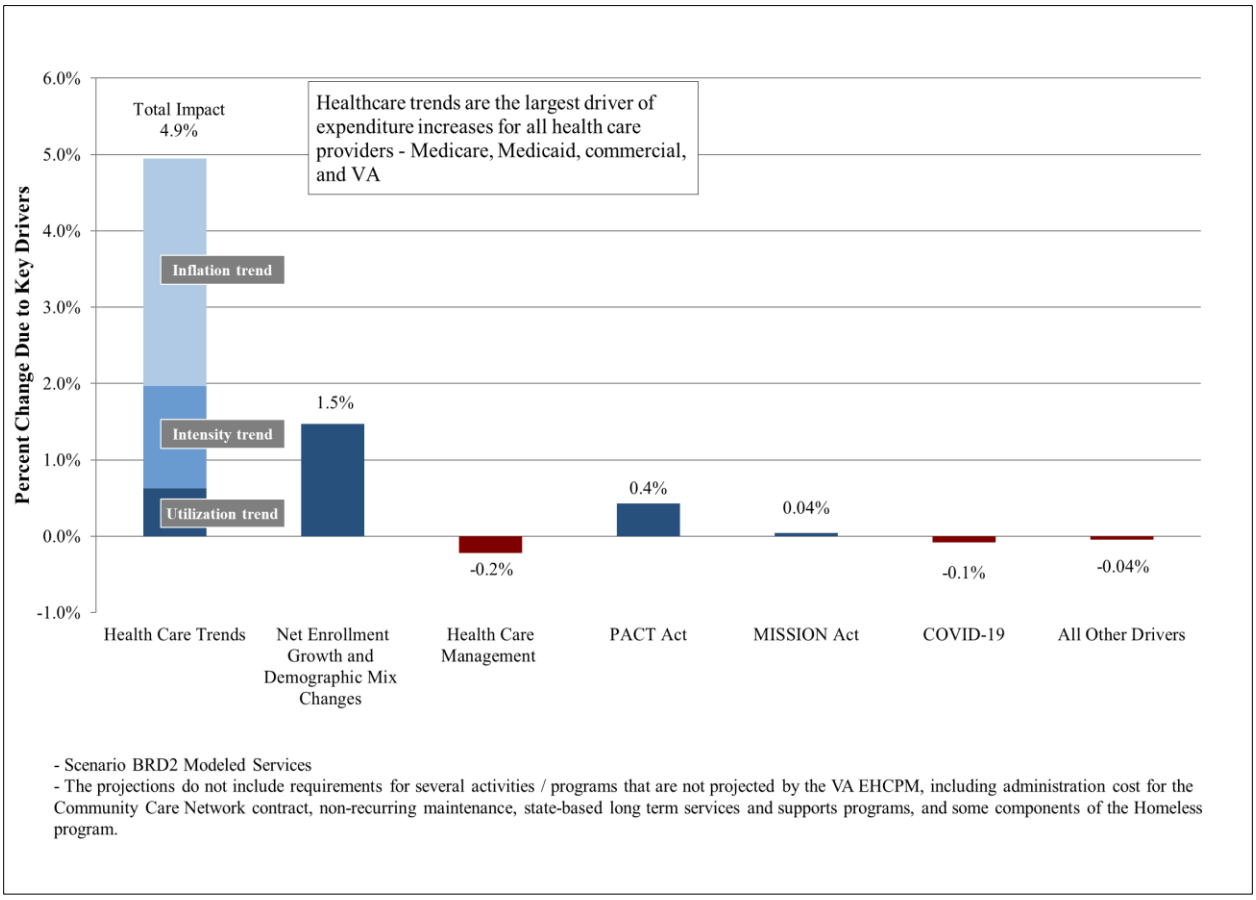
The MISSION Act policies continue to drive increases in services available in both VA facilities and the community, particularly the use of outpatient primary and specialty care and inpatient care. The MISSION growth assumptions were increased and extended in the 2021 EHCPM to reflect higher than anticipated growth in community care workload in 2020-2022 and continue to remain elevated in the 2023 EHCPM. However, is assumed that growth will slow as the impact of MISSION is saturated within the eligible enrollee population.

The COVID-19 pandemic continued to have a significant impact on VA health care in 2022, though in many areas the effects of the pandemic have largely subsided. For enrollment, by the end of FY 2022 new enrollment rates had largely recovered from the decline that followed the initial onset of the pandemic. Also, in many service areas, including ambulatory and acute inpatient care, enrollee health care utilization had returned to pre-pandemic expected levels (or close to it), or settled at a "new normal" that reflects a longer-term shift in health care utilization. For other service areas, particularly mental health care, LTSS, and inpatient rehabilitation care, the effects of COVID-19 deferred care remain and it is expected that there will be continued recovery of health care utilization in FY 2023 and beyond.

VHA staffing levels increased throughout the COVID-19 pandemic. The higher staffing levels, combined with reduced direct care workload led to a significant increase in direct care unit costs over the course of the pandemic. This trend persisted into FY 2022. VHA modeled a decrease in projected staffing levels for FY 2025 and FY 2026 to reflect VHA's response to that trend. These changes are assumed to be independent of total enrollee reliance on VA, so that projected decreases in VHA capacity are modeled with a complementary increase in community care utilization, although the overall year-over-year increase in community care is slowing. Only inpatient and ambulatory services available in both VA direct and community care settings are impacted by these FTE changes.

Figure A quantifies the key drivers of the projected increase in expenditure requirements for 2025 for all modeled services. Health care trends, net enrollment growth and demographic mix changes, and health care management and their impact on the resources required to provide health care to enrolled Veterans are discussed in detail in the following sections. MISSION Act, COVID-19 and PACT Act are discussed throughout the chapter.

Figure A. Key Drivers of Projected Expenditure Change, 2024 – 2025



Health Care Trends

Health care trends represent a significant driver of growth in the cost of health care in the United States and in the VA health care system. Health care trends (inflation, utilization, and intensity) represent anticipated changes in health care utilization and cost due to advances in technology, including new diagnostics, drugs, and treatments, as well as price inflation. Health care trends increase VA's projected expenditure requirements independent of any enrollment growth or demographic mix changes. The health care trends incorporated into the EHCPM are informed by federal policy and anticipated trends in Medicare, together with VA-specific trends for pharmacy and prosthetics, and private sector trends for community care.

Inflation is comprised of personnel and non-personnel components. Inflation on VA's personnel costs is determined by federal wage policy, including wage increases and freezes. VA's projected inflation for pharmacy and prosthetics products reflects VA's well managed purchasing programs for these products. VA's expected inflation on supplies, utilities, etc., is based on projected Consumer Price Index - Urban (CPI-U) and Producer Price Index (PPI) inflation trends for these items.

Utilization and intensity (cost) trends increase health care costs due to changes in health care practice and new technology. VA's costs are driven by these trends similar to other health care insurers and providers because Veterans expect access to these advances in the VA health care system. Utilization trends reflect expected changes in utilization of services due to changes in health care practice, such as updates to the clinical guidelines for preventive screenings. Intensity trends reflect changes in costs for services as technology advances; for example, the newer high-cost PCSK9 inhibitor drugs offer an alternative cholesterol management option for patients who do not respond well to less expensive conventional statin treatments, which increases VA's prescription drug costs.

VA's utilization and intensity trends for Medicare-covered medical services are informed by anticipated Medicare utilization and intensity trends, as projected by the Center for Medicare & Medicaid Services' Office of the Actuary. They have been adjusted downward for efficiencies in the VA health care system as compared to Medicare's primarily fee-for-service environment. VA's pharmacy and prosthetics trends are set by VA workgroups to reflect VA's unique practice patterns for these services.

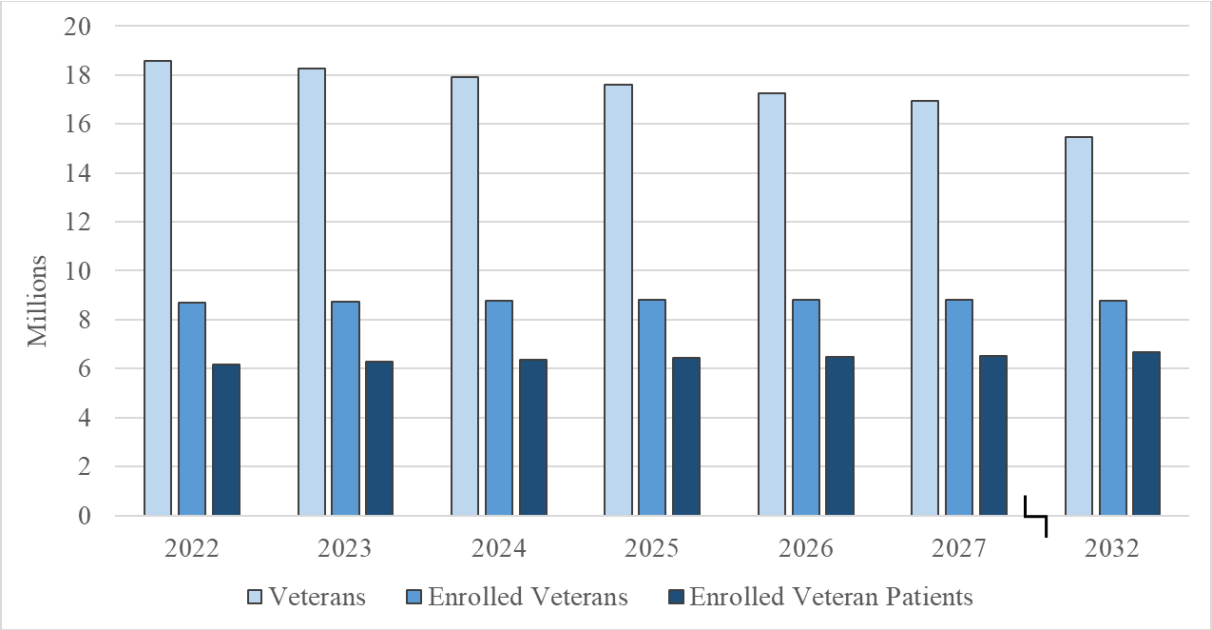
Net Enrollment Growth and Demographic Mix Changes

Veteran demand for VA health care is influenced by the following demographic characteristics of the Veteran population and environmental factors. Many of these factors are dynamic and are expected to change over time. Some can be anticipated (e.g., changing demographics) and some cannot (e.g., future economic downturns, pandemics, future military conflicts).

- Growth of the Post-9/11 Era Combat Veteran and female enrolled population.
- Enrollee age, gender, mortality, income, travel distance to VA facilities, and geographic migration patterns.
- Increases in prevalence of service-connected conditions and changes in enrollee income levels. These are associated with transitions between enrollment priorities.
- Health care utilization patterns of Post-9/11 Era Combat Veteran, female, disabled, new enrollees, and other enrollee cohorts with unique utilization patterns for particular services.
- Economic conditions, including changes in local unemployment rates and home values (as a proxy for asset values) over time.
- Policies, presidential executive orders, regulations, and new legislation, such as the elimination of net worth from the VA Means Test, automatic income verification through tax records, expanding eligibility with the PACT Act, and MISSION Act.

Using current assumptions, the 2023 EHCPM has projected Veteran enrollment in VHA to increase slightly from 2022 to 2027 and then slightly decline. The overall Veteran population is expected to decrease over time (Figure B).

Figure B. National Veterans, Enrollees, and Patients, 2022-2032



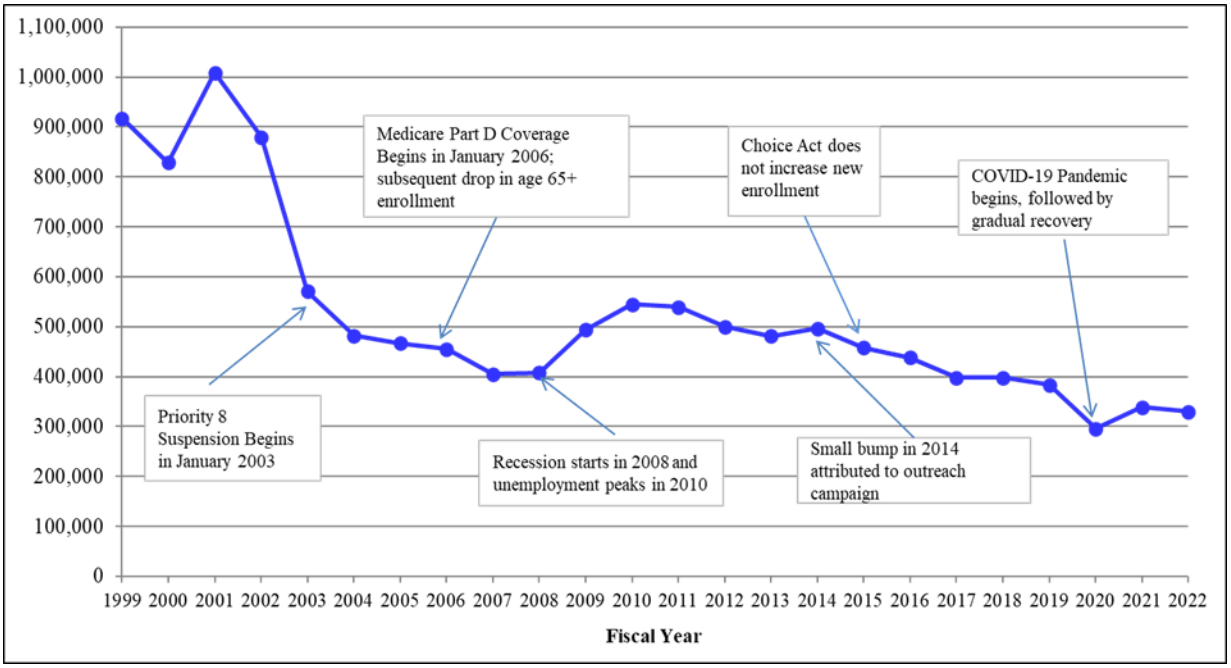
High enrollment rates for Post-9/11 Era Combat Veterans and Gulf War Veterans and expanded eligibility under the PACT Act are causing projected enrollment patterns to differ from the continuous decrease in the overall Veteran population. Enrollment is projected to increase in the short-term while new enrollment is expected to outpace mortality. After FY 2027, 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, the new enrollment declined between 2015 and 2017. Thus, even in the Veterans Choice Act environment, greater than expected new enrollment was not the driver of thegrowth in enrollee use of VA health care. This growth was the result of current enrollees increasingtheir reliance on VA versus their other health care options (Medicare, Medicaid, commercial insurance, etc.). See the section on Enrollee Reliance in this chapter for details.

The rate of new enrollment decreased significantly during the initial response to COVID-19 in 2020 and remained suppressed to varying degrees through 2021. By the end of FY 2022, rates of new enrollment among Veterans under age 65 had recovered to and surpassed pre-COVID levels, indicating a return to normal and potentially a fulfillment of previously pent-up demand. For Veterans age 65+, however, the rates continue to be suppressed while gradually approaching pre-COVID levels. Annual new enrollment rates are projected to increase further beginning in FY 2023 due to PACT Act.

Figure C. New Enrollment Over Time

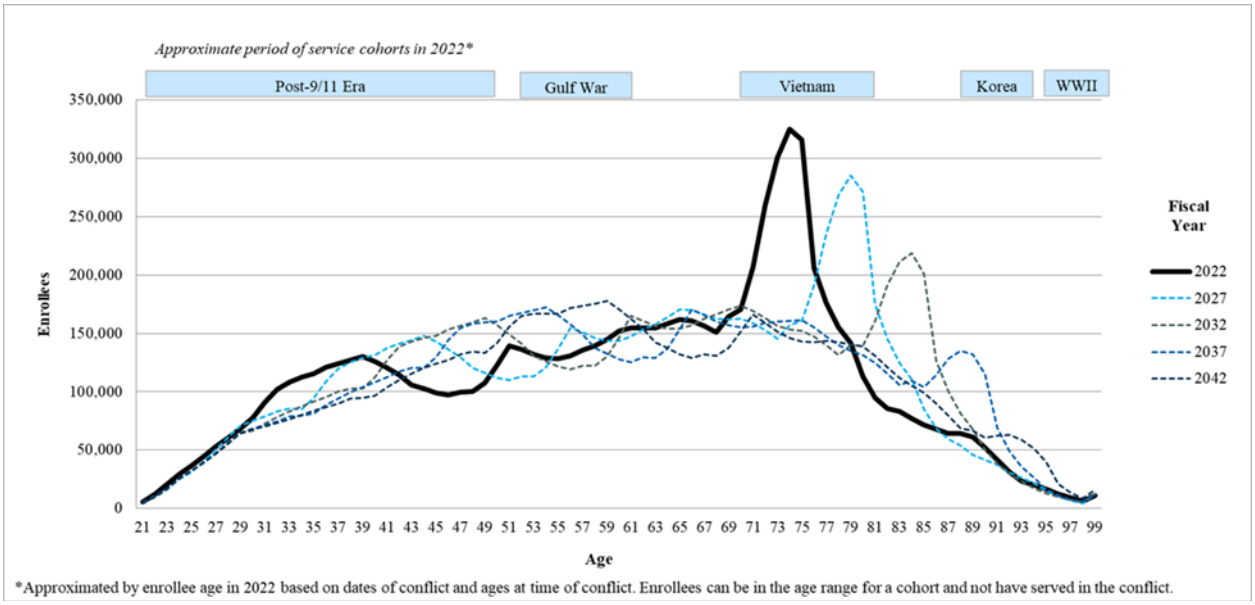


Net enrollment growth (new enrollment minus deaths) is not a significant driver of increases in annual expenditure requirements for most VA health care services. Enrollees who are dying are generally sicker and need more VA health care than new enrollees, so even modest increases in the number of enrollees can end up being budget neutral over the near term. However, the cost of caring for enrollees can change due to other demographic factors (e.g., priority transitions) and changes in the broader environment (e.g., economic recession).

Within the enrollee population, two dynamic demographic trends are impacting the projected future cost of VA health care more than other demographic factors: the aging of the Vietnam Era enrollee population and the increasing number of enrollees being adjudicated for service-connected disabilities, which increases the number of enrollees in Priorities 1, 2, and 3. These demographic trends combine in the Vietnam Era enrollee population with particular implications for demand for LTSS.

Figure D shows actual enrollment in 2022 and projected enrollment by age and highlights the relative size of the Vietnam Era enrollee cohort compared to other period-of-service cohorts.

Figure D. Enrollment by Age

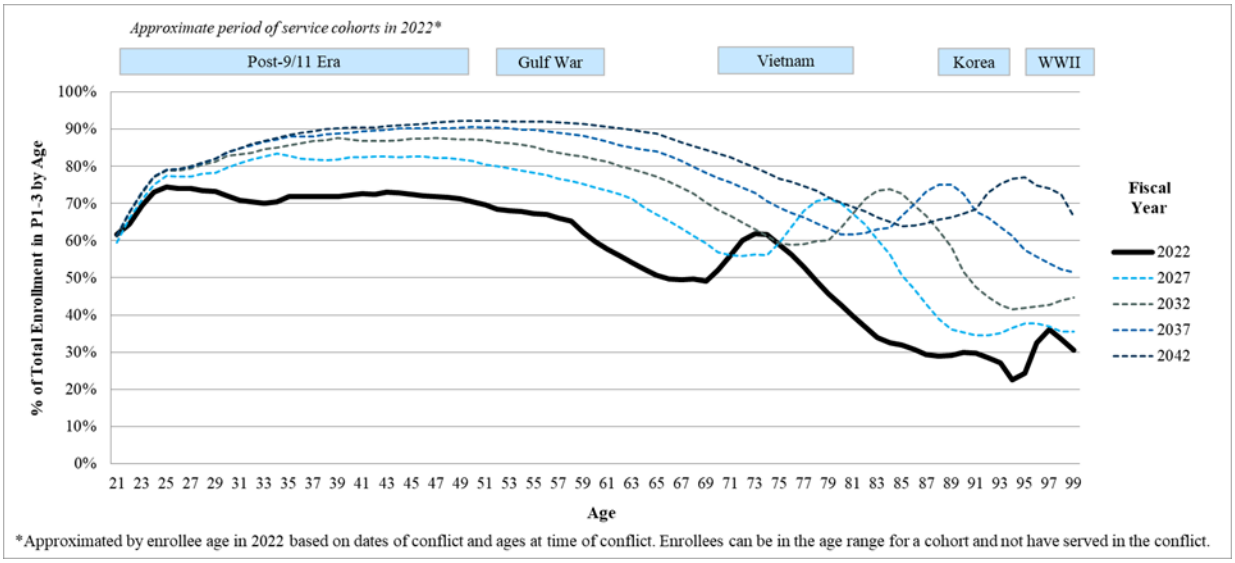


Aging has less of an impact on expenditures than might be expected because reliance on VA for health care decreases beginning at age 65 as enrollees become eligible for Medicare coverage (see section on Enrollee Reliance below). Although the large Vietnam Era enrollee cohort that has mostly become Medicare eligible magnifies this effect, enrollees who have become Medicare eligible more recently have shown a slightly lower decline in reliance than older enrollees. Aging is driving growth in LTSS, and other services generally not covered by private insurance or Medicare (e.g., hearing aids).

Veterans are enrolled in one of eight priority groups and/or sub-priority groups. The highest priority is Priority Group 1 and the lowest is Priority Group 8. See the "Veterans Enrollment Priority Group Definitions" section of the Budget Overview Chapter for more information. An enrollee's enrollment priority is dynamic. In recent experience, approximately 28% of new enrollees transitioned to a new priority level within three years of enrolling. Enrollees transition between Priorities 5, 7, and 8 due to changes in income. Enrollees also transition into Priorities 1,2, and 3 as a result of adjudication for service-connected disabilities by the Veterans Benefits Administration (VBA). The number of enrollees being adjudicated for service-connected disabilities has escalated in recent years. This is largely a result of the scope and definitions of service-connected conditions broadening over time and the improved capture of service-connected conditions at the time of military separation. These enrollees are expected to increase their reliance on VA health care, resulting in an increase in VA medical care costs.

Figure E shows the significant projected growth in service-connected status for Post-9/11 Era Combat Veteran, Gulf War, and Vietnam enrollee populations over the next 20 years. As a result of the increasing numbers of enrollees moving into Priorities 1-3, projected enrollment is declining in Priorities 5, 7, and 8.

Figure E. Percent of Enrollees in Priority 1-3, by Age



As a result of the previously mentioned trend of enrollees being adjudicated to higher service-connected priorities, as of 2022, 7% of enrollees had transitioned into Priority 1a (70% or higher service-connected disability) over the previous three years, compared with 4% as of 2012. The Priority 1a population is projected to continue to grow by 24% between 2022 and 2025 and by 61% between 2022 and 2032.

Aging and the changes in the Priority 1a population are significant drivers of projected expenditure increases for LTSS. VA is mandated by law to provide continuing care nursing home services to Priority 1a enrollees. Additionally, World War II and Korean War era enrollees are in the age bands (greater than age 85) that are the highest users of LTSS and are driving the recent and near-term annual growth in LTSS expenditure requirements, and Vietnam Era Veterans will be an increasing driver of LTSS expenditures, with most having aged beyond age 75 by 2027.

Enrollee Morbidity

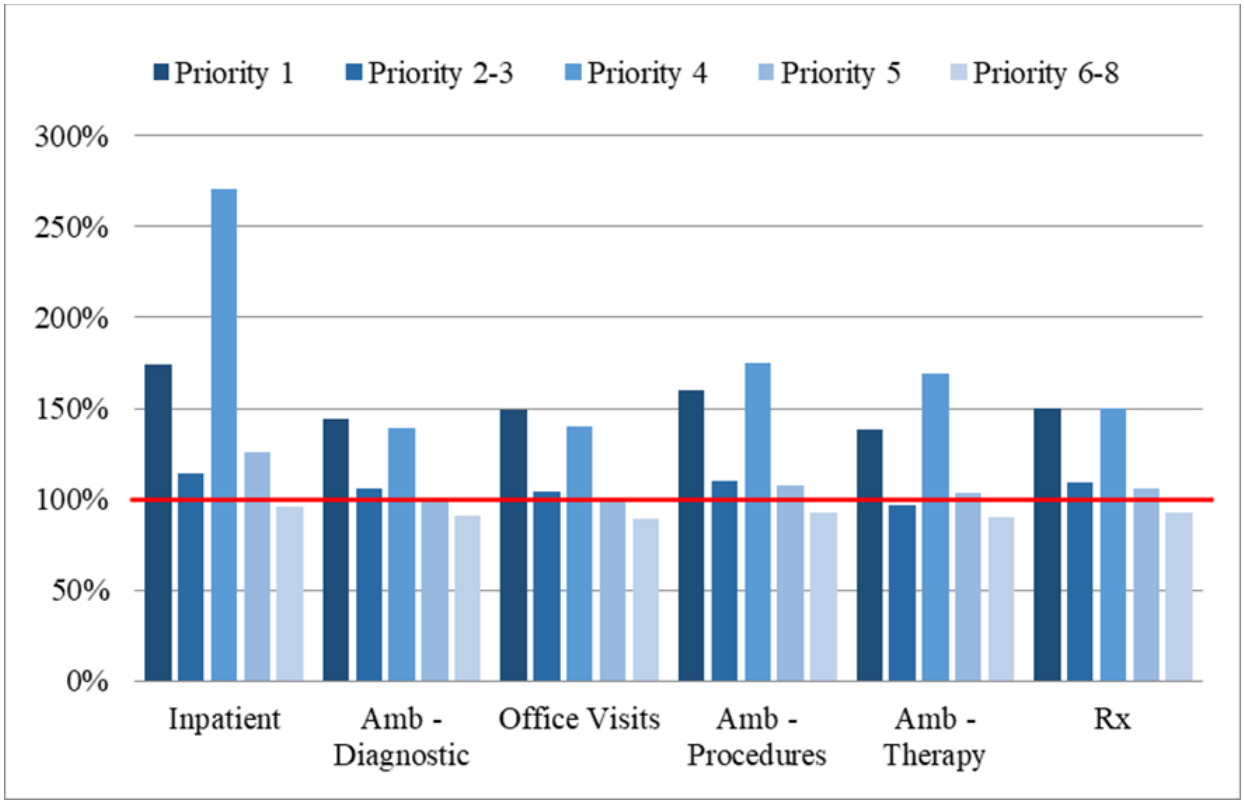
The VA enrollee population consists largely of older males, which is typically the segment of the population with the highest health care costs. Even after accounting for the age and gender mix ofthe enrollee population, the VA enrollee population is significantly more morbid (sicker) than thegeneral population in the U.S., and this higher morbidity further increases VA's cost of providingcare.

Using a diagnosis-based methodology, the average morbidity of the VA enrollee population is estimated to be approximately 28% higher than that of the general U.S. population. This analysis is corroborated by the 2022 VA Survey of Veteran Enrollees' Health and Use of Health Care which shows that 26% of enrollees rated their health as "fair" or "poor" compared to other people their age. Only 14.5% of the U.S. adult population responded similarly in Centers for Disease Control's (CDC) National Center for Health Statistics' 2022 National Health Interview Survey.

Similarly, 36% of enrollees rated their health as "excellent" or "very good" compared to approximately 56% of the U.S. population in the CDC survey.

Morbidity varies significantly by priority level and health care service. For example, the morbidity of Priority 4 (catastrophically disabled) enrollees results in inpatient care costs that are nearly three times that of the general U.S. population, even after accounting for the age and gender differences in the populations. Figure F shows the relative morbidity of enrollees by priority compared to the general population for several large categories of health care services. In the figure, 100% reflects the cost of health care based on the morbidity of the general U.S. population.

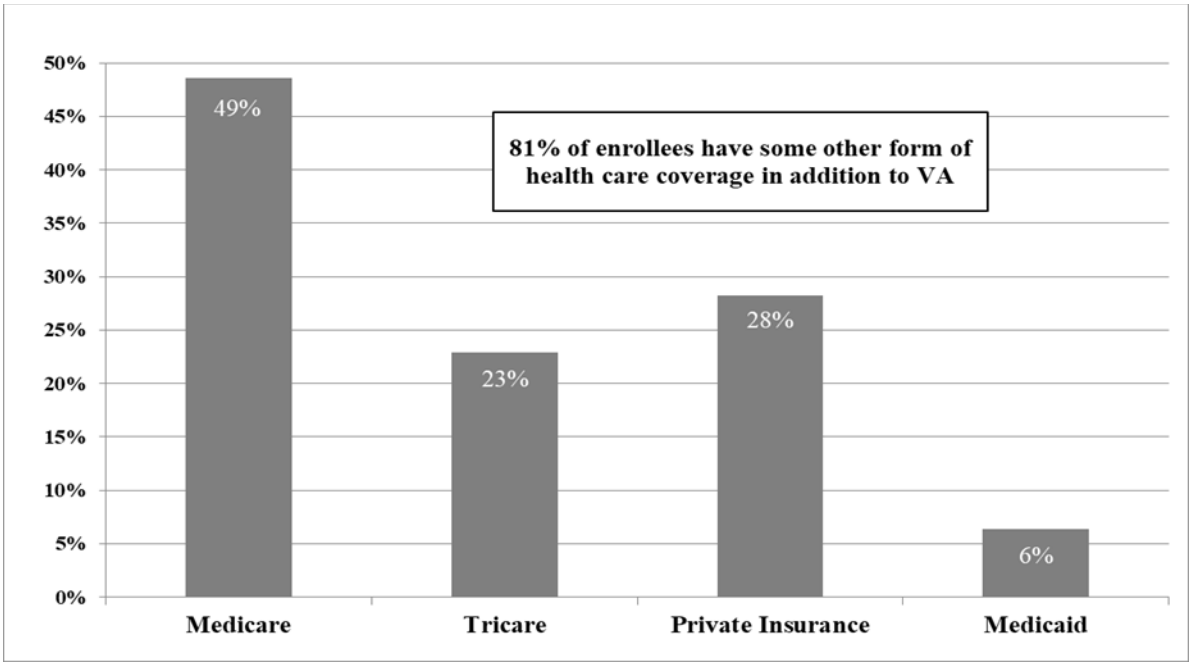
Figure F. Relative Morbidity of Veteran Enrollees vs. General Population



Enrollee Reliance on VA Health Care

Reliance refers to the portion of an enrollee's total health care needs that VA will provide either at VA facilities or purchase in the community. A unique aspect of the enrolled Veteran population is that enrollees have many options for health care coverage in addition to VA: Medicare, Medicaid, TRICARE, Indian Health Service, and private insurance. According to the VHA Survey of Enrollees, in 2022 approximately 81% of enrollees had one or more other sources of public or private health care coverage in addition to VA (Figure G). Enrollees with multiple sources of other health insurance are included in multiple categories in Figure G below.

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 40% of their health care needs (excluding LTSS). This represented $102 billion in 2022. If the Veterans enrolled in 2022 had chosen to receive all of their health care in VA (100% reliance), this would have required an additional $148 billion for a total of $250 billion in 2022.

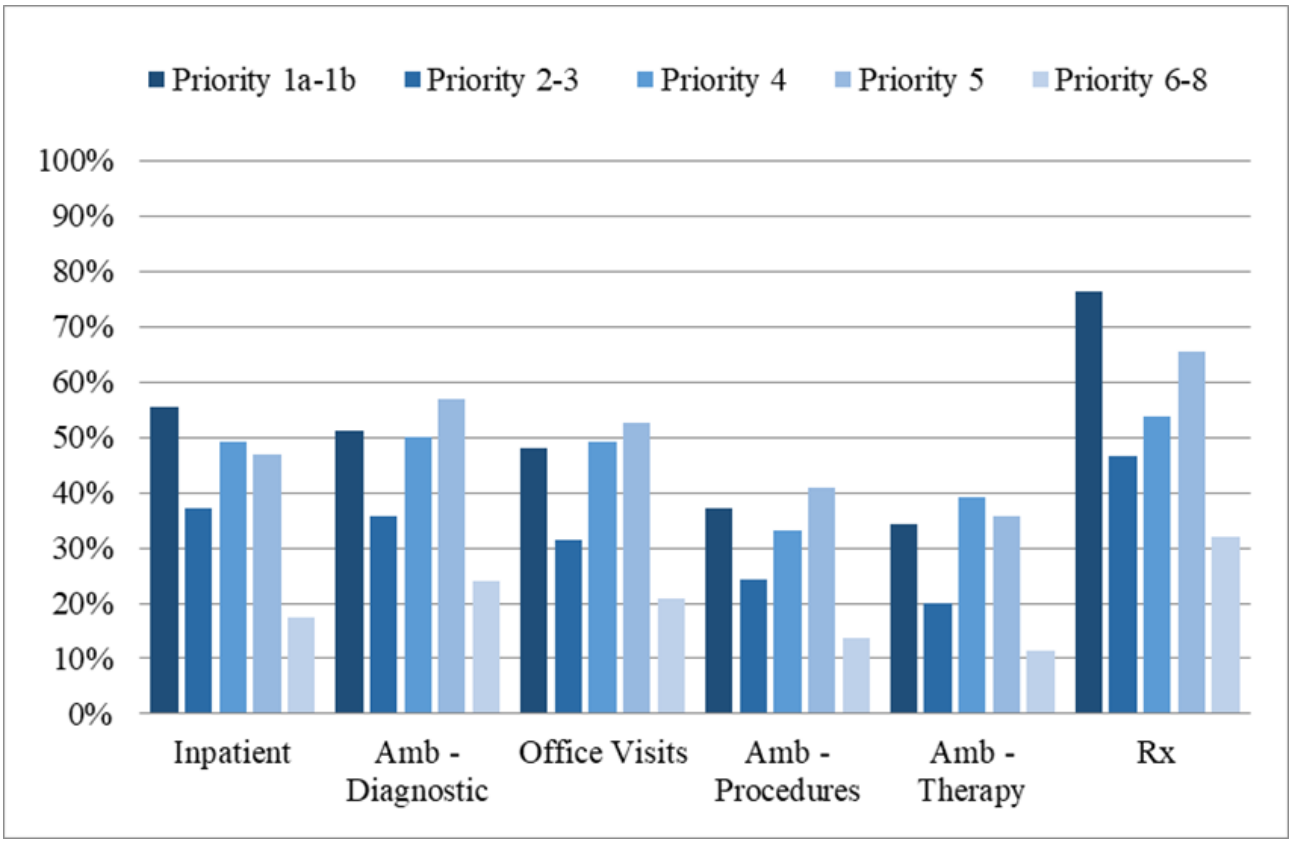
Like Veteran enrollment and demographics, enrollee reliance on VA health care is dynamic. Changes in enrollee reliance occur as a result of many factors: enrollee movement into service-connected priorities; changing economic conditions; VA's efforts to provide Veterans access to the services they need (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

onVA health care. VA expects this impact to continue as enrollees continue to get more of their carethrough VA versus their other health care options. Additionally, enrollees have exhibited a "generational shift" in their reliance on VA, slowly increasing reliance on VA over time for both VA direct care and community care. For example, enrollees aged 65-69 in 2022 had, on average, higher reliance than enrollees aged 65-69 in 2018. Similar community care growth is attributed to the generational shift as well. VA expects this impact to continue as younger (and more reliant) enrollees age and older (and less reliant) enrollees leave VA.

Figure H shows reliance by priority for several large categories of health care services. For example, Priority 4 enrollees get approximately 49% of the inpatient care they need in VA.

Figure H. Reliance of Veteran Enrollees



Enrollee Cohorts

Within the enrollee population, several cohorts of enrollees exhibit unique health care utilization patterns that reflect their morbidity and/or reliance on VA health care. These include Post-9/11 Era Combat Veteran, enrollees Pre, post-Vietnam Era, Vietnam Era, World War II Era, and female enrollees.

- Post-9/11 Era Combat Veteran enrollees have different utilization rates than non-Post-9/11 Era Combat Veteran enrollees of the same age for many services. For some services, the

difference is attributable to the higher utilization rates typically experienced by new enrollees, and therefore, is not expected to persist over time. Post-9/11 Era Combat Veterans represented 23% of the enrollee population in 2022 and are expected to grow to 29% in 2032.

- 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 12% of enrollees in 2022 but accounted for 25% 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 7% of the population by 2032, but still account for 15% of expenditures.
- Enrollees who served immediately after Vietnam have the highest health care utilization relative to other enrollees when they were at the same age. These enrollees exhibit higher than expected needs for many mental health and substance abuse services. This cohort represents about 18% of the enrollee population in 2022.
- Younger Vietnam Era enrollees represent a cohort that has largely aged into Medicare eligibility with a corresponding drop in reliance on VA health care. As they age and transition into Priority 1a, Vietnam Era enrollees are expected to be significant users of LTSS. Vietnam Era enrollees represent 29% of the enrollee population in 2022.
- World War II Era enrollees are high utilizers of LTSS, since those services are typically provided to older enrollees. This cohort represents about 1% of overall enrollment in 2022.
- Women are one of the fastest growing enrollee cohorts. Women comprised 10% of the enrollee population in 2022 and are expected to grow to 14% by 2032. Women tend to use more health care than men at younger ages and fewer services than men at older ages. Female enrollees also use a different mix of services than the historically male-dominated enrollee population. For example, women are more likely to use physical therapy and preventive services, but less likely to use dermatological services.

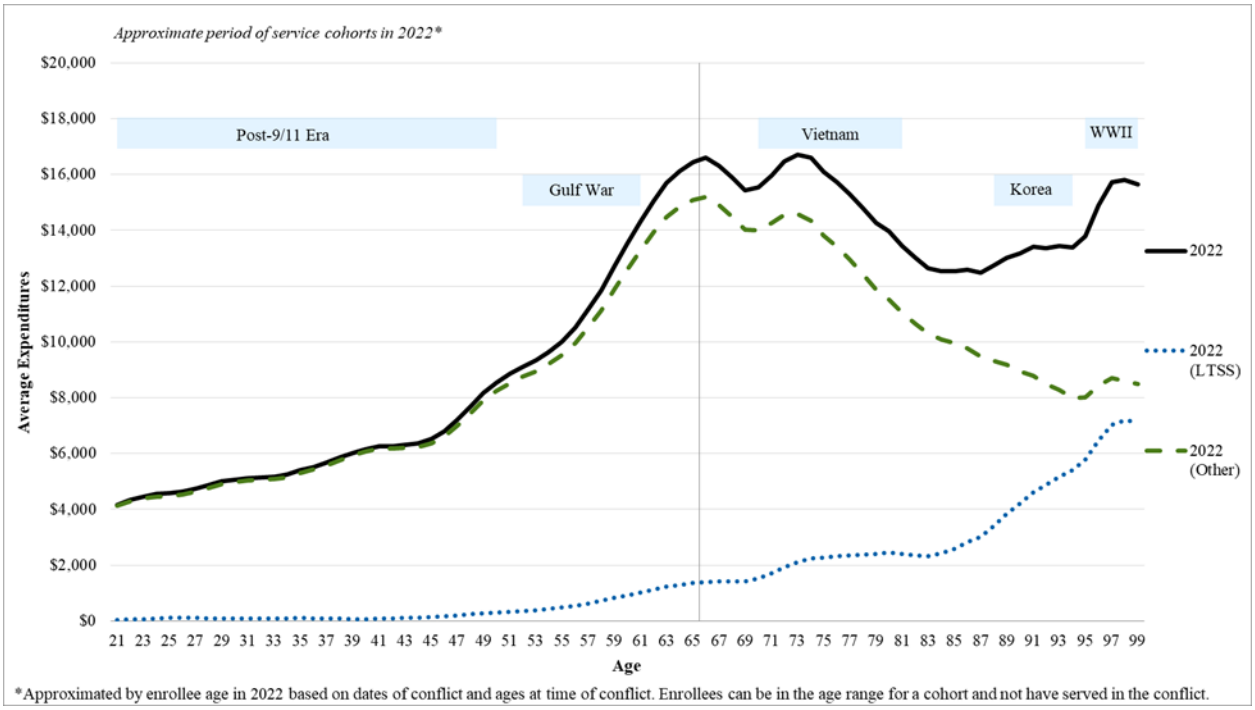
Expenditure Requirements by Enrollee Age

As discussed, many demographic and environmental factors influence Veteran demand for VA health care and the resources required to provide that care. Some of these factors increase VA's resource requirements and some decrease VA's resource requirements. Figure I shows the net impact of all the factors on expenditures.

In Figure I, the actual 2022 expenditures by age highlight the impact of key factors influencing the cost per enrollee. For the under age 65 enrollee population, the figure shows the impact of the increase in the need for health care services as enrollees age. It also highlights how the impact of aging is mitigated by a decline in reliance on VA health care beginning at age 65 when enrollees typically become eligible for Medicare. Enrollees who have become Medicare eligible more recently have shown a slightly lower decline in reliance than older enrollees. Expenditures per enrollee increase again beginning at age 70, attributed to the higher proportion of Priority 1

enrollees among the Vietnam era period of service. The impact of providing LTSS to enrollees (services that are generally not covered by Medicare) on expenditures by age is also illustrated.

Figure I. Average Expenditures per Enrollee by Age



Health Care Management and Dynamics of the VA Health Care System

The VA health care system is continually evolving due to VA's efforts to enhance its practice of health care, provide Veterans access to the services they need, and improve its level of health care management.

The EHCPM includes assumptions for initiatives to increase capacity for mental health, homeless services, and LTSS. These initiatives are discussed in the service-specific sections.

The EHCPM also includes assumptions that VA's level of management in providing health care will improve over time and reduce the cost of providing care to enrollees. The majority of these efficiencies result from improvements in VA's level of management in inpatient care. The future improvements are expected to result from a wide range of activities that collectively improve VA's level of management, including:

- Improved coordination of care as a result of Patient Aligned Care Teams (PACT), expansion of home telehealth services, and other disease management activities that result in reductions in hospitalizations for ambulatory care sensitive conditions.
- A focus on creating alternative services, such as intensive outpatient mental health programs, support services, and alternative locations of care.

- VHA's well-established inpatient system redesign initiative
- Admission appropriateness and continued stay reviews through the National Utilization Management Initiative

Assumptions for improvement in VA's level of health care management may increase or decrease ambulatory utilization projections depending on the service. Generally, well-managed organizations provide more preventative services and fewer diagnostic services. Improvements in management may also reduce the projected growth in utilization for inpatient acute bed days and admissions.

Expenditure Requirements by Service Category

The following sections discuss the key drivers of increases in expenditure requirements for categories 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, 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 2025 and 2026. 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.

Modeled Ambulatory Primary and Specialty Care

Diagnostics

- Cardiovascular
- Colonoscopy
- Dermatology Services and Diagnostic Exams
- Hearing and Speech Exams
- Miscellaneous Medical Services and Diagnostics
- Non-Invasive Vascular Studies
- Ophthalmology Services and Diagnostic Exams
- Pathology
- Pulmonology Services, Diagnostic Exams, and Ventilator Management
- Radiology – CT
- Radiology – General
- Radiology – MRI
- Radiology – Mammography Diagnostic
- Radiology – Mammography Screening
- Radiology – Nuclear Medicine
- Radiology – PET and PET/CT
- Radiology – Radiation Oncology
- Radiology – Ultrasound
- Vision Exams

Evaluation and Management Services

- Office Visits, including Physical Exams, Urgent Care Visits, and Telephone Care Visits
- Compensation & Pension Exams (only those provided in VA facilities)
- Outpatient Medication Therapy Management
- Case Management – Rehabilitation

Professional Services and Procedures

- Ambulance
- Ambulatory Surgery - Ambulatory Surgery Center Setting
- Ambulatory Surgery - Office Setting
- Ambulatory Surgery - Outpatient Setting
- Emergency Room Visits
- Eye Glasses Services
- Hearing Aid Services
- Prosthetics and Orthotics Services
- Maternity
- Nutritional Counseling
- Observation Care

The PACT Act is driving increases in annual expenditures for all ambulatory services.

Changes in enrollee reliance are increasing VA'sexpenditure requirements for providing dialysis services. Enrollee reliance on VA for dialysis and related services increased from 32% in 2013 to an estimated 49% in 2022 and is expected to continue to increase through 2030. 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)

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
- Over-the-Counter Medication
- Prescription Related Supplies

Expenditures required to provide pharmacy services to enrolled Veterans are expected to increase significantly in 2025 and 2026, driven primarily by health care trends, especially inflation, and the impact of priority transitions and aging. VA's well-managed pharmacy benefit management program and contracting practices do moderate inflation's impact, but price increases are still contributing substantially to VA's cost of providing prescription drugs. The prescription drug pipeline is monitored regularly, and potential impacts of emerging treatments are assessed in collaboration with the VA Pharmacy Benefits Management (PBM) Services. This information is considered when setting the trend assumptions for prescription drugs.

Inpatient Acute Care

Inpatient projections are developed for acute beddays 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.

Expenditures required to provide inpatient acute services to enrolled Veterans are expected to grow in both 2025 and 2026. 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 reducinginpatient 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

Inpatient Acute
- Medical
- Surgical
- Maternity Deliveries
- Maternity Non-Deliveries

Inpatient Encounters

- Cardiovascular
- Case Management - Rehabilitation Therapists
- Colonoscopy
- Dermatology Services and Diagnostic Exams
- Dialysis and Related Services
- Emergency and Observation – Facility Component
- Emergency and Observation – Professional Component
- Eye Glasses Services
- Hearing Aid Services
- Hearing and Speech Exams
- Inpatient Evaluation & Management (E&M) Services - Non- Mental Health
- Maternity
- Medication Therapy Management
- Miscellaneous Medical Services and Diagnostics
- Nephrology – End Stage Renal Disease Services
- Non-Invasive Vascular Studies
- Nutritional Counseling
- Office Administered Drugs
- Ophthalmology Services and Diagnostic Exams
- Pathology
- Prosthetic and Orthotic Services
- PT/OT/SLP
- Pulmonology Svcs, Diag Exams, Ventilator Mgmt
- Radiology – CT
- Radiology – General
- Radiology – MRI
- Radiology – Mammography (All)
- Radiology – Nuclear Medicine
- Radiology – PET and PET/CT
- Radiology – Radiation Oncology
- Radiology – Ultrasound
- Recreational Therapy
- Surgical Procedures
- Vision Exams

VA's cost of providing inpatient maternity care is increasing due to high-cost trend for maternity services in the private sector (most maternity care is purchased).

Mental Health Care

Mental health projections are developed for a continuum of mental health services, including general outpatient mental health, evidence-based psychotherapies, intensive outpatient programs, residential rehabilitation treatment, and inpatient mental health care (the cost of mental health inpatient encounters includes diagnostics, therapies, professional services, and procedures provided in the inpatient environment). These services treat a variety of common mental healthconditions as well as conditions requiring more specialized and/or intensive interventions including the most severe and persisting mental health conditions.

Expenditures required to provide mental health services to enrolled Veterans are expected to grow in both 2025 and 2026. The projected increase in expenditures is due to the impact of health care trends, primarily inflation, on the costper service, and VA's initiatives to expand access to mental health care through increased substance use disorder staffing. The growth in expenditure requirements slows after 2024 as the impact of the access initiatives are expected to be limited and utilization changes are primarily based on the demographics of the enrollee population.

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.

For example, Intensive Community Mental Health Recovery Services (ICMHR) is projected to grow 73% through 2025 due to increases in the delivery of telehealth services. Also recognizing the need for additional care to treat increasing nationwide substance use disorders, including care to combat the opioid crisis, the 2023 EHCPM includes one year of positive trend in utilization (included as utilization trend, not specifically a program

Modeled Mental Health Care

Mental Health Inpatient

- Inpatient Acute Mental Health
- Inpatient Acute Mental Health and Substance Use Disorder Extended Stays
- Inpatient Acute Substance Use Disorder
- Inpatient Mental Health Residential Rehabilitation
- Inpatient Compensated Work Therapy/Transitional Residence (CWT/TR)
- Inpatient Sustained Treatment and Rehabilitation (STAR)

Mental Health Inpatient Professional Services

- Mental Health
- Mental Health Inpatient E&M Services
- Psychotherapy
- Substance Use Disorder
- Psychosocial Rehabilitation and Recovery Centers
- Intensive Community Mental Health Recovery Services
- Work Therapy
- Mental Health Residential Rehabilitation Treatment Program Inpatient Encounters
- Homeless

Mental Health Outpatient

- Outpatient Mental Health
- Psychotherapy
- Outpatient Substance Use Disorder
- Mental Health Office Visits
- Psychosocial Rehabilitation and Recovery Centers
- Intensive Community Mental Health Recovery Services (ICMHR)
- Work Therapy
- Mental Health Residential Rehabilitation Treatment Program Outpatient and Residential Stay
- Homeless
- Telephone E&M Services – Mental Health

change). The overall effect is a 5% increase in acute inpatient care for substance use disorders by 2025. 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 2022 to 2025) and their high proportion of service-connected status (almost 83% of these enrollees are projected to be in service-connected Priorities 1-3 by 2025) are driving increases in utilization for this population. From 2022 to 2025, the utilization of Mental Health services by this populationis expected to increase by 47% for inpatient services and increase by 35% for ambulatory. This growth varies by service.

- In addition, post-Vietnam Era enrollees use a significant amount of inpatient mental health and substance abuse services.

However, the aging of the non-Post-9/11 Era Combat Veteran enrollee population is mitigating the projected growth in utilization of mental health services because use of mental health services declines at older ages. For example, utilization of many mental health services peaks around 60 then drops off dramatically by age 65.

Rehabilitative Care

Projections are developed for two special rehabilitative care inpatient services provided 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 2025 and 2026. 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.

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)

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, eg basic medical supplies cost very little while sophisticated implant and artificial limbs are much more expensive.

The requirements to provide prosthetic services to enrolled Veterans are expected to grow in both 2025 and 2026. The projected increase in expenditures is primarily due to health care trends.

The cost of prosthetic devices generally grows each year due to inflation and changes in health care practice. Extensive development and use of national committed-use contracts, as well as regional and local contracts, are expected to mitigate the expected inflation trends for prosthetics to some extent. These contracts provide quality assurance through active participation of clinicians and subject matter experts in developing requirements of the devices and the ability to obtain the best value for VA. As discussed in the Impact of 2023 EHCPM Update section, inflation has increased significantly in the wake of the pandemic and has been a leading driver of the increased costs across all modeled prosthetic categories in 2022. The cost of prosthetic devices such as hearing aids, oxygen, VA specialized products and services, 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 increase in diversity. For example, wireless communication devices and other devices compatible with hearing aids are being prescribed and provided in conjunction with hearing aids

with wireless capabilities. The increased diversity of prosthetic devices coupled with technological advances is driving material increases in utilization of prosthetic devices.

The increasing number of enrollees being adjudicated for service-connected disabilities is also driving increases in prosthetics utilization. As enrollees transition from non-service-connected priorities into Priorities 1-3, they are expected to reflect the significantly higher utilization rates of enrollees in Priorities 1-3, particularly for blind aids, artificial limbs, wheeled mobility devices, and VA specialized products and services.

Overall aging has a large impact on prosthetic services but does vary by service. For example, the use of hearing aids (which are often not covered by private insurance or Medicare) increases significantly with age, while utilization of surgical implants shows minor increases as enrollees elect to use Medicare for surgical procedures. Aging is driving material increases in utilization of hearing aids, blind aids, wheeled mobility devices, VA specialized products and services, and medical equipment and supplies.

The continued growth of the Post-9/11 Era Combat Veteran enrollee population (their aging, and their increase in service-connected conditions (and the resulting transition into service-connected Priorities 1-3) is driving significant growth in utilization for prosthetics services for this population. Since almost this entire population is not yet eligible for Medicare (with the associated decline in reliance on VA), aging is driving increases in this population's use of prosthetics, particularly for blind aids, hearing aids, VA specialized products and services, and wheeled mobility devices.

Long-Term Services and Supports

LTSS include the full range of services providedto help Veterans with functional limitations and chronic health conditions in non-acute settings. These services are provided through facility-based care or via home and community-based services (HCBS).

Modeled Long-Term Services and Supports

Facility Based Services

- VA Community Living Centers, long-stay (>90 days)
- VA Community Living Centers, short-stay
- Community Nursing Homes, long-stay
- Community Nursing Homes, short-stay

Home and Community Based Services

- VA Adult Day Health Care
- Community Adult Day Health Care
- Home Based Primary Care
- Home Respite Care
- Purchased Skilled Home Care
- Home Hospice Care
- Homemaker/ Home Health Aide Programs
- Spinal Cord Injury & Disorders Home Care
- Community Residential Care
- Home Telehealth
- Home-Based Bowel and Bladder Care
- Veteran Directed Home Health Care

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.

Expenditures required to provide LTSS to enrolled Veterans are expected to increase in both 2025 and 2026. The projected growth for expenditures is primarily the impact of inflation and two enrollment dynamics that have a very significant impact on LTSS in both facility and HCBS settings: priority transitions and the aging of the enrollee population. This growth is tempered by the impact of net new enrollment (new enrollees minus deaths). This net effect tends to reduce LTSS utilization because death rates are higher for older enrollees with relatively high utilization of LTSS, while new enrollment is primarily younger enrollees who tend to not yet need these services.

Enrollees transitioning into service-connected priorities are driving significant growth in utilization for facility-based LTSS as well as HCBS. In particular, the growth in Priority 1a enrollees (70% service-connected or more) is driving significant growth for long-stay facility-based LTSS. VA is legislatively mandated by the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) to provide continuing facility-based care for enrolled Veterans who have a 70% or greater service-connected disability, as well as those who need such care for a service-connected disability, or who have a rating of total disability based on individual un-employability. Additionally, the PACT Act is now contributing to the already significant growth through increases to priority transition rates, especially into Priorities 1-3 and higher enrollment rates as of FY 2023.

The aging of the enrollee population is also having a significant impact on expenditures and utilization. Unlike other modeled services, reliance on certain LTSS does not decline after Medicare eligibility, due to limited Medicare coverage for long-stay facility-based services and HCBS. Currently World War II and Korea era enrollees are in the age bands that are the highest users of LTSS. Vietnam era Veterans will be an increasing driver of LTSS, with most having aged

beyond 75 by 2027. CLC short-stay, which is used primarily for post-acute care and hospice care, is less impacted by aging than the other facility-based care categories.

Projected utilization for LTSS reflects programmatic changes in delivery of these services. Reflecting similar shifts in the health care system at large, VA is focusing efforts to provide care in the most appropriate setting for enrollees. This change includes deliberate shifts to CLC short-stay care for those who are in an inpatient setting and are not ready to be discharged to home, but no longer need acute care. It also includes VA's initiative to provide care through HCBS rather than in facility-based LTSS when appropriate. These efforts are driving some growth for short-stay facility-based care and HCBS but are mitigating expected growth for long-stay facility-based care.

Dental

Modeled Dental Care

- Preventive and Basic Dental Services
- Minor Restorative Dental Services
- Major Restorative Dental Services

Projections are developed for three categories of dental care services based on the intensity and complexity of the service. By law, VA provides dental care to enrollees based on special eligibility criteria, which are different than eligibility criteria for other VA medical care benefits. Providing preventive and basic dental services to enrollees aligns with VA's 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 2025 and 2026. The projected increase is driven by inflation, the transition of enrollees into higher priority groups, and impacts of the PACT Act and MISSION Act.

Impact of 2023 EHCPM Update

Health care is very dynamic. Further, the EHCPM projections supporting the VA budget are developed based on data that are three years removed from the beginning of the budget year (four years for the Advance Appropriation). During this time, new policies, legislation, regulations, and external factors, such as pandemics, can occur and change the projected demand for VA health care. Therefore, each year the EHCPM is updated to reflect the most recent data and emerging experience.

The 2023 EHCPM (BY 2022) was used to build the 2025 and 2026 VHA Medical Care budget requests. The 2023 EHCPM largely returns to the typical modeling process used prior to the COVID-19 pandemic. With this typical process, the 2023 EHCPM is updated using workload through FY 2022 to reflect emerging information on the enrollee population and their utilization of VHA health care. These analyses are tied to the most recent fiscal years of data and establish assumptions that are based on this recent information, which then persist throughout the full EHCPM projection period or are adjusted to reflect expected changes.

In addition to the base-year calibration process described above, the 2023 EHCPM includes a calibration to available high-level FY 2023 workload and expenditure data. Due to variation in the timeline for the various FY 2023 data items that inform the EHCPM, the level of detail in this calibration differs by VA direct care and community care and each is adjusted at a different high-level service area detail. VA direct care calibration was applied at the service line detail and was done separately for workload and unit cost while the community care calibration was applied by high-level service area (inpatient, ambulatory, dialysis, institutional LTSS, and home- & community-based services) and the same calibration adjustment applied to both workload and unit cost. Workload and unit cost calibration adjustments are applied at the service line and care location (VA direct vs community care) detail and do not impact variation in projected workload or cost by other variables (e.g., submarket, enrollment priority, gender). The underlying variation is retained from FY 2022 calibration and reflects non-calibration workload adjustments by these other variables.

Over the course of the COVID-19 pandemic, a much greater proportion of VA care has been provided through community care instead of direct care. Although the increasing level of community care can be attributed to the enactment of the Choice and MISSION Acts and was evident prior to the COVID-19 pandemic, the balance moved much more during the pandemic, so that in FY 2022 nearly 40% of all VHA health care is provided in the community. Some of this shift in care location is due to the differing degrees to which VA direct and community care workload have recovered from the pandemic. For VA direct care, workload remains below the pre-pandemic levels (i.e., FY 2019) and considerably below pre-pandemic expected growth trajectories. In contrast, community care workload has grown each fiscal year since the enactment of the MISSION Act, so that FY 2022 workload levels are 60%-70% greater than FY 2019.

Inflation has increased significantly in the wake of the pandemic. For the 2023 EHCPM, the non-personnel inflation trend derives from the 2022 Medicare Trustee's Report. Normally, a 20-year historical average trend would be used to project inflation from 2022 to 2026; however, 2022 and 2023 are based on a more recent CMS Market Basket forecast to recognize the near-term inflation experience. Similarly, pharmacy cost trends take into account expected increases in the Consumer Price Index for All Urban Consumers which, due to contracting provisions, has a direct impact on the acquisition cost of many brand-name and specialty drugs.

The newly incorporated VetPop2020 projections have modest decreases of total Veterans in the base period and in the long term compared to VetPop2018. VetPop provides the latest official Veteran population projection from the VA. It is a deterministic projection model developed by the VA National Center for Veterans Analysis and Statistics to estimate and project the Veteran Population from 2020 to 2050. Using the best available Veteran data at the end of 2020 as the base population, VetPop2020 projects living and deceased Veteran counts by key demographic characteristics such as age, gender, period of service and race/ethnicity at various geographic levels for the next 30 years.

PACT Act affects VHA enrollment by expanding eligibility for selected Veterans and by either introducing or increasing service-connected ratings for some Veterans, which increase the enrollment priority level for which the Veteran is eligible. PACT impacts are projected through

increases to priority transition rates (especially into Priority 1-3) and higher enrollment rates, beginning in FY 2023.

Historically, the most significant factors changing the EHCPM's projections have been external and could not have been anticipated in advance, such as the impacts of the COVID-19 pandemic, the MISSION Act, the civilian wage freeze policy, American Reinvestment and Recovery Act (ARRA) funding, and the PACT Act. Please see the section entitled "Uncertainty Associated with Actuarial Projections in the VA Enrollee Health Care Projection Model" later in this chapter for more information on the impact of COVID-19 and the PACT Act on the VA health care system as well as on sources of risk inherent in modeling.

Table: 2024 Revised Estimate and 2025 Advance Appropriation EHCPM Model & Non-Model Obligations
All Funding Sources
(dollars in thousands)

Description	2025 Revised Estimate			2026 Advance Appropriation		
	EHCPM	Non-EHCPM	Total	EHCPM	Non-EHCPM	Total
Health Care Services	$117,819,444	$7,452,544	$125,271,988	$125,813,604	$7,137,663	$132,951,267
Long-Term Care	$14,772,767	$2,263,793	$17,036,560	$15,444,257	$2,425,479	$17,869,736
Non-Add Included in Above Rows:						
Non-Recurring Maintenance (excluding PACT Act § 705)	*$0*	*$2,000,000*	*$2,000,000*	*$0*	*$2,000,000*	*$2,000,000*
State Home Programs	*$0*	*$1,809,660*	*$1,809,660*	*$0*	*$1,958,463*	*$1,958,463*
Other Health Care Programs:						
Camp Lejeune Families (P.L. 112-154)	$0	$7,597	$4,606	$0	$4,837	$4,837
Caregivers (Including CHAMPVA)	$0	$2,422,410	$2,913,000	$0	$3,500,000	$3,500,000
CHAMPVA & Other Dependent Prgs	$0	$2,335,332	$2,898,351	$0	$3,185,466	$3,185,466
Homeless Program Grants	$0	$1,067,265	$983,946	$0	$983,946	$983,946
PACT Act § 705 Enhanced-Use Leases	$0	$40,608	$40,608	$0	$17,280	$17,280
Readjustment Counseling	$0	$370,361	$370,361	$0	$370,361	$370,361
Obligations [Grand Total]	$132,592,211	$15,959,910	$149,519,420	$141,257,861	$17,625,032	$158,882,893

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 2022, CHAMPVA covered 592,789 beneficiaries. The number of beneficiaries is expected to rise to approximately 683,000 in 2025 and 716,000 in 2026.

The 2023 CHAMPVA Model was developed using the data from 2012 to 2022 for enrollment and 2012 to 2021 for detailed claims costs, publicly available research, and input from a development team (including subject matter experts from VHA and VHA's CHAMPVA program). The CHAMPVA Model consists of two major components: the enrollment model and

the claims cost model. The enrollment model projects the number of beneficiaries enrolled in CHAMPVA, and the claims cost model projects expenditures for providing care to beneficiaries.

The enrollment model projects the number of CHAMPVA sponsors and beneficiaries. For each fiscal year, sponsors are projected and then the beneficiaries of those sponsors are projected. Within a given fiscal year, sponsors are projected at an individual level, with modeled individual beneficiaries linked to each sponsor. Three categories of beneficiaries are projected: spouses, children, and helpless children. Beneficiaries eligible for CHAMPVA as a primary caregiver enrolled in the Program of Comprehensive Assistance for Family Caregivers (PCAFC) (i.e., who are not also an eligible spouse or child of a sponsor) are not modeled in the CHAMPVA projection model. Starting with the 2020 Model, such caregivers have been projected as part of the PCAFC Model. The Veteran population basis underlying the enrollment assumptions and projections is primarily based on VetPop2020.

The claims cost model is driven by several factors including: enrollment counts produced from the enrollment model, assumed annual claim cost trends, age/gender cost relativity factors, and the actual (historical) CHAMPVA paid claims data. The projected beneficiaries from the enrollment model are then linked to the claims cost model to generate expenditures. These projections no longer have explicit adjustments for COVID-19 as the workgroup determined an adjustment was no longer necessary. They do include assumptions for the impact of the CHAMPVA Modernization of Regulations (RIN 2900-AP02), which became effective August 12, 2022, and the PACT Act of 2022 on expenditures. The PACT Act is expected to make more Veterans eligible to be sponsors for the CHAMPVA program due to increases in heath conditions presumed to be related to military service. This Act is estimated to increase CHAMPVA Veteran sponsor counts both for living and deceased Veterans.

The Program of Comprehensive Assistance for Family Caregivers Model

From program inception through September 30, 2020, the Program of Comprehensive Assistance for Family Caregivers (PCAFC) has provided comprehensive assistance to caregivers of certain Veterans and Service members who were seriously injured during service on or after September 11, 2001. For enrolled Veterans, their primary caregivers are eligible for a monthly stipend payment, health care expense reimbursement through the CHAMPVA program (if they have no other health insurance), education and training, mental health care services, respite care services, travel, lodging and per diem expenses in order to attend required caregiver training and to travel to and from the Veteran's medical appointments. Following the program changes required by the MISSION Act effective starting October 1, 2020, 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 2025 budget submission.

The PCAFC Model was first developed in 2015 and has been updated each year since then. The PCAFC Model includes projections for unique Veteran sponsor counts, unique primary caregiver counts, stipend payment costs, CHAMPVA benefit costs, mental health benefit costs, and respite care benefit costs. The stipend cost projections make up the majority of total PCAFC costs. The CHAMPVA benefit cost projection in the PCAFC is limited to primary caregivers who qualify

for CHAMPVA purely through their involvement in the PCAFC; CHAMPVA beneficiaries who qualify for CHAMPVA by being eligible spouses or children of a Veteran are projected as part of the CHAMPVA Model. The PCAFC Model does not include other PCAFC program expenses such as training, travel, lodging, and per diem.

Projections are developed using a combination of historical program experience, projected enrollment pattern assumptions, stipend payment and cost trends, projected health care cost trends, projected payment tier/level enrollment distribution, projected PACT Act impacts, and assumptions regarding policy decisions to implement the MISSION Act.

PCAFC costs are largely driven by projected enrollment into the PCAFC program. From PCAFC inception in May 2011 through 2016, there was a steady increase in the number of caregivers enrolled in the PCAFC program. From 2017 to 2021, the program saw a reduced number of total Veteran sponsors and caregivers. However, due to program expansion to include Vietnam service era Veterans and Pre-Vietnam service era Veterans beginning October 1, 2020, and Post-Vietnam service era Veterans beginning October 1, 2022, the number of caregivers has begun growing and is expected to continue growing.

The PACT Act is expected to make more Veterans eligible to enroll in the PCAFC program due to increases in heath conditions presumed to be related to military service. This Act is estimated to increase PCAFC Veteran sponsor counts.

Uncertainty Associated with Actuarial Projections in the VA Enrollee Health Care Projection Model

VA develops the VA EHCPM, an actuarial projection of enrollment, utilization, and expenditures, to support its budget submission and long-term strategic planning. A critical function is to assess the sources and magnitude of overall uncertainty associated with actuarial projections and to communicate that information to stakeholders. This report fulfills part of this communication to stakeholders and describes the activities that comprise VA's assessment of uncertainty associated with the actuarial projections.

This report identifies sources of risk and describes the degree of uncertainty that they add to the actuarial projections in general and specifically for the projections supporting the 2025 VA health care budget (Budget Scenario).

This communication of risk is intended to inform stakeholders of sources of uncertainty, describe how they may affect the assumptions which drive the actuarial projections, and discuss their potential magnitude. The risk assessment includes sensitivity testing for enrollee reliance and enrollment to demonstrate the potential variability of the projections over the short term and long term. This report discusses ways VA manages uncertainty in the actuarial projections, but it does not address approaches to manage operational risk to the Department.

Framework for Assessing Actuarial Projection Uncertainty

The complex nature of health care is a challenge in all types of health coverage and must be addressed by all payers and providers alike. Utilization and expenditures are impacted by many different factors and are sensitive to the interaction between them. In addition, there is substantial random variation in health care needs over time. As a result, modeling health care utilization and expenditures is inherently challenging. The vast majority of payers and providers use actuarial methods to model health care by accounting for the key drivers and to understand and communicate uncertainty in projections. The EHCPM is structured in a manner consistent with tools used by other health care payors and providers, and it has been adapted to meet the specific needs of VA stakeholders.

One of the most important functions of an actuarial model is to describe how factors influence utilization and expenditures over time, in order to gain a deeper understanding and to communicate it to users. The EHCPM provides this cohesive and critical framework for evaluating and communicating results and the key drivers of those results. There is significant inherent uncertainty and there is risk of emerging experience differing from projections. Understanding the key drivers enables greater insight into the sources of risk and how they contribute to uncertainty.

The EHCPM produces projections of enrollment, utilization, and expenditures based on numerous model assumptions about how the future will be the same or different from past experience. There is uncertainty about how actual emerging experience will compare with these assumptions. A framework for assessing actuarial projection uncertainty involves identifying, analyzing, and responding to underlying risks, consistent with Principal 7 of the Government Accountability Office's "Standards for internal control in the federal government".

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.

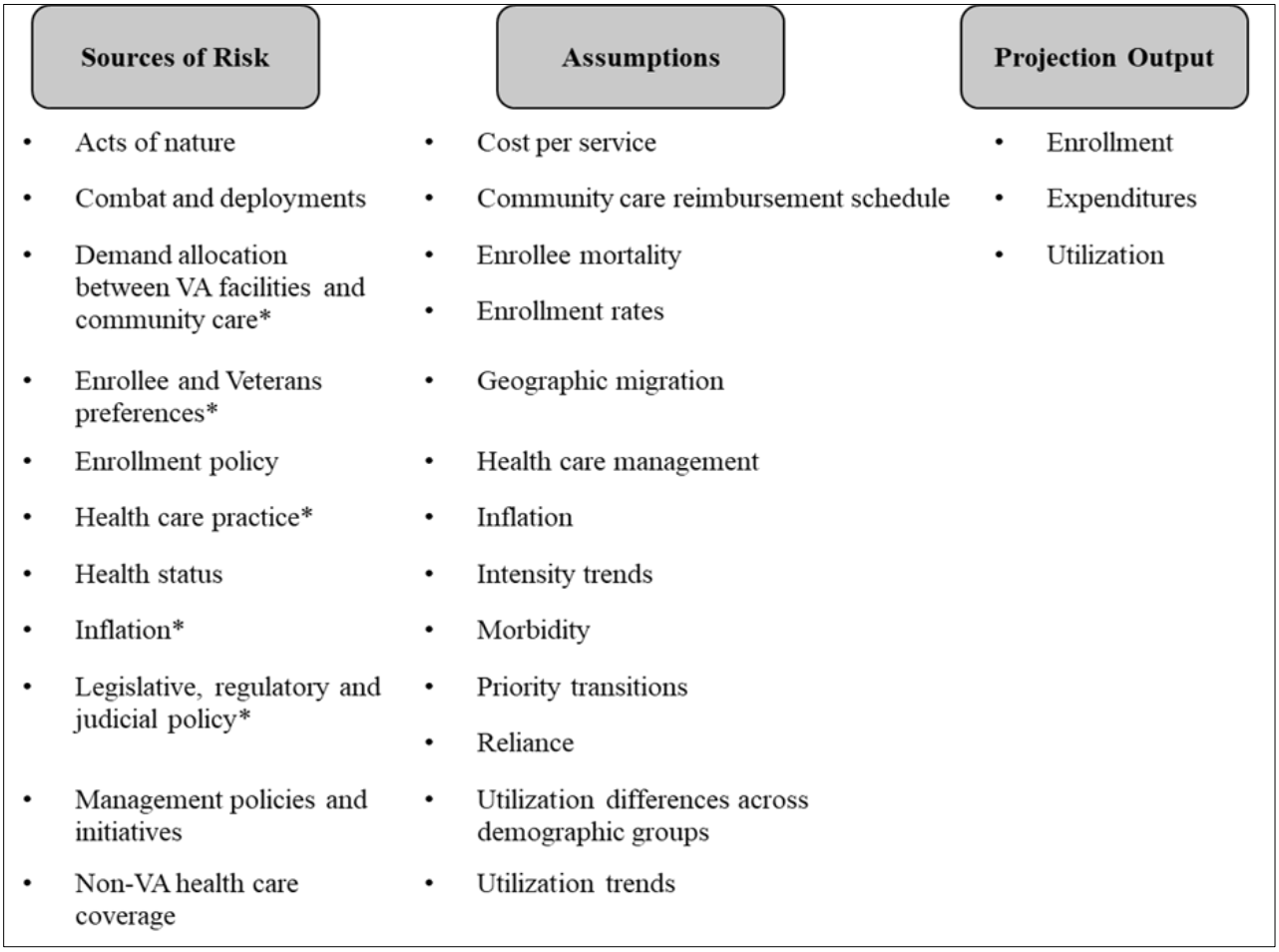
Many of the sources of risk that create uncertainty in the projections cannot be statistically measured in the first place. For example, there is uncertainty about future combat operations and deployment levels, which can have a material impact on long term enrollment levels and morbidity. Yet, VA cannot 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



*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 81% of enrollees have some type of public or private health care coverage other than VA. Enrollees with multiple sources of coverage can choose to use their VA or non-VA coverage for each health care service. Reliance is defined as the portion of enrollees' total health care needs expected from the VA health care system, including both VA direct care and community care paid by VA, versus other health care options. For example, if an enrollee received 10 office visits in a year, 4 from VA and 6 through Medicare, that enrollee would be considered 40% (= 4 / 10) reliant on VA for office visits.

Note that reliance is not the percentage of enrollees that receive health care from VA. Most enrollees who use VA health care are only partially reliant; that is, they use VA for some of their care but rely on other health care sources such as Medicare or private health insurance for their remaining care.

In FY 2022, average reliance was approximately 40% across all enrollees for their health care needs (excluding LTSS). The large portion of enrollee care that is not currently funded by VA creates a significant model risk since events that may cause only small increases in reliance can generate significant additional expenditures. A 1% unexpected increase in reliance levels (i.e., additive increase, or 100 points) is estimated to cause the EHCPM's budget projection to increase by around 2.5%, or $2.6 billion.

Characterizing the Degree of Uncertainty

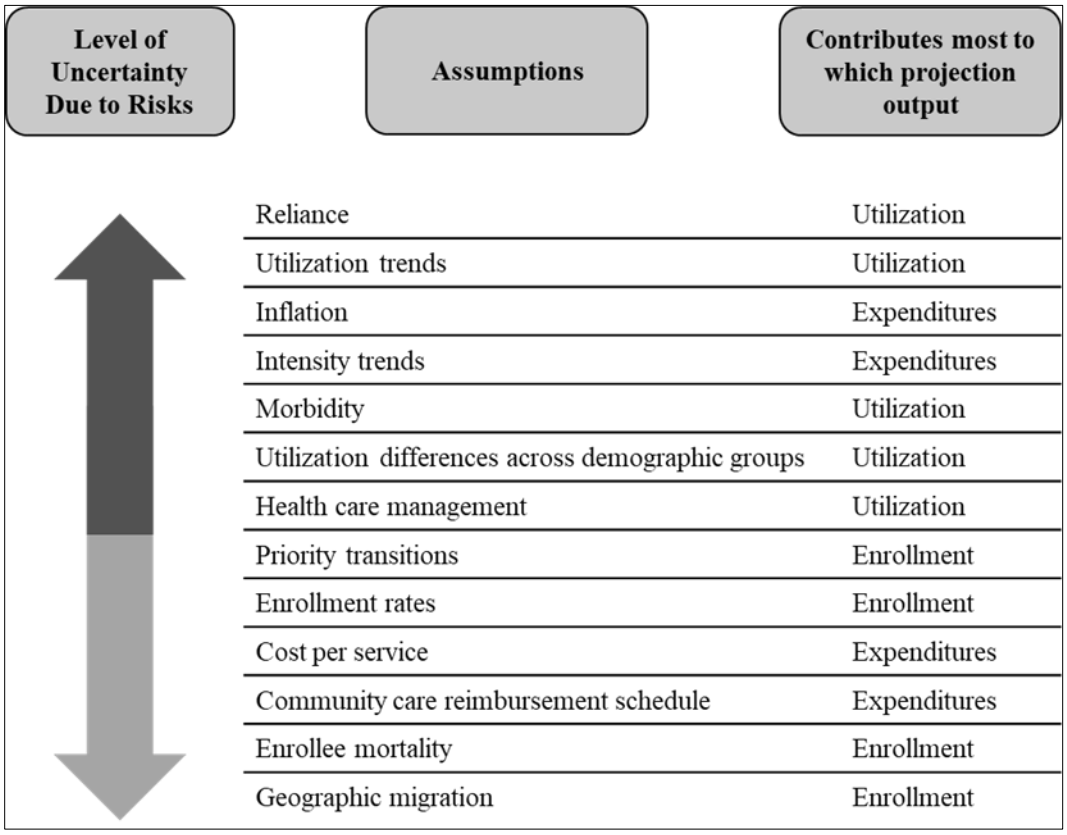
There are different ways to categorize sources of risk in terms of the type of uncertainty each brings into the model.

- Likelihood – Some events are very rare, and others occur more frequently. For example, a major overhaul to health care law is relatively rare, whereas unexpected changes in the inflation rate are nearly guaranteed, regular occurrences (though the magnitude and direction of the unexpected change are not known in advance).
- Magnitude – Notwithstanding the likelihood of an event occurring, the magnitude of the event is very important. For example, a pandemic is a rare, but high impact event.
- Single vs. Recurring Impact – Some events will create a one-time upward or downward shift in an assumption or the model projections (e.g., opening a new facility). Other sources of risk will lead to recurring changes in cost, therefore bending the expenditure curve upward or downward (e.g., expansion of enrollment eligibility).
- Time Horizon - The EHCPM projections serve two primary purposes:
    - First, there is the 3-4-year projection to support the budget submission and the advance appropriation.
    - Second, there is a longer-term projection over 20 years to support strategic planning at the market level.

Sources of risks that lead to uncertainty in the projections will affect these time horizons differently and so are prioritized differently depending on the time horizon being used. For example, uncertainty around a trend assumption, such as inflation or mortality rates, can have a relatively small impact on the three-year budget projection but will compound into a much larger impact over a 10-20-year strategic planning timeline. Conversely, events, such as an economic downturn, can have a relatively large impact over the short-term but then revert to "normal" conditions and thereby have less impact over a strategic planning timeline.

A particular source of risk can influence the uncertainty about several model assumptions and to varying degrees. Similarly, each model assumption is uncertain due to the underlying influence of several sources of risk. Generally, utilization trends and reliance levels create a greater uncertainty in the model projections than other key drivers such as enrollment rates, which only have a marginal impact on total enrollment in any given period. The list below is sorted in approximate order of impact over the budget horizon.

Affected EHCPM Assumptions by Level of Uncertainty



Assumptions	Contributes most to which projection output
Reliance	Utilization
Utilization trends	Utilization
Inflation	Expenditures
Intensity trends	Expenditures
Morbidity	Utilization
Utilization differences across demographic groups	Utilization
Health care management	Utilization
Priority transitions	Enrollment
Enrollment rates	Enrollment
Cost per service	Expenditures
Community care reimbursement schedule	Expenditures
Enrollee mortality	Enrollment
Geographic migration	Enrollment

Approaches to Assess and Reduce Modeling Uncertainty

There are several important activities that are undertaken prior to developing the projections, which are focused on collecting historical data and identifying sources of risk that have led to model uncertainty in the past.

Baselining the Model

VA gathers data from multiple sources, such as workload information from different facilities and information stored in multiple databases. Each year, the EHCPM is updated to reflect historical enrollment, utilization, and expenditure information. Historical information over several years is used to estimate important model assumptions, such as utilization trends by service category, enrollment rates and reliance. The EHCPM is calibrated so that it projects the enrollment, utilization and expenditures that actually occurred during the model's base year. For example, the base year (BY) of the 2023 EHCPM was fiscal year (FY) 2022. This process is referred to as "baselining," and is an important step toward reducing model uncertainty.

One of the challenges in baselining is to obtain accurate and comprehensive data through the base year. VA works extensively to collate data from within the department and to organize it in a timely manner. Great care is taken to evaluate the completeness and accuracy of each data source.

This is accomplished by reconciling data to other sources, testing it for both internal consistency and the validity of data entries, and through discussions with key subject matter experts.

Integrating Data Sources from Outside VA

VA also obtains important data from outside of the Department to help understand the base year. A Medicare data match is available to assist in the review of overall health care utilization for Veterans ages 65 and over. This is a valuable information in understanding a more complete picture of medical conditions, overall utilization, and reliance on VA health care for many enrollees ages 65 and over. There is no corresponding data set for Veterans under age 65, since health care data is fragmented across numerous private sector and government programs. As a result, modeling for Veterans under 65 years of age is primarily based on the VA health care and supplemented by VA's annual Survey of Enrollees, which provides self-reported responses on enrollee reliance. Through this process, VA arrives at an effective means of assessing overall utilization and reliance for enrollees under age 65.

Other outside data sources include date of death files from the Social Security Administration (SSA) and the VA/Department of Defense Identity Repository (VADIR) data. Since many Veteran enrollees may die outside of VA facilities and there is no direct requirement for their families or physicians to report this to VA, it is important to supplement dates of death that are reported within VA with information from outside sources, including SSA. This allows for a more up to date and accurate count of current enrollees. The VADIR data includes military discharge dates along with information about active-duty theaters of deployment, and this data is used to identify post-9/11 combat Veterans, other deployment cohorts, and to track time since separation.

Reducing the Impact of Reporting Lag

Most data sources have at least some degree of reporting lag. Enrollee deaths are not all immediately reported to VA and, therefore, there is a lag in complete reporting of enrollee deaths. For community care, VA, like other payers, experiences a gap between the provision of the service and the date of payment. This is an unavoidable feature of some data sources. Where the impact is expected to be material, adjustments are made to arrive at a more complete model of the base period experience. A primary benefit of making adjustments for reporting lag is that more recent, relevant data can be used to develop model assumptions. By contrast, waiting an extended period of time for a data source to be free of reporting lag can make it less relevant for identifying emerging trends.

As time passes, the information on prior periods develops and a more complete picture is formed. This development pattern is evaluated for older periods so that the impact of reporting lag can be modeled and applied to the most recent base year information.

The Medicare data match is usually about two years old by the time it is available for analysis, so additional review on trends is performed to better estimate key assumptions such as morbidity and reliance during the base year. Currently, the data match is only available through 2021.

Other Steps to Reduce Uncertainty

Some events or processes give rise to uncertainty that cannot be reduced through deeper analysis alone; for example, it is not possible to predict natural disasters or new military conflicts. Other risks that create uncertainty are more accurately measured by accessing better sources of data and gathering data that is more representative of the base year experience. Sometimes, sources of uncertainty, such as a new law, can be anticipated before their impacts show up in actual experience data, prompting model assumptions to be initially established and refined over time.

As an example, the model historically assumed that reliance for a given enrollee demographic profile was stable over time. As additional longitudinal data emerged, VA identified changes in enrollee reliance due to a "generational shift": enrollees in younger generations are more reliant than those in older generations. Using this data, VA developed and refined assumptions to more accurately project reliance changes over time due to the generational shift and reduce model uncertainty.

The first step in assessing projection uncertainty is to identify the underlying sources of risk. Actuarial, clinical, policy, and operational expertise are continually consulted to identify new sources of risk and reassess the importance of previously known sources.

The second step is to analyze each source of risk and evaluate its significance. A source of risk is considered significant if it can have a material impact on the accuracy of model projections. Often in these situations, alternative projection scenarios are presented along with a discussion of key causes of uncertainty (e.g., sensitivity testing).

The third step is to take appropriate action in response to the risk analysis. If a source of risk is contributing significant uncertainty, then it warrants deeper analysis, more data investigations, and other efforts to arrive at a better estimate of the model assumptions involved. As part of this work, the level of uncertainty is communicated with stakeholders along with the best estimate.

An important part of this framework involves monitoring emerging experience and comparing it to prior projections. When material deviations are found, they are analyzed so that the underlying cause can be identified. Through this process, new sources of risk can be identified as being material and relevant to the projection uncertainty. This activity is accomplished in several ways:

- Monthly monitoring of enrollment – Identifies changing trends and potential data quality issues. Relevant experts within VA are consulted depending on the issue being discussed. Material deviations in emerging experience can be communicated with leadership and changes in enrollment projection methodology are considered.
- Comprehensive annual analysis of prior year enrollment relative to projections – Establishes a new starting point for the enrollment projections and creates a new data set for evaluating projection assumptions. Key model assumptions are tested against the new data and changes are made where appropriate. These include monitoring separate drivers of enrollment change on a monthly basis, such as new enrollment, mortality, and transitions in priority level. As a result, material deviations from the projected enrollment trajectory can be isolated to the specific assumption that is causing the deviation to occur. This

assumption can then be investigated in more detail using the most appropriate data and in collaboration with subject matter experts within VA.

- Comprehensive annual analysis of prior year utilization and expenditures – Establishes a new starting point for the utilization and expenditure projections and creates a new data set for evaluating projection assumptions and differences in utilization patterns across demographic categories. Key model assumptions are tested against the new data and changes are made where appropriate. Utilization and expenditure projections are affected by a multitude of assumptions. Through this review, material deviations from projections can be isolated to the specific assumption that is causing the deviation to occur. This assumption can then be investigated in more detail using the most appropriate data and in collaboration with subject matter experts within VA.
- Ad hoc interim utilization review – Identifies material deviations at the service category level on a periodic basis. These deviations are investigated, and stakeholders are alerted to the new observations. Oftentimes, the interim results are not sufficiently conclusive to warrant an immediate change in the projections but are incorporated into later model scenarios as appropriate.
- Consultation with work groups of subject matter experts on major model components (e.g., mental health, women's health, pharmacy, health care economics) – Evaluates differences between historical experience and prior projections and updates methodology where appropriate. Emerging developments in care delivery and other information are collated to develop a new estimate of future trends. Emerging sources of risks are discussed (e.g., unknown outcomes of new blockbuster drugs, proposed legislation, impact of changing economic forecasts) in order to better understand uncertainty in the projections.

There are several important examples for assessing uncertainty, which inform the approach that is taken with the EHCPM. These include government and private industry examples for risk analysis:

- Comptroller General of the United States published standards for internal control for the Federal Government
- National Association of Insurance Commissioners Risk Based Capital Plan and Own Risk and Solvency Assessment Summary Report
- State Medicaid Agencies
- Actuarial Standards Board of the American Academy of Actuaries Actuarial Standards of Practice

Approaches to Address Evolving Events and Policies

Many risks are difficult to predict and occur suddenly, such as combat deployments, pandemics, and economic recessions. In addition, new policy directions can be considered by leadership or influenced by judicial decisions, such as the MISSION Act.

Depending on the timing of the event, the projections supporting the VA health care budget may not include estimates of the impact of the event or policy direction. However, as the event or policy unfolds, estimates are developed that provide high-level impacts to inform budgeting for

these costs. These high-level estimates allow for flexibility when the policy is in flux or when detailed information is not available to support integration into the EHCPM. These estimates are revised as new information and/or analyses are available.

The EHCPM scenario documentation identifies policies that are included in the scenario, provided as a high-level estimate, or not modeled.

Assessment of EHCPM Projection Uncertainty from the Perspective of Underlying Sources of Risk

All sources of risk are discussed below, including their impact on key model assumptions and potentially different impacts by projection time horizon. Sources of risk which have a specific impact to the scenario supporting the budget outside of the general impact on model assumptions will have an additional subsection labeled "Budget Scenario."

Acts of Nature

Acts of nature (e.g., hurricanes, tornadoes, wildfires, pandemics) affecting parts of or the entire nation are difficult to predict and can arrive suddenly, as was the case with Hurricane Katrina in 2005 and with the COVID-19 pandemic in 2020.

Assumptions most affected

Morbidity, mortality, reliance, enrollment rates, utilization trend, cost per service, community care reimbursement schedule:

- An act of nature is an unpredictable episode that can dramatically increase mortality and morbidity among vulnerable segments of the enrollee population until the disaster is contained.
- Uncertainty comes in part from the inability to predict the start of and severity of the act of nature. It also comes from unpredictable differences in how society responds.

Time horizon

Short-term and long-term:

- The impact of acts of nature is modeled primarily within a 3-4-year period, anticipating a return to normal over longer time horizons. In the case of COVID-19, it is likely that there will be permanent changes to health care delivery as well, such as a faster and more widespread adoption of telemedicine, but those outcomes are much less certain.

Budget Scenario

The COVID-19 pandemic still had a significant impact on nationwide health care utilization in FY 2022, even as the pandemic settles into the endemic stage. This is true of the VHA health care system as well, though in many areas the effects of the pandemic have largely subsided. For enrollment, by the end of FY 2022 new enrollment rates had largely recovered from the decline

that followed the initial onset of the pandemic. Also, in many service areas, including ambulatory and acute inpatient care, enrollee health care utilization had returned to pre-pandemic expected levels (or close to it), or settled at a "new normal" that reflects a longer-term shift in health care utilization. For other service areas, particularly mental health care, long term services and supports, and inpatient rehabilitation care, the effects of COVID deferred care remain and it is expected that there will be continued recovery of health care utilization in FY 2023 and beyond. At the same time, increased inflation that followed the pandemic has had a considerable impact on the US economy, and this is seen in the health care cost for VHA as well.

The pandemic could also affect enrollee health status and mortality and health care practice patterns. See the Health Status and Health Care Practice sections for discussion.

Economic Conditions

Economic conditions influence individual behavior primarily due to changes in employment (which in turn affect availability of non-VA health coverage) and a sense of financial security. These influences affect Veterans' propensity to enroll in VA and to use VA to satisfy their health care needs. It is difficult to predict future economic conditions, including the incidence and depth of recessions. Even when a recession has begun, it is difficult to forecast the recovery with precision.

Assumptions most affected

Reliance, enrollment rates, priority transitions:

- Most enrollees have other forms of health insurance, including employer-sponsored health coverage and individually purchased coverage. When unemployment increases, enrollees may lose other forms of insurance and begin to rely more on VA for their care. Conversely, as employment increases, enrollees may reduce their reliance as they become eligible for employer-sponsored coverage.
- There is significant uncertainty around how much reliance may change. A primary reason for this uncertainty is that reliance changes during previous recessions may not repeat in future recessions. For example, the Affordable Care Act introduced significant new safety nets for health coverage among unemployed and lower income individuals beginning in 2014. This safety net was not available during the economic downturn in 2008/2009. Therefore, there is more uncertainty about whether the potential reliance changes during a new economic downturn may be dampened.
- Enrollment rates may also increase as more Veterans decide to come to VA for the first time due to financial insecurity or lack of other health coverage options. Finally, priority transitions between income-based priority levels (i.e., priority 5, 7, 8) may occur with major changes in employment and income.

Time horizon

Short-term:

- Most economic forecasts that include a downturn revert to typical economic conditions over time. For example, during the Great Recession, the economic forecasts included a gradual recovery of unemployment over several years. Reliance is the most material assumption that moves during an economic downturn, and it is expected to revert back to pre-recessionary levels as the recovery develops. Therefore, the long-term projections are less affected by current economic downturns and recoveries.
- The greatest uncertainty is over the short-term. In the early months and years of an economic downturn, the future path of the downturn and recovery is usually the most variable, and so these are the times where uncertainty is greatest. The four recessions that began in 1981, 1990, 2001, and 2008, respectively, took on average 22 months (ranging from 16 to 27) to reach their peak unemployment levels prior to gradual recovery lasting 19 to 71 months in order to reach pre-recession levels. These prior precedents illustrate the variability of paths an economic downturn and recovery can take, and they are also not necessarily representative of the current economic downturn. Hence, the uncertainty is greatest especially in the first year or two after a recession begins.

Budget Scenario

The scenario supporting this request uses the Office of Management and Budget November 2023 economic projections to assume that the unemployment rates will decline from 3.8% in 2022 to 3.6% in 2023, then increase to 4.1% in 2025. This primary economic forecast is supplemented by the Bureau of Labor Statistics forecasted Civilian Non-institutional Population.

There is greater uncertainty about modeling the impact since starting assumptions are based on enrollee behavior changes during the downturn and recovery of the previous recession. There is a risk that enrollees today will respond differently. The factors driving the recession differ, sources of health care coverage have changed, and Federal stimulus and other measures have been much more significant than during the previous recession. All of these factors could change how enrollee reliance changes in the current environment.

Legislative, Regulatory, and Judicial Policies

It is difficult to anticipate the decisions of current and future congresses, courts and administrations, and they can have a substantial impact on expenditures. Also, there can be sweeping legislative changes or many small legislative or regulatory changes happening simultaneously leading to a large impact on VA's health care system.

Assumptions most affected

All changes to legislative, regulatory, and judicial policies over time have the potential to impact VA enrollment, utilization, and expenditures. Here is a list of examples:

- Medicare Modernization Act of 2003 – Among other Medicare reforms, this act expanded prescription drug coverage to seniors, thereby increasing the attractiveness of Medicare benefits. This created uncertainty about how seniors would change their use of VA over time. Ultimately, the rates of new enrollment into VA began to fall and reliance on VA pharmacy benefits change due to seniors having more options outside of VA.
- Affordable Care Act (ACA) of 2010 – Expanded guaranteed policy issuance (including for pre-existing conditions) and subsidized health care primarily for individuals under the age of 65 who are not otherwise eligible for Medicaid. Initially, the law included a mandate for individuals to obtain coverage. This created uncertainty about whether more Veterans would enroll with VA to satisfy the mandate. It also created uncertainty about whether Veterans would choose ACA coverage instead of VA in the future.
- Choice Act of 2014 and MISSION Act of 2018 – Among other reforms, these acts expanded access to community care. This introduced more uncertainty about how community care utilization and expenditures would trend over time. While the Choice Act did not significantly increase enrollment, it did create more demand on the system for the eligible groups of enrollees. Community care growth has continued since the implementation of the MISSION Act, though the full impact of the MISSION Act is still uncertain. Further, VA has begun to consider policies that could control community care cost growth.
- Honoring our PACT Act of 2022 (PACT Act) – This act became Public Law No 117-168 in August of 2022, expanding benefits for Veterans exposed to certain toxins in the course of their military service, with a focus on Gulf War era Veterans as well new groups of Vietnam Veterans who were exposed to Agent Orange. Over the long-term, this law is expected to increase the number of enrollees, patients, and overall expenditures of VA. There remains significant uncertainty about the full impact of PACT Act as emerging experience develops on eligibility changes, enrollment rate changes, reliance shifts, and other impacts. These drivers of enrollment, utilization, and expenditures will be impacted by several factors, including but not limited to VBA caseload levels, the timing of adjudication and program implementation, the kind of outreach from VHA to Veterans, and the response among Veterans to the PACT Act. Over time, by evaluating emerging experience, the uncertainty and variability will diminish.

Time horizon

Short-term and long-term:

- Unlike other sources of risk, historical experience is not always an effective guide to projecting the course of future legislative or regulatory changes. The short-term uncertainty is that emerging experience will be different than projected. Uncertainty is greater over the long term, as the divergence between the two compounds over a longer period of time.

Budget Scenario

- Includes estimated impacts for a number of MISSION Act provisions, including the enhanced drive time access, best medical interest provisions, and wait time benefit. While these provisions went into effect in June 2019, enrollee behavior is still evolving over time in response.
- Experience from 2020 and 2021 showed a larger than initially expected increase in community care workload and costs. This follows 2019 which also had a larger than expected increase. This can be traced to an acceleration in growth beginning in June 2019 as the Act became effective. The 2020 and 2021 experience was also significantly impacted by changes in claim processing speed and COVID-19 deferring or eliminating care. These impacts have obfuscated MISSION's impact on community care utilization growth. The community care growth has continued in 2022 and 2023. Based on currently available data, VA cannot definitively determine whether the higher-than-expected growth so far is an indication that the MISSION Act is increasing enrollee reliance more quickly than anticipated, that the MISSION Act will have a larger ultimate impact on enrollee reliance, or that another force unrelated to MISSION is having a role in changing enrollee behavior. This adds to the overall model uncertainty.
- Enrollee reliance has been projected to increase over time due to MISSION as the program implementation and enrollee behavior matures. Projected reliance growth is then expected to slow as it reaches an assumed steady state by 2024 and then level off. Based on the analysis supporting the budget scenario, emerging experience from FY 2023 suggests that community care claims are continuing to increase and may have actually accelerated in the second half of FY 2023 after slowing in late FY 2022 and early FY 2023. There is a significant uncertainty as to how long enrollee reliance will continue to increase before reaching a steady state or whether the growth in late FY 2023 is related to MISSION rather than some other source, producing a risk around 2024 and later projections.

Health Care Practice

Advancements in medical technology and pharmaceuticals occur regularly, though the timing of these inventions is difficult to predict. Examples include the widespread introduction of magnetic resonance imaging over the past two decades, advancements in prosthetics for lost limbs, and the discovery of more effective Hepatitis C treatments in the mid-2010s.

Assumptions most affected

Utilization trends, intensity trends, morbidity, mortality:

- The introduction of new treatments and devices can change the trend in utilization levels by introducing treatments for the first time or changing the price and effectiveness of existing treatments. Often, these advancements may be focused on a very specific service category (e.g., prosthetics). Changes in cost will affect the cost per service (e.g., a more intense, higher cost service) as well. Uncertainty around the timing and impact of these advancements translates into uncertainty about these model assumptions.

- Improvements in health care, especially life-saving treatments, tend to reduce mortality rates over time, improve overall health (morbidity) and extend lifespans. The EHCPM specifically includes mortality improvement assumptions and uncertainty about the pace of future changes in mortality compounds over the long-term.
- The utilization and intensity trend assumptions incorporated into the model will, barring any specific information, account for average trend movements over time. These trends cannot anticipate rare and/or exceptional events.

Time horizon

Short-term and long-term:

- Due to the gradual nature of most innovations, whether it be changing practice patterns or the gradual adoption of new medical technologies, the uncertainty about their effects compounds more significantly over the long-term.
- However, short-term breakthroughs, especially the introduction of new and expensive pharmaceuticals, contribute to uncertainty over the shorter-term budget horizon. For example, the introduction of genotype-specific Hepatitis C drugs (e.g., Harvoni, Viekira, Daklinza) beginning in 2014, which had an initial price approaching $100,000 per patient, came to market quickly and within the time frame of the three-year budget projection.

Budget Scenario

COVID-19, in addition to the extensive disruptions to short-term care due to deferral of care and treatment of COVID patients, may also affect underlying health care practice trends. For example, resources directed toward the development of the vaccine may be affecting the speed with which other drugs come to market, the increase in video telehealth care could be sustained, or the significant disruption in regular care patterns could affect future treatment protocols. These possibilities, among others, cause a higher than usual level of uncertainty in emerging health care patterns. The Budget Scenario assumes some long-term changes in health care practice in addition to higher vaccination rates. For LTSS, many adult day health care centers (ADHC) closed during the initial lockdowns in 2020 and 2021, and many of them went on to permanently close. Based on these developments, the Budget Scenario reflects lower long-term utilization as a result of the reduced supply of ADHCs. Finally, the trajectory of telehealth services provided by VA was increased further to account for additional projected mental health evaluation & management provided via telehealth. VA continues to evaluate emerging experience and available information to assess whether long-term changes in health care practice for other services is developing and measurable, and the assumptions will be revised as appropriate.

Allocation between VA Direct Care and Community Care

The EHCPM projects enrollees' total enrollee demand for VA health care. Then, the total projected demand is allocated to VA direct care and community care based on eligibility criteria for community care (e.g., MISSION Act) and referral authorities, operational guidelines, and VA direct care staffing and capacity.

Assumptions most affected

Reliance, cost per service:

- The projected resource requirements for VA direct care and community care represent a division of the total enrollee demand projected by the EHCPM. Therefore, both care locations need to be funded at the projected expenditure levels to meet the total projected enrollee demand for VA health care. For example, if VA direct care is not funded at the projected level, VA would need to purchase this care in the community, which would increase the projected resource requirements for community care.

  The EHCPM implicitly assumes that clinical productivity levels among VA providers remain fixed throughout the projection period based on historical data, and that changes in staffing and capacity are consistent with workload changes over time. However, a change in clinical productivity would affect the distribution of workload between the direct care and community care and the corresponding expenditure levels.

- 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 change staffing and capacity in VA facilities to meet changes in resource needs, then this projected increase in services will need to be met in the community, which would increase the projected resource

requirements for community care. Under the MISSION Act, if VA cannot provide care in VA facilities in a timely manner, enrollees are eligible to receive care in the community.

Likewise, if VA's community care network cannot expand to meet the projected growth in demand, VA may not be able to meet all of enrollees' projected demand. This would suppress enrollees' preferred reliance on VA health care.

Mismatches in resource availability or the inability to increase capacity in VA facilities or the community care network to meet the projected service growth could disrupt timely access to care for enrollees.

Also, because these two locations of care require different funding streams and operational support, there is risk associated with the allocation of care between locations, and not just the total amount of care provided by VA. In particular, an over-funding of VA direct care without a commensurate increase in the workload provided will not be offset by a decrease in community care obligations, and this would result in elevated VA direct care unit costs.

Time horizon

Short-term:

- The allocation of the total projected health care demand between VA direct care and community care allows VA to budget and plan to meet enrollees total demand for VA health care. The short-term uncertainty is that emerging experience will be different than the projected allocation of care between these settings, causing operational disruption.

Budget Scenario

Assumes the projected future growth in services follows the historical split between VA direct care and community care except for (a) reliance growth due to the expanded eligibility criteria for community care under the MISSION Act, and (b) short-term changes in VA direct care staffing and capacity. If these staffing and capacity levels do not align with direct care workload, then there is an elevated risk that more or less care will shift to the community than what was projected.

Enrollee and Veteran Preferences

Eligible Veterans have a choice to enroll with VA and, once enrolled, can choose how much of their health care to get through VA instead of through their other coverage. Because most Veterans have these choices, their individual preferences will influence the result.

Assumptions most affected

Enrollment rates, reliance:

- Enrollment with VA is free (i.e., there is no monthly premium like there is in Medicare and private insurance); yet not all eligible Veterans choose to enroll with VA. As a result, there can be large swings in new enrollment over time, affected by a wide variety of external factors and the individual preferences of Veterans (see Figure C). It should be noted, however, that new enrollment represents a small part of total enrollment. If approximately 400,000 new enrollees join in a year, it represents about 4.4% of the 9 million unique Veterans enrolled in that year. An unexpected increase of +4,000 new enrollees (i.e., 1% of the annual new enrollment) would only increase the total enrollment by 0.04% and budget requirements may increase by even less if the additional enrollees are younger and have fewer health care needs.

  Similarly, those enrolled with VA may not get all of their care through VA. Indeed, enrollee reliance has been trending up gradually over the past few years. There is considerable room for increases in reliance if Veteran preferences were to change dramatically, and this could have a large impact on utilization and expenditures.

Average Reliance for All Enrollees Across All Services (Excluding LTSS)

	2017	2018	2019	2020
Estimated Aggregate Reliance	36.4%	37.2%	38.3%	36.7%

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 caused a reduction in enrollment rates beginning in 2020, and they have gradually returned to typical levels in recent years. This process was slower for older Veterans and quicker for younger Veterans (with some evidence of pent-up demand leading to higher, short-term enrollment rates). The pandemic is not expected to impact longer-term enrollment rates.

Health care utilization patterns are subject to significant inertia. That is, health care users will tend to continue using the same care providers over time, even if changes in circumstances would suggest that choice is no longer optimal. The significant disruption of care that occurred during the COVID-19 pandemic may have caused more enrollees to re-evaluate their care patterns. As reliance data continues to emerge, this may reveal an increase or decrease in reliance following the COVID-19 pandemic recovery, and changes to the demand for VA direct care vs. community care.

Enrollment policy

VA has discretion over many aspects of enrollment eligibility. For example, VA can decide to expand enrollment to previously suspended income levels.[6]

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

[6] New enrollment is suspended for Veterans with household incomes above the VA Means Test (VMT) r more than 10% greater than the Geographic Means Test (GMT), provided they do not meet other eligibility criteria, such as a service-connected disability rnow.ating.

change caused shifts in priority levels, which took several years to adjust to the new policy. Most changes involved enrollees getting a priority upgrade, which may have induced some additional reliance on VA for care. For a change like this, uncertainty mostly comes from the change in categorization by priority rather than an underlying change in morbidity, a technical change that increases the uncertainty around modeling future assumptions by priority using historical data that is categorized differently.

Time horizon

Short-term and long-term:

- There is uncertainty in the short-term due to Veteran responses to policy changes, and this can compound more substantially over the long-term horizon.

Health Status

Acute illnesses among enrollees may require substantial care by VA, and ongoing treatment for chronic medical conditions account for a significant part of VA direct care and community care workload. However, due to the approximately 9 million Veterans currently enrolled, of which approximately 6 million are patients during the year, the uncertainty about the workload required for individuals is spread and diversified across a very large population. The impact of an individual enrollee's medical condition is even diversified across the patients of a particular VA facility.

If, however, there are systematic changes in the prevalence and severity of medical conditions across a large portion of the enrollee population, then this diversification may become less effective at reducing potential volatility in the overall demand for health care services.

Assumptions most affected

Morbidity, utilization trends, utilization differences across demographic groups:

- Systematic changes across large groups of enrollees will impact morbidity levels for specific service categories at the market and national level. For example, increases in opioid addiction raise uncertainty about how to model long term substance abuse disorder morbidity. These types of systematic changes in disease prevalence tend to be gradual and may be detected through ongoing monitoring of workload and through consultation with VHA program offices.

Time horizon

Short-term and long-term:

- Due to the diversification of risks across a large enrollee population, short-term uncertainty arises more from systematic and sudden changes across a broad portion of the population, such as a pandemic. Uncertainty is greater over the long-term, as emerging trends in disease prevalence compound over a longer period of time.

Budget Scenario

The long-term health status impacts of the pandemic are not fully known. Emerging literature, including VA research, demonstrates an increase in demand for health care following recovery from COVID-19, particularly care related to cardiovascular disease and mental health conditions. However, a number of factors could cause changes in health status in the broader enrollee population:

- Mental health strain caused by the pandemic and resulting quarantine.
- Complications caused by the deferral of care. This includes both the deferral of treatments and the deferral of preventive care services, which could lead to missed or delayed identification of health care conditions.
- While most patients contracting the virus appear to have recovered fully, there is uncertainty about the potential for emerging complications.

The Budget Scenario does not include any adjustments to reflect these factors. VA continues to consult with subject matter experts, reviewing literature and analyzing emerging data and will incorporate adjustments to the model as appropriate.

Inflation

The cost of goods and services tends to increase over time, and the rate of inflation is difficult to forecast over both short and long periods. For example, the consumer price index for all urban consumers (CPI-U) increased 8.6% on a 12-month basis as of May 2022, which was about 6% higher than typical projections made as recently as January 2020[7]. 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

[7] Congressional Budget Office's (CBO's) January 2020 "The Budget and Economic Outlook from 2020 to 2030", Table 2-1, indicated a projected annual CPI-U increases of 2.6% during 2021 and 2022. On June 10, 2022, the Bureau of Labor Statistics reported that the CPI-U increased by 8.6% over the prior 12 months ending May 2022.https://www.cbo.gov/publication/56073

Department. Assumptions are set regarding the trajectory of wage schedules and benefit levels for staff, though the actual amounts are uncertain.

- Community care claim costs are directly linked to the amounts paid to community providers for each service according to negotiated fee schedules. Those schedules are in turn often tied to Medicare fee-for-service payment rates which are impacted by inflation.

Time horizon

Short-term and long-term:

- Divergence of actual inflation trends over the EHCPM's assumptions will have a small impact over the short-term, but they may compound substantially over time. This risk is higher than normal at the current time due to the recent increase in inflation.
- While the fee schedules for community care may be set over a short period of time, over the long-term it is more difficult to anticipate the reimbursement levels that will be negotiated in the future. Similarly, uncertainty around inflation in both variable and fixed expenses will compound over time for services at VA facilities.
- Salaries are a significant component of VA facilities cost per service and change based on federal wage policy, which is generally set just prior to the impacted calendar year. In the short-term, differences between the actual wage increase/freeze and the assumptions in the EHCPM are addressed in the budget submission.

Budget Scenario

The CPI based forecast for VA's operational expenses was updated from using a twenty-year average inflation forecast (appropriate for the stable inflation environment preceding this year) to reflect a rise in inflation based on the recent CPI outcomes. This adjustment was applied to the near-term fiscal year forecasts before reverting back to a stable inflation rate for the long term.

Management Policies and Initiatives

VA leadership exercises some discretion in how health care benefits are provided through program policies and initiatives; as leadership changes, so can the top priorities of the organization. Changes in management approach and policy can impact many aspects of how care is delivered. VA may pursue new ways to improve the provision of care, but it may be difficult to predict what specific initiatives will be implemented and how they might affect future capacity for budget, capital and strategic planning purposes.

Assumptions most affected

- Enrollment rates, health care management, cost per service, priority transitions, reliance, utilization trends.
- Changes in management policies and initiatives range from broad, sweeping transformations of the health care system through leadership priorities to detailed decisions

by program offices that promote patient centered care. Examples of policies and initiatives that have impacted the EHCPM include:

- ***Programmatic adjustments for LTSS*** – VA is required to meet the LTSS needs of Veterans by providing facility-based care for enrollees with service-connected disabilities of 70% or greater as well as for those in need of such care due to service-connected conditions. Resources permitting, VA also must provide such care for enrollees who do not meet these criteria. VA is also required to provide home and community-based services to all enrollees as needed. Each year, the Office of Geriatrics and Extended Care provides policy assumptions to shift projected utilization to align with their initiative of keeping enrollees out of long-term facility-based care for as long as is feasible.
- ***Mental health and homeless staff hiring initiatives*** – VA places a high priority on ensuring that all enrolled Veterans have access to needed mental health services. VA also offers a wide array of special programs and initiatives specifically designed to help homeless Veterans live as self-sufficiently and independently as possible. Staffing for these programs, and subsequently projected utilization, can be dependent on temporary special purpose funds targeted for hiring mental health providers or availability of Housing and Urban Development-VA Supportive Housing vouchers. Each year, the Office of Mental Health and Suicide Prevention and the Homeless Program Office provide guidance on the presence of internal and external drivers impacting staffing so that appropriate adjustments can be made to projected utilization.
- ***Inpatient System Redesign*** – VA seeks to continuously improve its level of inpatient care management through initiatives such as the Flow Improvement Inpatient Initiative, full implementation of utilization management review programs, and improvements in disease management and care coordination through the Patient Aligned Care Team initiative. The EHCPM incorporates assumptions about VA's current efficiency level and the impact of system redesign on its future level. These assumptions are incorporated into the EHCPM to project utilization. Any expected savings from increased efficiency are reported as clinical efficiencies in the budget impact analysis.

Time horizon

Long-term:

- The expectation is that changes in the organization will occur gradually. In the long-term, there is uncertainty about their efficacy.

Non-VA Health Care Coverage

Veterans have access to other forms of health care, including through Medicare, Medicaid, employer-sponsored coverage, TRICARE, and individual health insurance. As the availability and affordability of external health care coverage changes, it can materially impact the choices available to a Veteran. For example, the ACA significantly expanded coverage options for

individuals beginning in 2014 by regulating and subsidizing individual coverage and funding expanded eligibility for Medicaid coverage in many states. Even for those with coverage, gradual increases in cost sharing over time may cause enrollees to shift more care to VA, thereby increasing reliance.

Medicare coverage is available to most seniors ages 65 and over and many disabled individuals under 65. Medicaid coverage is also available to lower income Veterans. Federal statute and regulation determine eligibility and benefits for Medicare coverage throughout the country whereas both the Federal government and each state's own Medicaid program determines eligibility and benefits of each state's Medicaid coverage. The ACA affects the availability of health care through individual and employer-sponsored coverage. It is difficult to predict long-term changes to these programs.

Assumptions most affected

Reliance, enrollment rates, community care reimbursement schedule:

- The availability, affordability, and scope of health insurance options outside of VA will affect both the likelihood that individual Veterans enroll with VA and once enrolled, may impact the portion of care and scope of services for which they rely on VA.
- Other sources of health insurance will affect a Veteran's behavior in different ways as they age or as their life situation changes. The loss of health coverage from the Department of Defense upon separating from the military is a key motivator for new Veterans to enroll with VA. If a Veteran has not yet enrolled with VA, they may reconsider it at key points in their life, such as after the loss of a job, when nearing retirement, or after losing health coverage from a spouse. Even when already enrolled, their reliance may change over time as they move from employer-sponsored coverage to Medicare, for example.
- Program changes may increase the benefit richness or generosity of Medicare and Medicaid. This can cause some enrollees to have less reliance for services. If a state expands Medicaid eligibility to higher income levels, then there could be a new portion of enrollees in that state who decide to get more of their care through Medicaid or who move over to Medicaid for the first time. Similarly, if subsidies for individual coverage under ACA are expanded, then these options will be more attractive when Veterans are deciding whether to get their care at VA.
- Projections of changes in reliance are hampered by incomplete data on enrollees' non-VA care, specifically, the lack of a comprehensive source to capture claims for enrollees under age 65.
- Community providers often derive a significant part of their income from serving Medicare and Medicaid beneficiaries, and so changes to the fee schedules under those programs can make providers more or less willing to participate in VA's community care contracts. Private insurance coverage, offered through ACA marketplaces or sponsored by employers, often reimburses providers more than they get from Medicare and Medicaid. There could be more pressure from community providers to be reimbursed by VA at higher levels if they think Medicare, Medicaid and private insurance reimbursement levels are insufficient. Conversely, contractions in the scope of coverage by other health care

coverages may reduce their workload and make them more willing to provide care purchased by VA. This increases uncertainty about future cost per service levels for community care.

- Much of the VA Community Care Network contract references Medicare reimbursement rates, so changes to Medicare's fee schedules will also directly affect community care reimbursement.

Time horizon

Short-term and long-term:

- There is uncertainty in the short-term due to Veteran responses to changes in their health care coverage, and this can compound more substantially over the long-term horizon. Enrollment in other sources of coverage tends to be "sticky" in the sense that individuals tend to stay with their current health coverage and health care providers.
- Short-term changes in other sources of health insurance, such as during an economic downturn, can introduce uncertainty about reliance levels over the short-term budget horizon. For example, when a Veteran loses their job or insurance from an employer, they may consider a variety of options, including COBRA coverage, subsidized insurance through ACA marketplaces, or Medicaid, in addition to VA. If their period of unemployment is short, then they may go back to employer-sponsored coverage without ever considering VA health care.
- Longer-term, there is much more uncertainty about insurance markets and public programs. Programs can become more or less attractive over time, and gradual changes can compound over many years as Veteran decisions on where to get their care begin to change on an individual basis.

Combat and deployments

Military conflicts are difficult to predict. Yet, they can have a dramatic impact on the number of Service members, the timing of their separations from the military, the nature of medical conditions related to military service, and the long-term relationship between former Service members and government agencies. In each conflict era, newly separating Service members initially represent a small and young cohort of the enrolled Veteran population. Over time, they may grow to be a more substantial portion of the population. Historical data from Veterans of earlier conflicts may be a guide but is not a perfect template for predicting the behaviors and health care needs of more recent Veterans.

Extended combat deployments can lead to greater morbidity and higher prevalence of service-connection disability which can lead greater health care needs after discharge. Furthermore, each period of combat gives rise to different types of disability due to the changing nature of warfare, changes in survivability of injuries, and other factors.

Assumptions most affected

Enrollment rates, morbidity, reliance:

- Recently separated post-9/11 combat Veterans have much different health care needs and enrollment rates than Veterans of the earlier Gulf War era. Similarly, Vietnam era Veterans (representing about 29% of current enrollees) have different health care needs than WWII Veterans (currently representing about 1% of enrollees), even after adjusting for the passage of time and aging. For example, exposure to Agent Orange during the Vietnam War has led to a unique mix of medical conditions over the lifetime of those combat Veterans, requiring VA to develop a presumptive service-connected disability authority. In addition, battlefield injuries among surviving Veterans are different, causing morbidity differences by service category to differ. There are other generational differences that show up in various model assumptions, including enrollment rates and reliance.
- Women Veterans currently represent about 10% of enrollees, a share that continues to increase and which is projected to reach 14% by 2032. 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.

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Medical Facilities by Type

As of September 30, 2023, the Veterans Health Administration (VHA) operates a portfolio of approximately 5,593 owned buildings with a total of 153.1 million square feet of space on 16,025 acres of land. The portfolio also includes 1,714 leases with a total of 23.1 million square feet of space.

The table below provides a more granular level of detail based on the services provided and is consistent with the current classification methodology. A description of each of category of facility, along with an explanation of any changes in the number of installations, is provided after the table. Tables containing the names and locations of each installation within each facility category are located at the end of the chapter.

Medical Care
Number of Installations

		2024		2025		2026		
Description	2023 Actual 1/	Budget Estimate	Current Estimate	Advance Approp.	Revised Request	Advance Approp.	+/- 2024-2025	+/- 2025-2026
Veterans Integrated Service Networks (VISN)	**18**	**18**	**18**	**18**	**18**	**18**	0	0
VA Medical Centers (VAMC), Total	**173**	**172**	**173**	**172**	**173**	**173**	0	0
Included in VA Medical Centers, Total:								
VA Hospitals	144	145	144	145	144	144	0	0
Community Living Centers (CLC)	135	135	135	135	136	137	1	1
Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)	120	127	125	129	126	128	1	2
VAMC-Based Outpatient Care Sites	173	172	173	172	173	173	0	0
Health Care Centers (HCC)	**12**	**12**	**12**	**12**	**12**	**12**	0	0
Community-Based Outpatient Clinics (CBOC)	**733**	**704**	**736**	**704**	**741**	**741**	5	0
Multi-Specialty CBOC	311	289	311	289	312	312	1	0
Primary Care CBOC	422	415	425	415	429	429	4	0
Other Outpatient Services (OOS) Sites, Total	**423**	**415**	**423**	**415**	**423**	**423**	0	0
Included in OOS Sites, Total:								
Dialysis Centers	70	70	70	70	70	70	0	0
Community Resource and Referral Centers (CRRC)	33	33	33	33	33	33	0	0
Vet Centers	**302**	**300**	**303**	**300**	**303**	**303**	0	0
Mobile Vet Centers	**84**	**83**	**86**	**83**	**86**	**86**	0	0
Vet Center Outstations	**20**	**23**	**21**	**23**	**21**	**21**	0	0

1/ Reflects historical data as of September 30, 2023.

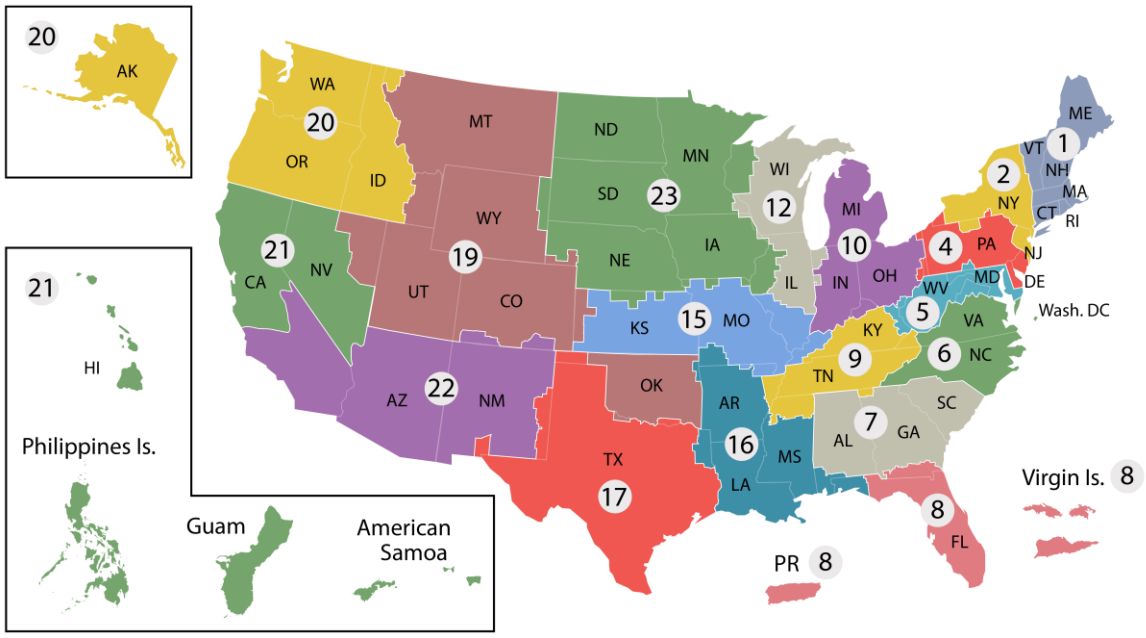
Annual Changes in Medical Care Installations

Veterans Integrated Service Networks (VISN)

In the late 1990s, VHA was geographically separated into 21 areas known as Veterans Integrated Service Networks (VISNs) and was further modified in October 2015 in compliance with the VA Memorandum on VISN Realignment. As a result of the VISN realignment, VHA currently has a five districts and 18 VISNs. 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



VA Medical Centers (VAMC)
VAMCs are facilities that provide two or more categories of care (inpatient, outpatient, residential rehabilitation, or institutional extended care).

VAMC changes in 2023
Based on the workload data, 1 OOS site has been reclassified into VAMC in 2023, resulting in a net increase from 172 to 173 (+1 VAMC):

- +1 VAMC: VISN 19 Friendship House VA Compensated Work Therapy/Transitional Residence, Oklahoma City, OK (635PA)

Of the 173 VAMCs, 144 were classified as VA Hospitals in 2023. The other 29 VAMCs provided a mix of other bed-care services, such as CLCs and/or residential rehabilitation care, thus meeting the VAMC criteria.

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. To meet the criteria of a VA Hospital, a facility must report over 500 inpatient acute bed days of care.

VA Hospital changes in 2023
Based on the workload data, 1 Hospital site has been reclassified into a non-hospital VAMC in 2023, resulting in a net decrease from 145 to 144 (-1 Hospital VAMC):

- -1 Hospital VAMC: VISN 2 Lyons VAMC, Lyons, NJ (561A4)

Please refer to the section titled "FY 2023 VA Medical Centers and Hospitals" for the complete list of VA Medical Centers and Hospitals in 2023.

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.

In 2023, there were 135 CLC sites. Please refer to the section titled "FY 2023 Community Living Centers (CLC)" for the complete list of CLCs in 2023.

CLC changes in 2025
In 2025, 1 site is projected to be activated, resulting in a net increase from 135 to 136 (+1 CLC):

- +1 CLC: VISN 5 Hershel "Woody" Williams VA Medical Center, Huntington WV (581)

CLC changes in 2026
In 2026, 1 site is projected to be activated, resulting in a net increase from 136 to 137 (+1 CLC):

- +1 CLC: VISN 10 VA Northern Indiana Health Care System, Fort Wayne, IN (610A4)

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 2023
There were a 120 MH RRTP sites in 2023. Based on the workload data, 1 site of care has been activated and 1 site deactivated:

- +1 Domiciliary Substance Use Disorder (DOM SUD): VISN 16 Alexandria VA Medical Center, LA (502)
- - 1 MH RRTP: VISN 20 VA Roseburg Healthcare, Cincinnati, OH (653)

Please refer to the section titled "FY 2023 Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)" for the complete list of MH RRTPs in 2023.

MH RRTP changes in 2024
In 2024, 5 sites of care are projected to be activated, resulting in a net increase from 120 to 125 (+5 MH RRTP):

- +1 Domiciliary Care for Homeless Veterans, Houston, TX
- +1 DOM SUD, Amarillo, TX
- +1 Domiciliary Post-Traumatic Stress Disorder (DOM PTSD), Denver, CO
- +1 MH RRTP Jacksonville, FL
- +1 MH RRTP, San Juan, PR

MH RRTP changes in 2025
In 2025, MH RRTPs are projected to increase from 125 to 126 (+1 MH RRTP):

- +1 DOM SUD, Poplar Bluff, MO

MH RRTP changes in 2026
In 2026, MH RRTPs are projected to increase from 126 to 128 (+2 MH RRTP):

- +1 DOM SUD, Togus, ME

- +1 DOM SUD, Oklahoma City, OK

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 medical facilities are classified based on workload (i.e., encounters) by the following services: Primary Care, Mental Health, Specialty Care, and Ambulatory Surgery. Please refer to the "Outpatient Classification Criteria" table below for complete detail.

Outpatient Classification Criteria

Outpatient Medical Facilities	Primary Care Encounters 1/	Mental Health Encounters 1/	Specialty Care Encounters 1/	Ambulatory Surgery Services 2/
Health Care Center (HCC)	Greater than 500	Greater than 500	Greater than 500 in any 2 or more Specialties	Yes
Multi-Specialty CBOC	Greater than 500	Greater than 500	Greater than 500 in any 2 or more Specialties	None
Primary Care CBOC	Greater than 500	Greater than 500	Greater than 500 in any 1 Specialty	None
Primary Care CBOC	Greater than 500	Greater than 500	500 or less in 1 or more Specialties	None
Other Outpatient Service Site (OOS)	Greater than 500	Less than 500	Greater than 0	None
Other Outpatient Service Site (OOS)	Less than or equal to 500	Greater than 500	None	None
Other Outpatient Service Site (OOS)	Less than or equal to 500	Greater than 500	Greater than 0	None
Other Outpatient Service Site (OOS)	Less than or equal to 500	Less than or equal to 500	Greater than 0	None
Other Outpatient Service Site (OOS)	None	Less than or equal to 500	None	None

1/ Source: VSSC Outpatient Encounters data
2/ Source: Surgery and Clinical Inventory data (Ambulatory Surgery Center, Ambulatory Surgery Services and / or Moderate Sedation)

There are four outpatient classifications: (1) Health Care Center (HCC); (2) Multi-Specialty Community Based Outpatient Clinic (MS CBOC); (3) Primary Care Community Based Outpatient Clinic (PC CBOC); and (4) Other Outpatient Services site (OOS).

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 2023</u>
In 2023, 1 new site of care has been activated and 1 HCC has been reclassified into MS CBOC, resulting in a total of 12 HCC sites:
- +1 HCC: VISN 1 Concord VA Clinic, Concord, NH (608BY)
- -1 HCC: VISN 17 North West San Antonio VA Clinic, San Antonio, TX (671GS)

Please refer to the section titled "FY 2023 Health Care Centers (HCC)" for the complete list of HCCs in 2023.

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 2023

In 2023, 4 MS CBOC sites have been activated, 1 HCC, 9 OOS sites and 43 PC CBOCs have been reclassified into MS CBOC (+57 MS CBOC); 3 MS CBOC sites have been deactivated, 10 MS CBOCs have been reclassified into OOS, and 22 MS CBOCs have been reclassified into PC CBOC (-35 MS CBOC), resulting in a net increase from 289 to 311 (+22 MS CBOC).

Activations (+4 MS CBOC):

- +1 MS CBOC: VISN 4 Croasdaile VA Clinic, Monroeville, PA (646GF)
- +1 MS CBOC: VISN 6 Croasdaile VA Clinic, Durham, NC (558GI)
- +1 MS CBOC: VISN 17 Corpus Christi West Point VA Clinic, Corpus Christi, TX (740QB)
- +1 MS CBOC: VISN 21 Modesto VA Clinic, Modesto, CA (612GM)

HCC reclassified into MS CBOCs (+1 MS CBOC):

- +1 MS CBOC: VISN 17 North West San Antonio VA Clinic, San Antonio, TX (671GS)

OOS sites reclassified into MS CBOCs (+9 MS CBOC):

- +1 MS CBOC: VISN 1 Worcester VA Clinic, Worcester, MA (631GE)
- +1 MS CBOC: VISN 7 Tucker VA Clinic, Atlanta, GA (508QJ)
- +1 MS CBOC: VISN 8 Lakeland VA Clinic, Lakeland, FL (673GB)
- +1 MS CBOC: VISN 8 Boca Raton VA Clinic, Boca Raton, FL (548GD)
- +1 MS CBOC: VISN 10 Terre Haute VA Clinic, Terre Haute, IN (583GA)
- +1 MS CBOC: VISN 15 Lenexa VA Clinic, Lenexa, KS (589JG)
- +1 MS CBOC: VISN 21 Clearlake VA Clinic, Clearlake, CA (662GG)
- +1 MS CBOC: VISN 21 Oakland VA Clinic, Oakland, CA (662GH)
- +1 MS CBOC: VISN 23 Sterling VA Clinic, Sterling, IL (636GT)

PC CBOCs reclassified into MS CBOCs (+43 MS CBOC):

- +1 MS CBOC: VISN 1 Lewiston VA Clinic, Lewiston, ME (402GE)
- +1 MS CBOC: VISN 1 Portland VA Clinic, Portland, ME (402HC)
- +1 MS CBOC: VISN 2 Patchogue VA Clinic, Patchogue, NY (632HD)
- +1 MS CBOC: VISN 4 Kent County VA Clinic, Dover, DE (460GC)
- +1 MS CBOC: VISN 4 Cape May County VA Clinic, Rio Grande, NJ (460GD)
- +1 MS CBOC: VISN 4 Crawford County VA Clinic, Meadville, PA (562GA)
- +1 MS CBOC: VISN 4 Warren County VA Clinic, Warren, PA (562GE)
- +1 MS CBOC: VISN 5 Monongalia County VA Clinic, Westover, WV (540GD)
- +1 MS CBOC: VISN 6 Jacksonville VA Clinic, Jacksonville, NC (565GA)
- +1 MS CBOC: VISN 6 Lee County VA Clinic, Sanford, NC (565GG)

- +1 MS CBOC: VISN 6 Franklin VA Clinic, Franklin, NC (637GA)
- +1 MS CBOC: VISN 6 Clayton-East Raleigh VA Clinic, Clayton, NC (558GH)
- +1 MS CBOC: VISN 7 North Charleston VA Clinic, North Charleston, SC (534GF)
- +1 MS CBOC: VISN 7 Fort Benning VA Clinic, Fort Benning, GA (619QB)
- +1 MS CBOC: VISN 8 Pembroke Pines VA Clinic, Hollywood, FL (546GD)
- +1 MS CBOC: VISN 8 Hollywood VA Clinic, Hollywood, FL (546GF)
- +1 MS CBOC: VISN 8 Deerfield Beach VA Clinic, Deerfield Beach, FL (546GH)
- +1 MS CBOC: VISN 8 Lecanto VA Clinic, Lecanto, FL (673GH)
- +1 MS CBOC: VISN 8 Deltona VA Clinic, Deltona, FL (675GD)
- +1 MS CBOC: VISN 9 Fort Knox VA Clinic, Fort Knox, KY (603GA)
- +1 MS CBOC: VISN 9 Stonybrook VA Clinic, Louisville, KY (603GD)
- +1 MS CBOC: VISN 9 Jonesboro VA Clinic, Jonesboro, AR (614GB)
- +1 MS CBOC: VISN 9 Dannie A. Carr Veterans Outpatient Clinic, Sevierville, TN (621GI)
- +1 MS CBOC: VISN 10 Georgetown VA Clinic, Georgetown, OH (539GF)
- +1 MS CBOC: VISN 10 Lafayette VA Clinic, Lafayette, IN (583GE)
- +1 MS CBOC: VISN 10 Navy Corpsman Steve Andrews Department of Veterans Affairs Health Care Clinic, Gaylord, MI (655GA)
- +1 MS CBOC: VISN 12 Bloomington VA Clinic, Bloomington, IL (550GG)
- +1 MS CBOC: VISN 12 Madison West VA Clinic, Madison, WI (607GG)
- +1 MS CBOC: VISN 12 Wausau VA Clinic, Rothschild, WI (676GA)
- +1 MS CBOC: VISN 12 La Crosse VA Clinic, La Crosse, WI (676GC)
- +1 MS CBOC: VISN 15 Sedalia VA Clinic, Sedalia, MO (589JA)
- +1 MS CBOC: VISN 15 Honor VA Clinic, Kansas City, MO (589JF)
- +1 MS CBOC: VISN 17 Laredo VA Clinic, Laredo, TX (740GD)
- +1 MS CBOC: VISN 17 Las Cruces VA Clinic, Las Cruces, NM (756GA)
- +1 MS CBOC: VISN 19 Pocatello VA Clinic, Pocatello, ID (660GA)
- +1 MS CBOC: VISN 20 West Linn VA Clinic, West Linn, OR (648GG)
- +1 MS CBOC: VISN 21 Pahrump VA Clinic, Pahrump, NV (593GC)
- +1 MS CBOC: VISN 21 Southeast Las Vegas VA Clinic, Las Vegas, NV (593GF)
- +1 MS CBOC: VISN 21 Sierra Foothills VA Clinic, Auburn, CA (612GK)
- +1 MS CBOC: VISN 23 Hibbing VA Clinic, Hibbing, MN (618GB)
- +1 MS CBOC: VISN 23 Lane A. Evans VA Community Based Outpatient Clinic, Galesburg, IL (636GI)
- +1 MS CBOC: VISN 23 Shenandoah VA Clinic, Shenandoah, IA (636GP)
- +1 MS CBOC: VISN 23 Max J. Beilke Department of Veterans Affairs Outpatient Clinic, Alexandria, MN (656GC)

Deactivations (-3 MS CBOC):

- -1 MS CBOC: VISN 21 Stockton VA Clinic, French Camp, CA (640HA)
- -1 MS CBOC: VISN 21 Modesto VA Clinic, Modesto, CA (640HB)
- -1 MS CBOC: VISN 22 Oxnard VA Clinic, Oxnard, CA (691GM)

MS CBOCs reclassified into OOS sites (-10 MS CBOC):

- -1 MS CBOC: VISN 7 Cobb County VA Clinic, Marietta, GA (508GQ)
- -1 MS CBOC: VISN 7 Pike County VA Clinic, Zebulon, GA (508GS)

- -1 MS CBOC: VISN 7 Market Commons VA Clinic, Myrtle Beach, SC (534QA)
- -1 MS CBOC: VISN 10 Shelbyville VA Clinic, Shelbyville, IN (583GG)
- -1 MS CBOC: VISN 19 Fort Collins VA Clinic, Fort Collins, CO (442GC)
- -1 MS CBOC: VISN 19 North Oklahoma City VA Clinic, Oklahoma City, OK (635GL)
- -1 MS CBOC: VISN 21 Stockton VA Clinic, French Camp, CA (612QE)
- -1 MS CBOC: VISN 23 North Platte VA Clinic, North Platte, NE (636GB)
- -1 MS CBOC: VISN 23 Holdrege VA Clinic, Holdrege, NE (636GQ)
- -1 MS CBOC: VISN 23 South Des Moines VA Clinic, Des Moines, IA (636GZ)

MS CBOCs reclassified into PC CBOCs (-22 MS CBOC):

- -1 MS CBOC: VISN 1 New Bedford VA Clinic, New Bedford, MA (650GA)
- -1 MS CBOC: VISN 1 Hyannis VA Clinic, Hyannis, MA (650GA)
- -1 MS CBOC: VISN 2 Port Jervis VA Clinic, Port Jervis, NY (620GE)
- -1 MS CBOC: VISN 5 Cumberland VA Clinic, Cumberland, MD (613GA)
- -1 MS CBOC: VISN 6 Morehead City VA Clinic, Morehead City, NC (558GC)
- -1 MS CBOC: VISN 7 Rome VA Clinic, Rome, GA (508GL)
- -1 MS CBOC: VISN 12 Springfield VA Clinic, Springfield, IL (550GD)
- -1 MS CBOC: VISN 15 St. Louis County VA Clinic, Florissant, MO (657GB)
- -1 MS CBOC: VISN 15 St. Charles County VA Clinic, St. Charles, MO (657GD)
- -1 MS CBOC: VISN 15 Sikeston VA Clinic, Sikeston, MO (657GV)
- -1 MS CBOC: VISN 16 Searcy VA Clinic, Searcy, AR (598GF)
- -1 MS CBOC: VISN 17 Garland VA Medical Center, Garland, TX (549A5)
- -1 MS CBOC: VISN 17 Tyler Broadway VA Clinic, Tyler, TX (549QC)
- -1 MS CBOC: VISN 17 Frank M. Tejeda Department of Veterans Affairs Outpatient Clinic, San Antonio, TX (671BY)
- -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 22 Murrieta VA Clinic, Murrieta, CA (605GB)
- -1 MS CBOC: VISN 22 Sy Kaplan VA Clinic, Palm Desert, CA (605GC)
- -1 MS CBOC: VISN 22 Phoenix 32nd Street VA Clinic, Phoenix, AZ (644GI)
- -1 MS CBOC: VISN 22 Northwest Tucson VA Clinic, Tucson, AZ (678GF)
- -1 MS CBOC: VISN 23 Sioux City VA Clinic, Dakota Dunes, SD (438GC)
- -1 MS CBOC: VISN 23 Aberdeen VA Clinic, Aberdeen, SD (438GD)

Please refer to the section titled "FY 2023 Multi-Specialty Community Based Clinics (MS CBOC)" for the complete list of MS CBOCs in 2023.

<u>MS CBOC changes in 2025</u>

In 2025, MS CBOCs are projected to increase from 311 to 312 (+1 MS CBOC):

- +1 MS CBOC: VISN 5 Prince William County MS CBOC, Prince William County, VA

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 2023

In 2023, 8 PC CBOC sites have been activated, 22 MS CBOCs and 48 OOS sites have been reclassified into PC CBOCs (+78 PC CBOC); 1 PC CBOC has been deactivated, 43 PC CBOCs have been reclassified into MS CBOCs, and 25 PC CBOCs have been reclassified into OOS sites (-69 PC CBOC), resulting in a net increase from 413 to 422 (+9 PC CBOC).

Activations (+8 PC CBOC):

- +1 PC CBOC: VISN 6 Johnson Air Force Base VA Clinic, Goldsboro, NC (565GO)
- +1 PC CBOC: VISN 10 Huntington VA Clinic, Huntington, IN (610GF)
- +1 PC CBOC: VISN 17 San Antonio Pecan Valley VA Clinic, San Antonio, TX (671GU)
- +1 PC CBOC: VISN 17 Killeen VA Clinic, Killeen, TX (674GH)
- +1 PC CBOC: VISN 17 Copperas Cove VA Clinic, Copperas Cove, TX (674GG)
- +1 PC CBOC: VISN 19 Space Center VA Clinic, Colorado Springs, CO (554GM)
- +1 PC CBOC: VISN 19 Claremore VA Clinic, Claremore, OK (623GD)
- +1 PC CBOC: VISN 21 Sonora VA Clinic, Sonora, CA (612GL)

MS CBOCs reclassified into PC CBOCs (+22 PC CBOC):

- +1 PC CBOC: VISN 1 New Bedford VA Clinic, New Bedford, MA (650GA)
- +1 PC CBOC: VISN 1 Hyannis VA Clinic, Hyannis, MA (650GB)
- +1 PC CBOC: VISN 2 Port Jervis VA Clinic, Port Jervis, NY (620GE)
- +1 PC CBOC: VISN 5 Cumberland VA Clinic, Cumberland, MD (613GA)
- +1 PC CBOC: VISN 6 Morehead City VA Clinic, Morehead City, NC (558GC)
- +1 PC CBOC: VISN 7 Rome VA Clinic, Rome, GA (508GL)
- +1 PC CBOC: VISN 12 Springfield VA Clinic, Springfield, IL (550GD)
- +1 PC CBOC: VISN 15 St. Louis County VA Clinic, Florissant, MO (657GB)
- +1 PC CBOC: VISN 15 St. Charles County VA Clinic, St. Charles, MO (657GD)
- +1 PC CBOC: VISN 15 Sikeston VA Clinic, Sikeston, MO (657GV)
- +1 PC CBOC: VISN 16 Searcy VA Clinic, Searcy, AR (598GF)
- +1 PC CBOC: VISN 17 Garland VA Medical Center, Garland, TX (549A5)
- +1 PC CBOC: VISN 17 Tyler Broadway VA Clinic, Tyler, TX (549QC)
- +1 PC CBOC: VISN 17 Frank M. Tejeda Department of Veterans Affairs Outpatient Clinic, San Antonio, TX (671BY)
- +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 22 Murrieta VA Clinic, Murrieta, CA (605GB)
- +1 PC CBOC: VISN 22 Sy Kaplan VA Clinic, Palm Desert, CA (605GC)
- +1 PC CBOC: VISN 22 Phoenix 32nd Street VA Clinic, Phoenix, AZ (644GI)
- +1 PC CBOC: VISN 22 Northwest Tucson VA Clinic, Tucson, AZ (678GF)

- +1 PC CBOC: VISN 23 Sioux City VA Clinic, Dakota Dunes, SD (438GC)
- +1 PC CBOC: VISN 23 Aberdeen VA Clinic, Aberdeen, SD (438GD)

OOS sites reclassified into PC CBOCs (+48 PC CBOC):

- +1 PC CBOC: VISN 1 Rumford VA Clinic, Rumford, ME (402GC)
- +1 PC CBOC: VISN 1 Gloucester VA Clinic, Gloucester, MA (518GE)
- +1 PC CBOC: VISN 1 Plymouth VA Clinic, Plymouth, MA (523GD)
- +1 PC CBOC: VISN 1 Errera VA Clinic, West Haven, CT (689QA)
- +1 PC CBOC: VISN 1 Stamford VA Clinic, Stamford, CT (689GB)
- +1 PC CBOC: VISN 2 Niagara Falls VA Clinic, Niagara Falls, NY (528GD)
- +1 PC CBOC: VISN 2 Lockport VA Clinic, Lockport, NY (528GK)
- +1 PC CBOC: VISN 2 Glens Falls VA Clinic, Glens Falls, NY (528GT)
- +1 PC CBOC: VISN 2 Hamilton VA Clinic, Hamilton, NJ (561GA)
- +1 PC CBOC: VISN 2 Piscataway VA Clinic, Piscataway, NJ (561GF)
- +1 PC CBOC: VISN 2 Morristown VA Clinic, Morristown, NJ (561GH)
- +1 PC CBOC: VISN 2 Carmel VA Clinic, Carmel, NY (620GB)
- +1 PC CBOC: VISN 2 Goshen VA Clinic, Goshen, NY (620GD)
- +1 PC CBOC: VISN 2 Poughkeepsie VA Clinic, Poughkeepsie, NY (620GG)
- +1 PC CBOC: VISN 2 Riverhead VA Clinic, Riverhead, NY (632HB)
- +1 PC CBOC: VISN 6 Tazewell VA Clinic, Tazewell, VA (658GA)
- +1 PC CBOC: VISN 7 Ray Hendrix Department Of Veterans Affairs Clinic, Statesboro, GA (509QA)
- +1 PC CBOC: VISN 7 Columbus Downtown VA Clinic, Columbus, GA (619GG)
- +1 PC CBOC: VISN 7 Selma VA Clinic, Selma, AL (679GA)
- +1 PC CBOC: VISN 9 Carrollton VA Clinic, Carrollton, KY (603GH)
- +1 PC CBOC: VISN 9 Dover VA Clinic, Dover, TN (626GA)
- +1 PC CBOC: VISN 12 Gladstone VA Clinic, Gladstone, MI (585GG)
- +1 PC CBOC: VISN 15 Belton VA Clinic, Belton, MO (589GB)
- +1 PC CBOC: VISN 15 Kirksville VA Clinic, Kirksville, MO (589GE)
- +1 PC CBOC: VISN 15 St. Clair County VA Clinic, Shiloh, IL (657GA)
- +1 PC CBOC: VISN 15 Franklin County VA Clinic, Washington, MO (657GS)
- +1 PC CBOC: VISN 16 Panama City Beach VA Clinic, Panama City Beach, FL (520GB)
- +1 PC CBOC: VISN 16 Sugar Land VA Clinic, Sugar Land, TX (580GL)
- +1 PC CBOC: VISN 16 Natchez VA Clinic, Natchez, MS (586GE)
- +1 PC CBOC: VISN 17 Decatur VA Clinic, Decatur, TX (549GE)
- +1 PC CBOC: VISN 17 Palestine VA Clinic, Palestine, TX (674GA)
- +1 PC CBOC: VISN 19 Dr. Joseph Medicine Crow VA Clinic, Billings, MT (436GN)
- +1 PC CBOC: VISN 19 Ada VA Clinic, Ada, OK (635GD)
- +1 PC CBOC: VISN 19 Enid VA Clinic, Enid, OK (635GG)
- +1 PC CBOC: VISN 19 Tinker VA Clinic, Tinker Air Force Base, OK (635QE)
- +1 PC CBOC: VISN 20 Mountain Home VA Clinic, Mountain Home, ID (531GI)
- +1 PC CBOC: VISN 20 Brookings VA Clinic, Brookings, OR (653GB)
- +1 PC CBOC: VISN 20 Olympia VA Clinic, Olympia, WA (663GI)
- +1 PC CBOC: VISN 20 Puyallup VA Clinic, Puyallup, WA (663GJ)
- +1 PC CBOC: VISN 20 Grants Pass VA Clinic, Grants Pass, OR (692GB)

- +1 PC CBOC: VISN 21 Windward VA Clinic, Kaneohe, HI (459QC)
- +1 PC CBOC: VISN 21 Yreka VA Clinic, Yreka, CA (612GJ)
- +1 PC CBOC: VISN 21 Reno East VA Clinic, Reno, NV (654GE)
- +1 PC CBOC: VISN 21 North Reno VA Clinic, Reno, NV (654GF)
- +1 PC CBOC: VISN 22 Farmington VA Clinic, Farmington, NM (501GB)
- +1 PC CBOC: VISN 23 Rice Lake VA Clinic, Rice Lake, WI (618GM)
- +1 PC CBOC: VISN 23 Fort Dodge VA Clinic, Fort Dodge, IA (636GK)
- +1 PC CBOC: VISN 23 Burlington VA Clinic, Burlington, IA (636GY)

Deactivations (-1 PC CBOC):

- -1 PC CBOC: VISN 17 Frank M. Tejeda Department of Veterans Affairs Outpatient Clinic, San Antonio, TX (671BY)

PC CBOCs reclassified into OOS sites (-25 PC CBOC):

- -1 PC CBOC: VISN 6 Fredericksburg VA Clinic, Fredericksburg, VA (652GA)
- -1 PC CBOC: VISN 8 Vero Beach VA Clinic, Vero Beach, FL (548GE)
- -1 PC CBOC: VISN 9 Mountain City VA Clinic, Mountain City, TN (621GO)
- -1 PC CBOC: VISN 9 Morristown East VA Clinic, Morristown, TN (621GP)
- -1 PC CBOC: VISN 9 Albion Street VA Clinic, Nashville, TN (626QA)
- -1 PC CBOC: VISN 10 Howell VA Clinic, Howell, MI (506GE)
- -1 PC CBOC: VISN 10 Vine Street VA Clinic, Cincinnati, OH (539QC)
- -1 PC CBOC: VISN 12 Clark County VA Clinic, Owen, WI (676GE)
- -1 PC CBOC: VISN 15 Heartland Street VA Clinic, Marion, IL (657QD)
- -1 PC CBOC: VISN 16 Kosciusko VA Clinic, Kosciusko, MS (586GA)
- -1 PC CBOC: VISN 17 Hobbs VA Clinic, Hobbs, NM (519GB)
- -1 PC CBOC: VISN 17 Walzem VA Clinic, San Antonio, TX (671GT)
- -1 PC CBOC: VISN 19 Butte VA Clinic, Butte, MT (436GO)
- -1 PC CBOC: VISN 19 Merril Lundman Department of Veterans Affairs Outpatient Clinic, Havre, MT (436HC)
- -1 PC CBOC: VISN 19 Alamosa VA Clinic, Alamosa, CO (554GF)
- -1 PC CBOC: VISN 19 Denver VA Clinic, Denver, CO (554GJ)
- -1 PC CBOC: VISN 19 Glenwood Springs VA Clinic, Glenwood Springs, CO (575QA)
- -1 PC CBOC: VISN 19 Shawnee VA Clinic, Shawnee, OK (635GK)
- -1 PC CBOC: VISN 19 Riverton VA Clinic, Riverton, WY (666GC)
- -1 PC CBOC: VISN 20 Everett VA Clinic, Everett, WA (663GK)
- -1 PC CBOC: VISN 20 La Grande VA Clinic, La Grande, OR (687GC)
- -1 PC CBOC: VISN 22 North Loma Linda VA Clinic, Redlands, CA (605GF)
- -1 PC CBOC: VISN 22 Mesa VA Clinic, Mesa, AZ (644GJ)
- -1 PC CBOC: VISN 22 Captain Rosemary Bryant Mariner Outpatient Clinic, Ventura, CA (691GQ)
- -1 PC CBOC: VISN 23 Scottsbluff VA Clinic, Scottsbluff, NE (568HH)

PC CBOCs reclassified into MS CBOCs (-43 PC CBOC):

- -1 PC CBOC: VISN 1 Lewiston VA Clinic, Lewiston, ME (402GE)
- -1 PC CBOC: VISN 1 Portland VA Clinic, Portland, ME (402HC)
- -1 PC CBOC: VISN 2 Patchogue VA Clinic, Patchogue, NY (632HD)
- -1 PC CBOC: VISN 4 Kent County VA Clinic, Dover, DE (460GC)

- -1 PC CBOC: VISN 4 Cape May County VA Clinic, Rio Grande, NJ (460GD)
- -1 PC CBOC: VISN 4 Crawford County VA Clinic, Meadville, PA (562GA)
- -1 PC CBOC: VISN 4 Warren County VA Clinic, Warren, PA (562GE)
- -1 PC CBOC: VISN 5 Monongalia County VA Clinic, Westover, WV (540GD)
- -1 PC CBOC: VISN 6 Jacksonville VA Clinic, Jacksonville, NC (565GA)
- -1 PC CBOC: VISN 6 Lee County VA Clinic, Sanford, NC (565GG)
- -1 PC CBOC: VISN 6 Franklin VA Clinic, Franklin, NC (637GA)
- -1 PC CBOC: VISN 6 Clayton-East Raleigh VA Clinic, Clayton, NC (558GH)
- -1 PC CBOC: VISN 7 North Charleston VA Clinic, North Charleston, SC (534GF)
- -1 PC CBOC: VISN 7 Fort Benning VA Clinic, Fort Benning, GA (619QB)
- -1 PC CBOC: VISN 8 Pembroke Pines VA Clinic, Hollywood, FL (546GD)
- -1 PC CBOC: VISN 8 Hollywood VA Clinic, Hollywood, FL (546GF)
- -1 PC CBOC: VISN 8 Deerfield Beach VA Clinic, Deerfield Beach, FL (546GH)
- -1 PC CBOC: VISN 8 Lecanto VA Clinic, Lecanto, FL (673GH)
- -1 PC CBOC: VISN 8 Deltona VA Clinic, Deltona, FL (675GD)
- -1 PC CBOC: VISN 9 Fort Knox VA Clinic, Fort Knox, KY (603GA)
- -1 PC CBOC: VISN 9 Stonybrook VA Clinic, Louisville, KY (603GD)
- -1 PC CBOC: VISN 9 Jonesboro VA Clinic, Jonesboro, AR (614GB)
- -1 PC CBOC: VISN 9 Dannie A. Carr Veterans Outpatient Clinic, Sevierville, TN (621GI)
- -1 PC CBOC: VISN 10 Georgetown VA Clinic, Georgetown, OH (539GF)
- -1 PC CBOC: VISN 10 Lafayette VA Clinic, Lafayette, IN (583GE)
- -1 PC CBOC: VISN 10 Navy Corpsman Steve Andrews Department of Veterans Affairs Health Care Clinic, Gaylord, MI (655GA)
- -1 PC CBOC: VISN 12 Bloomington VA Clinic, Bloomington, IL (550GG)
- -1 PC CBOC: VISN 12 Madison West VA Clinic, Madison, WI (607GG)
- -1 PC CBOC: VISN 12 Wausau VA Clinic, Rothschild, WI (676GA)
- -1 PC CBOC: VISN 12 La Crosse VA Clinic, La Crosse, WI (676GC)
- -1 PC CBOC: VISN 15 Sedalia VA Clinic, Sedalia, MO (589JA)
- -1 PC CBOC: VISN 15 Honor VA Clinic, Kansas City, MO (589JF)
- -1 PC CBOC: VISN 17 Laredo VA Clinic, Laredo, TX (740GD)
- -1 PC CBOC: VISN 17 Las Cruces VA Clinic, Las Cruces, NM (756GA)
- -1 PC CBOC: VISN 19 Pocatello VA Clinic, Pocatello, ID (660GA)
- -1 PC CBOC: VISN 20 West Linn VA Clinic, West Linn, OR (648GG)
- -1 PC CBOC: VISN 21 Pahrump VA Clinic, Pahrump, NV (593GC)
- -1 PC CBOC: VISN 21 Southeast Las Vegas VA Clinic, Las Vegas, NV (593GF)
- -1 PC CBOC: VISN 21 Sierra Foothills VA Clinic, Auburn, CA (612GK)
- -1 PC CBOC: VISN 23 Hibbing VA Clinic, Hibbing, MN (618GB)
- -1 PC CBOC: VISN 23 Lane A. Evans VA Community Based Outpatient Clinic, Galesburg, IL (636GI)
- -1 PC CBOC: VISN 23 Shenandoah VA Clinic, Shenandoah, IA (636GP)
- -1 PC CBOC: VISN 23 Max J. Beilke Department of Veterans Affairs Outpatient Clinic, Alexandria, MN (656GC)

Please refer to the section titled "FY 2023 Primary Community Based Outpatient Clinics (PC CBOC)" for the complete list of PC CBOCs in 2023.

PC CBOC changes in 2024

In 2024, PC CBOCs are projected to increase from 422 to 425 (+3 PC CBOC):

- +1 PC CBOC: VISN 8 Thomas County PC CBOC, Thomas County, GA
- +1 PC CBOC: VISN 8 Flagler County PC CBOC, Flagler County, FL
- +1 PC CBOC: VISN 8 Levy County PC CBOC, Levy County, FL

PC CBOC changes in 2025

In 2025, PC CBOCs are projected to increase from 425 to 429 (+4 PC CBOC):

- +1 PC CBOC: VISN 4 Adams County PC CBOC, Adams County, PA
- +1 PC CBOC: VISN 7 Georgetown PC CBOC, Georgetown, SC
- +1 PC CBOC: VISN 23 Cambridge PC CBOC, Cambridge, MN
- +1 PC CBOC: VISN 23 Litchfield PC CBOC, Litchfield, MN

Other Outpatient Services (OOS) Sites

OOS sites are sites in which Veterans receive services that do not generate VHA encounter workload, or do not meet minimum workload criteria to be classified as a CBOC or HCC. Many of the services provided at these sites are contacts made by VA or VHA personnel to provide information, social services, homelessness outreach services, activities to increase Veteran awareness of benefits and services, and support services, such as those provided in Vet Centers. Other services could be more clinical in nature, which can be provided to remote areas through a Telehealth clinic or other arrangement. If any other services are provided in this venue (external to a VA clinic or facility), they must be associated with, attached to, and coordinated by a health care delivery site located in a clinic or facility.

OOS site changes in 2023

In 2023, 45 OOS sites have been activated, 10 MS CBOC and 25 PC CBOC sites have been reclassified into OOS (+80 OOS); 14 OOS sites have been deactivated, 1 OOS site has been reclassified into VAMC, 9 OOS sites have been reclassified into MS CBOCs, and 48 OOS sites have been reclassified into PC CBOCs (-72 OOS), resulting in a net increase from 415 to 423 (+8 OOS).

Activations (+45 OOS):

- +1 OOS: VISN 1 Maple Street VA Domiciliary, New Haven, CT (689BW)
- +1 OOS: VISN 1 Norton Street VA Domiciliary, New Haven, CT (689BX)
- +1 OOS: VISN 1 West Haven VA Mobile Clinic, West Haven, CT (689QB)
- +1 OOS: VISN 4 Cedar Crest Boulevard VA Clinic, Allentown, PA (693QB)
- +1 OOS: VISN 6 Salem VA Mobile Clinic, Salem, VA (658QA)
- +1 OOS: VISN 7 Atlanta VA Mobile Clinic, Atlanta, GA (508QK)
- +1 OOS: VISN 7 Montgomery VA Mobile Clinic, Montgomery, AL (619QC)
- +1 OOS: VISN 8 Gainesville VA Clinic, Gainesville, FL (573QL)
- +1 OOS: VISN 8 Saint Thomas VA Clinic, Saint Thomas, VI (672GB)
- +1 OOS: VISN 8 San Juan 1 VA Mobile Clinic, San Juan, PR (672QD)

- +1 OOS: VISN 8 San Juan 2 VA Mobile Clinic, San Juan, PR (672QE)
- +1 OOS: VISN 8 Saint Croix VA Mobile Clinic, St. Croix, VI (672QG)
- +1 OOS: VISN 8 Orlando 3 VA Mobile Clinic, Orlando, FL (675QI)
- +1 OOS: VISN 9 Mountain Home 1 VA Mobile Clinic, Mountain Home, TN (621QI)
- +1 OOS: VISN 10 Cincinnati 1 VA Mobile Clinic, Cincinnati, OH (539QE)
- +1 OOS: VISN 15 Wichita 1 VA Mobile Clinic, Wichita, KS (589QE)
- +1 OOS: VISN 15 Wichita 2 VA Mobile Clinic, Wichita, KS (589QF)
- +1 OOS: VISN 15 Wichita 3 VA Mobile Clinic, Wichita, KS (589QG)
- +1 OOS: VISN 15 Jefferson Barracks VA Mobile Clinic, St. Louis, MO (657QF)
- +1 OOS: VISN 16 Alexandria VA Mobile Clinic, Pineville, LA (502QC)
- +1 OOS: VISN 16 Alexandria 2 VA Mobile Clinic, Pineville, LA (502QD)
- +1 OOS: VISN 16 North College Avenue VA Mobile Clinic, Fayetteville, AR (564QC)
- +1 OOS: VISN 16 Houston Webster VA Clinic, Houston, TX (580QE)
- +1 OOS: VISN 16 Houston 4 VA Mobile Clinic, Houston, TX (580QF)
- +1 OOS: VISN 16 Little Rock 2 VA Mobile Clinic, Little Rock, AR (598QC)
- +1 OOS: VISN 16 Little Rock 3 VA Mobile Clinic, Little Rock, AR (598QD)
- +1 OOS: VISN 16 Shreveport 1 VA Mobile Clinic, Shreveport, LA (667QB)
- +1 OOS: VISN 16 Shreveport 2 VA Mobile Clinic, Shreveport, LA (667QC)
- +1 OOS: VISN 17 Amarillo VA Mobile Clinic, Amarillo, TX (504QA)
- +1 OOS: VISN 17 Big Spring VA Mobile Clinic, Big Spring, TX (519QA)
- +1 OOS: VISN 17 Temple VA Mobile Clinic, Temple, TX (674QA)
- +1 OOS: VISN 17 Austin VA Mobile Clinic, Temple, TX (674QB)
- +1 OOS: VISN 17 Corpus Christi VA Mobile Clinic, Corpus Christi, TX (740QC)
- +1 OOS: VISN 19 Montana VA Mobile Clinic, Billings, MT (436QF)
- +1 OOS: VISN 19 Sterling VA Clinic, Sterling, CO (442QG)
- +1 OOS: VISN 19 Bartlesville VA Clinic, Bartlesville, OK (623QD)
- +1 OOS: VISN 19 Oklahoma City VA Mobile Clinic, Oklahoma City, OK (635QF)
- +1 OOS: VISN 19 Salt Lake City VA Mobile Clinic, Salt Lake City, UT (660QE)
- +1 OOS: VISN 20 American Lake VA Mobile Clinic, Seattle, WA (663QD)
- +1 OOS: VISN 22 San Diego VA Mobile Clinic, San Diego, CA (664QB)
- +1 OOS: VISN 22 Greater Los Angeles VA Mobile Clinic, Los Angeles, CA (691QA)
- +1 OOS: VISN 23 Fort Yates VA Clinic, Fort Yates, ND (568QA)
- +1 OOS: VISN 23 Richfield VA Clinic, Richfield, MN (618QC)
- +1 OOS: VISN 23 Minneapolis VA Mobile Clinic, Minneapolis, MN (618QD)
- +1 OOS: VISN 23 Iowa City 2 VA Mobile Clinic, Iowa City, IA (636QL)

MS CBOCs reclassified into OOS sites (+10 OOS):

- +1 OOS: VISN 7 Cobb County VA Clinic, Marietta, GA (508GQ)
- +1 OOS: VISN 7 Pike County VA Clinic, Zebulon, GA (508GS)
- +1 OOS: VISN 7 Market Commons VA Clinic, Myrtle Beach, SC (534QA)
- +1 OOS: VISN 10 Shelbyville VA Clinic, Shelbyville, IN (583GG)
- +1 OOS: VISN 19 Fort Collins VA Clinic, Fort Collins, CO (442GC)
- +1 OOS: VISN 19 North Oklahoma City VA Clinic, Oklahoma City, OK (635GL)
- +1 OOS: VISN 21 Stockton VA Clinic, French Camp, CA (612QE)
- +1 OOS: VISN 23 North Platte VA Clinic, North Platte, NE (636GB)

- +1 OOS: VISN 23 Holdrege VA Clinic, Holdrege, NE (636GQ)
- +1 OOS: VISN 23 South Des Moines VA Clinic, Des Moines, IA (636GZ)

PC CBOCs reclassified into OOS sites (+25 OOS):

- +1 OOS: VISN 6 Fredericksburg VA Clinic, Fredericksburg, VA (652GA)
- +1 OOS: VISN 8 Vero Beach VA Clinic, Vero Beach, FL (548GE)
- +1 OOS: VISN 9 Mountain City VA Clinic, Mountain City, TN (621GO)
- +1 OOS: VISN 9 Morristown East VA Clinic, Morristown, TN (621GP)
- +1 OOS: VISN 9 Albion Street VA Clinic, Nashville, TN (626QA)
- +1 OOS: VISN 10 Howell VA Clinic, Howell, MI (506GE)
- +1 OOS: VISN 10 Vine Street VA Clinic, Cincinnati, OH (539QC)
- +1 OOS: VISN 12 Clark County VA Clinic, Owen, WI (676GE)
- +1 OOS: VISN 15 Heartland Street VA Clinic, Marion, IL (657QD)
- +1 OOS: VISN 16 Kosciusko VA Clinic, Kosciusko, MS (586GA)
- +1 OOS: VISN 17 Hobbs VA Clinic, Hobbs, NM (519GB)
- +1 OOS: VISN 17 Walzem VA Clinic, San Antonio, TX (671GT)
- +1 OOS: VISN 19 Butte VA Clinic, Butte, MT (436GO)
- +1 OOS: VISN 19 Merril Lundman Department of Veterans Affairs Outpatient Clinic, Havre, MT (436HC)
- +1 OOS: VISN 19 Alamosa VA Clinic, Alamosa, CO (554GF)
- +1 OOS: VISN 19 Denver VA Clinic, Denver, CO (554GJ)
- +1 OOS: VISN 19 Glenwood Springs VA Clinic, Glenwood Springs, CO (575QA)
- +1 OOS: VISN 19 Shawnee VA Clinic, Shawnee, OK (635GK)
- +1 OOS: VISN 19 Riverton VA Clinic, Riverton, WY (666GC)
- +1 OOS: VISN 20 Everett VA Clinic, Everett, WA (663GK)
- +1 OOS: VISN 20 La Grande VA Clinic, La Grande, OR (687GC)
- +1 OOS: VISN 22 North Loma Linda VA Clinic, Redlands, CA (605GF)
- +1 OOS: VISN 22 Mesa VA Clinic, Mesa, AZ (644GJ)
- +1 OOS: VISN 22 Captain Rosemary Bryant Mariner Outpatient Clinic, Ventura, CA (691GQ)
- +1 OOS: VISN 23 Scottsbluff VA Clinic, Scottsbluff, NE (568HH)

Deactivations (-14 OOS):

- -1 OOS: VISN 2 Coudersport VA Clinic, Coudersport, PA (528QE)
- -1 OOS: VISN 5 Clarksburg VA Mobile Clinic, Clarksburg, WV (540HK)
- -1 OOS: VISN 6 Hampton VA Mobile Clinic, Hampton, VA (590QA)
- -1 OOS: VISN 6 Hampton City County VA Mobile Clinic, Hampton, VA (590QB)
- -1 OOS: VISN 6 Fayetteville 2 VA Mobile Clinic, Fayetteville, NC (565QC)
- -1 OOS: VISN 8 New Port Richey South VA Clinic, New Port Richey, FL (673QE)
- -1 OOS: VISN 8 Little Road VA Clinic, New Port Richey, FL (673QG)
- -1 OOS: VISN 9 Marion VA Clinic, Marion, VA (621QB)
- -1 OOS: VISN 10 Cincinnati VA Mobile Clinic, Cincinnati, OH (539QA)
- -1 OOS: VISN 10 Columbia Place VA Clinic, South Bend, IN (610QB)
- -1 OOS: VISN 17 Seguin VA Clinic, Seguin, TX (671GN)
- -1 OOS: VISN 17 North Tenth Street VA Clinic, McAllen, TX (740GJ)
- -1 OOS: VISN 21 Howe Road VA Clinic, Martinez, CA (612QD)

- -1 OOS: VISN 23 Fort Dodge North VA Clinic, Fort Dodge, IA (636GX)

OOS sites reclassified into VAMC (-1 OOS):

- -1 OOS: VISN 19 Friendship House VA Compensated Work Therapy/Transitional Residence, Oklahoma City, OK (635PA)

OOS sites reclassified into MS CBOCs (-9 OOS):

- -1 OOS: VISN 1 Worcester VA Clinic, Worcester, MA (631GE)
- -1 OOS: VISN 7 Tucker VA Clinic, Atlanta, GA (508QJ)
- -1 OOS: VISN 8 Lakeland VA Clinic, Lakeland, FL (673GB)
- -1 OOS: VISN 8 Boca Raton VA Clinic, Boca Raton, FL (548GD)
- -1 OOS: VISN 10 Terre Haute VA Clinic, Terre Haute, IN (583GA)
- -1 OOS: VISN 15 Lenexa VA Clinic, Lenexa, KS (589JG)
- -1 OOS: VISN 21 Clearlake VA Clinic, Clearlake, CA (662GG)
- -1 OOS: VISN 21 Oakland VA Clinic, Oakland, CA (662GH)
- -1 OOS: VISN 23 Sterling VA Clinic, Sterling, IL (636GT)

OOS sites reclassified into PC CBOCs (-48 OOS):

- -1 OOS: VISN 1 Rumford VA Clinic, Rumford, ME (402GC)
- -1 OOS: VISN 1 Gloucester VA Clinic, Gloucester, MA (518GE)
- -1 OOS: VISN 1 Plymouth VA Clinic, Plymouth, MA (523GD)
- -1 OOS: VISN 1 Errera VA Clinic, West Haven, CT (689QA)
- -1 OOS: VISN 1 Stamford VA Clinic, Stamford, CT (689GB)
- -1 OOS: VISN 2 Niagara Falls VA Clinic, Niagara Falls, NY (528GD)
- -1 OOS: VISN 2 Lockport VA Clinic, Lockport, NY (528GK)
- -1 OOS: VISN 2 Glens Falls VA Clinic, Glens Falls, NY (528GT)
- -1 OOS: VISN 2 Hamilton VA Clinic, Hamilton, NJ (561GA)
- -1 OOS: VISN 2 Piscataway VA Clinic, Piscataway, NJ (561GF)
- -1 OOS: VISN 2 Morristown VA Clinic, Morristown, NJ (561GH)
- -1 OOS: VISN 2 Carmel VA Clinic, Carmel, NY (620GB)
- -1 OOS: VISN 2 Goshen VA Clinic, Goshen, NY (620GD)
- -1 OOS: VISN 2 Poughkeepsie VA Clinic, Poughkeepsie, NY (620GG)
- -1 OOS: VISN 2 Riverhead VA Clinic, Riverhead, NY (632HB)
- -1 OOS: VISN 6 Tazewell VA Clinic, Tazewell, VA (658GA)
- -1 OOS: VISN 7 Ray Hendrix Department Of Veterans Affairs Clinic, Statesboro, GA (509QA)
- -1 OOS: VISN 7 Columbus Downtown VA Clinic, Columbus, GA (619GG)
- -1 OOS: VISN 7 Selma VA Clinic, Selma, AL (679GA)
- -1 OOS: VISN 9 Carrollton VA Clinic, Carrollton, KY (603GH)
- -1 OOS: VISN 9 Dover VA Clinic, Dover, TN (626GA)
- -1 OOS: VISN 12 Gladstone VA Clinic, Gladstone, MI (585GG)
- -1 OOS: VISN 15 Belton VA Clinic, Belton, MO (589GB)
- -1 OOS: VISN 15 Kirksville VA Clinic, Kirksville, MO (589GE)
- -1 OOS: VISN 15 St. Clair County VA Clinic, Shiloh, IL (657GA)
- -1 OOS: VISN 15 Franklin County VA Clinic, Washington, MO (657GS)
- -1 OOS: VISN 16 Panama City Beach VA Clinic, Panama City Beach, FL (520GB)
- -1 OOS: VISN 16 Sugar Land VA Clinic, Sugar Land, TX (580GL)

- -1 OOS: VISN 16 Natchez VA Clinic, Natchez, MS (586GE)
- -1 OOS: VISN 17 Decatur VA Clinic, Decatur, TX (549GE)
- -1 OOS: VISN 17 Palestine VA Clinic, Palestine, TX (674GA)
- -1 OOS: VISN 19 Dr. Joseph Medicine Crow VA Clinic, Billings, MT (436GN)
- -1 OOS: VISN 19 Ada VA Clinic, Ada, OK (635GD)
- -1 OOS: VISN 19 Enid VA Clinic, Enid, OK (635GG)
- -1 OOS: VISN 19 Tinker VA Clinic, Tinker Air Force Base, OK (635QE)
- -1 OOS: VISN 20 Mountain Home VA Clinic, Mountain Home, ID (531GI)
- -1 OOS: VISN 20 Brookings VA Clinic, Brookings, OR (653GB)
- -1 OOS: VISN 20 Olympia VA Clinic, Olympia, WA (663GI)
- -1 OOS: VISN 20 Puyallup VA Clinic, Puyallup, WA (663GJ)
- -1 OOS: VISN 20 Grants Pass VA Clinic, Grants Pass, OR (692GB)
- -1 OOS: VISN 21 Windward VA Clinic, Kaneohe, HI (459QC)
- -1 OOS: VISN 21 Yreka VA Clinic, Yreka, CA (612GJ)
- -1 OOS: VISN 21 Reno East VA Clinic, Reno, NV (654GE)
- -1 OOS: VISN 21 North Reno VA Clinic, Reno, NV (654GF)
- -1 OOS: VISN 22 Farmington VA Clinic, Farmington, NM (501GB)
- -1 OOS: VISN 23 Rice Lake VA Clinic, Rice Lake, WI (618GM)
- -1 OOS: VISN 23 Fort Dodge VA Clinic, Fort Dodge, IA (636GK)
- -1 OOS: VISN 23 Burlington VA Clinic, Burlington, IA (636GY)

Please refer to the section titled "FY 2023 Other Outpatient Services (OOS) Sites" for the complete list of OOS sites in 2023.

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.

In 2023, there were 70 Dialysis Center sites. Please refer to the section titled, "FY 2023 Outpatient Dialysis Centers" for the complete list of Dialysis Centers in 2023.

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.

<u>CRRC changes in 2023</u>
In 2023, 1 CRRC site has been activated, resulting in a net increase from 32 to 33 (+1 CRRC):

- +1 CRRC: VISN 16 Overton Brooks VA Medical Center, Shreveport, LA

For the complete list, please refer to the section titled "FY 2023 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.

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.

<u>VC/MVC/VC Outstation changes in 2023</u>
In 2023, based on the workload data, 1 MVC site has been activated, 2 VC Outstation sites have been converted to Vet Centers, and 1 VC Outstation has been deactivated, resulting in an increase from 300 to 302 VC (+2 VC), an increase from 83 to 84 MVC (+1 MVC), and a net decrease from 23 to 20 VC Outstations (-3 VC Outstation):

- +1 MVC: VISN 8 Hatillo Mobile Vet Center, Hatillo, PR
- +1 VC/-1 VC Outstation: VISN 9 Clarksville Vet Center, Clarksville, TN
- +1 VC/-1 VC Outstation: VISN 8 U.S. Virgin Islands Vet Center, St. Thomas, VI
- -1 VC Outstation: VISN 22 Sepulveda Vet Center Outstation, Sepulveda, CA

For the complete list, please refer to the section titled "FY 2023 Vet Centers, Mobile Vet Centers and Vet Center Outstations."

<u>VC/MVC/VC Outstation changes in 2024</u>
In 2024, 1 VC, 2 MVC and 1 VC Outstation sites are projected to be activated, resulting in an increase from 302 to 303 VC (+1 VC), an increase from 84 to 86 MVC (+2 MVC), and an increase from 20 to 21 VC Outstations (+1 VC Outstation):

- +1 VC: VISN 6 Fredericksburg Vet Center, Fredericksburg, VA

- +1 MVC: VISN 8 Palm Beach Mobile Vet Center, Palm Beach, FL
- +1 MVC: VISN 19 Tulsa Mobile Vet Center, Tulsa, OK
- +1 VC Outstation: VISN 2 Vineland Vet Center Outstation, Vineland, NJ

FY 2023 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	VA Hospital in FY 2023 (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)	No
2	620	Franklin Delano Roosevelt Hospital	VA Medical Center (VAMC)	Yes
2	620A4	Castle Point VA Medical Center	VA Medical Center (VAMC)	Yes
2	630	Manhattan VA Medical Center	VA Medical Center (VAMC)	Yes
2	630A4	Brooklyn VA Medical Center	VA Medical Center (VAMC)	Yes
2	630A5	St. Albans VA Medical Center	VA Medical Center (VAMC)	No
2	632	Northport VA Medical Center	VA Medical Center (VAMC)	Yes
4	460	Wilmington VA Medical Center	VA Medical Center (VAMC)	Yes
4	503	James E. Van Zandt Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
4	529A4	Butler VA Medical Center	VA Medical Center (VAMC)	No
4	542	Coatesville VA Medical Center	VA Medical Center (VAMC)	Yes
4	562	Erie VA Medical Center	VA Medical Center (VAMC)	No
4	595	Lebanon VA Medical Center	VA Medical Center (VAMC)	Yes
4	642	Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
4	646	Pittsburgh VA Medical Center-University Drive	VA Medical Center (VAMC)	Yes
4	646A4	H. John Heinz III Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	No
4	693	Wilkes-Barre VA Medical Center	VA Medical Center (VAMC)	Yes
5	512	Baltimore VA Medical Center	VA Medical Center (VAMC)	Yes
5	512A5	Perry Point VA Medical Center	VA Medical Center (VAMC)	No
5	512GD	Loch Raven VA Medical Center	VA Medical Center (VAMC)	No
5	517	Beckley VA Medical Center	VA Medical Center (VAMC)	Yes
5	540	Louis A. Johnson Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
5	581	Huntington / Hershel "Woody" Williams VA Medical Center	VA Medical Center (VAMC)	Yes
5	613	Martinsburg VA Medical Center	VA Medical Center (VAMC)	Yes
5	688	Washington VA Medical Center	VA Medical Center (VAMC)	Yes
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

FY 2023 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	VA Hospital in FY 2023 (Yes / No)
6	658	Salem VA Medical Center	VA Medical Center (VAMC)	Yes
6	659	W.G. (Bill) Hefner Salisbury Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
7	508	Atlanta VA Medical Center	VA Medical Center (VAMC)	Yes
7	508GA	Fort McPherson VA Clinic	VA Medical Center (VAMC)	No
7	508GK	Trinka Davis Veterans Village	VA Medical Center (VAMC)	No
7	509	Charlie Norwood Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
7	509A0	Augusta VA Medical Center-Uptown	VA Medical Center (VAMC)	Yes
7	521	Birmingham VA Medical Center	VA Medical Center (VAMC)	Yes
7	534	Ralph H. Johnson Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
7	544	Wm. Jennings Bryan Dorn Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
7	557	Carl Vinson Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
7	619	Central Alabama VA Medical Center-Montgomery	VA Medical Center (VAMC)	Yes
7	619A4	Central Alabama VA Medical Center-Tuskegee	VA Medical Center (VAMC)	Yes
7	679	Tuscaloosa VA Medical Center	VA Medical Center (VAMC)	Yes
8	516	C.W. Bill Young Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
8	546	Bruce W. Carter Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
8	548	West Palm Beach VA Medical Center	VA Medical Center (VAMC)	Yes
8	573	Malcom Randall Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
8	573A4	Lake City VA Medical Center	VA Medical Center (VAMC)	Yes
8	672	San Juan VA Medical Center	VA Medical Center (VAMC)	Yes
8	673	James A. Haley Veterans' Hospital	VA Medical Center (VAMC)	Yes
8	675	Orlando VA Medical Center	VA Medical Center (VAMC)	Yes
8	675GG	Lake Baldwin VA Clinic	VA Medical Center (VAMC)	No
9	596	Lexington VA Medical Center (Franklin R. Sousley Campus)	VA Medical Center (VAMC)	No
9	596A4	Lexington VA Medical Center (Troy Bowling Campus)	VA Medical Center (VAMC)	Yes
9	603	Robley Rex Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
9	614	Memphis VA Medical Center	VA Medical Center (VAMC)	Yes
9	621	James H. Quillen Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
9	626	Nashville VA Medical Center	VA Medical Center (VAMC)	Yes
9	626A4	Alvin C. York Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
10	506	Ann Arbor VA Medical Center	VA Medical Center (VAMC)	Yes
10	515	Battle Creek VA Medical Center	VA Medical Center (VAMC)	Yes
10	538	Chillicothe VA Medical Center	VA Medical Center (VAMC)	Yes
10	539	Cincinnati VA Medical Center	VA Medical Center (VAMC)	Yes
10	541	Louis Stokes Cleveland Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
10	552	Dayton VA Medical Center	VA Medical Center (VAMC)	Yes
10	553	John D. Dingell Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
10	553A4	Detroit VA Medical Center (Valor Center)	VA Medical Center (VAMC)	No
10	583	Richard L. Roudebush Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
10	610	Marion VA Medical Center	VA Medical Center (VAMC)	Yes
10	610A4	Fort Wayne VA Medical Center	VA Medical Center (VAMC)	Yes
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

FY 2023 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	VA Hospital in FY 2023 (Yes / No)
15	589	Kansas City VA Medical Center	VA Medical Center (VAMC)	Yes
15	589A4	Harry S. Truman Memorial Veterans' Hospital	VA Medical Center (VAMC)	Yes
15	589A5	Colmery-O'Neil Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
15	589A6	Dwight D. Eisenhower Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
15	589A7	Robert J. Dole Department of Veterans Affairs Medical and Regional Office Center	VA Medical Center (VAMC)	Yes
15	657	John Cochran Veterans Hospital	VA Medical Center (VAMC)	Yes
15	657A0	St. Louis VA Medical Center-Jefferson Barracks	VA Medical Center (VAMC)	Yes
15	657A4	John J. Pershing Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
15	657A5	Marion VA Medical Center	VA Medical Center (VAMC)	Yes
16	502	Alexandria VA Medical Center	VA Medical Center (VAMC)	Yes
16	520	Biloxi VA Medical Center	VA Medical Center (VAMC)	Yes
16	564	Fayetteville VA Medical Center	VA Medical Center (VAMC)	Yes
16	580	Michael E. DeBakey Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
16	586	G.V. (Sonny) Montgomery Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
16	598	John L. McClellan Memorial Veterans' Hospital	VA Medical Center (VAMC)	Yes
16	598A0	Eugene J. Towbin Healthcare Center	VA Medical Center (VAMC)	Yes
16	629	New Orleans VA Medical Center	VA Medical Center (VAMC)	Yes
16	667	Overton Brooks Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
17	504	Thomas E. Creek Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
17	519	George H. O'Brien, Jr., Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	No
17	549	Dallas VA Medical Center	VA Medical Center (VAMC)	Yes
17	549A4	Sam Rayburn Memorial Veterans Center	VA Medical Center (VAMC)	No
17	671	Audie L. Murphy Memorial Veterans' Hospital	VA Medical Center (VAMC)	Yes
17	671A4	Kerrville VA Medical Center	VA Medical Center (VAMC)	No
17	674	Olin E. Teague Veterans' Center	VA Medical Center (VAMC)	Yes
17	674A4	Doris Miller Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
19	436	Fort Harrison VA Medical Center	VA Medical Center (VAMC)	Yes
19	436A4	Miles City VA Medical Center	VA Medical Center (VAMC)	No
19	442	Cheyenne VA Medical Center	VA Medical Center (VAMC)	Yes
19	554	Rocky Mountain Regional VA Medical Center	VA Medical Center (VAMC)	Yes
19	575	Grand Junction VA Medical Center	VA Medical Center (VAMC)	Yes
19	623	Jack C. Montgomery Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
19	635	Oklahoma City VA Medical Center	VA Medical Center (VAMC)	Yes
19	635PA	Friendship House VA Compensated Work Therapy/Transitional Residence	VA Medical Center (VAMC)	No
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

FY 2023 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	VA Hospital in FY 2023 (Yes / No)
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 2023 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 2023 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 2023 Community Living Centers (CLC)

CLC Program Count	VISN	Station Number	Official Name
84	16	502	Alexandria VA
85	16	520	Gulf Coast VA-Biloxi
86	16	580	Michael E. DeBakey VA
87	16	586	G. V. (Sonny) Montgomery VA
88	16	598A0	Central Arkansas VA-Eugene J. Tobin
89	16	629	New Orleans VA
90	17	549	North Texas VA-Dallas
91	17	549A4	North Texas VA-Sam Rayburn
92	17	671	South Texas VA-Audie L. Murphy
93	17	671A4	South Texas VA-Kerrville
94	17	674	Central Texas VA-Olin E. Teague
95	17	674A4	Central Texas VA-Waco
96	17	504	Thomas E. Creek VA
97	17	519	West Texas VA-George H. O'Brien, Jr.
98	19	635	Oklahoma City VA
99	19	436GJ	Miles City VA Clinic
100	19	442	Cheyenne VA
101	19	554A4	Eastern Colorado VA-Pueblo
102	19	575	Grand Junction VA
103	19	666	Sheridan VA
104	20	531	Boise VA
105	20	648A4	Portland VA-Vancouver
106	20	653	Roseburg VA
107	20	663	Puget Sound VA-Seattle
108	20	663A4	Puget Sound VA-American Lake
109	20	668	Mann-Grandstaff VA
110	21	459	Pacific Islands VA-Spark M. Matsunaga
111	21	570	Central California VA-Fresno
112	21	612	Northern California VA-East Bay (Martinez)
113	21	640	Palo Alto VA
114	21	640A0	Palo Alto VA-Menlo Park
115	21	640A4	Palo Alto VA-Livermore
116	21	654	Sierra Nevada VA-Ioannis A. Lougaris
117	21	662	San Francisco VA
118	22	501	New Mexico VA-Raymond G. Murphy
119	22	644	Carl T. Hayden VA
120	22	649	Northern Arizona VA-Prescott
121	22	678	Southern Arizona VA-Tucson
122	22	600	Long Beach VA
123	22	605	Loma Linda VA
124	22	664	San Diego VA
125	22	691	Greater Los Angeles VA-West Los Angeles
126	22	691A4	Sepulveda VA Clinic

FY 2023 Community Living Centers (CLC)

CLC Program Count	VISN	Station Number	Official Name
127	23	437	Fargo VA
128	23	438	Sioux Falls VA
129	23	568	Black Hills VA-Fort Meade
130	23	568A4	Black Hills VA-Hot Springs
131	23	618	Minneapolis VA
132	23	636A4	Grand Island VA Clinic
133	23	636A6	Central Iowa VA-Des Moines
134	23	6369AA	Papillion VA Community Living Center
135	23	656	St. Cloud VA

FY 2023 Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

MH RRTP Program Count	VISN	Station Number	Official Name	Classification	Type of Service
1	1	405	White River Junction VA	VA Medical Center (VAMC)	Domiciliary Program
2	1	518	Edith Nourse Rogers VA- Bedford	VA Medical Center (VAMC)	Dom & CWT/TR Program
3	1	523	Boston VA-Jamaica Plain	VA Medical Center (VAMC)	Dom & CWT/TR Program
4	1	523A5	Boston VA-Brockton	VA Medical Center (VAMC)	Dom & CWT/TR Program
5	1	631	Central Western Massachusetts VA-Leeds (Northampton)	VA Medical Center (VAMC)	Dom & CWT/TR Program
6	1	689BW	Connecticut - VA West Haven - Maple Street	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary Only
7	1	689BX	Connecticut VA West Haven - Norton Street	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary Only
8	2	528	Western New York VA-Buffalo	VA Medical Center (VAMC)	Domiciliary Program
9	2	528A4	Western New York VA-Batavia	VA Medical Center (VAMC)	Domiciliary Program
10	2	528A5	Canandaigua VA	VA Medical Center (VAMC)	Domiciliary Program
11	2	528A6	Bath VA	VA Medical Center (VAMC)	Domiciliary Program
12	2	528A8	Samuel S. Stratton VA- Albany	VA Medical Center (VAMC)	Domiciliary Program
13	2	561	New Jersey VA-East Orange	VA Medical Center (VAMC)	Domiciliary Program
14	2	561A4	New Jersey VA-Lyons	VA Medical Center (VAMC)	Domiciliary Program
15	2	620	Franklin Delano Roosevelt VA (Montrose)	VA Medical Center (VAMC)	Domiciliary Program
16	2	630A4	New York Harbor VA-Brooklyn Division	VA Medical Center (VAMC)	Domiciliary Program
17	2	632	Northport VA	VA Medical Center (VAMC)	Domiciliary Program
18	4	529	Butler VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
19	4	542	Coatesville VA	VA Medical Center (VAMC)	Domiciliary Program
20	4	595	Lebanon VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
21	4	642BU	Philadelphia VA Domiciliary	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	Stand Alone Domiciliary Only
22	4	646A4	Pittsburgh VA-H.J. Heinz VA	VA Medical Center (VAMC)	Domiciliary Program &
23	4	562	Erie VA	VA Medical Center (VAMC)	Domiciliary Program
24	4	693	Wilkes-Barre VA	VA Medical Center (VAMC)	Domiciliary Program
25	5	512A5	Maryland VA-Perry Point	VA Medical Center (VAMC)	Dom & CWT/TR Program
26	5	540	Louis A. Johnson VA (Clarksburg)	VA Medical Center (VAMC)	Domiciliary Program
27	5	581	Huntington, West VA	VA Medical Center (VAMC)	Domiciliary Program
28	5	613	Martinsburg VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
29	6	590	Hampton VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
30	6	637	Charles George VA (Asheville)	VA Medical Center (VAMC)	Domiciliary Program
31	6	652	Hunter Holmes McGuire VA (Richmond)	VA Medical Center (VAMC)	Domiciliary Program
32	6	658	Salem VA	VA Medical Center (VAMC)	Domiciliary Program
33	6	659	W.G. (Bill) Hefner VA (Salisbury)	VA Medical Center (VAMC)	Dom & CWT/TR Program
34	7	508	Atlanta VA - Decatur	VA Medical Center (VAMC)	CWT/TR Program
35	7	508GA	Atlanta VA - Fort McPherson	VA Medical Center (VAMC)	Domiciliary Program
36	7	509A0	Augusta VA-Uptown	VA Medical Center (VAMC)	Domiciliary Program
37	7	521	Birmingham VA	VA Medical Center (VAMC)	CWT/TR Program
38	7	557	Carl Vinson VA (Dublin)	VA Medical Center (VAMC)	Domiciliary Program
39	7	619A4	Central Alabama VA-Tuskegee	VA Medical Center (VAMC)	Dom & CWT/TR Program
40	7	679	Tuscaloosa VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
41	8	516	C.W. Bill Young VA (Bay Pines)	VA Medical Center (VAMC)	Domiciliary Program
42	8	546	Bruce W. Carter VAMC (Miami)	VA Medical Center (VAMC)	Domiciliary Program
43	8	548	West Palm Beach	VA Medical Center (VAMC)	Domiciliary Program
44	8	573A4	North Florida-South Georgia VA-Lake City	VA Medical Center (VAMC)	Domiciliary Program
45	8	573BU	Gainesville VA Domiciliary	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	Stand Alone Domiciliary Only
46	8	673BV	Tampa VA Domiciliary	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	Stand Alone Domiciliary Only
47	8	675GG	Orlando VA (Lake Baldwin)	VA Medical Center (VAMC)	Domiciliary Program
48	8	675	Orlando VA (Lake Nona)	VA Medical Center (VAMC)	Domiciliary Program
49	9	596	Franklin R. Sousley Campus (Lexington VA-Leestown)	VA Medical Center (VAMC)	Domiciliary Program
50	9	603	Robley Rex VA (Louisville)	VA Medical Center (VAMC)	Domiciliary Program
51	9	614	Memphis VA	VA Medical Center (VAMC)	Domiciliary Program
52	9	621	James H. Quillen VA (Mountain Home)	VA Medical Center (VAMC)	Domiciliary Program
53	9	626A4	Alvin C. York VA (Murfreesboro)	VA Medical Center (VAMC)	Domiciliary Program
54	10	538	Chillicothe VA	VA Medical Center (VAMC)	Domiciliary Program
55	10	539A4	Cincinnati VA-Fort Thomas	VA Medical Center (VAMC)	Domiciliary Program
56	10	541	Louis Stokes VA (Cleveland - Wade Park Division)	VA Medical Center (VAMC)	Dom & CWT/TR Program
57	10	552	Dayton VA	VA Medical Center (VAMC)	Domiciliary Program
58	10	515	Battle Creek VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
59	10	553A4	Detroit VAMC Valor Center	VA Medical Center (VAMC)	Domiciliary Program
60	10	583BU	Indianapolis VA Domiciliary	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	Stand Alone Domiciliary Only

FY 2023 Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

MH RRTP Program Count	VISN	Station Number	Official Name	Classification	Type of Service
61	10	610	Northern Indiana VA (Marion)	VA Medical Center (VAMC)	Domiciliary Program
62	12	537	Jesse Brown VA (Chicago)	VA Medical Center (VAMC)	Domiciliary Program
63	12	550	Illiana VA-Danville	VA Medical Center (VAMC)	Dom & CWT/TR Program
64	12	556	Captain James A. Lovell VA (North Chicago)	VA Medical Center (VAMC)	Dom & CWT/TR Program
65	12	578	Edward Hines Jr. VA	VA Medical Center (VAMC)	Domiciliary Program
66	12	607	William S. Middleton VA (Madison)	VA Medical Center (VAMC)	CWT-TR Program
67	12	676	Tomah VA	VA Medical Center (VAMC)	Domiciliary Program
68	12	676PA	La Crosse VA CWT-TR	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	CWT/TR Program
69	12	695	Clement J. Zablocki VA (Milwaukee)	VA Medical Center (VAMC)	Dom & CWT/TR Program
70	15	589	Kansas City VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
71	15	589A4	Harry S. Truman VA (Columbia MO)	VA Medical Center (VAMC)	Dom & CWT/TR Program
72	15	589A5	Eastern Kansas VA - Topeka Division	VA Medical Center (VAMC)	Dom & CWT/TR Program
73	15	589A6	Eastern Kansas VA - Dwight D. Eisenhower (Leavenworth Division)	VA Medical Center (VAMC)	Domiciliary Program
74	15	657A0	St. Louis VA-Jefferson Barracks	VA Medical Center (VAMC)	Domiciliary Program
75	15	657A5	Marion IL VA	VA Medical Center (VAMC)	Domiciliary Program
76	15	589A7	Wichita VA	VA Medical Center (VAMC)	Domiciliary Program
77	16	502	Alexandria VAMC	VA Medical Center (VAMC)	Domiciliary Program
78	16	520	Gulf Coast VA-Biloxi	VA Medical Center (VAMC)	Domiciliary Program
79	16	564	Veterans HCS of the Ozarks - Fayetteville	VA Medical Center (VAMC)	Domiciliary Program
80	16	586BU	Jackson VA Domiciliary	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	Stand Alone Domiciliary Only
81	16	598A0	Central Arkansas VA-Eugene J. Tobin (N.Little Rock)	VA Medical Center (VAMC)	Dom & CWT/TR Program
82	17	549	North Texas VA-Dallas	VA Medical Center (VAMC)	Dom & CWT/TR Program
83	17	549A4	North Texas VA-Sam Rayburn (Bonham)	VA Medical Center (VAMC)	Dom & CWT/TR Program
84	17	671	South Texas VA-Audie L. Murphy (San Antonio)	VA Medical Center (VAMC)	Stand Alone Domiciliary Only
85	17	674	Central Texas VA-Olin E. Teague (Temple)	VA Medical Center (VAMC)	Dom & CWT/TR Program
86	17	674A4	Central Texas VA-Waco	VA Medical Center (VAMC)	Domiciliary Program
87	17	519	West Texas VA-George H. O'Brien, Jr. (Big Spring)	VA Medical Center (VAMC)	Domiciliary Program
88	19	436	Montana VA-Fort Harrison	VA Medical Center (VAMC)	Domiciliary Program
89	19	442	Cheyenne	VA Medical Center (VAMC)	Domiciliary Program
90	19	554BU	Valor Point VA Domiciliary	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	Stand Alone Domiciliary Only
91	19	660	George E. Wahlen VA (Salt Lake)	VA Medical Center (VAMC)	Domiciliary Program
92	19	635	Oklahoma City VA	VA Medical Center (VAMC)	CWT/TR Program
93	19	666	Sheridan VA	VA Medical Center (VAMC)	Domiciliary Program
94	19	575	VA Western Colorado Healthcare System (Grand Junction)	VA Medical Center (VAMC)	Domiciliary Program
95	20	463	Alaska VA-Anchorage	VA Medical Center (VAMC)	Dom & CWT/TR Program
96	20	531	Boise VA	VA Medical Center (VAMC)	Domiciliary Program
97	20	648A4	Portland VA-Vancouver	VA Medical Center (VAMC)	Domiciliary Program
98	20	663A4	Puget Sound VA-American Lake	VA Medical Center (VAMC)	Dom & CWT/TR Program
99	20	687	Jonathan M. Wainwright VA (Walla Walla)	VA Medical Center (VAMC)	Domiciliary Program
100	20	692	Southern Oregon VA-White City	VA Medical Center (VAMC)	Domiciliary Program
101	21	459	Pacific Islands VA-Spark M. Matsunaga	VA Medical Center (VAMC)	Domiciliary Program
102	21	593	Southern Nevada (Las Vegas)	VA Medical Center (VAMC)	Domiciliary Program
103	21	640A0	Palo Alto VA-Menlo Park	VA Medical Center (VAMC)	Dom & CWT/TR Program
104	21	640BV	Palo Alto VA	VA Medical Center (VAMC)	Domiciliary
105	21	662	San Francisco VA	VA Medical Center (VAMC)	CWT/TR Program
106	22	664	San Diego VA	VA Medical Center (VAMC)	Domiciliary Program
107	22	664BV	San Diego VA Domiciliary	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	Stand Alone Domiciliary Only
108	22	501	New Mexico VA-Raymond G. Murphy (Albuquerque)	VA Medical Center (VAMC)	Dom & CWT/TR Program
109	22	644	Carl T. Hayden VA (Phoenix)	VA Medical Center (VAMC)	Domiciliary Program
110	22	649	Northern Arizona VA-Prescott	VA Medical Center (VAMC)	Domiciliary Program
111	22	678	Southern Arizona VA-Tucson	VA Medical Center (VAMC)	Domiciliary Program
112	22	691	Greater Los Angeles VA-West Los Angeles	VA Medical Center (VAMC)	Domiciliary Program
113	23	568A4	Black Hills VA-Hot Springs	VA Medical Center (VAMC)	Domiciliary Program
114	23	568PC	Black Hills VA - Pine Ridge VA CWT-TR	Residential Care Site (CWT/TR) (Stand-Alone)	CWT/TR Program
115	23	568 PB	Black Hills VA - Sturgis VA CWT-TR	Residential Care Site (CWT/TR) (Stand-Alone)	CWT/TR Program
116	23	568PD	Black Hills VA - Rapid City CWT-TR	Residential Care Site (CWT/TR) (Stand-Alone)	CWT/TR Program
117	23	636	Nebraska-Western Iowa VA-Omaha	VA Medical Center (VAMC)	Domiciliary Program
118	23	636A4	Grand Island VA Clinic	VA Medical Center (VAMC)	Dom & CWT/TR Program
119	23	636A6	Central Iowa VA-Des Moines	VA Medical Center (VAMC)	Domiciliary Program
120	23	656	St. Cloud VA	VA Medical Center (VAMC)	Domiciliary Program

FY 2023 Health Care Centers (HCC)

HCC Count	VISN	Station Number	Station Name & Location
1	1	608BY	Concord VA Clinic, Concord, NH
2	6	565GL	Cumberland County VA Clinic, Fayetteville, NC
3	6	659BY	Kernersville VA Clinic, Kernersville, NC
4	6	659BZ	South Charlotte VA Clinic, Charlotte, NC
5	8	516BZ	Lee County VA Clinic, Cape Coral, FL
6	10	757	Chalmers P. Wylie Veterans Outpatient Clinic, Columbus, OH
7	12	695GD	Milo C. Huempfner VA Outpatient Clinic, Green Bay, WI
8	15	657GJ	Evansville VA Clinic, Evansville, IN
9	17	740	Harlingen VA Clinic, Harlingen, TX
10	17	756	El Paso VA Clinic, El Paso, TX
11	19	436GH	Billings VA Clinic, Billings, MT
12	20	653BY	Eugene VA Clinic, Eugene, OR

FY 2023 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
1	1	402GE	Lewiston VA Clinic	Lewiston, Maine
2	1	402HB	Bangor VA Clinic	Bangor
3	1	402HC	Portland VA Clinic	Portland, Maine
4	1	405HA	Burlington Lakeside VA Clinic	Burlington Lakeside
5	1	405HC	Littleton VA Clinic	Littleton
6	1	523BY	Lowell VA Clinic	Lowell
7	1	631BY	Springfield VA Clinic	Springfield, Massachusetts
8	1	631GE	Worcester VA Clinic	Worcester
9	1	689A4	Newington VA Clinic	Newington
10	2	528GM	Donald J. Mitchell Department of Veterans Affairs Outpatient Clinic	Rome, New York
11	2	528GN	Binghamton VA Clinic	Binghamton
12	2	528QC	Rochester Calkins VA Clinic	Rochester Calkins
13	2	561BZ	James J. Howard Veterans' Outpatient Clinic	Brick
14	2	561GD	Hackensack VA Clinic	Hackensack
15	2	620GA	New City VA Clinic	New City
16	2	630GB	Staten Island Community VA Clinic	Staten Island
17	2	632GA	East Meadow VA Clinic	East Meadow
18	2	632HD	Patchogue VA Clinic	Patchogue
19	4	460GC	Kent County VA Clinic	Kent County
20	4	460GD	Cape May County VA Clinic	Cape May County
21	4	460HG	Cumberland County VA Clinic	Cumberland County, New Jersey
22	4	503GA	Johnstown VA Clinic	Johnstown
23	4	503GB	DuBois VA Clinic	DuBois
24	4	503GC	State College VA Clinic	State College
25	4	503GD	Huntingdon County VA Clinic	Huntingdon County
26	4	503GE	Indiana County VA Clinic	Indiana County
27	4	529	Abie Abraham VA Clinic	Butler
28	4	562GA	Crawford County VA Clinic	Crawford County
29	4	562GE	Warren County VA Clinic	Warren County
30	4	595GA	Cumberland County VA Clinic	Cumberland County,
31	4	595GC	Lancaster County VA Clinic	Lancaster County
32	4	595GE	York VA Clinic	York
33	4	642GA	Burlington County VA Clinic	Burlington County
34	4	642GC	Victor J. Saracini Department of Veterans Affairs Outpatient Clinic	Horsham
35	4	642GD	Gloucester County VA Clinic	Gloucester County
36	4	646GA	Belmont County VA Clinic	Belmont County
37	4	646GC	Beaver County VA Clinic	Beaver County
38	4	646GD	Washington County VA Clinic	Washington County
39	4	646GE	Fayette County VA Clinic	Fayette County
40	4	646GF	Monroeville VA Clinic	Monroeville
41	4	693B4	Allentown VA Clinic	Allentown

FY 2023 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
42	5	512GA	Cambridge VA Clinic	Cambridge, Maryland
43	5	512GC	Glen Burnie VA Clinic	Glen Burnie
44	5	512GG	Fort Meade VA Clinic	Fort Meade, Maryland
45	5	540GD	Monongalia County VA Clinic	Monongalia County
46	5	581GB	Charleston VA Clinic	Charleston, West Virginia
47	5	613GG	Fort Detrick VA Clinic	Fort Detrick
48	5	688GA	Fort Belvoir VA Clinic	Fort Belvoir
49	5	688GD	Charlotte Hall VA Clinic	Charlotte Hall
50	6	558GA	Greenville VA Clinic	Greenville, North Carolina
51	6	558GB	Raleigh VA Clinic	Raleigh, North Carolina
52	6	558GG	Raleigh III VA Clinic	Raleigh III
53	6	558GH	Clayton-East Raleigh VA Clinic	Clayton East Raleigh
54	6	558GI	Croasdaile VA Clinic	Croasdaile
55	6	565GA	Jacksonville VA Clinic	Jacksonville, North Carolina
56	6	565GC	Wilmington VA Clinic	Wilmington, North Carolina
57	6	565GG	Lee County VA Clinic	Lee County, North Carolina
58	6	590GD	Chesapeake VA Clinic	Chesapeake
59	6	637GA	Franklin VA Clinic	Franklin, North Carolina
60	6	637GC	Hickory VA Clinic	Hickory
61	6	652GC	Henrico County VA Clinic	Henrico County
62	6	652GE	Charlottesville VA Clinic	Charlottesville
63	6	659GA	North Charlotte VA Clinic	North Charlotte
64	7	508GE	Oakwood VA Clinic	Oakwood
65	7	508GF	West Cobb County VA Clinic	West Cobb County
66	7	508GG	Stockbridge VA Clinic	Stockbridge
67	7	508GH	Lawrenceville VA Clinic	Lawrenceville
68	7	508GJ	Blairsville VA Clinic	Blairsville
69	7	508GO	Northeast Cobb County VA Clinic	Northeast Cobb County
70	7	508QF	Atlanta VA Clinic	Atlanta North Arcadia Avenue
71	7	508QJ	Tucker VA Clinic	DeKalb County
72	7	509GA	Athens VA Clinic	Athens, Georgia
73	7	521GA	Huntsville VA Clinic	Huntsville
74	7	521GJ	Birmingham VA Clinic	Birmingham 7th Avenue South
75	7	534BY	Savannah VA Clinic	Savannah, Georgia
76	7	534GB	Myrtle Beach VA Clinic	Myrtle Beach
77	7	534GC	Beaufort VA Clinic	Beaufort
78	7	534GD	Goose Creek VA Clinic	Goose Creek
79	7	534GE	Hinesville VA Clinic	Hinesville
80	7	534GF	North Charleston VA Clinic	North Charleston
81	7	544BZ	Lance Corporal Dana Cornell Darnell VA Clinic	Greenville, South Carolina
82	7	544GB	Florence VA Clinic	Florence, South Carolina
83	7	544GD	Anderson VA Clinic	Anderson
84	7	557GA	Macon VA Clinic	Macon

FY 2023 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
85	7	557GB	Albany VA Clinic	Albany, Georgia
86	7	557GE	Brunswick VA Clinic	Brunswick
87	7	619GA	Robert S. Poydasheff VA Clinic	Columbus, Georgia
88	7	619GD	Wiregrass VA Clinic	Wiregrass
89	7	619GF	Central Alabama Montgomery VA Clinic	Central Alabama Montgomery
90	7	619QB	Fort Benning VA Clinic	Fort Benning
91	8	516GA	Sarasota VA Clinic	Sarasota
92	8	516GC	North Pinellas VA Clinic	North Pinellas
93	8	516GD	Bradenton VA Clinic	Bradenton
94	8	516GE	Port Charlotte VA Clinic	Port Charlotte
95	8	516GF	Naples VA Clinic	Naples
96	8	516GH	Sebring VA Clinic	Sebring
97	8	546BZ	William "Bill" Kling Department of Veterans Affairs Outpatient Clinic	Sunrise
98	8	546GB	Key West VA Clinic	Key West
99	8	546GC	Homestead VA Clinic	Homestead
100	8	546GD	Pembroke Pines VA Clinic	Pembroke Pines
101	8	546GF	Hollywood VA Clinic	Hollywood
102	8	546GH	Deerfield Beach VA Clinic	Deerfield Beach
103	8	548GA	Fort Pierce VA Clinic	Fort Pierce
104	8	548GB	Delray Beach VA Clinic	Delray Beach
105	8	548GC	Stuart VA Clinic	Stuart
106	8	548GD	Boca Raton VA Clinic	Boca Raton
107	8	573BY	Jacksonville 1 VA Clinic	Jacksonville 1
108	8	573GD	Ocala VA Clinic	Ocala
109	8	573GE	Leo C. Chase Jr. VA Clinic	Saint Augustine
110	8	573GF	Sergeant Ernest I. "Boots" Thomas VA Clinic	Tallahassee
111	8	573GI	The Villages VA Clinic	The Villages
112	8	573QJ	Jacksonville 2 VA Clinic	Jacksonville 2
113	8	672B0	Eurípides Rubio Department of Veterans Affairs Outpatient Clinic	Ponce
114	8	672BZ	Mayaguez VA Clinic	Mayaguez
115	8	673BZ	New Port Richey VA Clinic	New Port Richey
116	8	673GB	Lakeland VA Clinic	Lakeland
117	8	673GC	Brooksville VA Clinic	Brooksville
118	8	673GG	South Hillsborough VA Clinic	South Hillsborough
119	8	673GH	Lecanto VA Clinic	Lecanto
120	8	673QJ	Hidden River VA Clinic	Hidden River
121	8	675GA	Viera VA Clinic	Viera
122	8	675GB	William V. Chappell, Jr. Veterans' Outpatient Clinic	Daytona Beach
123	8	675GD	Deltona VA Clinic	Deltona
124	8	675GE	Tavares VA Clinic	Tavares
125	9	596GA	Somerset VA Clinic	Somerset
126	9	603GA	Fort Knox VA Clinic	Fort Knox
127	9	603GB	New Albany VA Clinic	New Albany
128	9	603GD	Stonybrook VA Clinic	Stonybrook

FY 2023 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
129	9	614GA	Tupelo VA Clinic	Tupelo
130	9	614GB	Jonesboro VA Clinic	Jonesboro
131	9	614GF	Nonconnah Boulevard VA Clinic	Nonconnah Boulevard
132	9	614GG	Jackson VA Clinic	Jackson, Tennessee
133	9	621BY	William C. Tallent Department of Veterans Affairs Outpatient Clinic	Knoxville, Tennessee
134	9	621GI	Dannie A. Carr Veterans Outpatient Clinic	Sevierville
135	9	626GE	Clarksville VA Clinic	Clarksville
136	9	626GF	Chattanooga VA Clinic	Chattanooga
137	9	626GO	International Plaza VA Clinic	International Plaza
138	10	506GA	Toledo VA Clinic	Toledo
139	10	515BY	Wyoming VA Clinic	Wyoming
140	10	538GC	Marietta VA Clinic	Marietta
141	10	539GB	Clermont County VA Clinic	Clermont County
142	10	539GC	Dearborn VA Clinic	Dearborn
143	10	539GD	Florence VA Clinic	Florence, Kentucky
144	10	539GE	Hamilton VA Clinic	Hamilton, Ohio
145	10	539GF	Georgetown VA Clinic	Georgetown
146	10	541BY	Canton VA Clinic	Canton, Ohio
147	10	541BZ	Carl Nunziato VA Clinic	Youngstown
148	10	541GB	Lorain VA Clinic	Lorain
149	10	541GD	David F. Winder Department of Veterans Affairs Community Based Outpatient Clinic	Mansfield
150	10	541GF	Lake County VA Clinic	Lake County
151	10	541GG	Akron VA Clinic	Akron
152	10	541GL	Parma VA Clinic	Parma
153	10	552GA	Middletown VA Clinic	Middletown, Ohio
154	10	552GB	Lima VA Clinic	Lima
155	10	552GC	Richmond VA Clinic	Richmond, Indiana
156	10	552GD	Springfield VA Clinic	Springfield, Ohio
157	10	583GA	Terre Haute VA Clinic	Terre Haute
158	10	583GB	Bloomington VA Clinic	Bloomington, Indiana
159	10	583GC	Martinsville VA Clinic	Martinsville
160	10	583GD	Brownsburg VA Clinic	Brownsburg
161	10	583GE	Lafayette VA Clinic	Lafayette, Indiana
162	10	583GF	Wakeman VA Clinic	Wakeman
163	10	610BY	Jackie Walorski VA Clinic	Mishawaka
164	10	655GA	Navy Corpsman Steve Andrews Department of Veterans Affairs Health Care Clinic	Gaylord
165	10	655GB	Colonel Demas T. Craw VA Clinic	Traverse City
166	10	757GB	Grove City VA Clinic	Grove City
167	10	757GD	Daniel L. Kinnard VA Clinic	Newark
168	12	537BY	Adam Benjamin Jr., Veterans' Administration Outpatient Clinic	Crown Point
169	12	550BY	Bob Michel Department of Veterans Affairs Outpatient Clinic	Peoria
170	12	550GA	Decatur VA Clinic	Decatur, Illinois
171	12	550GG	Bloomington VA Clinic	Bloomington, Illinois
172	12	578GA	Joliet VA Clinic	Joliet

FY 2023 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
173	12	578GC	Kankakee County VA Clinic	Kankakee County
174	12	578GD	Aurora VA Clinic	Aurora, Illinois
175	12	578GE	Hoffman Estates VA Clinic	Hoffman Estates
176	12	578GF	LaSalle VA Clinic	LaSalle
177	12	607GG	Madison West VA Clinic	Madison West
178	12	607HA	Rockford VA Clinic	Rockford
179	12	676GA	Wausau VA Clinic	Wausau
180	12	676GC	La Crosse VA Clinic	La Crosse
181	12	676GD	Wisconsin Rapids VA Clinic	Wisconsin Rapids
182	12	695BY	John H. Bradley Department of Veterans Affairs Outpatient Clinic	Appleton
183	15	589G1	Warrensburg VA Clinic	Warrensburg
184	15	589G8	Jefferson City VA Clinic	Jefferson City
185	15	589JA	Sedalia VA Clinic	Sedalia
186	15	589JD	Marshfield VA Clinic	Marshfield
187	15	589JF	Honor VA Clinic	Honor
188	15	589JG	Lenexa VA Clinic	Lenexa
189	16	502GB	Lafayette VA Clinic	Lafayette, Louisiana
190	16	502GE	Douglas Fournet Department of Veterans Affairs Clinic	Lake Charles
191	16	502GF	Fort Johnson VA Clinic	Fort Johnson
192	16	520BZ	Pensacola VA Clinic	Pensacola
193	16	520GA	Mobile VA Clinic	Mobile
194	16	520GC	Eglin Air Force Base VA Clinic	Eglin Air Force Base
195	16	564BY	Gene Taylor Veterans' Outpatient Clinic	Springfield, Missouri
196	16	564GB	Fort Smith VA Clinic	Fort Smith
197	16	564GC	Branson VA Clinic	Branson
198	16	564GF	Joplin VA Clinic	Joplin
199	16	580BY	Beaumont VA Clinic	Beaumont
200	16	580BZ	Charles Wilson Department of Veterans Affairs Outpatient Clinic	Lufkin
201	16	580GD	Conroe VA Clinic	Conroe
202	16	580GE	Katy VA Clinic	Katy
203	16	580GG	Richmond VA Clinic	Richmond, Texas
204	16	580GH	Tomball VA Clinic	Tomball
205	16	580GJ	Texas City VA Clinic	Texas City
206	16	598GA	Mountain Home VA Clinic	Mountain Home, Arkansas
207	16	598GC	Hot Springs VA Clinic	Hot Springs, Arkansas
208	16	598GE	Pine Bluff VA Clinic	Pine Bluff
209	16	598GG	Conway VA Clinic	Conway, Arkansas
210	16	598GH	Russellville VA Clinic	Russellville
211	16	629BY	Baton Rouge VA Clinic	Baton Rouge
212	16	629GB	Hammond VA Clinic	Hammond
213	16	629GC	Slidell VA Clinic	Slidell
214	16	667GA	Texarkana VA Clinic	Texarkana
215	16	667GB	Monroe VA Clinic	Monroe
216	16	667GC	Longview VA Clinic	Longview

FY 2023 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
217	17	504BY	Lubbock VA Clinic	Lubbock
218	17	519HC	Abilene VA Clinic	Abilene
219	17	549BY	Fort Worth VA Clinic	Fort Worth
220	17	549GN	Tyler Centennial VA Clinic	Tyler Centennial
221	17	671GO	North Central Federal VA Clinic	North Central Federal
222	17	671GP	Balcones Heights VA Clinic	Balcones Heights
223	17	671GS	North West San Antonio VA Clinic	North West San Antonio
224	17	674BY	Austin VA Clinic	Austin
225	17	740GA	Harlingen VA Clinic-Treasure Hills	Harlingen Treasure Hills
226	17	740GB	McAllen VA Clinic	McAllen
227	17	740GD	Laredo VA Clinic	Laredo
228	17	740GH	South Enterprize VA Clinic	South Enterprize
229	17	740QB	Corpus Christi West Point VA Clinic	Corpus Christi West Point
230	17	756GA	Las Cruces VA Clinic	Las Cruces
231	17	756GB	El Paso Eastside VA Clinic	El Paso Eastside
232	19	436GC	David J. Thatcher VA Clinic	Missoula
233	19	442GD	Loveland VA Clinic	Loveland
234	19	442GE	Northern Colorado VA Clinic	Northern Colorado
235	19	554GC	Golden VA Clinic	Golden
236	19	554GD	PFC James Dunn VA Clinic	Pueblo, Colorado
237	19	554GE	PFC Floyd K. Lindstrom Department of Veterans Affairs Clinic	Colorado Springs
238	19	623BY	Ernest Childers Department of Veterans Affairs Outpatient Clinic	Tulsa
239	19	635GA	Lawton VA Clinic	Lawton
240	19	635GB	Wichita Falls VA Clinic	Wichita Falls
241	19	635GJ	Yukon VA Clinic	Yukon
242	19	635QB	South Oklahoma City VA Clinic	South Oklahoma City
243	19	660GA	Pocatello VA Clinic	Pocatello
244	19	660GB	Ogden VA Clinic	Ogden
245	20	531GG	Caldwell VA Clinic	Caldwell
246	20	648GA	Robert D. Maxwell Department of Veterans Affairs Clinic	Bend
247	20	648GB	Salem VA Clinic	Salem, Oregon
248	20	648GF	Hillsboro VA Clinic	Hillsboro
249	20	648GG	West Linn VA Clinic	West Linn
250	20	663GB	Silverdale VA Clinic	Silverdale
251	20	663GC	Mount Vernon VA Clinic	Mount Vernon, Washington
252	20	668GA	Elwood “Bud” Link Department of Veterans Affairs Outpatient Clinic	Wenatchee
253	20	668GB	Coeur d 'Alene VA Clinic	Coeur d 'Alene
254	21	570GA	Merced VA Clinic	Merced
255	21	593GC	Pahrump VA Clinic	Pahrump
256	21	593GE	Southeast Las Vegas VA Clinic	Southeast Las Vegas
257	21	593GF	Southwest Las Vegas VA Clinic	Southwest Las Vegas
258	21	612B4	Redding VA Clinic	Redding
259	21	612GD	Fairfield VA Clinic	Fairfield
260	21	612GE	Mare Island VA Clinic	Mare Island

FY 2023 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
261	21	612GG	Chico VA Clinic	Chico
262	21	612GH	McClellan VA Clinic	McClellan Park
263	21	612GK	Sierra Foothills VA Clinic	Sierra Foothills
264	21	612GM	Modesto VA Clinic	Modesto
265	21	640BY	San Jose VA Clinic	San Jose
266	21	640HC	Major General William H. Gourley VA-DoD Outpatient Clinic	Monterey
267	21	662GA	South Santa Rosa VA Clinic	South Santa Rosa
268	21	662GC	Eureka VA Clinic	Eureka
269	21	662GD	Ukiah VA Clinic	Ukiah
270	21	662GE	San Bruno VA Clinic	San Bruno
271	21	662GG	Clearlake VA Clinic	Clearlake
272	21	662GH	Oakland VA Clinic	Oakland
273	22	600GB	Santa Ana VA Clinic	Santa Ana
274	22	605BZ	Loma Linda VA Clinic	Loma Linda Redlands
275	22	644BY	Staff Sergeant Alexander W. Conrad Veterans Affairs Health Care Clinic	Southeast Gilbert
276	22	644GA	Northwest VA Clinic	Northwest Surprise
277	22	664BY	Kearny Mesa VA Clinic	Kearny Mesa
278	22	664GB	Oceanside VA Clinic	Oceanside
279	22	664GC	Chula Vista VA Clinic	Chula Vista
280	22	678GA	Sierra Vista VA Clinic	Sierra Vista
281	22	678GB	Yuma VA Clinic	Yuma
282	22	678GC	Casa Grande VA Clinic	Casa Grande
283	22	678GG	Southeast Tucson VA Clinic	Southeast Tucson
284	22	691GD	Bakersfield VA Clinic	Bakersfield
285	22	691GE	Los Angeles VA Clinic	Los Angeles
286	22	691GG	Antelope Valley VA Clinic	Antelope Valley
287	22	691GL	Santa Maria VA Clinic	Santa Maria
288	23	568GA	Rapid City VA Clinic	Rapid City
289	23	618BY	Twin Ports VA Clinic	Twin Ports
290	23	618GB	Hibbing VA Clinic	Hibbing
291	23	618GD	Maplewood VA Clinic	Maplewood
292	23	618GE	Chippewa Valley VA Clinic	Chippewa Valley
293	23	618GG	Rochester VA Clinic	Rochester, Minnesota
294	23	618GI	Northwest Metro VA Clinic	Northwest Metro Minnesota
295	23	618GJ	Shakopee VA Clinic	Shakopee
296	23	636A5	Lincoln VA Clinic	Lincoln, Nebraska
297	23	636GA	Norfolk VA Clinic	Norfolk
298	23	636GC	Mason City VA Clinic	Mason City
299	23	636GD	Marshalltown VA Clinic	Marshalltown
300	23	636GF	Quad Cities VA Clinic	Quad Cities

FY 2023 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
301	23	636GG	Quincy VA Clinic	Quincy, Illinois
302	23	636GI	Lane A. Evans VA Community Based Outpatient Clinic	Galesburg
303	23	636GJ	Dubuque VA Clinic	Dubuque
304	23	636GM	Carroll VA Clinic	Carroll
305	23	636GP	Shenandoah VA Clinic	Shenandoah
306	23	636GR	Knoxville VA Clinic	Knoxville, Iowa
307	23	636GS	Ottumwa VA Clinic	Ottumwa
308	23	636GT	Sterling VA Clinic	Sterling
309	23	636GU	Decorah VA Clinic	Decorah
310	23	656GA	Brainerd VA Clinic	Brainerd
311	23	656GC	Max J. Beilke Department of Veterans Affairs Outpatient Clinic	Alexandria, Minnesota

FY 2023 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
1	1	402GA	Caribou VA Clinic	Caribou
2	1	402GC	Rumford VA Clinic	Rumford
3	1	405GA	Bennington VA Clinic	Bennington
4	1	405GC	Brattleboro VA Clinic	Brattleboro
5	1	405HE	Keene VA Clinic	Keene
6	1	405HF	Rutland VA Clinic	Rutland
7	1	405QB	Newport VA Clinic	Newport, Vermont
8	1	518GA	Lynn VA Clinic	Lynn
9	1	518GE	Gloucester VA Clinic	Gloucester
10	1	523BZ	Causeway VA Clinic	Causeway
11	1	523GA	Framingham VA Clinic	Framingham
12	1	523GD	Plymouth VA Clinic	Plymouth
13	1	608GA	Portsmouth VA Clinic	Portsmouth, New Hampshire
14	1	608GC	Somersworth VA Clinic	Somersworth
15	1	608HA	Tilton VA Clinic	Tilton
16	1	631GC	Pittsfield VA Clinic	Pittsfield
17	1	631GD	Greenfield VA Clinic	Greenfield
18	1	631GF	Fitchburg VA Clinic	Fitchburg
19	1	650GA	New Bedford VA Clinic	New Bedford
20	1	650GB	Hyannis VA Clinic	Hyannis
21	1	650GD	Middletown VA Clinic	Middletown, Rhode Island
22	1	689GA	Waterbury VA Clinic	Waterbury
23	1	689GB	Stamford VA Clinic	Stamford
24	1	689GC	Willimantic VA Clinic	Willimantic
25	1	689GD	Winsted VA Clinic	Winsted
26	1	689GE	Danbury VA Clinic	Danbury
27	1	689HC	John J. McGuirk Department of Veterans Affairs Outpatient Clinic	New London
28	1	689QA	Errera VA Clinic	Errera
29	2	526GA	White Plains VA Clinic	White Plains
30	2	526GB	Yonkers VA Clinic	Yonkers
31	2	528G3	Oneonta VA Clinic	Oneonta
32	2	528G4	Elmira VA Clinic	Elmira
33	2	528G5	Auburn VA Clinic	Auburn
34	2	528G8	Wellsville VA Clinic	Wellsville
35	2	528G9	Tompkins County VA Clinic	Tompkins County

FY 2023 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
36	2	528GB	Jamestown VA Clinic	Jamestown, New York
37	2	528GC	Dunkirk VA Clinic	Dunkirk
38	2	528GD	Niagara Falls VA Clinic	Niagara Falls
39	2	528GK	Lockport VA Clinic	Lockport
40	2	528GL	Potsdam VA Clinic	Potsdam
41	2	528GO	Watertown VA Clinic	Watertown, New York
42	2	528GP	Oswego VA Clinic	Oswego
43	2	528GQ	West Seneca VA Clinic	West Seneca
44	2	528GR	Olean VA Clinic	Olean
45	2	528GT	Glens Falls VA Clinic	Glens Falls
46	2	528GV	Plattsburgh VA Clinic	Plattsburgh
47	2	528GZ	Kingston VA Clinic	Kingston
48	2	561GA	Hamilton VA Clinic	Hamilton, New Jersey
49	2	561GE	Jersey City VA Clinic	Jersey City
50	2	561GF	Piscataway VA Clinic	Piscataway
51	2	561GH	Morristown VA Clinic	Morristown, New Jersey
52	2	561GI	Tinton Falls VA Clinic	Tinton Falls
53	2	561GJ	Paterson VA Clinic	Paterson
54	2	620GB	Carmel VA Clinic	Carmel
55	2	620GD	Goshen VA Clinic	Goshen
56	2	620GE	Port Jervis VA Clinic	Port Jervis
57	2	620GG	Poughkeepsie VA Clinic	Poughkeepsie
58	2	632HA	Valley Stream VA Clinic	Valley Stream
59	2	632HB	Riverhead VA Clinic	Riverhead
60	2	632HC	Bay Shore VA Clinic	Bay Shore
61	4	460GA	Sussex County VA Clinic	Sussex County
62	4	460HE	Atlantic County VA Clinic	Atlantic County
63	4	529GA	Michael A. Marzano Department of Veterans Affairs Outpatient Clinic	Hermitage
64	4	529GB	Lawrence County VA Clinic	Lawrence County
65	4	529GC	Armstrong County VA Clinic	Armstrong County
66	4	529GF	Cranberry Township VA Clinic	Cranberry Township
67	4	542GA	Delaware County VA Clinic	Delaware County
68	4	542GE	West Norriton VA Clinic	West Norriton
69	4	562GB	Ashtabula County VA Clinic	Ashtabula County
70	4	562GD	Venango County VA Clinic	Venango County

FY 2023 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
71	4	595GD	Berks County VA Clinic	Berks County
72	4	595GF	Schuylkill County VA Clinic	Schuylkill County
73	4	642GF	Camden VA Clinic	Camden
74	4	642GH	West Philadelphia VA Clinic	West Philadelphia
75	4	646GB	Westmoreland County VA Clinic	Westmoreland County
76	4	693GA	Sayre VA Clinic	Sayre
77	4	693GB	Williamsport VA Clinic	Williamsport
78	5	512GE	Pocomoke City VA Clinic	Pocomoke City
79	5	512GF	Eastern Baltimore County VA Clinic	Eastern Baltimore County
80	5	517GB	Greenbrier County VA Clinic	Greenbrier County
81	5	517QA	Princeton VA Clinic	Princeton
82	5	540GB	Wood County VA Clinic	Wood County
83	5	581GA	Prestonsburg VA Clinic	Prestonsburg
84	5	613GA	Cumberland VA Clinic	Cumberland
85	5	613GB	Hagerstown VA Clinic	Hagerstown
86	5	613GC	Winchester VA Clinic	Winchester
87	5	613GE	Petersburg VA Clinic	Petersburg
88	5	613GF	Harrisonburg VA Clinic	Harrisonburg
89	5	688GE	Southern Prince George's County VA Clinic	Southern Prince George's County
90	5	688GF	Montgomery County VA Clinic	Montgomery County
91	5	688GG	Lexington Park VA Clinic	Lexington Park
92	6	558GC	Morehead City VA Clinic	Morehead City
93	6	565GD	Hamlet VA Clinic	Hamlet
94	6	565GE	Robeson County VA Clinic	Robeson County
95	6	565GF	Goldsboro VA Clinic	Goldsboro
96	6	565GH	Brunswick County VA Clinic	Brunswick County
97	6	565GO	Johnson Air Force Base VA Clinic	Johnson Air Force Base
98	6	590GB	Virginia Beach VA Clinic	Virginia Beach
99	6	590GC	Albemarle VA Clinic	Albemarle
100	6	590GE	Portsmouth VA Clinic	Portsmouth, Virginia
101	6	637GB	Master Sergeant Jerry K. Crump VA Clinic	Rutherford County Forest City
102	6	652GB	Fredericksburg 2 VA Clinic	Fredericksburg 2
103	6	652GI	Massaponax VA Clinic	Massaponax
104	6	658GA	Tazewell VA Clinic	Tazewell
105	6	658GB	Danville VA Clinic	Danville, Virginia

FY 2023 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
106	6	658GC	Lynchburg VA Clinic	Lynchburg
107	6	658GD	Staunton VA Clinic	Staunton
108	6	658GE	Wytheville VA Clinic	Wytheville
109	7	508GI	Newnan VA Clinic	Newnan
110	7	508GL	Rome VA Clinic	Rome, Georgia
111	7	508GM	Pickens County VA Clinic	Pickens County
112	7	508GN	Covington VA Clinic	Covington, Georgia
113	7	508QE	Gwinnett County VA Clinic	Gwinnett County
114	7	509GB	Aiken VA Clinic	Aiken
115	7	509QA	Ray Hendrix Department Of Veterans Affairs Clinic	Statesboro
116	7	521GC	Florence VA Clinic	Florence, Alabama
117	7	521GD	Rainbow City VA Clinic	Rainbow City
118	7	521GE	Oxford VA Clinic	Oxford
119	7	521GF	Jasper VA Clinic	Jasper
120	7	521GG	Bessemer VA Clinic	Bessemer
121	7	521GH	Childersburg VA Clinic	Childersburg
122	7	521GI	Guntersville VA Clinic	Guntersville
123	7	544GC	Rock Hill VA Clinic	Rock Hill
124	7	544GE	Orangeburg VA Clinic	Orangeburg
125	7	544GF	Sumter VA Clinic	Sumter
126	7	544GG	Spartanburg VA Clinic	Spartanburg
127	7	557GC	Milledgeville VA Clinic	Milledgeville
128	7	557GF	Tifton VA Clinic	Tifton
129	7	557HA	Perry VA Clinic	Perry, Georgia
130	7	619GE	Monroe County VA Clinic	Monroe County, Alabama
131	7	619GG	Columbus Downtown VA Clinic	Columbus Downtown
132	7	619QA	Dothan 2 VA Clinic	Dothan 2
133	7	679GA	Selma VA Clinic	Selma
134	8	516GB	St. Petersburg VA Clinic	St. Petersburg
135	8	573GA	Valdosta VA Clinic	Valdosta
136	8	573GJ	St. Marys VA Clinic	St. Marys
137	8	573GK	Marianna VA Clinic	Marianna
138	8	573GL	Palatka VA Clinic	Palatka
139	8	573GM	Waycross VA Clinic	Waycross
140	8	573GO	A.K. Baker VA Clinic	Middleburg

FY 2023 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
141	8	573QG	Jacksonville Southpoint VA Clinic	Jacksonville Southpoint
142	8	672GC	Arecibo VA Clinic	Arecibo
143	8	672GD	Ceiba VA Clinic	Ceiba
144	8	672GE	Guayama VA Clinic	Guayama
145	8	673GF	Zephyrhills VA Clinic	Zephyrhills
146	8	675GC	Kissimmee VA Clinic	Kissimmee
147	8	675GF	Clermont VA Clinic	Clermont
148	9	596GB	Morehead VA Clinic	Morehead
149	9	596GC	Hazard VA Clinic	Hazard
150	9	596GD	Berea VA Clinic	Berea
151	9	603GC	Greenwood VA Clinic	Greenwood
152	9	603GE	Newburg VA Clinic	Newburg
153	9	603GF	Grayson County VA Clinic	Grayson County
154	9	603GG	Scott County VA Clinic	Scott County
155	9	603GH	Carrollton VA Clinic	Carrollton, Kentucky
156	9	614GC	Holly Springs VA Clinic	Holly Springs
157	9	614GD	Savannah VA Clinic	Savannah, Tennessee
158	9	614GE	Covington VA Clinic	Covington, Tennessee
159	9	614GI	Dyersburg VA Clinic	Dyersburg
160	9	614GN	Helena VA Clinic	Helena, Arkansas
161	9	621GC	Norton VA Clinic	Norton
162	9	621GG	Morristown VA Clinic	Morristown, Tennessee
163	9	621GJ	Bristol VA Clinic	Bristol
164	9	621GK	Campbell County VA Clinic	Campbell County
165	9	626GA	Dover VA Clinic	Dover
166	9	626GC	Bowling Green VA Clinic	Bowling Green
167	9	626GH	Cookeville VA Clinic	Cookeville
168	9	626GJ	Hopkinsville VA Clinic	Hopkinsville
169	9	626GK	McMinnville VA Clinic	McMinnville
170	9	626GL	Roane County VA Clinic	Roane County
171	9	626GM	Columbia VA Clinic	Columbia
172	9	626GN	Athens VA Clinic	Athens, Tennessee
173	9	626GP	Gallatin VA Clinic	Gallatin
174	9	626QB	Charlotte Avenue VA Clinic	Charlotte Avenue
175	10	506GB	Flint VA Clinic	Flint

FY 2023 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
176	10	506GC	Jackson VA Clinic	Jackson, Michigan
177	10	506GD	Major General Oliver W. Dillard VA Clinic	Canton, Michigan
178	10	515GA	Muskegon VA Clinic	Muskegon
179	10	515GB	Lansing VA Clinic	Lansing
180	10	515GC	Benton Harbor VA Clinic	Benton Harbor
181	10	538GA	Athens VA Clinic	Athens, Ohio
182	10	538GB	Portsmouth VA Clinic	Portsmouth, Ohio
183	10	538GD	Lancaster VA Clinic	Lancaster
184	10	538GE	Cambridge VA Clinic	Cambridge, Ohio
185	10	538GF	Wilmington VA Clinic	Wilmington, Ohio
186	10	539GA	Bellevue VA Clinic	Bellevue, Kentucky
187	10	541GC	Sandusky VA Clinic	Sandusky
188	10	541GH	East Liverpool VA Clinic	East Liverpool
189	10	541GI	Warren VA Clinic	Warren
190	10	541GJ	New Philadelphia VA Clinic	New Philadelphia
191	10	541GK	Ravenna VA Clinic	Ravenna
192	10	541QB	Cleveland VA Clinic-Euclid	Cleveland Euclid Avenue
193	10	553GA	Yale VA Clinic	Yale
194	10	553GB	Pontiac VA Clinic	Pontiac
195	10	610GB	Muncie VA Clinic	Muncie
196	10	610GD	Hoosier VA Clinic	Hoosier
197	10	610GF	Huntington VA Clinic	Huntington
198	10	655GC	Oscoda VA Clinic	Oscoda
199	10	655GD	Lt. Colonel Clement C. Van Wagoner Department of Veterans Affairs Clinic	Alpena
200	10	655GE	Clare VA Clinic	Clare
201	10	655GF	Bad Axe VA Clinic	Bad Axe
202	10	655GG	Cadillac VA Clinic	Cadillac
203	10	655GH	Pfc. Justin T. Paton Department of Veterans Affairs Clinic	Mackinaw City
204	10	655GI	Grayling VA Clinic	Grayling
205	10	757GA	Zanesville VA Clinic	Zanesville
206	10	757GC	Marion VA Clinic	Marion, Ohio
207	12	537GA	Chicago Heights VA Clinic	Chicago Heights
208	12	537HA	Auburn Gresham VA Clinic	Chicago Auburn Gresham
209	12	550GD	Springfield VA Clinic	Springfield, Illinois
210	12	550GF	Mattoon VA Clinic	Mattoon
211	12	556GA	Evanston VA Clinic	Evanston, Illinois

FY 2023 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
212	12	556GC	McHenry VA Clinic	McHenry
213	12	556GD	Kenosha VA Clinic	Kenosha
214	12	578GG	Oak Lawn VA Clinic	Oak Lawn
215	12	585GA	Hancock VA Clinic	Hancock
216	12	585GB	Rhinelander VA Clinic	Rhinelander
217	12	585GC	Menominee VA Clinic	Menominee
218	12	585GD	Ironwood VA Clinic	Ironwood
219	12	585GF	Manistique VA Clinic	Manistique
220	12	585GG	Gladstone VA Clinic	Gladstone
221	12	585HA	Marquette VA Clinic	Marquette
222	12	585HB	Sault Saint Marie VA Clinic	Sault Saint Marie
223	12	695GA	Union Grove VA Clinic	Union Grove
224	12	695GC	Cleveland VA Clinic	Cleveland, Wisconsin
225	15	589G4	Hays VA Clinic	Hays
226	15	589G5	Parsons VA Clinic	Parsons
227	15	589G7	Hutchinson VA Clinic	Hutchinson
228	15	589GB	Belton VA Clinic	Belton
229	15	589GC	Paola VA Clinic	Paola
230	15	589GE	Kirksville VA Clinic	Kirksville
231	15	589GF	Waynesville VA Clinic	Waynesville
232	15	589GH	Camdenton VA Clinic	Camdenton
233	15	589GI	St. Joseph VA Clinic	St. Joseph
234	15	589GJ	Kansas City Kansas VA Clinic	Kansas City Kansas
235	15	589GR	Lieutenant General Richard J. Seitz Community-Based Outpatient Clinic	Junction City
236	15	589GU	Lawrence VA Clinic	Lawrence
237	15	589GV	Fort Scott VA Clinic	Fort Scott
238	15	589GW	Salina VA Clinic	Salina
239	15	589GX	Mexico VA Clinic	Mexico
240	15	589GY	St. James VA Clinic	St. James, Missouri
241	15	589JB	Excelsior Springs VA Clinic	Excelsior Springs
242	15	589JE	Platte City VA Clinic	Platte City
243	15	657GA	St. Clair County VA Clinic	St. Clair County
244	15	657GB	St. Louis County VA Clinic	St. Louis County
245	15	657GD	St. Charles County VA Clinic	St. Charles County
246	15	657GF	West Plains VA Clinic	West Plains
247	15	657GG	Paragould VA Clinic	Paragould

FY 2023 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
248	15	657GH	Cape Girardeau VA Clinic	Cape Girardeau
249	15	657GI	Robert Silvey Department of Veterans Affairs Outpatient Clinic	Farmington, Missouri
250	15	657GK	Mount Vernon VA Clinic	Mount Vernon, Illinois
251	15	657GL	Paducah VA Clinic	Paducah
252	15	657GM	Effingham VA Clinic	Effingham
253	15	657GP	Owensboro VA Clinic	Owensboro
254	15	657GQ	Vincennes VA Clinic	Vincennes
255	15	657GR	Mayfield VA Clinic	Mayfield
256	15	657GS	Franklin County VA Clinic	Franklin County
257	15	657GT	Carbondale VA Clinic	Carbondale
258	15	657GU	Harrisburg VA Clinic	Harrisburg
259	15	657GV	Sikeston VA Clinic	Sikeston
260	15	657GW	Pocahontas VA Clinic	Pocahontas
261	15	657GX	Washington Avenue VA Clinic	Washington Avenue
262	15	657GY	Manchester Avenue VA Clinic	Manchester Avenue
263	15	657QA	Olive Street VA Clinic	Olive Street
264	16	502GA	Jennings VA Clinic	Jennings
265	16	502GG	Natchitoches VA Clinic	Natchitoches
266	16	520GB	Panama City Beach VA Clinic	Panama City Beach, Florida
267	16	520QA	Panama City Beach West VA Clinic	Panama City Beach West
268	16	564GD	Ozark VA Clinic	Ozark
269	16	564GE	Jay VA Clinic	Jay
270	16	580GC	Galveston County VA Clinic	Galveston County
271	16	580GF	Lake Jackson VA Clinic	Lake Jackson
272	16	580GL	Sugar Land VA Clinic	Sugar Land
273	16	586GB	Meridian VA Clinic	Meridian
274	16	586GC	Greenville VA Clinic	Greenville, Mississippi
275	16	586GD	Hattiesburg VA Clinic	Hattiesburg
276	16	586GE	Natchez VA Clinic	Natchez
277	16	586GF	Columbus VA Clinic	Columbus, Mississippi
278	16	598GB	El Dorado VA Clinic	El Dorado
279	16	598GD	Mena VA Clinic	Mena
280	16	598GF	Searcy VA Clinic	Searcy
281	16	629GA	Houma VA Clinic	Houma
282	16	629GD	St. John VA Clinic	St. John
283	16	629GE	Franklin VA Clinic	Franklin, Louisiana

FY 2023 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
284	16	629GF	Bogalusa VA Clinic	Bogalusa
285	17	504BZ	Clovis VA Clinic	Clovis
286	17	519GA	Wilson and Young Medal of Honor VA Clinic	Permian Basin
287	17	519HF	Colonel Charles and JoAnne Powell VA Clinic	San Angelo
288	17	549A5	Garland VA Medical Center	Garland
289	17	549GD	Denton VA Clinic	Denton
290	17	549GE	Decatur VA Clinic	Decatur, Texas
291	17	549GH	Greenville VA Clinic	Greenville, Texas
292	17	549GJ	Sherman VA Clinic	Sherman
293	17	549GL	Plano VA Clinic	Plano
294	17	549GM	Grand Prairie VA Clinic	Grand Prairie
295	17	549QC	Tyler Broadway VA Clinic	Tyler Broadway
296	17	671GB	Victoria VA Clinic	Victoria
297	17	671GF	South Bexar County VA Clinic	South Bexar County
298	17	671GK	San Antonio VA Clinic	San Antonio Fredericksburg Road
299	17	671GQ	Shavano Park VA Clinic	Shavano Park
300	17	671GR	North Bexar VA Clinic	North Bexar
301	17	671GU	San Antonio Pecan Valley VA Clinic	San Antonio Pecan Valley
302	17	674GA	Palestine VA Clinic	Palestine
303	17	674GB	Brownwood VA Clinic	Brownwood
304	17	674GC	Bryan VA Clinic	Bryan
305	17	674GD	Cedar Park VA Clinic	Cedar Park
306	17	674GF	Temple VA Clinic	Temple South General Bruce Drive
307	17	674GG	Copperas Cove VA Clinic	Copperas Cove
308	17	674GH	Killeen VA Clinic	Killeen
309	17	674HB	LaGrange VA Clinic	LaGrange
310	17	740GC	Corpus Christi VA Clinic	Corpus Christi
311	17	756GC	El Paso Westside VA Clinic	El Paso Westside
312	19	436GB	Great Falls VA Clinic	Great Falls
313	19	436GD	Travis W. Atkins Department of Veterans Affairs Clinic	Bozeman
314	19	436GF	Kalispell VA Clinic	Kalispell
315	19	436GK	Glendive VA Clinic	Glendive
316	19	436GN	Dr. Joseph Medicine Crow VA Clinic	Billings Spring Creek Lane
317	19	554GB	Aurora VA Clinic	Aurora, Colorado
318	19	554GG	La Junta VA Clinic	La Junta
319	19	554GM	Space Center VA Clinic	Space Center

FY 2023 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
320	19	623GA	McAlester VA Clinic	McAlester
321	19	623GB	Vinita VA Clinic	Vinita
322	19	623GC	McCurtain County VA Clinic	McCurtain County
323	19	623GD	Claremore VA Clinic	Claremore
324	19	635GD	Ada VA Clinic	Ada
325	19	635GE	Stillwater VA Clinic	Stillwater
326	19	635GF	Altus VA Clinic	Altus
327	19	635GG	Enid VA Clinic	Enid
328	19	635GI	Norman VA Clinic	Norman
329	19	635HB	Ardmore VA Clinic	Ardmore
330	19	635QA	North May VA Clinic	North May
331	19	635QE	Tinker VA Clinic	Tinker
332	19	660GE	Orem VA Clinic	Orem
333	19	660GG	St. George VA Clinic	St. George
334	19	660GJ	South Jordan VA Clinic	South Jordan
335	19	660QA	Idaho Falls VA Clinic	Idaho Falls
336	19	666GB	Casper VA Clinic	Casper
337	20	463GA	Fairbanks VA Clinic	Fairbanks
338	20	463GB	Soldotna VA Clinic	Soldotna
339	20	463GC	Mat-Su VA Clinic	Mat-Su
340	20	531GE	Twin Falls VA Clinic	Twin Falls
341	20	531GI	Mountain Home VA Clinic	Mountain Home, Idaho
342	20	648GE	Fairview VA Clinic	Fairview
343	20	648GI	Portland VA Clinic	Portland 1st Avenue
344	20	653GA	North Bend VA Clinic	North Bend
345	20	653GB	Brookings VA Clinic	Brookings
346	20	663GI	Olympia VA Clinic	Olympia
347	20	663GJ	Puyallup VA Clinic	Puyallup
348	20	687GA	Richland VA Clinic	Richland
349	20	687GB	Lewiston VA Clinic	Lewiston, Idaho
350	20	687HA	Yakima Valley VA Clinic	Yakima
351	20	692GA	Klamath Falls VA Clinic	Klamath Falls
352	20	692GB	Grants Pass VA Clinic	Grants Pass
353	21	459GA	Maui VA Clinic	Maui
354	21	459GB	Hilo VA Clinic	Hilo
355	21	459GC	Kailua-Kona VA Clinic	Kailua-Kona

FY 2023 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
356	21	459GD	Lihue VA Clinic	Lihue
357	21	459GE	Guam VA Clinic	Guam
358	21	459GF	Faleomavaega Eni Fa'aua'a Hunkin VA Clinic	American Samoa
359	21	459GG	Leeward Oahu VA Clinic	Leeward Oahu
360	21	459QC	Windward VA Clinic	Windward
361	21	570GB	Tulare VA Clinic	Tulare
362	21	593GD	Northwest Las Vegas VA Clinic	Northwest Las Vegas
363	21	593GG	Northeast Las Vegas VA Clinic	Northeast Las Vegas
364	21	612GI	Yuba City VA Clinic	Yuba City
365	21	612GJ	Yreka VA Clinic	Yreka
366	21	612GL	Sonora VA Clinic	Sonora
367	21	640GA	Capitola VA Clinic	Capitola
368	21	640GC	Fremont VA Clinic	Fremont
369	21	654GE	Reno East VA Clinic	Reno East
370	21	654GF	North Reno VA Clinic	North Reno
371	21	654QB	Capitol Hill VA Clinic	Capitol Hill
372	21	662GF	San Francisco VA Clinic	San Francisco Downtown
373	22	501GA	Artesia VA Clinic	Artesia
374	22	501GB	Farmington VA Clinic	Farmington, New Mexico
375	22	501GK	Santa Fe VA Clinic	Santa Fe
376	22	600GA	Placentia VA Clinic	Placentia
377	22	600GD	Santa Fe Springs VA Clinic	Santa Fe Springs
378	22	600GE	Laguna Hills VA Clinic	Laguna Hills
379	22	600GF	Gardena VA Clinic	Gardena
380	22	605GA	Victorville VA Clinic	Victorville
381	22	605GB	Murrieta VA Clinic	Murrieta
382	22	605GC	Sy Kaplan VA Clinic	Palm Desert
383	22	605GD	Corona VA Clinic	Corona
384	22	605GE	Rancho Cucamonga VA Clinic	Rancho Cucamonga
385	22	644GB	Show Low VA Clinic	Show Low
386	22	644GC	Southwest VA Clinic	Southwest Phoenix
387	22	644GE	Thunderbird VA Clinic	Thunderbird
388	22	644GG	Northeast Phoenix VA Clinic	Northeast Phoenix
389	22	644GH	Phoenix Midtown VA Clinic	Phoenix Midtown
390	22	644GI	Phoenix 32nd Street VA Clinic	Phoenix 32nd Street

FY 2023 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
391	22	649GA	Kingman VA Clinic	Kingman
392	22	649GB	Flagstaff VA Clinic	Flagstaff
393	22	649GC	Lake Havasu City VA Clinic	Lake Havasu City
394	22	649GD	Anthem VA Clinic	Anthem
395	22	649GE	Cottonwood VA Clinic	Cottonwood
396	22	664GD	Escondido VA Clinic	Escondido
397	22	678GF	Northwest Tucson VA Clinic	Northwest Tucson
398	22	691GB	Santa Barbara VA Clinic	Santa Barbara
399	22	691GF	East Los Angeles VA Clinic	East Los Angeles
400	22	691GK	San Luis Obispo VA Clinic	San Luis Obispo
401	22	691GP	San Gabriel Valley VA Clinic	San Gabriel Valley
402	23	437GB	Bismarck VA Clinic	Bismarck
403	23	437GC	Fergus Falls VA Clinic	Fergus Falls
404	23	437GD	Minot VA Clinic	Minot
405	23	437GE	Bemidji VA Clinic	Bemidji
406	23	437GF	Williston VA Clinic	Williston
407	23	437GI	Grand Forks VA Clinic	Grand Forks
408	23	437QA	North Fargo VA Clinic	North Fargo
409	23	438GA	Spirit Lake VA Clinic	Spirit Lake
410	23	438GC	Sioux City VA Clinic	Sioux City
411	23	438GD	Aberdeen VA Clinic	Aberdeen
412	23	438GF	Watertown VA Clinic	Watertown, South Dakota
413	23	618GK	Albert Lea VA Clinic	Albert Lea
414	23	618GL	Minneapolis VA Clinic	Minneapolis Harmon Place
415	23	618GM	Rice Lake VA Clinic	Rice Lake
416	23	618GN	Lyle C. Pearson Community Based Outpatient Clinic	Mankato
417	23	636GH	Waterloo VA Clinic	Waterloo
418	23	636GK	Fort Dodge VA Clinic	Fort Dodge
419	23	636GL	Bellevue VA Clinic	Bellevue, Nebraska
420	23	636GN	Cedar Rapids VA Clinic	Cedar Rapids
421	23	636GW	Coralville VA Clinic	Coralville
422	23	636GY	Burlington VA Clinic	Burlington

FY 2023 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
1	1	402GB	Calais VA Clinic	Calais
2	1	402GF	Lincoln VA Clinic	Lincoln, Maine
3	1	402QA	Fort Kent VA Clinic	Fort Kent
4	1	402QB	Houlton VA Clinic	Houlton
5	1	518GB	Haverhill VA Clinic	Haverhill
6	1	523GC	Quincy VA Clinic	Quincy, Massachusetts
7	1	608GD	Conway VA Clinic	Conway, New Hampshire
8	1	631QA	Plantation Street VA Clinic	Plantation Street
9	1	650QA	Eagle Square VA Clinic	Eagle Square
10	1	650QB	Eagle Street VA Clinic	Eagle Street
11	1	689BW	Maple Street VA Domiciliary	Maple Street Domiciliary
12	1	689BX	Norton Street VA Domiciliary	Norton Street Domiciliary
13	1	689GF	Orange VA Clinic	Orange
14	1	689QB	West Haven VA Mobile Clinic	West Haven Mobile
15	2	526GD	Thomas P. Noonan Jr. Department of Veterans Affairs Outpatient Clinic	Sunnyside
16	2	526QA	Bronx VA Mobile Clinic	Bronx Mobile
17	2	528G2	Westport VA Clinic	Westport
18	2	528G6	Fonda VA Clinic	Fonda
19	2	528G7	Catskill VA Clinic	Catskill
20	2	528GE	Rochester Clinton Crossings VA Clinic	Rochester Clinton Crossings
21	2	528GW	Schenectady VA Clinic	Schenectady
22	2	528GY	Clifton Park VA Clinic	Clifton Park
23	2	528QA	Buffalo VA Clinic	Buffalo Main Street
24	2	528QB	Packard VA Clinic	Packard
25	2	528QF	Wellsboro VA Clinic	Wellsboro
26	2	528QG	Erie West VA Clinic	Erie West
27	2	528QH	South Salina VA Clinic	South Salina
28	2	528QI	Erie East VA Clinic	Erie East
29	2	528QK	Saranac Lake VA Clinic	Saranac Lake
30	2	528QN	Watertown 2 VA Clinic	Watertown 2
31	2	561GK	Sussex VA Clinic	Sussex
32	2	620GF	Monticello VA Clinic	Monticello
33	2	620GH	Eastern Dutchess VA Clinic	Eastern Dutchess
34	2	630GA	Harlem VA Clinic	Harlem
35	2	630QA	New York Harbor 1 VA Mobile Clinic	New York Harbor 1 Mobile

FY 2023 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
36	2	630QB	New York Harbor 2 VA Mobile Clinic	New York Harbor 2 Mobile
37	2	632QA	Northport 1 VA Mobile Clinic	Northport 1 Mobile
38	2	632QB	Northport 2 VA Mobile Clinic	Northport 2 Mobile
39	4	460HK	Wilmington VA Mobile Clinic	Wilmington Mobile
40	4	529GD	Clarion County VA Clinic	Clarion County
41	4	562GC	McKean County VA Clinic	McKean County
42	4	595QA	Fort Indiantown Gap VA Clinic	Annville
43	4	642QA	Chestnut Street VA Clinic	Chestnut Street
44	4	642QB	Fourth Street VA Clinic	Fourth Street
45	4	693GC	Tobyhanna VA Clinic	Tobyhanna
46	4	693GF	Columbia County VA Clinic	Columbia County
47	4	693GG	Northampton County VA Clinic	Northampton County
48	4	693QA	Wayne County VA Clinic	Wayne County
49	4	693QB	Cedar Crest Boulevard VA Clinic	Cedar Crest Boulevard
50	5	512QA	Baltimore VA Clinic	Baltimore West Fayette Street
51	5	517HK	Beckley VA Mobile Clinic	Beckley Mobile
52	5	540GA	Tucker County VA Clinic	Tucker County
53	5	540GC	Braxton County VA Clinic	Braxton County
54	5	581GG	Gallipolis VA Clinic	Gallipolis
55	5	581GH	Lenore VA Clinic	Lenore
56	5	581QA	Huntington Ninth Street VA Clinic	Huntington Ninth Street
57	5	581QB	Huntington VA Mobile Clinic	Huntington Mobile
58	5	613GD	Franklin VA Clinic	Franklin, West Virginia
59	5	688GB	Southeast Washington VA Clinic	Southeast Washington
60	5	688QA	Franklin Street VA Clinic	Franklin Street
61	6	558GD	Durham County VA Clinic	Durham County
62	6	558GE	Hillandale Road VA Clinic	Hillandale Road
63	6	558GF	Wake County VA Clinic	Wake County
64	6	558QA	Brier Creek VA Clinic	Brier Creek
65	6	565GJ	Jacksonville 2 VA Clinic	Jacksonville 2 North Carolina
66	6	565GM	Jacksonville 3 VA Clinic	Jacksonville 3
67	6	565GN	Jacksonville 4 VA Clinic	Jacksonville 4
68	6	565QA	Robeson Street VA Clinic	Robeson Street
69	6	565QB	Fayetteville VA Mobile Clinic	Fayetteville Mobile
70	6	565QD	Raeford Road VA Clinic	Raeford Road

FY 2023 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
71	6	565QE	Womack VA Clinic	Womack
72	6	652GA	Fredericksburg VA Clinic	Fredericksburg
73	6	652GF	Emporia VA Clinic	Emporia
74	6	652GG	Richmond 1 VA Mobile Clinic	Richmond 1 Mobile
75	6	652GH	Richmond 2 VA Mobile Clinic	Richmond 2 Mobile
76	6	658QA	Salem VA Mobile Clinic	Salem Mobile
77	7	508GP	South Cobb County VA Clinic	South Cobb County
78	7	508GQ	Cobb County VA Clinic	Cobb County
79	7	508GS	Pike County VA Clinic	Pike County
80	7	508QC	Henderson Mill VA Clinic	Henderson Mill
81	7	508QH	South Fulton County VA Clinic	South Fulton County
82	7	508QI	North DeKalb County VA Clinic	North DeKalb County
83	7	508QK	Atlanta VA Mobile Clinic	Atlanta Mobile
84	7	521QB	Birmingham East VA Clinic	Birmingham East
85	7	534QA	Market Commons VA Clinic	Market Commons
86	7	534QB	Trident VA Clinic	Trident
87	7	534QC	Charleston VA Clinic	Charleston City Hall Lane
88	7	544HK	Columbia VA Mobile Clinic	Columbia Mobile
89	7	557GG	Robins VA Clinic	Robins
90	7	619QC	Montgomery VA Mobile Clinic	Montgomery Mobile
91	8	546GA	Miami Flagler VA Clinic	Miami Flagler
92	8	546GE	Key Largo VA Clinic	Key Largo
93	8	548GE	Vero Beach VA Clinic	Vero Beach
94	8	548GF	Okeechobee VA Clinic	Okeechobee
95	8	548QA	Port Saint Lucie VA Clinic	Port Saint Lucie
96	8	573GN	Perry VA Clinic	Perry, Florida
97	8	573QB	Gainesville Ninety-Eighth Street VA Clinic	Gainesville Ninety-Eighth Street
98	8	573QC	Gainesville Sixty-Fourth Street 1 VA Clinic	Gainesville Sixty-Fourth Street 1
99	8	573QD	Gainesville Sixty-Fourth Street 2 VA Clinic	Gainesville Sixty-Fourth Street 2
100	8	573QE	Gainesville Sixty-Fourth Street 3 VA Clinic	Gainesville Sixty-Fourth Street 3
101	8	573QF	Gainesville 1 VA Clinic	Gainesville 1
102	8	573QH	Ocala West VA Clinic	Ocala West
103	8	573QK	Lake City VA Clinic	Lake City-Commerce Drive
104	8	573QL	Gainesville VA Clinic	Gainesville-34th Street
105	8	672GA	Saint Croix VA Clinic	Saint Croix

FY 2023 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
106	8	672GB	Saint Thomas VA Clinic	Saint Thomas
107	8	672QA	Comerio VA Clinic	Comerio
108	8	672QB	Utuado VA Clinic	Utuado
109	8	672QC	Vieques VA Clinic	Vieques
110	8	672QD	San Juan 1 VA Mobile Clinic	San Juan 1 Mobile
111	8	672QE	San Juan 2 VA Mobile Clinic	San Juan 2 Mobile
112	8	672QF	Saint Thomas VA Mobile Clinic	Saint Thomas Mobile
113	8	672QG	Saint Croix VA Mobile Clinic	Saint Croix Mobile
114	8	673QA	Forty Sixth Street North VA Clinic	Forty Sixth Street North
115	8	673QB	Forty Sixth Street South VA Clinic	Forty Sixth Street South
116	8	673QC	West Lakeland VA Clinic	West Lakeland
117	8	673QD	Deer Park VA Clinic	Deer Park
118	8	673QF	Winners Circle VA Clinic	Winners Circle
119	8	673QH	Bruce B. Downs Boulevard VA Clinic	Bruce B. Downs Boulevard
120	8	673QI	Medical View Lane VA Clinic	Medical View Lane
121	8	673QK	Tampa 1 VA Mobile Clinic	Tampa 1 Mobile
122	8	673QL	Tampa 2 VA Mobile Clinic	Tampa 2 Mobile
123	8	675QB	Port Orange VA Clinic	Port Orange
124	8	675QC	Westside Pavilion VA Clinic	Westside Pavilion
125	8	675QE	Orlando 1 VA Mobile Clinic	Orlando 1 Mobile
126	8	675QG	Palm Bay VA Clinic	Palm Bay
127	8	675QH	Orlando 2 VA Mobile Clinic	Orlando 2 Mobile
128	8	675QI	Orlando 3 VA Mobile Clinic	Orlando 3 Mobile
129	9	614QA	Phelan Avenue VA Clinic	Phelan Avenue
130	9	621GA	Rogersville VA Clinic	Rogersville
131	9	621GO	Mountain City VA Clinic	Mountain City
132	9	621GP	Morristown East VA Clinic	Morristown East
133	9	621QA	Jonesville VA Clinic	Jonesville
134	9	621QC	Vansant VA Clinic	Vansant
135	9	621QD	Knox County VA Clinic	Knox County
136	9	621QE	Downtown West VA Clinic	Downtown West
137	9	621QF	Johnson City VA Clinic	Johnson City
138	9	621QG	Knox West VA Clinic	Knox West
139	9	621QI	Mountain Home 1 VA Mobile Clinic	Mountain Home 1 Mobile
140	9	626GG	Tullahoma VA Clinic	Tullahoma

FY 2023 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
141	9	626QA	Albion Street VA Clinic	Albion Street
142	9	626QC	Pointe Centre VA Clinic	Pointe Centre
143	9	626QD	Glenis Drive VA Clinic	Glenis Drive
144	9	626QE	Glenis Drive 2 VA Clinic	Glenis Drive 2
145	9	626QF	Dalton Drive VA Clinic	Dalton Drive
146	10	506GE	Howell VA Clinic	Howell
147	10	506GF	Adrian VA Clinic	Adrian
148	10	506QA	Packard Road VA Clinic	Ann Arbor Packard Road
149	10	506QB	Green Road VA Clinic	Green Road
150	10	515QB	Century Avenue VA Clinic	Century Avenue
151	10	538QA	Chillicothe VA Mobile Clinic	Chillicothe Mobile
152	10	539QB	Highland Avenue VA Clinic	Highland Avenue
153	10	539QC	Vine Street VA Clinic	Vine Street
154	10	539QD	Norwood VA Clinic	Norwood
155	10	539QE	Cincinnati 1 VA Mobile Clinic	Cincinnati 1 Mobile
156	10	541GM	Cleveland VA Clinic-Superior	Cleveland Superior Avenue
157	10	541QA	Summit County VA Clinic	Summit County
158	10	541QC	Cleveland 1 VA Mobile Clinic	Cleveland 1 Mobile
159	10	541QE	Cleveland East Boulevard 3 VA Mobile Clinic	Cleveland East Boulevard 3 Mobile
160	10	541QF	Cuyahoga County 4 VA Mobile Clinic	Cuyahoga County 4 Mobile
161	10	552GF	Wright-Patterson VA Clinic	Wright-Patterson
162	10	553QA	Piquette Street VA Clinic	Piquette Street
163	10	583GG	Shelbyville VA Clinic	Shelbyville
164	10	583QA	Monroe County VA Clinic	Monroe County, Indiana
165	10	583QB	Indianapolis VA Clinic	Indianapolis Meridian Street
166	10	583QD	Indianapolis YMCA VA Clinic	Indianapolis YMCA
167	10	583QE	Cold Spring Road VA Clinic	Cold Spring Road
168	10	610GE	Defiance VA Clinic	Defiance
169	10	610QA	Fort Wayne VA Clinic	Fort Wayne East State Boulevard
170	10	655QA	Saginaw VA Clinic	Saginaw Barnard Road
171	10	655QC	Saginaw North VA Clinic	Saginaw North
172	10	757QA	Columbus 1 VA Mobile Clinic	Columbus 1 Mobile
173	10	757QB	North James Road 2 VA Mobile Clinic	North James Road 2 Mobile
174	10	757QC	Columbus VA Clinic	Columbus Airport Drive
175	12	537GD	Lakeside VA Clinic	Chicago Lakeside

FY 2023 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
176	12	537QA	Chicago VA Clinic	Chicago South California Avenue
177	12	607GC	Janesville VA Clinic	Janesville
178	12	607GD	Baraboo VA Clinic	Baraboo
179	12	607GE	Beaver Dam VA Clinic	Beaver Dam
180	12	607GF	Freeport VA Clinic	Freeport
181	12	676GE	Clark County VA Clinic	Clark County
182	12	695QA	Milwaukee VA Clinic	Milwaukee MLK Drive
183	15	589G2	Dodge City VA Clinic	Dodge City
184	15	589GD	Nevada VA Clinic	Nevada
185	15	589GM	Chanute VA Clinic	Chanute
186	15	589GP	Garnett VA Clinic	Garnett
187	15	589GZ	Cameron VA Clinic	Cameron
188	15	589HK	Kansas City VA Mobile Clinic	Kansas City Mobile
189	15	589JC	Shawnee VA Clinic	Shawnee, Kansas
190	15	589QA	Overland Park VA Clinic	Overland Park
191	15	589QB	Sedgwick County VA Clinic	Sedgwick County
192	15	589QD	Wichita VA Mobile Clinic	Wichita Mobile
193	15	589QE	Wichita 1 VA Mobile Clinic	Wichita 1 Mobile
194	15	589QF	Wichita 2 VA Mobile Clinic	Wichita 2 Mobile
195	15	589QG	Wichita 3 VA Mobile Clinic	Wichita 3 Mobile
196	15	657GO	Madisonville VA Clinic	Madisonville
197	15	657QB	Jefferson Avenue VA Clinic	Jefferson Avenue
198	15	657QD	Heartland Street VA Clinic	Heartland Street
199	15	657QE	Scott Air Force Base VA Clinic	Scott Air Force Base
200	15	657QF	Jefferson Barracks VA Mobile Clinic	Jefferson Barracks Mobile
201	16	502QB	Lafayette Campus B VA Clinic	Lafayette Campus B
202	16	502QC	Alexandria VA Mobile Clinic	Alexandria Mobile
203	16	502QD	Alexandria 2 VA Mobile Clinic	Alexandria 2 Mobile
204	16	520QB	Gulf Coast West VA Mobile Medical Unit-Clinic	Gulf Coast West MMU
205	16	564GA	Harrison VA Clinic	Harrison
206	16	564QA	Township VA Clinic	Township
207	16	564QB	Sunbridge VA Clinic	Sunbridge
208	16	564QC	North College Avenue VA Mobile Clinic	North College Avenue Mobile
209	16	580GK	Kingwood VA Clinic	Kingwood
210	16	580QB	Houston VA Mobile Clinic	Houston Mobile
211	16	580QC	Houston 2 VA Mobile Clinic	Houston 2 Mobile

FY 2023 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
212	16	580QD	Houston 3 VA Mobile Clinic	Houston 3 Mobile
213	16	580QE	Houston Webster VA Clinic	Houston Webster
214	16	580QF	Houston 4 VA Mobile Clinic	Houston 4 Mobile
215	16	586GA	Kosciusko VA Clinic	Kosciusko
216	16	586GG	McComb VA Clinic	McComb
217	16	586QA	Jackson VA Mobile Clinic	Jackson Mobile
218	16	586QB	Dogwood View Parkway VA Clinic	Dogwood View Parkway
219	16	586QD	Jackson 2 VA Mobile Clinic	Jackson 2 Mobile
220	16	598QA	Little Rock VA Clinic	Little Rock Main Street
221	16	598QB	Little Rock VA Mobile Clinic	Little Rock Mobile
222	16	598QC	Little Rock 2 VA Mobile Clinic	Little Rock 2 Mobile
223	16	598QD	Little Rock 3 VA Mobile Clinic	Little Rock 3 Mobile
224	16	629QA	Baton Rouge South VA Clinic	Baton Rouge South
225	16	629QB	New Orleans South VA Mobile Clinic	New Orleans South Mobile
226	16	667QA	Knight Street VA Clinic	Knight Street
227	16	667QB	Shreveport 1 VA Mobile Clinic	Shreveport 1 Mobile
228	16	667QC	Shreveport 2 VA Mobile Clinic	Shreveport 2 Mobile
229	17	504GA	Childress VA Clinic	Childress
230	17	504HB	Dalhart VA Clinic	Dalhart
231	17	504QA	Amarillo VA Mobile Clinic	Amarillo Mobile
232	17	519GB	Hobbs VA Clinic	Hobbs
233	17	519GD	Fort Stockton VA Clinic	Fort Stockton
234	17	519QA	Big Spring VA Mobile Clinic	Big Spring Mobile
235	17	549GF	Granbury VA Clinic	Granbury
236	17	549GK	Polk Street VA Clinic	Polk Street
237	17	549HK	North Texas VA Mobile Clinic	North Texas Mobile
238	17	549QA	Dallas VA Clinic	Dallas South Lancaster Road
239	17	549QB	Fort Worth New York VA Clinic	Fort Worth New York
240	17	671GL	New Braunfels VA Clinic	New Braunfels
241	17	671GT	Walzem VA Clinic	Walzem
242	17	671QA	South Texas VA Mobile Clinic	South Texas Mobile
243	17	671QB	Data Point VA Clinic	Data Point
244	17	671QC	Christus Santa Rosa VA Clinic	Christus Santa Rosa San Antonio
245	17	674QA	Temple VA Mobile Clinic	Temple Mobile
246	17	674QB	Austin VA Mobile Clinic	Austin Mobile
247	17	740GI	Old Brownsville VA Clinic	Old Brownsville

FY 2023 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
248	17	740QA	McAllen VA Mobile Clinic	McAllen Mobile
249	17	740QC	Corpus Christi VA Mobile Clinic	Corpus Christi Mobile
250	17	756GD	El Paso Northeast VA Clinic	El Paso Northeast
251	17	756QA	El Paso South Central VA Clinic	El Paso South Central
252	17	756QB	El Paso Central VA Clinic	El Paso Central
253	19	436GI	Glasgow VA Clinic	Glasgow
254	19	436GL	Cut Bank VA Clinic	Cut Bank
255	19	436GM	Lewistown VA Clinic	Lewistown
256	19	436GO	Butte VA Clinic	Butte
257	19	436HC	Merril Lundman Department of Veterans Affairs Outpatient Clinic	Havre
258	19	436QA	Hamilton VA Clinic	Hamilton, Montana
259	19	436QB	Plentywood VA Clinic	Plentywood
260	19	436QC	Helena VA Clinic	Helena, Montana
261	19	436QD	Browning VA Clinic	Browning
262	19	436QE	Miles City VA Clinic	MIles City
263	19	436QF	Montana VA Mobile Clinic	Montana Mobile
264	19	442GB	Sidney VA Clinic	Sidney
265	19	442GC	Fort Collins VA Clinic	Fort Collins
266	19	442HK	Wheatland VA Mobile Clinic	Wheatland Mobile
267	19	442QA	Rawlins VA Clinic	Rawlins
268	19	442QB	Torrington VA Mobile Clinic	Torrington Mobile
269	19	442QD	Laramie VA Mobile Clinic	Laramie Mobile
270	19	442QF	Cheyenne VA Mobile Clinic	Cheyenne Mobile
271	19	442QG	Sterling VA Clinic	Sterling, Colorado
272	19	554GF	Alamosa VA Clinic	Alamosa
273	19	554GH	Lamar VA Clinic	Lamar
274	19	554GI	Burlington VA Clinic	Burlington, Colorado
275	19	554GK	Union Boulevard VA Clinic	Union Boulevard
276	19	554QA	York Street VA Clinic	York Street
277	19	554QB	Jewell VA Clinic	Jewell
278	19	554QC	Salida VA Clinic	Salida
279	19	554QD	Evans VA Clinic	Evans
280	19	554QE	Academy VA Clinic	Academy
281	19	554QF	Garden of the Gods VA Clinic	Garden of the Gods
282	19	575GA	Montrose VA Clinic	Montrose, Colorado
283	19	575GB	Major William Edward Adams Department of Veterans Affairs Clinic	Craig

FY 2023 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
284	19	575QA	Glenwood Springs VA Clinic	Glenwood Springs
285	19	575QB	Moab VA Clinic	Moab
286	19	575QC	Grand Junction VA Mobile Clinic	Grand Junction Mobile
287	19	575QD	Grand Junction 28 Road VA Clinic	Grand Junction 28 Road
288	19	575QE	Western Colorado VA Mobile Clinic	Western Colorado Mobile
289	19	623QA	Muskogee East VA Clinic	Muskogee East
290	19	623QB	Tulsa Eleventh Street VA Clinic	Tulsa Eleventh Street
291	19	623QC	Yale Avenue VA Clinic	Yale Avenue
292	19	623QD	Bartlesville VA Clinic	Bartlesville
293	19	635GC	Blackwell VA Clinic	Blackwell
294	19	635GH	Clinton VA Clinic	Clinton
295	19	635GK	Shawnee VA Clinic	Shawnee, Oklahoma
296	19	635GL	North Oklahoma City VA Clinic	North Oklahoma City
297	19	635QC	Fourteenth Street VA Clinic	Fourteenth Street
298	19	635QD	Lawton North VA Clinic	Lawton North
299	19	635QF	Oklahoma City VA Mobile Clinic	Oklahoma City Mobile
300	19	660GD	Roosevelt VA Clinic	Roosevelt
301	19	660GK	Elko VA Clinic	Elko
302	19	660QB	Price VA Clinic	Price
303	19	660QD	Cache Valley VA Clinic	Cache Valley
304	19	660QE	Salt Lake City VA Mobile Clinic	Salt Lake City Mobile
305	19	666GC	Riverton VA Clinic	Riverton
306	19	666GD	Cody VA Clinic	Cody
307	19	666GE	Gillette VA Clinic	Gillette
308	19	666GF	Rock Springs VA Clinic	Rock Springs
309	19	666QA	Afton VA Clinic	Afton
310	19	666QB	Evanston VA Clinic	Evanston, Wyoming
311	19	666QC	Worland VA Clinic	Worland
312	20	463GD	Homer VA Clinic	Homer
313	20	463GE	Juneau VA Clinic	Juneau
314	20	463QA	Elmendorf-Richardson VA Clinic	Elmendorf-Richardson
315	20	531GH	Eastern Oregon VA Clinic	Eastern Oregon
316	20	531GJ	Salmon VA Clinic	Salmon
317	20	648GD	North Coast VA Clinic	North Coast
318	20	648GH	Newport VA Clinic	Newport, Oregon
319	20	648GJ	Loren R. Kaufman VA Clinic	The Dalles

FY 2023 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
320	20	648GK	Lincoln City VA Clinic	Lincoln City
321	20	653QA	Downtown Eugene VA Clinic	Downtown Eugene
322	20	663GE	North Olympic Peninsula VA Clinic	North Olympic Peninsula
323	20	663GH	Edmonds VA Clinic	Edmonds
324	20	663GK	Everett VA Clinic	Everett
325	20	663HK	Puget Sound VA Mobile Clinic	Puget Sound Mobile
326	20	663QA	Renton VA Clinic	Renton
327	20	663QB	South Lucile Street VA Clinic	South Lucile Street
328	20	663QD	American Lake VA Mobile Clinic	American Lake Mobile
329	20	668GC	East Front Avenue VA Clinic	East Front Avenue
330	20	668HK	Spokane VA Mobile Clinic	Spokane Mobile
331	20	668QB	Libby VA Clinic	Libby
332	20	668QD	Bonner County VA Clinic	Bonner County Kootenai
333	20	668QE	Spokane VA Clinic	Spokane 2nd Avenue
334	20	687GC	La Grande VA Clinic	La Grande
335	20	687QB	Morrow County VA Clinic	Morrow County
336	20	687QC	Wallowa County VA Clinic	Wallowa County
337	21	358	Manila VA Clinic	Manila
338	21	459GH	Saipan VA Clinic	Saipan
339	21	459QA	Lanai VA Clinic	Lanai
340	21	459QB	Molokai VA Clinic	Molokai
341	21	570GC	Oakhurst VA Clinic	Oakhurst
342	21	593GH	Master Chief Petty Officer Jesse Dean VA Clinic	Laughlin
343	21	593QC	West Cheyenne VA Clinic	West Cheyenne
344	21	612QC	Cypress Avenue VA Clinic	Cypress Avenue
345	21	612QE	Stockton VA Clinic	Stockton
346	21	640QA	Palo Alto 1 VA Mobile Clinic	Palo Alto 1 Mobile
347	21	640QB	Palo Alto 2 VA Mobile Clinic	Palo Alto 2 Mobile
348	21	654GB	Carson Valley VA Clinic	Carson Valley
349	21	654GC	Lahontan Valley VA Clinic	Lahontan Valley
350	21	654GD	Diamond View VA Clinic	Diamond View
351	21	654QA	Kietzke VA Clinic	Kietzke
352	21	654QC	Winnemucca VA Clinic	Winnemucca
353	21	654QD	Virginia Street VA Clinic	Virginia Street
354	21	662QA	Twenty First Street VA Clinic	Twenty First Street
355	21	662QB	North Santa Rosa VA Clinic	North Santa Rosa

FY 2023 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
356	22	501G2	Las Vegas VA Clinic	Las Vegas
357	22	501GC	Silver City VA Clinic	Silver City
358	22	501GD	Gallup VA Clinic	Gallup
359	22	501GE	Espanola VA Clinic	Espanola
360	22	501GH	Truth or Consequences VA Clinic	Truth or Consequences
361	22	501GI	Alamogordo VA Clinic	Alamogordo
362	22	501GJ	Durango VA Clinic	Durango
363	22	501GM	Northwest Metro VA Clinic	Northwest Metro New Mexico
364	22	501GN	Taos VA Clinic	Taos
365	22	501HB	Raton VA Clinic	Raton
366	22	600GC	Cabrillo VA Clinic	Cabrillo
367	22	600QA	West Santa Ana VA Clinic	West Santa Ana
368	22	605GF	North Loma Linda VA Clinic	North Loma Linda
369	22	605QA	Blythe VA Clinic	Blythe
370	22	644GD	Payson VA Clinic	Payson
371	22	644GF	Globe VA Clinic	Globe
372	22	644GJ	Mesa VA Clinic	Mesa
373	22	644QA	Phoenix VA Clinic	Phoenix East Thomas Road
374	22	644QB	Phoenix VA Mobile Clinic	Phoenix Mobile
375	22	649QA	Chinle VA Clinic	Chinle
376	22	649QB	Holbrook VA Clinic	Holbrook
377	22	649QD	Page VA Clinic	Page
378	22	649QF	Tuba City VA Clinic	Tuba City
379	22	649QG	Polacca VA Clinic	Polacca
380	22	649QH	Kayenta VA Clinic	Kayenta
381	22	664GA	Imperial Valley VA Clinic	Imperial Valley
382	22	664GF	Sorrento Valley VA Clinic	Sorrento Valley
383	22	664QA	Rio VA Clinic	Rio
384	22	664QB	San Diego VA Mobile Clinic	San Diego Mobile
385	22	678GD	Safford VA Clinic	Safford
386	22	678GE	Green Valley VA Clinic	Green Valley
387	22	678QA	Cochise County VA Clinic	Cochise County
388	22	678QB	Pinal County VA Clinic	Pinal County
389	22	691GQ	Captain Rosemary Bryant Mariner Outpatient Clinic	Ventura
390	22	691QA	Greater Los Angeles VA Mobile Clinic	Greater Los Angeles Mobile

FY 2023 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
391	23	437GA	Grafton VA Clinic	Grafton
392	23	437GJ	Dickinson VA Clinic	Dickinson
393	23	437GK	Jamestown VA Clinic	Jamestown, North Dakota
394	23	437GL	Devils Lake VA Clinic	Devils Lake
395	23	438GE	Wagner VA Clinic	Wagner
396	23	568GB	Pierre VA Clinic	Pierre
397	23	568HA	Newcastle VA Clinic	Newcastle
398	23	568HB	Gordon VA Clinic	Gordon
399	23	568HF	Pine Ridge VA Clinic	Pine Ridge
400	23	568HH	Scottsbluff VA Clinic	Scottsbluff
401	23	568HK	Cheyenne River VA Clinic	Cheyenne River
402	23	568HP	Winner VA Clinic	Winner
403	23	568QA	Fort Yates VA Clinic	Fort Yates
404	23	618GA	St. James VA Clinic	St. James, Minnesota
405	23	618GH	Hayward VA Clinic	Hayward
406	23	618QA	Fort Snelling VA Clinic	Fort Snelling
407	23	618QB	Ely VA Clinic	Ely
408	23	618QC	Richfield VA Clinic	Richfield
409	23	618QD	Minneapolis VA Mobile Clinic	Minneapolis Mobile
410	23	6369BA	Papillion VA Community Living Center	Papillion CLC
411	23	636GB	North Platte VA Clinic	North Platte
412	23	636GQ	Holdrege VA Clinic	Holdrege
413	23	636GZ	South Des Moines VA Clinic	South Des Moines
414	23	636QA	Omaha VA Clinic	Omaha Dorcas Street
415	23	636QB	Des Moines VA Clinic	Des Moines Center Street
416	23	636QC	Linn County VA Clinic	Linn County
417	23	636QD	Macomb VA Clinic	Macomb
418	23	636QG	Iowa City VA Mobile Clinic	Iowa City Mobile
419	23	636QH	Des Moines VA Mobile Clinic	Des Moines Mobile
420	23	636QI	Davenport VA Clinic	Davenport
421	23	636QJ	Iowa City VA Clinic	Iowa City South Clinton Street
422	23	636QL	Iowa City 2 VA Mobile Clinic	Iowa City 2 Mobile
423	23	656GB	Montevideo VA Clinic	Montevideo

FY 2023 Outpatient Dialysis Centers

Dialysis Center Count	Station Number	Station Name	City	State
1	523	VA Boston HCS	Boston	MA
2	650	Providence VA Med Center	Providence	RI
3	689	VA Connecticut HCS	West Haven	CT
4	526	James J. Peters VA Med Center	Bronx	NY
5	528	Albany Stratton VA Med Center	Albany	NY
6	528	VA Western NY HCS	Buffalo	NY
7	561	VA New Jersey HCS	East Orange	NJ
8	630	VA NY Harbor HCS - Brooklyn	Brooklyn	NY
9	630	VA NY Harbor HCS - Manhattan	New York	NY
10	632	Northport VA Med Center	Northport	NY
11	460	Wilmington VA Med Center	Wilmington	DE
12	642	Philadelphia Free Standing Dialysis Center	Philadelphia	PA
13	646	VA Pittsburgh HCS	Pittsburgh	PA
14	693	Wilkes-Barre VA Med Center	Wilkes-Barre	PA
15	688	Washington DC VA Med Center	Washington	DC
16	558	Durham VA Med Center	Durham	NC
17	558	Raleigh Dialysis Center	Raleigh	NC
18	565	Fayetteville VA Med Center	Fayetteville	NC
19	659	Charlotte Dialysis Center	Charlotte	NC
20	659	Kernersville Dialysis Center	Kernersville	NC
21	590	Hampton VA Med Center	Hampton	VA
22	652	Hunter Holmes McGuire VA Med Center	Richmond	VA
23	658	Salem VA Med Center	Salem	VA
24	508	Atlanta VA Med Center	Decatur	GA
25	521	Birmingham VA Med Center	Birmingham	AL
26	534	Ralph H. Johnson VA Med Center	Charleston	SC
27	544	Wm. Jennings Bryan Dorn VA Med Center	Columbia	SC
28	546	Miami VA HCS	Miami	FL
29	548	West Palm Beach VA Med Center	West Palm Beach	FL
30	573	North Florida/South Georgia HCS-Gainesville	Gainesville	FL
31	672	VA Caribbean HCS	San Juan	PR
32	673	James A. Haley Veterans' Hospital	Tampa	FL
33	675	Orlando	Orlando	FL
34	596	Lexington VA Med Center	Lexington	KY
35	614	Memphis VA Med Center	Memphis	TN

FY 2023 Outpatient Dialysis Centers

Dialysis Center Count	Station Number	Station Name	City	State
36	626	Tennessee Valley HCS	Nashville	TN
37	506	VA Ann Arbor HCS	Ann Arbor	MI
38	539	Cincinnati VA Med Center	Cincinnati	OH
39	541	Cleveland- Freestanding Dialysis Center	Cleveland	Oh
40	541	Louis Stokes Cleveland VA Med	Cleveland	OH
41	552	Dayton VA Med Center	Dayton	OH
42	553	John D. Dingell VA Med Center	Detroit	MI
43	583	Richard L. Roudebush VAMC	Indianapolis	IN
44	537	Jesse Brown VA Med Center	Chicago	IL
45	578	Edward Hines, Jr. VA Hospital	Hines	IL
46	695	Milo C Huempfner	Green Bay	WI
47	695	Milwaukee VA Med Center	Milwaukee	WI
48	589	Kansas City VA Med Center	Kansas City	MO
49	657	St. Louis VA Med Center	St. Louis	MO
50	598	Central Arkansas Veterans HCS	Little Rock	AR
51	549	VA North Texas HCS	Dallas	TX
52	671	South Texas Veterans HCS (STVHCS)	San Antonio	TX
53	501	New Mexico VA HCS	Albuquerque	NM
54	678	Southern Arizona VA HCS	Tucson	AZ
55	554	VA Eastern Colorado HCS	Denver	CO
56	648	Portland VA Med Center	Portland	OR
57	663	VA Puget Sound HCS	Seattle	WA
58	459	VA Pacific Islands HCS	Honolulu	HI
59	593	Southern Nevada HCS	North Las Vegas	NV
60	612	David Grant USAF Med Center (JV VA/DoD)	Travis AFB	CA
61	640	VA Palo Alto HCS	Palo Alto	CA
62	662	San Francisco VA Med Center	San Francisco	CA
63	600	VA Long Beach HCS	Long Beach	CA
64	605	VA Loma Linda HCS	Loma Linda	CA
65	664	VA San Diego HCS	San Diego	CA
66	691	VA Great Los Angeles HCS	Los Angeles	CA
67	568	VA Black Hills HCS	Hot Springs	SD
68	618	Minneapolis VA HCS	Minneapolis	MN
69	636	Iowa City VA HCS	Iowa City	IA
70	636	VA Nebraska-Western Iowa HCS	Omaha	NE

FY 2023 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
33	Overton Brooks VA Medical Center	Shreveport, LA

FY 2023 Vet Centers, Mobile Vet Centers and Vet Center Outstations

VISN	Station Number	Station Name	City	State	VC / MVC / Outstation Number	MVC (Yes / No)	VC Outstation (Yes / No)
1	523	Boston Vet Center	Boston	MA	0101V	N	N
1	631	Springfield Vet Center	West Springfield	MA	0103V	N	N
1	523	Brockton Vet Center	Brockton	MA	0104V	N	N
1	689	Hartford Mobile Vet Center	Rocky Hill	CT	0801MVC	Y	N
1	608	Manchester Vet Center	Hooksett	NH	0108V	N	N
1	608	Newington Outstation	Newington	NH	1081OS	N	Y
1	405	Keene Outstation	Keene	NH	1221OS	N	Y
1	650	Providence Vet Center	Warwick	RI	0113V	N	N
1	402	Portland Vet Center	Portland	ME	0115V	N	N
1	689	New Haven Vet Center	Orange	CT	0116V	N	N
1	689	Hartford Vet Center	Rocky Hill	CT	0117V	N	N
1	405	South Burlington Vet Center	South Burlington	VT	0118V	N	N
1	402	Northern Maine Vet Center	Caribou	ME	0119V	N	N
1	402	Bangor Vet Center	Bangor	ME	0121V	N	N
1	405	White River Junction Mobile Vet Center	White River Junction	VT	0803MVC	Y	N
1	405	White River Junction Vet Center	White River Junction	VT	0122V	N	N
1	518	Lowell Vet Center	Lowell	MA	0125V	N	N
1	631	Worcester Vet Center	Worcester	MA	0126V	N	N
1	689	Norwich Vet Center	Norwich	CT	0127V	N	N
1	402	Lewiston Mobile Vet Center	Lewiston	ME	0804MVC	Y	N
1	650	New Bedford Vet Center	Fairhaven	MA	0128V	N	N
1	402	Lewiston Vet Center	Lewiston	ME	0129V	N	N
1	402	Sanford Vet Center	Springvale	ME	0130V	N	N
1	405	Berlin Vet Center	Gorham	NH	0134V	N	N
1	650	Cape Cod Vet Center	Hyannis	MA	0136V	N	N
1	689	Danbury Vet Center	Danbury	CT	0140V	N	N
2	561	Secaucus Vet Center	Secaucus	NJ	0102V	N	N
2	630	Brooklyn Vet Center	Brooklyn	NY	0105V	N	N
2	630	Manhattan Vet Center	New York	NY	0106V	N	N
2	528	Buffalo Vet Center	Amherst	NY	0107V	N	N
2	630	Queens Vet Center	Woodhaven	NY	0109V	N	N
2	526	Bronx Vet Center	Bronx	NY	0110V	N	N
2	528A8	Albany Vet Center	Albany	NY	0111V	N	N
2	561	Bloomfield Vet Center	Bloomfield	NJ	0112V	N	N
2	561	Trenton Vet Center	Ewing	NJ	0114V	N	N
2	632	Babylon Vet Center	Babylon	NY	0120V	N	N
2	620	White Plains Vet Center	White Plains	NY	0123V	N	N
2	528A6	Rochester Vet Center	Rochester	NY	0124V	N	N
2	528A7	Syracuse Vet Center	Syracuse	NY	0131V	N	N
2	630	Staten Island Vet Center	Staten Island	NY	0132V	N	N
2	630	Harlem Vet Center	New York	NY	0133V	N	N
2	528A7	Watertown Vet Center	Watertown	NY	0135V	N	N
2	528A7	Binghamton Vet Center	Binghamton	NY	0137V	N	N
2	528A7	Watertown Mobile Vet Center	Watertown	NY	0805MVC	Y	N
2	632	Nassau Vet Center	Hicksville	NY	0138V	N	N
2	620	Middletown Vet Center	Middletown	NY	0139V	N	N
2	561	Lakewood Vet Center	Lakewood	NJ	0141V	N	N
2	561	Secaucus Mobile Vet Center	Secaucus	NJ	0857MVC	Y	N
2	528A6	Rochester Mobile Vet Center	Rochester	NY	0873MVC	Y	N
4	562	Erie Mobile Vet Center	Erie	PA	0809MVC	Y	N
4	642	Center City Philadelphia Vet Center	Philadelphia	PA	0210V	N	N
4	646	Pittsburgh Vet Center	Pittsburgh	PA	0211V	N	N
4	693	Williamsport Vet Center	Williamsport	PA	0212V	N	N
4	460	Wilmington Vet Center	Wilmington	DE	0215V	N	N
4	595	Harrisburg Vet Center	Harrisburg	PA	0218V	N	N
4	642	Northeast Philadelphia Vet Center	Philadelphia	PA	0219V	N	N
4	646	White Oak Vet Center	White Oak	PA	0220V	N	N
4	693	Scranton Mobile Vet Center	Scranton	PA	0811MVC	Y	N

FY 2023 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	562	Erie Vet Center	Erie	PA	0222V	N	N
4	503	DuBois Vet Center	DuBois	PA	0227V	N	N
4	693	Scranton Vet Center	Scranton	PA	0229V	N	N
4	460	South Jersey Vet Center	Egg Harbor Township	NJ	0230V	N	N
4	646	Wheeling Vet Center	Wheeling	WV	0233V	N	N
4	642	Bucks County Vet Center	Bristol	PA	0238V	N	N
4	642	Norristown Vet Center	Norristown	PA	0239V	N	N
4	595	Lancaster Vet Center	Lancaster	PA	0242V	N	N
4	460	Sussex County Vet Center	Georgetown	DE	0243V	N	N
4	460	Sussex County Mobile Vet Center	Georgetown	DE	0874MVC	Y	N
4	503	DuBois Mobile Vet Center	DuBois	PA	0876MVC	Y	N
5	512	Baltimore Vet Center	Baltimore	MD	0201V	N	N
5	581	Huntington Mobile Vet Center	Huntington	WV	0807MVC	Y	N
5	581	Huntington Vet Center	Huntington	WV	0208V	N	N
5	512	Elkton Vet Center	Elkton	MD	0209V	N	N
5	688	Silver Spring Vet Center	Silver Spring	MD	0213V	N	N
5	688	Washington, D.C. Vet Center	Washington	DC	0214V	N	N
5	540	Morgantown Vet Center	Morgantown	WV	0216V	N	N
5	540	Parkersburg Outstation	Parkersburg	WV	2081OS	N	Y
5	512	Salisbury Outstation	Salisbury	MD	2091OS	N	Y
5	512	Aberdeen Outstation	Aberdeen	MD	2092OS	N	Y
5	517	Beckley Mobile Vet Center	Beckley	WV	0812MVC	Y	N
5	581	Charleston Vet Center	Charleston	WV	0223V	N	N
5	613	Martinsburg Vet Center	Martinsburg	WV	0224V	N	N
5	688	Alexandria Vet Center	Alexandria	VA	0228V	N	N
5	TBD	Leesburg Outstation	Leesburg	VA	TBD	N	Y
5	517	Beckley Vet Center	Beckley	WV	0231V	N	N
5	517	Princeton Vet Center	Princeton	WV	0232V	N	N
5	512	Annapolis Vet Center	Annapolis	MD	0235V	N	N
5	512	Dundalk Vet Center	Dundalk	MD	0236V	N	N
5	688	Prince George's County Vet Center	Clinton	MD	0237V	N	N
5	512	Baltimore Mobile Vet Center	Baltimore	MD	0858MVC	Y	N
6	652	Richmond Mobile Vet Center	Richmond	VA	0808MVC	Y	N
6	590	Chesapeake Vet Center	Chesapeake	VA	0207V	N	N
6	652	Richmond Vet Center	Richmond	VA	0217V	N	N
6	658	Roanoke Vet Center	Roanoke	VA	0226V	N	N
6	558	Greenville Mobile Vet Center	Greenville	NC	0814MVC	Y	N
6	590	Virginia Beach Vet Center	Virginia Beach	VA	0240V	N	N
6	565	Fayetteville Vet Center	Fayetteville	NC	0315V	N	N
6	659	Charlotte Vet Center	Charlotte	NC	0317V	N	N
6	558	Greenville Vet Center	Greenville	NC	0319V	N	N
6	659	Greensboro Vet Center	Greensboro	NC	0327V	N	N
6	558	Raleigh Vet Center	Raleigh	NC	0328V	N	N
6	558	Spindale Outstation	Spindale	NC	3271OS	N	Y
6	565	Jacksonville Vet Center	Jacksonville	NC	0343V	N	N
6	659	Greensboro Mobile Vet Center	Greensboro	NC	0862MVC	Y	N
7	544	Columbia Mobile Vet Center	Columbia	SC	0817MVC	Y	N
7	534	Charleston Vet Center	North Charleston	SC	0303V	N	N
7	508	Atlanta Vet Center	College Park	GA	0304V	N	N
7	557	Macon Mobile Vet Center	Macon	GA	0818MVC	Y	N
7	544	Greenville Vet Center	Greenville	SC	0316V	N	N
7	534	Savannah Vet Center	Savannah	GA	0323V	N	N
7	544	Columbia Vet Center	Columbia	SC	0324V	N	N
7	508	Lawrenceville Vet Center	Lawrenceville	GA	0329V	N	N
7	557	Macon Vet Center	Macon	GA	0333V	N	N
7	619	Montgomery Vet Center	Montgomery	AL	0334V	N	N
7	508	Marietta Vet Center	Marietta	GA	0342V	N	N

FY 2023 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
7	557	Augusta Vet Center	Augusta	GA	0346V	N	N
7	534	Myrtle Beach Vet Center	Myrtle Beach	SC	0347V	N	N
7	509	Columbus Vet Center	Columbus	GA	0349V	N	N
7	508	Atlanta Mobile Vet Center	College Park	GA	0860MVC	Y	N
7	521	Birmingham Mobile Vet Center	Hoover	AL	0866MVC	Y	N
7	521	Huntsville Vet Center	Huntsville	AL	0738V	N	N
7	521	Birmingham Vet Center	Hoover	AL	0739V	N	N
8	672	Arecibo Vet Center	Arecibo	PR	0802MVC	Y	N
8	573	Jacksonville Mobile Vet Center	Jacksonville	FL	0813MVC	Y	N
8	672	St. Croix Outstation	Kingshill	VI	3121OS	N	Y
8	516	Clearwater Mobile Vet Center	Clearwater	FL	0816MVC	Y	N
8	516	St. Petersburg Vet Center	St. Petersburg	FL	0301V	N	N
8	573	Jacksonville Vet Center	Jacksonville	FL	0305V	N	N
8	672	San Juan Vet Center	Guaynabo	PR	0307V	N	N
8	672	Arecibo Vet Center	Arecibo	PR	0309V	N	N
8	546	Miami Vet Center	Miami	FL	0310V	N	N
8	546	Fort Lauderdale Vet Center	Lauderdale Lakes	FL	0311V	N	N
8	672	Hatillo Vet Center	Hatillo	PR	0309V	Y	N
8	672	Ponce Vet Center	Ponce	PR	0312V	N	N
8	675	Orlando Vet Center	Orlando	FL	0314V	N	N
8	673	Tampa Vet Center	Tampa	FL	0318V	N	N
8	516	Sarasota Vet Center	Sarasota	FL	0320V	N	N
8	573	Tallahassee Vet Center	Tallahassee	FL	0325V	N	N
8	548	Palm Beach Vet Center	Greenacres	FL	0326V	N	N
8	516	Fort Myers Vet Center	Fort Myers	FL	0330V	N	N
8	573	Gainesville Vet Center	Gainesville	FL	0331V	N	N
8	675	Melbourne Vet Center	Melbourne	FL	0332V	N	N
8	672	U.S. Virgin Islands Vet Center	St Thomas	VI	0308V	N	N
8	546	Pompano Beach Vet Center	Pompano Beach	FL	0336V	N	N
8	548	Jupiter Vet Center	Jupiter	FL	0337V	N	N
8	673	Pasco County Vet Center	New Port Richey	FL	0338V	N	N
8	516	Clearwater Vet Center	Clearwater	FL	0339V	N	N
8	673	Lakeland Vet Center	Lakeland	FL	0340V	N	N
8	675	Daytona Beach Vet Center	Daytona Beach	FL	0341V	N	N
8	573	Ocala Vet Center	Ocala	FL	0344V	N	N
8	675	Clermont Vet Center	Clermont	FL	0345V	N	N
8	516	Naples Vet Center	Naples	FL	0348V	N	N
8	672	Ponce Mobile Vet Center	Ponce	PR	0861MVC	Y	N
9	596	Lexington Mobile Vet Center	Lexington	KY	0806MVC	Y	N
9	603	Louisville Vet Center	Louisville	KY	0202V	N	N
9	596	Lexington Vet Center	Lexington	KY	0203V	N	N
9	621	Knoxville Mobile Vet Center	Knoxville	TN	0844MVC	Y	N
9	614	Memphis Mobile Vet Center	Memphis	TN	0848MVC	Y	N
9	675	Clermont Mobile Vet Center	Clermont	FL	0864MVC	Y	N
9	621	Johnson City Vet Center	Johnson City	TN	0701V	N	N
9	614	Memphis Vet Center	Memphis	TN	0719V	N	N
9	621	Knoxville Vet Center	Knoxville	TN	0720V	N	N
9	626	Chattanooga Vet Center	Chattanooga	TN	0722V	N	N
9	626	Nashville Vet Center	Nashville	TN	0724V	N	N
9	626	Clarksville Vet Center	Clarksville	TN	0350V	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	552	Dayton Mobile Vet Center	Kettering	OH	0810MVC	Y	N
10	757	Columbus Vet Center	Columbus	OH	0221V	N	N
10	552	Dayton Vet Center	Kettering	OH	0225V	N	N
10	506	Toledo Vet Center	Toledo	OH	0234V	N	N

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VISN	Station Number	Station Name	City	State	VC / MVC / Outstation Number	MVC (Yes / No)	VC Outstation (Yes / No
10	541	Stark County Vet Center	Canton	OH	0241V	N	N
10	553	Dearborn Vet Center	Dearborn	MI	0401V	N	N
10	553	Detroit Vet Center	Detroit	MI	0402V	N	N
10	515	Grand Rapids Vet Center	Grand Rapids	MI	0403V	N	N
10	610	Fort Wayne Vet Center	Fort Wayne	IN	0409V	N	N
10	583	Indianapolis Vet Center	Indianapolis	IN	0413V	N	N
10	655	Saginaw Vet Center	Saginaw	MI	0433V	N	N
10	553	Macomb County Vet Center	Clinton Township	MI	0437V	N	N
10	553	Pontiac Vet Center	Pontiac	MI	0438V	N	N
10	610	South Bend Vet Center	South Bend	IN	0444V	N	N
10	655	Traverse City Vet Center	Traverse City	MI	0445V	N	N
10	583	Indianapolis Mobile Vet Center	Indianapolis	IN	0852MVC	Y	N
10	553	Pontiac Mobile Vet Center	Pontiac	MI	0855MVC	Y	N
10	541	Stark County Mobile Vet Center	Canton	OH	0859MVC	Y	N
12	550	Springfield Mobile Vet Center	Springfield	IL	0822MVC	Y	N
12	585	Escanaba Mobile Vet Center	Escanaba	MI	0826MVC	Y	N
12	537	Chicago Heights Vet Center	Chicago Heights	IL	0407V	N	N
12	537	Chicago Vet Center	Chicago	IL	0410V	N	N
12	578	Forest Park Vet Center	Forest Park	IL	0411V	N	N
12	537	Gary Area Vet Center	Crown Point	IN	0412V	N	N
12	695	Milwaukee Vet Center	Milwaukee	WI	0415V	N	N
12	550	Peoria Vet Center	Peoria	IL	0417V	N	N
12	607	Madison Vet Center	Madison	WI	0419V	N	N
12	556	Evanston Vet Center	Evanston	IL	0420V	N	N
12	537	Wausau Outstation	Wausau	WI	4421OS	N	Y
12	550	Springfield Vet Center	Springfield	IL	0421V	N	N
12	585	Escanaba Vet Center	Escanaba	MI	0434V	N	N
12	578	Orland Park Vet Center	Orland Park	IL	0435V	N	N
12	578	Aurora Vet Center	Aurora	IL	0436V	N	N
12	695	Green Bay Vet Center	Green Bay	WI	0441V	N	N
12	676	La Crosse Vet Center	La Crosse	WI	0442V	N	N
12	556	Rockford Vet Center	Rockford	IL	0447V	N	N
12	556	Evanston Mobile Vet Center	Evanston	IL	0853MVC	Y	N
12	695	Green Bay Mobile Vet Center	Green Bay	WI	0856MVC	Y	N
15	589A7	Wichita Mobile Vet Center	Wichita	KS	0824MVC	Y	N
15	589	Kansas City Vet Center	Kansas City	MO	0408V	N	N
15	657	St. Louis Vet Center	Creve Coeur	MO	0414V	N	N
15	657A5	Evansville Vet Center	Evansville	IN	0418V	N	N
15	657	Metro East Vet Center	Swansea	IL	0422V	N	N
15	589A7	Wichita Vet Center	Wichita	KS	0426V	N	N
15	589	Manhattan Vet Center	Manhattan	KS	0432V	N	N
15	589A4	Columbia Vet Center	Columbia	MO	0443V	N	N
15	589	Kansas City Mobile Vet Center	Kansas City	MO	0851MVC	Y	N
15	657A5	Evansville Mobile Vet Center	Evansville	IN	0872MVC	Y	N
15	589A4	Columbia Mobile Vet Center	Columbia	MO	0875MVC	Y	N
16	520	Pensacola Mobile Vet Center	Pensacola	FL	0815MVC	Y	N
16	629	New Orleans Mobile Vet Center	New Orleans	LA	0847MVC	Y	N
16	598	Little Rock Mobile Vet Center	Little Rock	AR	0850MVC	Y	N
16	586	Jackson Mobile Vet Center	Jackson	MS	0863MVC	Y	N
16	667	Shreveport Vet Center	Shreveport	LA	0704V	N	N
16	586	Jackson Vet Center	Jackson	MS	0709V	N	N
16	580	Houston Southwest Vet Center	Houston	TX	0710V	N	N
16	580	Houston West Vet Center	Houston	TX	0711V	N	N
16	598	Little Rock Vet Center	North Little Rock	AR	0713V	N	N
16	629	New Orleans Vet Center	New Orleans	LA	0717V	N	N
16	667	Shreveport Mobile Vet Center	Shreveport	LA	0877MVC	Y	N
16	629	Baton Rouge Vet Center	Baton Rouge	LA	0725V	N	N
16	564	Fayetteville Vet Center	Fayetteville	AR	0727V	N	N

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VISN	Station Number	Station Name	City	State	VC / MVC / Outstation Number	MVC (Yes / No)	VC Outstation (Yes / No
16	580	Spring Vet Center	Houston	TX	0731V	N	N
16	502	Alexandria Vet Center	Alexandria	LA	0734V	N	N
16	580	Beaumont Vet Center	Beaumont	TX	0735V	N	N
16	564	Springfield Vet Center	Springfield	MO	0736V	N	N
16	520	Biloxi Vet Center	Biloxi	MS	0737V	N	N
16	520	Mobile Vet Center	Mobile	AL	0741V	N	N
16	520	Pensacola Vet Center	Pensacola	FL	0742V	N	N
16	520	Okaloosa County Vet Center	Shalimar	FL	0743V	N	N
16	520	Bay County Vet Center	Panama City	FL	0744V	N	N
17	504	Amarillo Mobile Vet Center	Amarillo	TX	0845MVC	Y	N
17	519	Abilene Mobile Vet Center	Abilene	TX	0846MVC	Y	N
17	671	San Antonio Northwest Mobile Vet Center	San Antonio	TX	0849MVC	Y	N
17	756	Las Cruces Vet Center	Las Cruces	NM	0530V	N	N
17	504	Amarillo Vet Center	Amarillo	TX	0702V	N	N
17	674	Austin Vet Center	Austin	TX	0703V	N	N
17	671	Corpus Christi Vet Center	Corpus Christi	TX	0705V	N	N
17	549	Dallas Vet Center	Dallas	TX	0706V	N	N
17	756	El Paso Vet Center	El Paso	TX	0707V	N	N
17	549	Fort Worth Vet Center	Westworth Village	TX	0708V	N	N
17	671	Laredo Vet Center	Laredo	TX	0712V	N	N
17	504	Lubbock Vet Center	Lubbock	TX	0714V	N	N
17	671	McAllen Vet Center	McAllen	TX	0715V	N	N
17	519	Midland Vet Center	Midland	TX	0716V	N	N
17	671	San Antonio Northeast Vet Center	San Antonio	TX	0721V	N	N
17	674	Killeen Heights Vet Center	Harker Heights	TX	0726V	N	N
17	671	San Antonio Northwest Vet Center	San Antonio	TX	0729V	N	N
17	671	McAllen Mobile Vet Center	McAllen	TX	0879MVC	Y	N
17	549	Mesquite Vet Center	Mesquite	TX	0730V	N	N
17	549	Arlington Vet Center	Pantego	TX	0732V	N	N
17	519	Abilene Vet Center	Abilene	TX	0733V	N	N
19	436	Billings Mobile Vet Center	Billings	MT	0829MVC	Y	N
19	660	Salt Lake City Mobile Vet Center	Murray	UT	0831MVC	Y	N
19	442	Casper Mobile Vet Center	Casper	WY	0834MVC	Y	N
19	554	Pueblo Mobile Vet Center	Pueblo	CO	0836MVC	Y	N
19	436	Missoula Mobile Vet Center	Missoula	MT	0837MVC	Y	N
19	442	Cheyenne Vet Center	Cheyenne	WY	0501V	N	N
19	554	Denver Vet Center	Denver	CO	0504V	N	N
19	436	Billings Vet Center	Billings	MT	0509V	N	N
19	660	Salt Lake City Vet Center	Murray	UT	0514V	N	N
19	442	Casper Vet Center	Casper	WY	0519V	N	N
19	554	Colorado Springs Vet Center	Colorado Springs	CO	0525V	N	N
19	575	Grand Junction Vet Center	Grand Junction	CO	0526V	N	N
19	554	Boulder Vet Center	Boulder	CO	0527V	N	N
19	436	Missoula Vet Center	Missoula	MT	0528V	N	N
19	660	Pocatello Vet Center	Pocatello	ID	0531V	N	N
19	660	Provo Vet Center	Orem	UT	0532V	N	N
19	436	Great Falls Vet Center	Great Falls	MT	0538V	N	N
19	436	Kalispell Vet Center	Kalispell	MT	0539V	N	N
19	660	Saint George Vet Center	Saint George	UT	0540V	N	N
19	554	Pueblo Vet Center	Pueblo	CO	0542V	N	N
19	442	Fort Collins Vet Center	Fort Collins	CO	0543V	N	N
19	660	Major Brent Taylor Vet Center Outstation	North Ogden	UT	5141OS	N	Y
19	635	Lawton Mobile Vet Center	Lawton	OK	0865MVC	Y	N
19	660	Saint George Mobile Vet Center	Saint George	UT	0868MVC	Y	N
19	436	Helena Outstation	Helena	MT	5381OS	N	Y
19	635	Oklahoma City Vet Center	Oklahoma City	OK	0718V	N	N
19	623	Tulsa Vet Center	Tulsa	OK	0723V	N	N
19	635	Lawton Vet Center	Lawton	OK	0728V	N	N

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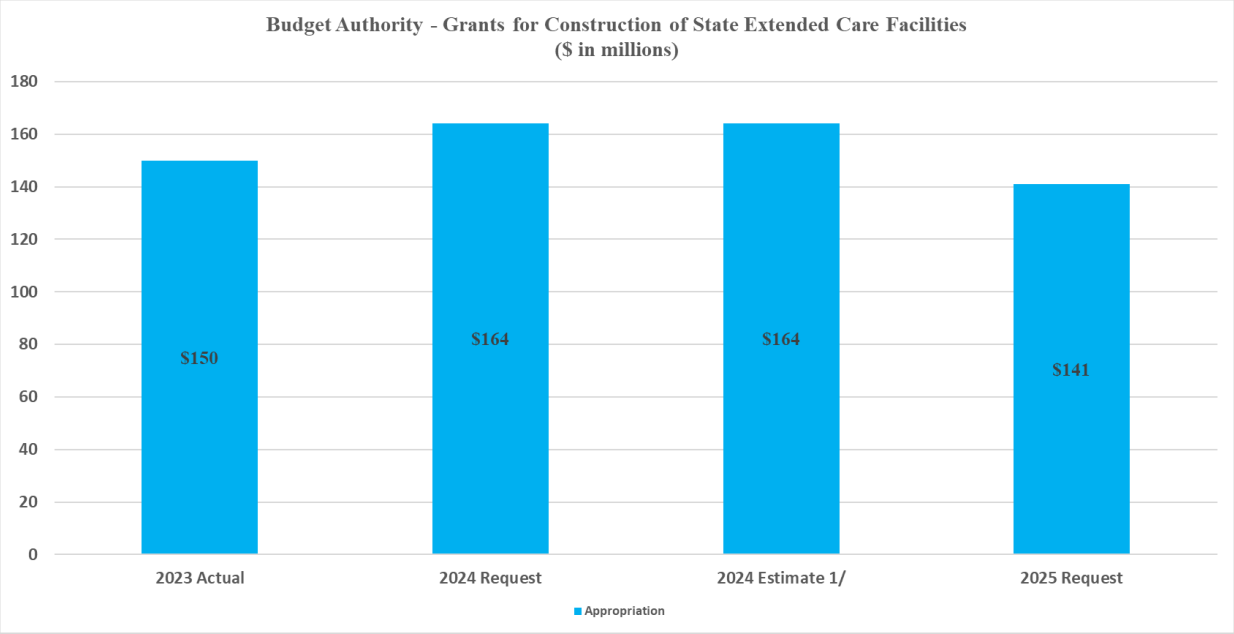
19	442	Fort Collins Mobile Vet Center	Fort Collins	CO	0881MVC	Y	N
20	531	Boise Mobile Vet Center	Boise	ID	0827MVC	Y	N
20	663	Tacoma Mobile Vet Center	Tacoma	WA	0828MVC	Y	N
20	668	Spokane Mobile Vet Center	Spokane Valley	WA	0830MVC	Y	N
20	648	Salem Mobile Vet Center	Salem	OR	0840MVC	Y	N
20	463	Anchorage Vet Center	Anchorage	AK	0502V	N	N
20	531	Boise Vet Center	Boise	ID	0503V	N	N
20	663	Seattle Vet Center	Seattle	WA	0507V	N	N
20	663	Tacoma Vet Center	Tacoma	WA	0508V	N	N
20	668	Spokane Vet Center	Spokane	WA	0510V	N	N
20	463	Fairbanks Vet Center	Fairbanks	AK	0511V	N	N
20	463	Wasilla Vet Center	Wasilla	AK	0512V	N	N
20	663	Bellingham Vet Center	Bellingham	WA	0522V	N	N
20	663	Yakima Valley Vet Center	Yakima	WA	0523V	N	N
20	663	Everett Vet Center	Everett	WA	0529V	N	N
20	463	Kenai Outstation	Soldotna	AK	5021OS	N	Y
20	663	Federal Way Vet Center	Federal Way	WA	0535V	N	N
20	687	Walla Walla Vet Center	Walla Walla	WA	0541V	N	N
20	463	Lacey Outstation	Lacey	WA	5081OS	N	Y
20	648	Portland Vet Center	Portland	OR	0617V	N	N
20	648	Central Oregon Vet Center	Bend	OR	0622V	N	N
20	653	Eugene Vet Center	Eugene	OR	0626V	N	N
20	648	Salem Vet Center	Salem	OR	0640V	N	N
20	692	Grants Pass Vet Center	Grants Pass	OR	0645V	N	N
20	692	Grants Pass Mobile Vet Center	Grants Pass	OR	0871MVC	Y	N
21	593	Las Vegas Vet Center	Las Vegas	NV	0505V	N	N
21	654	Reno Vet Center	Reno	NV	0506V	N	N
21	640	Santa Cruz County Mobile Vet Center	Capitola	CA	0842MVC	Y	N
21	593	Henderson Vet Center	Henderson	NV	0534V	N	N
21	612A4	Concord Vet Center	Concord	CA	0602V	N	N
21	459	Honolulu Vet Center	Honolulu	HI	0609V	N	N
21	570	Citrus Heights Vet Center	Citrus Heights	CA	0610V	N	N
21	612A4	Oakland Vet Center	Oakland	CA	0612V	N	N
21	640	San Jose Vet Center	San Jose	CA	0615V	N	N
21	TBD	Solano County Outstation	Fairfield	CA	TBD	N	Y
21	TBD	Mariana Islands Outstation	Saipan	MP	TBD	N	Y
21	459	American Samoa Vet Center	Pago Pago	AS	0616V	N	N
21	662	San Francisco Vet Center	San Francisco	CA	0620V	N	N
21	459	Western Oahu Vet Center	Kapolei	HI	0621V	N	N
21	570	Fresno Vet Center	Fresno	CA	0628V	N	N
21	459	Kauai Vet Center	Lihue	HI	0633V	N	N
21	459	Maui Vet Center	Kahului	HI	0634V	N	N
21	459	Hilo Vet Center	Hilo	HI	0635V	N	N
21	459	Kailua-Kona Vet Center	Kailua-Kona	HI	0636V	N	N
21	612A4	Sacramento Vet Center	Sacramento	CA	0638V	N	N
21	640	Santa Cruz County Vet Center	Capitola	CA	0639V	N	N
21	662	Eureka Vet Center	Eureka	CA	0644V	N	N
21	654	Reno Mobile Vet Center	Reno	NV	0867MVC	Y	N
21	662	Northbay Vet Center	Rohnert Park	CA	0646V	N	N
21	640	Peninsula Vet Center	Menlo Park	CA	0647V	N	N
21	459	Guam Vet Center	Maite	GU	0648V	N	N
21	612A4	Chico Vet Center	Chico	CA	0649V	N	N
21	640	Delta Vet Center	Manteca	CA	0650V	N	N
21	459	Western Oahu Mobile Vet Center	Kapolei	HI	0870MVC	Y	N
21	612A4	Sacramento Mobile Vet Center	Sacramento	CA	0880MVC	Y	N
21	593	Henderson Mobile Vet Center	Henderson	NV	0886MVC	Y	N
22	501	Hopi Mobile Vet Center	Hotevilla	AZ	0832MVC	Y	N
22	649	Prescott Mobile Vet Center	Prescott	AZ	0833MVC	Y	N

FY 2023 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	Santa Fe Mobile Vet Center	Santa Fe	NM	0835MVC	Y	N
22	501	Las Cruces Mobile Vet Center	Las Cruces	NM	0838MVC	Y	N
22	605	Corona Mobile Vet Center	Corona	CA	0839MVC	Y	N
22	691	Bakersfield Mobile Vet Center	Bakersfield	CA	0841MVC	Y	N
22	501	Albuquerque Vet Center	Albuquerque	NM	0515V	N	N
22	501	Farmington Vet Center	Farmington	NM	0516V	N	N
22	644	Phoenix Vet Center	Phoenix	AZ	0517V	N	N
22	649	Dr. Cameron McKinley Vet Center	Prescott	AZ	0518V	N	N
22	501	Santa Fe Vet Center	Sante Fe	NM	0520V	N	N
22	678	Tucson Vet Center	Tucson	AZ	0521V	N	N
22	644	Mesa Vet Center	Mesa	AZ	0524V	N	N
22	644	West Valley Vet Center	Peoria	AZ	0533V	N	N
22	649	Lake Havasu Vet Center	Lake Havasu	AZ	0536V	N	N
22	678	Yuma Vet Center	Yuma	AZ	0537V	N	N
22	691	Bakersfield Vet Center	Bakersfield	CA	0601V	N	N
22	691	Antelope Valley Vet Center	Palmdale	CA	0603V	N	N
22	600	South Orange County Vet Center	Mission Viejo	CA	0604V	N	N
22	691	Chatsworth Vet Center	Chatsworth	CA	0605V	N	N
22	691	Los Angeles Vet Center	Gardena	CA	0606V	N	N
22	691	West Los Angeles Vet Center	Culver City	CA	0607V	N	N
22	501	Navajo Outstation	Chinle	AZ	5161OS	N	Y
22	TBD	Sierra Vista Outstation	Sierra Vista	AZ	TBD	N	Y
22	605	Temecula Vet Center	Temecula	CA	0608V	N	N
22	605	Corona Vet Center	Corona	CA	0611V	N	N
22	605	High Desert Vet Center	Victorville	CA	0613V	N	N
22	664	Chula Vista Vet Center	Bonita	CA	0614V	N	N
22	664	San Diego Vet Center	San Diego	CA	0618V	N	N
22	691	San Luis Obispo Vet Center	San Luis Obispo	CA	0619V	N	N
22	691	East Los Angeles Vet Center	Commerce	CA	0623V	N	N
22	600	North Orange County Vet Center	Garden Grove	CA	0624V	N	N
22	605	San Bernardino Vet Center	San Bernardino	CA	0637V	N	N
22	664	San Marcos Vet Center	San Marcos	CA	0642V	N	N
22	691	Ventura Vet Center	Ventura	CA	0643V	N	N
22	600	South Orange County Mobile Vet Center	Mission Viejo	CA	0869MVC	Y	N
22	501	Hopi Outstation	Hotevilla	AZ	5162OS	N	Y
22	691	Sepulveda Outstation	Sepulveda	CA	6051OS	N	Y
22	501	Chinle Mobile Vet Center	Chinle	AZ	0882MVC	Y	N
22	664	San Marcos Mobile Vet Center	San Marcos	CA	0883MVC	Y	N
22	678	Yuma Mobile Vet Center	Yuma	AZ	0885MVC	Y	N
23	437	Bismarck Mobile Vet Center	Bismarck	ND	0819MVC	Y	N
23	437	Fargo Mobile Vet Center	Fargo	ND	0820MVC	Y	N
23	618	Brooklyn Park Mobile Vet Center	Brooklyn Park	MN	0821MVC	Y	N
23	568	Rapid City Mobile Vet Center	Rapid City	SD	0823MVC	Y	N
23	636	Lincoln Mobile Vet Center	Lincoln	NE	0825MVC	Y	N
23	437	Grand Forks Outstation	Grand Forks	ND	4061OS	N	Y
23	437	Minot Vet Center	Minot	ND	0404V	N	N
23	636A6	Des Moines Vet Center	West Des Moines	IA	0405V	N	N
23	437	Fargo Vet Center	Fargo	ND	0406V	N	N
23	618	St. Paul Vet Center	Saint Paul	MN	0416V	N	N
23	TBD	St. Cloud Outstation	St. Cloud	MN	TBD	N	Y
23	568	Rapid City Vet Center	Rapid City	SD	0423V	N	N
23	636	Omaha Vet Center	Omaha	NE	0424V	N	N
23	438	Sioux Falls Vet Center	Sioux Falls	SD	0425V	N	N
23	636	Lincoln Vet Center	Lincoln	NE	0427V	N	N
23	438	Sioux City Vet Center	Sioux City	IA	0428V	N	N
23	618	Duluth Vet Center	Duluth	MN	0429V	N	N
23	636A8	Quad Cities Vet Center	East Moline	IL	0430V	N	N
23	636A8	Cedar Rapids Vet Center	Cedar Rapids	IA	0431V	N	N
23	618	Brooklyn Park Vet Center	Anoka	MN	0439V	N	N
23	437	Bismarck Vet Center	Bismarck	ND	0446V	N	N
23	636A8	Cedar Rapids Mobile Vet Center	Cedar Rapids	IA	0854MVC	Y	N

Grants for Construction of State Extended Care Facilities

Chart: Total Appropriations



1/A full-year 2024 appropriation for this account has not been enacted prior to the submission of the 2025 President's Budget. The funding level in the 2024 Estimate column assumes the 2024 President's Budget request for 2024 with updates to unobligated balances.

Authority for Action

- Title 38 CFR Part 59, *Grants to States for Construction or Acquisition of State Homes*
- Public Law (P.L.) 95-62, *State Veterans' Home Assistance Improvement Act of 1977*
- P.L. 98-528, *Veterans' Health Care Act of 1984*
- P.L. 99-576, *Veterans' Benefits Improvement and Health Care Authorization Act of 1986*
- P.L. 100-322, *Veterans' Benefits and Services Act of 1988*
- P.L. 102-585, *Veterans Health Care Act of 1992*
- P.L. 104-262, *Veterans' Health Care Eligibility Reform Act of 1996*
- P.L. 106-117, *Veteran's Millennium Health Care and Benefits Act of 1999*

Annual Discretionary Funding Highlights
(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Request	2024 to 2025 Inc/Dec
Appropriation	$150,000	$164,000	$164,000	$141,000	($23,000)
Adjustments to Obligations:					
Unobligated Balance (SOY)	$210,552	$0	$147,308	$0	($147,308)
Unobligated Balance (EOY)	($147,308)	$0	$0	$0	$0
Change in Unobligated Balance	$63,244	$0	$147,308	$0	($147,308)
Prior Year Recoveries	$9,188	$0	$0	$0	$0
Obligations	$222,432	$164,000	$311,308	$141,000	($170,308)

American Rescue Plan (ARP) Act 8004 Highlights
(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Request	2024 to 2025 Inc/Dec
Mandatory Appropriations (Sec. 8004)	$0	$0	$0	$0	$0
nts to Obligations:					
Unobligated Balance (SOY)	$938	$0	$938	$0	($938)
Unobligated Balance (EOY)	($938)	$0	$0	$0	$0
Change in Unobligated Balance	$0	$0	$938	$0	($938)
Prior Year Recoveries	$0	$0	$0	$0	$0
Obligations	$0	$0	$938	$0	($938)

Total Funding Highlights
(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Request	2024 to 2025 Inc/Dec
Appropriation	$150,000	$164,000	$164,000	$141,000	($23,000)
ents to Obligations:					
Unobligated Balance (SOY)	$211,490	$0	$148,246	$0	($148,246)
Unobligated Balance (EOY)	($148,246)	$0	$0	$0	$0
Change in Unobligated Balance	$63,244	$164,000	$312,246	$141,000	($171,246)
Prior Year Recoveries	$9,188	$0	$0	$0	$0
Obligations	$222,432	$164,000	$312,246	$141,000	($171,246)

Note: A full-year 2024 appropriation for this account has not been enacted prior to the submission of the 2025 President's Budget. The funding level in the 2024 Estimate column assumes the 2024 President's Budget request for 2024 with updates to unobligated balances.

Purpose

The State Home Construction Grant program (SHCGP) is regulated in 38 C.F.R. Part 59. The program provides funding up to 65% of construction or renovation cost for state Veterans homes (SVH). Applications must be received by April 15 of each calendar year to be listed on the following fiscal year's annual Priority List. It is required by 38 U.S.C. § 8135 to fund projects in the order of their ranking on the annual Priority List.

Evidence
In 2023, the program obligated funding for four grant projects with total obligations of $222.4 million.

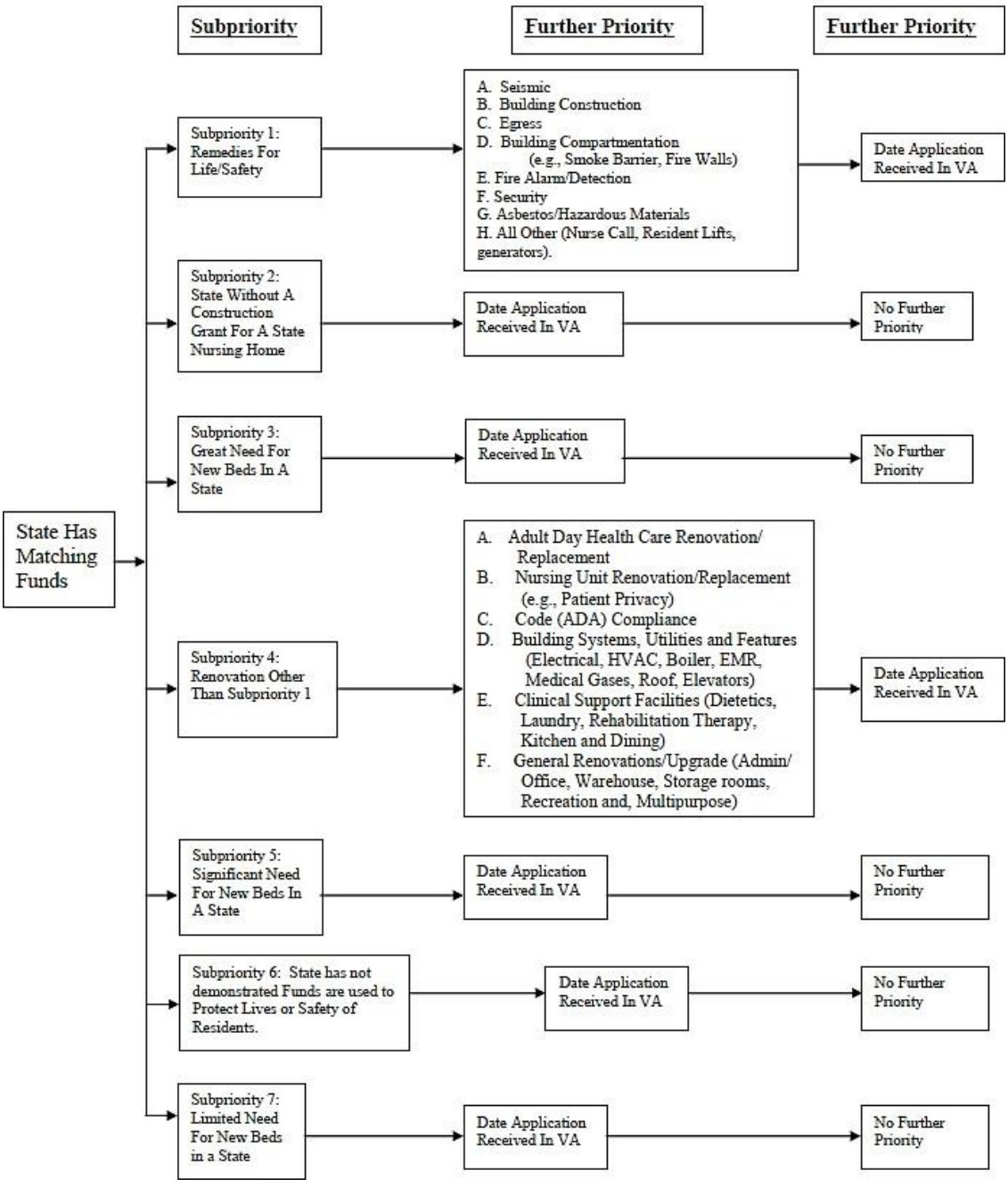
Implementation Plan
Per 38 C.F.R. § 59.50, Priority List, VA must follow the prioritization in ranking of projects in a specific order. Finalization of the 2024 Priority List and confirmed appropriated funds amount will determine the order of disbursement of awards to states.

- States must submit an initial application by April 15 of each year in order to be considered for the following fiscal year's priority list.
- States must complete the entire grant application by August 1 of the fiscal year to be considered for a final grant award.
- States must complete the entire grant application by June 30 of the fiscal year to be considered for a conditional grant award.
    - States that do not complete a final grant award by the deadline may apply for a conditional grant award with the expectation that the remaining grant process will be completed by the following June 30 deadline.
    - If states cannot complete a grant that was offered for an award, they may request a deferment to the following year for reconsideration.

Budget Request
VA requests $141 million in 2025 for construction of state home facilities, for furnishing domiciliary or nursing home care to Veterans and to expand, remodel or alter existing buildings for furnishing domiciliary, nursing home care or adult day health care to Veterans in state homes. VA is required by section 8135 of title 38 U.S.C. to prioritize state grant applications, and its highest priority is to protect Veterans from those conditions that threaten the lives and safety of residents of an existing facility. State homes are owned and operated by the state.

The 2025 budget request, matched with state funding, is based on the 2024 construction projects priority listing for projects ranked with highest priority in accordance of 38 C.F.R. § 59.50 and will support essential life-safety renovation projects to help ensure quality care for Veterans and also ensure SVH facilities at a minimum meet the code requirements for the Americans with Disabilities Act. Any remaining funds will be used to support new construction projects and non-life safety renovation projects.

Prioritization for Priority Group 1



Joint Medical Care Special Programs

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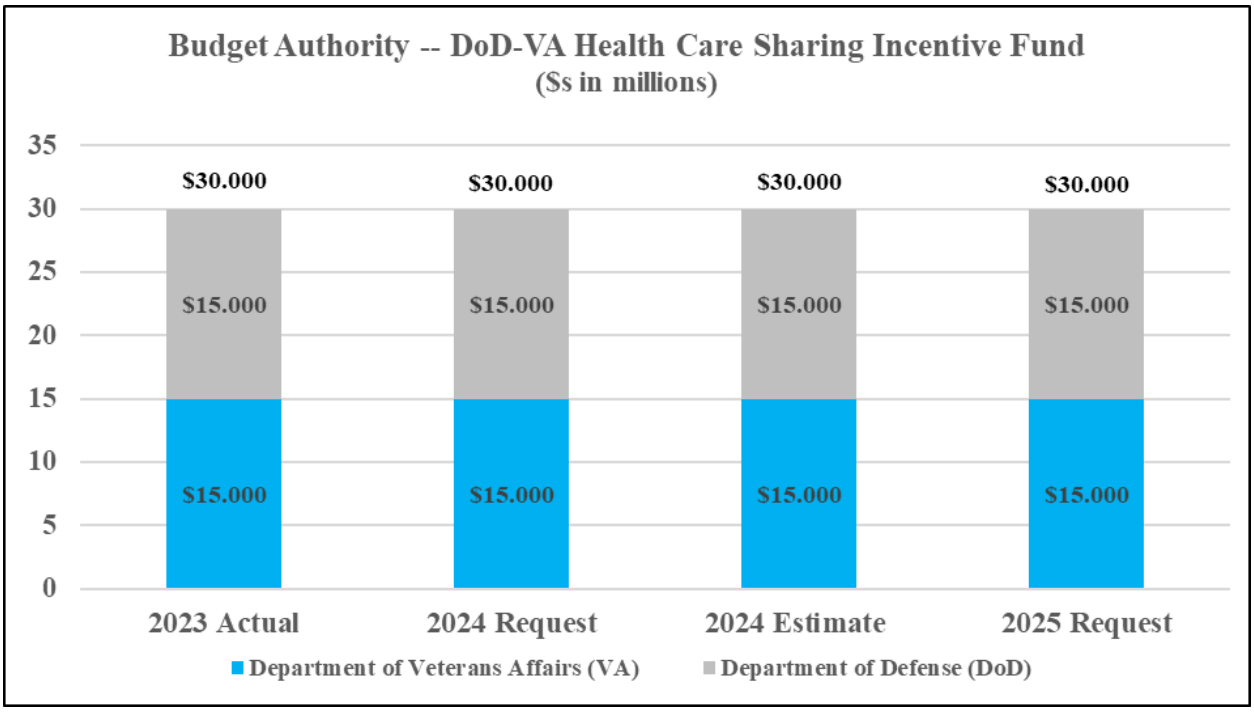
DoD-VA Health Care Sharing Incentive Fund



Funding contributions anticipated from VA and DoD.

Summary of Budget Request

Congress created the DoD-VA Health Care Sharing Incentive Fund, regularly referred to as the Joint Incentive Fund (JIF), between the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to encourage development of sharing initiatives at the facility, intra-regional, and nationwide level. The JIF program has been very successful in fostering collaboration and new approaches to problem solving that mutually benefit both VA and DoD.

Through the JIF, there is a minimum of $30 million available annually to enable VA and DoD to identify and provide incentives to implement creative sharing initiatives at the facility, intra-regional, and nationwide levels. Pursuant to 38 U.S.C. § 8111(d), each Secretary is required to contribute a minimum of $15 million from the funds appropriated to that Secretary's Department. The JIF became effective on October 1, 2003. The Continuing Appropriations and Ukraine Supplemental Appropriations Act, 2023 (P.L. 117-180 § 103) and amended 38 U.S.C. § 8111(d)(3) extends the program to September 30, 2026. The funds are available until expended.

In 2025, 31 VA and 50 DoD full-time equivalents (FTE) are projected to be funded by this appropriation account.

Administrative Provision

An administrative provision related to the JIF will be included in the VA chapter of the President's Budget Appendix:

> The purpose of the JIF is to enable the Departments to carry out a program to identify and provide incentives to implement creative sharing initiatives at the facility, intra-regional, and nationwide levels. The JIF promotes collaboration and new approaches to problem solving to enable the Departments to improve the coordination of health care services. The Departments have established the fund and developed processes and criteria to solicit and select projects. Section 721 of the National Defense Authorization Act for Fiscal Year 2003, Public Law 107-314, established the fund and requires the Departments to establish a join incentive program. In 2025, each Secretary shall contribute a minimum of $15 million to the fund after the appropriation is enacted.
>
> 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). The Veterans Health Administration (VHA) administers the fund under the policy, guidance, and direction of the HEC and executes funding transfers for projects approved by the HEC. The VHA Chief Financial Officer (CFO) provides periodic status reports of the financial balance of the Fund to the Defense Health Agency (DHA) CFO and to the HEC.

2023 Program Successes

- ***DoD/VA National - Individual Longitudinal Exposure Record (ILER):*** The development of the ILER is a joint enterprise initiative between the DoD and VA to create a complete record of every Service member's environmental exposures over the course of their career. It profoundly changes the way DoD and VA process exposure-related claims and benefits. The ILER will be central to the documentation and tracking of exposures and providing an improved basis for delivering DoD and VA exposure-related health care, medical surveillance, research and development, and disability benefits. **Funding: $16.8 million from 2013-23**

- ***Uniformed Services University of the Health Sciences/Miami VA HCS - Mobile Device Rehabilitation:*** In 2014, the Mobile Device Outcomes-based Rehabilitation Program introduced a home-based system of care designed to provide Service members and Veterans with limb loss a more comprehensive level of care. It called for the purchase of Rehabilitative Lower-limb Orthopedic Accommodating-feedback Devices, which use a

system of electronic sensors, validated outcome measures, targeted exercises, and a feedback system that enables the patient to exercise at home and receive corrective feedback while the therapist monitors their progress from the clinic. This effort assists those with lower limb amputation(s) in the return to their everyday activities while reducing the risk of secondary co-morbidities related to limb loss that would limit activity. **Funding: $8.9 million from 2019-23**

- ***DoD/VA National – Three-Dimensional (3D) Printing*:** The project unifies existing field-level DoD and VA 3D printing efforts into a scalable DoD/VA 3D Printing Consortium. It will allow rapid sharing of best practices and organizational knowledge across field sites, which will increase the number of patients who receive 3D printing health care solutions. It will also provide for the adoption of a unified, inter-government 3D printing quality system that meets industry standards, enabling both agencies to build the infrastructure needed to maximize utilization of resources and return on investment. **Funding: $8.9 million from 2019-24**

2024 Projects

JIF funding is an initial investment in the project to facilitate the mutually beneficial exchanges of health care resources, with the goal of improving the access to high quality and cost-effective health care provided to beneficiaries of both Departments. JIF funding is designed and programmed to cover the start-up costs during the initial two-year JIF financial support period, after which time sustainment funding will be provided by the designated Department(s) as appropriate. The approval and implementation of the following list of anticipated projects is subject to availability of funds and may execute over multiple years. Additional projects may be selected at a later date.

- ***96th Medical Group Eglin Airforce Base/Gulf Coast Healthcare System (HCS) - Primary Care Clinic:*** Utilizing a mobile, modular clinic concept, and in partnership with municipal, DoD, or Veteran Service Organization partners, this initiative proposes to establish a primary presence in the Crestview, Florida, community capable of meeting the urgent care needs of the active duty and beneficiary population as well as much-needed Veteran-centric primary care to Veterans. With this clinic, both VA and DoD beneficiaries will receive screenings that are not provided at traditional community care and urgent care clinics. The additional screenings will include suicide risk, traumatic brain injury (TBI), military sexual trauma, and post-traumatic stress disorder (PTSD). The providers in the newly established clinic will enhance medication management for patients and will be pivotal in monitoring the use of certain medications, such as opioids, which tend to be more readily prescribed by community providers. Beyond primary care, the clinic design will allow for expansion of services via a shared rotational exam room with telehealth capability, which can provide services, such as pharmaceutical and dietary consultation, foundational behavioral health care, and other medical specialties identified as a community need by the primary care teams. **Funding: $2 million**

- ***DoD/VA National - Comprehensive Health and Musculoskeletal (MSK) Prediction, Intervention, and Optimization (CHAMPION):*** The MSK health initiative proposes to conduct the CHAMPION Project to achieve an integrative, holistic framework for MSK

prevention, treatment, and rehabilitation. This operational data-sharing collaboration between the DoD and VA would allow for building MSK and chronic pain risk predictive algorithms, tracking of high-risk Service members, and developing targeted prevention and treatment programs that are essential for reducing the burden of MSK injuries and chronic conditions on active-duty Service members (ADSM) and Veterans. The collaboration will build on the substantive body of peer-reviewed research and predictive modeling-based programs already developed by members of this project team. **Funding: $4 million**

- ***DoD/VA National - Patient Safety Incident Reporting:*** The primary goals of this JIF project are to improve patient safety by patient harm events by 5% in 2025, 10% in 2026, and in following years, sustain progress toward zero preventable harm. The innovative objectives to reduce patient harm include, but are not limited to, improving organizational transparency and safety culture with increased reporting and learning from near miss/close call events; the employment of integrated data sets to enable proactive risk assessment and improvement strategies, through interagency collaboration, to advance highly reliable care processes, and the implementation and standardization of Comprehensive Systematic Analysis capability to capture critical information effectively using a systems approach with human factors engineering methods and apply high reliability organization concepts to eliminate system vulnerabilities. **Funding: $7.2 million**

- ***Fort Belvoir Community Hospital/Washington VA Medical Center (VAMC) - Joint Imaging Collaborative:*** This proposal will establish the first joint VA/DoD Magnetic Resonance Imaging and Breast Imaging collaboration between the National Capital Region (NCR) Market and Veterans Integrated Service Network (VISN) 5 Capitol Health Care Network. The NCR Market has one of the largest concentrations of ADSMs in the Nation, and the Washington, DC VAMC has a substantial VA population. Female Veterans have comprised an increasing proportion of the number of Veterans nationwide. Female Veterans currently comprise 18% of the total Veteran population and there are more than 21,000 female Veterans enrolled at the Washington, DC VA Medical Center; this is the second highest number of female Veterans by catchment area in the United States, and those numbers are expected to increase. **Funding: $5.2 million**

- ***Naval Hospital Charleston/Navy Medicine Readiness and Training Command Beaufort (NHB)/Ralph H. Johnson (RHJ) VA HCS - Cardiology Service:*** The intent of this initiative is to create a Joint Cardiovascular Clinic (JCC) between RHJ VA HCS, in Charleston, South Carolina, and NHB, in Beaufort, South Carolina. This JCC will improve quality of available Cardiovascular Care for more than 80,000 VA beneficiaries and 12,000 NHB beneficiaries. RHJ VA HCS is referring approximately 250 beneficiaries to civilian care each year at an estimated cost of $2,107.45 per beneficiary and this does not represent potential captures from the Savannah, Georgia area. This JCC is expected to improve RHJ VA HCS beneficiaries' access to cardiology specialty care and to recapture approximately $590,000 per year of network purchased care. To meet American Heart Association and American College of Cardiology criteria, RHJ VA HCS and NHB require three staff positions for this JCC. **Funding: $800,000**

DoD-VA Health Care Sharing Incentive Fund Highlights

(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Estimate	2024-2025 Increase/ Decrease
Transfer from Medical Services	$15,000	$15,000	$15,000	$15,000	$0
Transfer from DoD	$15,000	$15,000	$15,000	$15,000	$0
Transfers Total	$30,000	$30,000	$30,000	$30,000	$0
Total Budget Authority	$30,000	$30,000	$30,000	$30,000	$0
Adjustments to Obligations:					
No-Year Unobligated Balance (SOY)	$98,924	$103,582	$105,887	$109,787	$3,900
No-Year Unobligated Balance (EOY)	($105,887)	($108,240)	($109,787)	($113,687)	($3,900)
Recovery Prior Year Obligations	$996	$0	$0	$0	$0
Obligations	$24,033	$25,342	$26,100	$26,100	$0
FTE:					
VA Civilian*	28	34	31	31	0
DoD Personnel**	55	55	63	50	(13)
Total FTE	83	89	94	81	(13)

*Data source: VA Financial Management System. VA assumes a steady-state number of FTE through the budget years.

**Data source: DHA. The counts reflect all FTE working on active JIF projects across the country.

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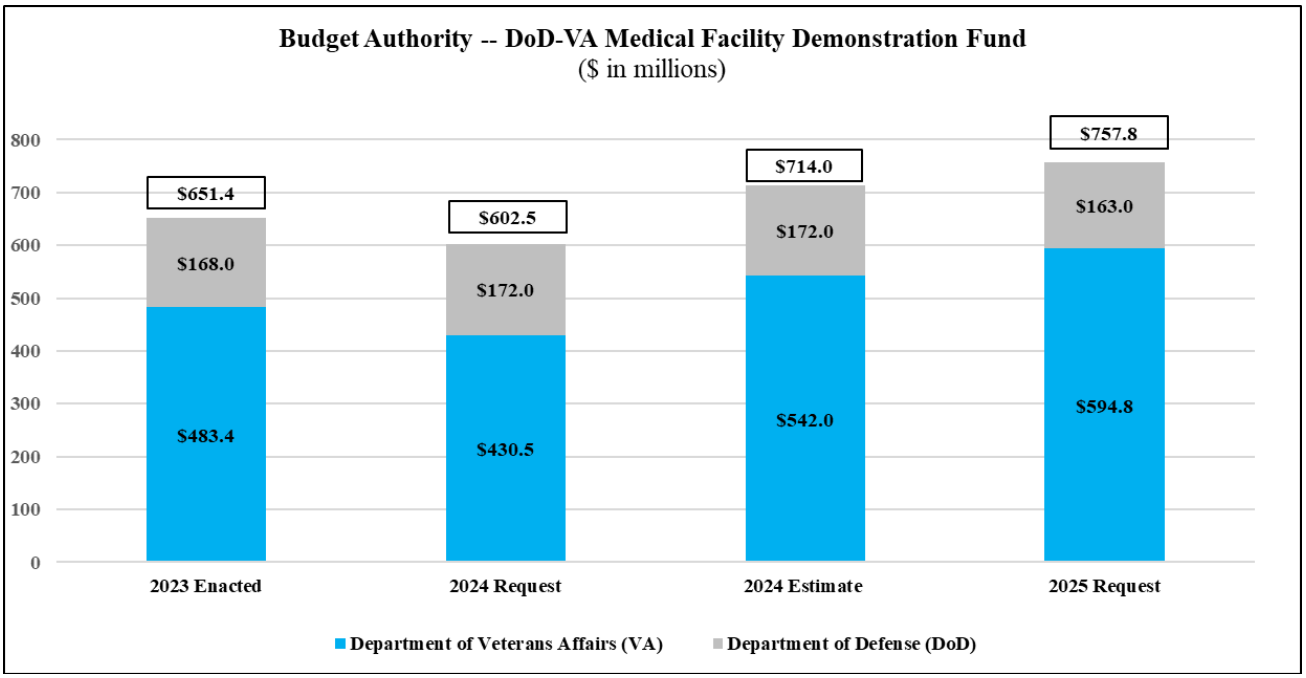
Joint DoD-VA Medical Facility Demonstration Fund for Captain James A. Lovell Federal Health Care Center, Illinois



Financial Highlights

($s in thousands)	2023 Enacted	2024 Request	2024 Estimate[/1]	2025 Request[/1]	Change 2025 vs. 2024 $	Change 2025 vs. 2024 %
Appropriation, Transfers From:						
Medical Services	$233,005	$263,141	$332,510	$384,926	$52,416	16%
Medical Community Care	$67,500	$70,000	$81,000	$93,500	$12,500	15%
Medical Support & Compliance	$32,144	$33,751	$44,887	$42,193	($2,694)	-6%
Medical Facilities	$142,715	$55,452	$75,452	$66,021	($9,431)	-12%
VA Information Technology	$8,085	$8,188	$8,085	$8,085	$0	0%
Subtotal, VA Contribution	$483,449	$430,532	$541,934	$594,725	$52,791	10%
Department of Defense (DoD) /2	$168,000	$172,000	$172,000	$162,500	($9,500)	-6%
Total Appropriations /3	$651,449	$602,532	$713,934	$757,225	$43,291	6%
Collections /4	$16,086	$20,444	$16,860	$17,336	$476	3%
Reimbursements /5	$9,870	$10,000	$10,000	$12,000	$2,000	20%
Unob. Bal. (SOY)	$566	$0	$7,508	$0	($7,508)	-100%
Unob. Bal. (EOY)	($7,508)	$0	$0	$0	$0	0%
Recovery Prior Year Obligations	$14	$0	$0	$0	$0	0%
Lapse	($214)	$0	$0	$0	$0	0%
Obligations	$670,263	$632,976	$748,302	$786,561	$38,259	5%
Other DoD Contributions:						
MERHCF DoD reimbursement (Included Above)	*$6,399*	*$6,479*	*$6,479*	*$8,050*	$1,571	24%
DoD "Stay Navy" (Excluded from Total Obligations) /6	*$13,706*	*$1,706*	*$14,781*	*$14,781*	$0	0%
FTE:						
Civilian	2,300	2,490	2,491	2,491	0	0%
DoD Uniformed Military /7	719	826	826	826	0	0%
Total FTE	3,019	3,316	3,317	3,317	0	0%

1/ The 2024 and 2025 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 P.L. 111-84 which established this fund. Under P.L. 114-223, VA is authorized to transfer funds from Medical Community Care beginning in 2017.
2/ The actual amount of the Medicare-Eligible Retiree Health Care Fund (MERHCF) reimbursement will impact the DoD transfer amount.
3/ Total excludes Stay Navy contribution and MERHCF reimbursement.
4/ Reflects estimated medical care collections, as provided by the VA Office of Integrated Veteran Care.
5/ Reflects estimated MERHCF reimbursement from DoD.
6/ Non-add for Personal Services Contract funded by DoD for the East Campus.
7/ The 2024 and 2025 Estimates are from the 2023 Navy Manning Plan. Estimates do not reflect the number of DoD Uniform Military FTE subject to Reconciliation in the JALFHCC Joint Areas.

Summary of Budget Request

The 2025 projected transfers from the Department of Veterans Affairs (VA) and the Department of Defense (DoD) fund a total of 3,317 full-time equivalents (FTE) and 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), Medical Community Care costs, and salary rate increases. In 2024, the facility anticipates executing additional NRM projects to support EHRM. VA will work to achieve the right balance between care provided in the community and care provided through VA throughout the VA health care system, including at JALFHCC.

On May 27, 2005, the VA/ DoD Health Executive Council signed an agreement to integrate the North Chicago VA Medical Center (NCVAMC) and the Navy Health Clinic Great Lakes (NHCGL). This landmark agreement created an organization composed of all the medical and dental components on both VA and Department of Navy property under the leadership of a VA Senior Executive Service Medical Center Director and a Navy Captain (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, United States Code requirement that one entity may not endanger the mission of the other entity engaged in an RSA.

The integrated organization, JALFHCC, is comprised of two campuses, West and East Campuses. The West Campus has 48 buildings on 94 acres of land between Green Bay Road and Buckley Road in North Chicago, Illinois. The East Campus has four medical facilities on Naval Station Great Lakes, Illinois. There are two Community Based Outpatient Clinics in Evanston, Illinois and McHenry, Illinois, and one in Kenosha, Wisconsin. The JALFHCC has 339 available beds and treated 890,597 outpatient encounters and 3,737 inpatient admissions in 2023.

The JALFHCC began using a single unified budget in 2011 to operate the integrated facility and execute funding using the VA Financial Management System. An account under the VA, Joint DoD - VA Medical Facility Demonstration Fund (JMFDF), was effective beginning in 2011.

VA and DoD determine the JALFHCC expenses that can be attributed to VA and DoD based on cost, workload, and the consumption of resources by each Department's beneficiaries. This reconciliation model is used as the basis for preparing future budgets. The reconciliation methodology uses agreed-upon full costing methods and execution data to determine the costs attributable to each Department. The reconciliation methodology uses industry standard measurements such as Relative Value Units and Relative Weighted Products for the determinations of workload values to be compared to VA's Decision Support System full costs. Both Departments will continue to work together to improve upon an equitable reconciliation process and ensure respective Department financial controls are implemented.

The authorities to use this Fund shall terminate on September 30, 2024. VA proposes to extend the authority for this Fund through September 30, 2025.

Administrative Provisions

VA is proposing continuing the following administrative provisions in accordance with the National Defense Authorization Act (NDAA) of 2010 (P.L. 111-84), for 2025, as included in the President's Budget:

SEC. 219. Of the amounts appropriated to the Department of Veterans Affairs for fiscal year 2025 for "Medical Services", "Medical Community Care", "Medical Support and Compliance", "Medical Facilities", "Construction, Minor Projects", and "Information Technology Systems", up to $594,828,000, plus reimbursements, may be transferred to the Joint Department of Defense—Department of Veterans Affairs Medical Facility Demonstration Fund, established by section 1704 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111–84; 123 Stat. 2571) and may be used for operation of the facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110–417; 122 Stat. 4500): Provided, That additional funds may be transferred from accounts designated in this section to the Joint Department of Defense—Department of Veterans Affairs Medical Facility Demonstration Fund upon written notification by the Secretary of Veterans Affairs to the Committees on Appropriations of both Houses of Congress: Provided further, That section 220 of title II of division J of Public Law 117–103 is repealed.

SEC. 220. Of the amounts appropriated to the Department of Veterans Affairs which become available on October 1, 2025, for "Medical Services", "Medical Community Care", "Medical Support and Compliance", and "Medical Facilities", up to $644,025,000, plus reimbursements, may be transferred to the Joint Department of Defense—Department of Veterans Affairs Medical Facility Demonstration Fund, established by section 1704 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111–84; 123 Stat. 2571) and may be used for operation of the facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110–417; 122 Stat. 4500): Provided, That additional funds may be transferred from accounts designated in this section to the Joint Department of Defense—Department of Veterans Affairs Medical Facility Demonstration Fund upon written notification by the Secretary of Veterans Affairs to the Committees on Appropriations of both Houses of Congress.

SEC. 221. Such sums as may be deposited to the Medical Care Collections Fund pursuant to section 1729A of title 38, United States Code, for healthcare provided at facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110–417; 122 Stat. 4500) shall also be available: (1) for transfer to the Joint Department of Defense—Department of Veterans Affairs Medical Facility Demonstration Fund, established by section 1704 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111–84; 123 Stat. 2571); and (2) for operations of the facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110–417; 122 Stat. 4500): Provided, That, notwithstanding section 1704(b)(3) of the

> National Defense Authorization Act for Fiscal Year 2010 (Public Law 111–84; 123 Stat. 2573), amounts transferred to the Joint Department of Defense—Department of Veterans Affairs Medical Facility Demonstration Fund shall remain available until expended.

Also, in accordance with P.L. 111-84, DoD is proposing the following general provision, for 2025, as included in the President's Budget:

> SEC. 8048. From within the funds appropriated for operation and maintenance for the Defense Health Program in this Act, up to $162,500,000 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.

The first VA provision (Section 219) requests authority to transfer funds appropriated for 2025 from specific VA appropriations to JMFDF, which was established by P.L. 111-84 § 1704. Section 1704(a)(2)(A) and (B) specify that JMFDF will consist of amounts transferred from amounts authorized and appropriated for DoD and VA specifically for the purpose of providing resources for this Fund.

The second provision (Section 220) requests authority to transfer to JMFDF from the 2026 advance appropriations that are requested for Medical Services, Medical Support and Compliance, Medical Facilities, and Medical Community Care in the 2025 budget.

The third provision (Section 221) authorizes the transfer of funds from the Medical Care Collections Fund to JMFDF. P.L. 111-84 § 1704 allows VA and DoD to deposit medical care collections to JMFDF. P.L. 111-84 § 1704(b)(2) specifies that the availability of funds transferred to JMFDF under subsection (a)(2)(C) shall be subject to the provisions of 38 U.S.C. § 1729A. Pursuant to 38 U.S.C. § 1729A(e): (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).

Mission Statement

The mission of the FHCC is to provide comprehensive, compassionate, patient-centered care to VA and DoD beneficiaries while supporting the highest level of operational readiness. The vision of the FHCC is to create the model for the future of federal interagency health care integration.

2023 Program Successes

- FHCC was awarded a positron emission tomography/computerized tomography (PET-CT) contract. The implemented services resulted in shortened wait/travel times for patients who have sought services outside FHCC and an anticipated cost savings of $280,000 a year. During the last quarter of fiscal year 2023, FHCC saw a reduction in community care consults over the same period last year and a cost savings of over $69,000.
- The FHCC's Blood Donor Center received FDA licensure to manufacture pre-pooled cryo. The Navy Medicine Readiness and Training Command (NMRTC) is the first of the DoD donor centers to produce a licensed pre-pooled product that can be shipped across state lines.
- In support of VA's nationwide goal to house 38,000 homeless Veterans in 2022, the Lovell FHCC team, with the help of community partners, provided 117 permanent housing placements to homeless Veterans last year. Currently 100% of FHCC's homeless Veterans have been rehoused.
- The FHCC's Limited Duty/Disability Evaluation System (LIMDU/DES) programs consistently meet or exceed National Strategic goals; zero expired LIMDU cases in past six months and the DES program is steadily in the top 3 of 15 military treatment facilities (MTF) in the Region.
- Our Tactical Causality Combat Course (TCCC) was recognized at a national level as a 'best practice' in teaching our Department of Defense (DOD) medical staff that are given the task of caring for others in conflict situations.
- FHCC received a 5-star quality rating from the Centers for Medicare & Medicaid Services (CMS).
- FHCC was issued Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation. There were no recommendations. This accomplishment is achieved in only 3 percent of CARF surveys.

Health Care Sharing

The Department of Veterans Affairs (VA) procures medical services to strengthen the medical programs at VA medical centers (VAMC) and to improve the quality of health care provided to Veterans under title 38, United States Code. Title 38 U.S.C. § 8153 authorizes contracting officers to sole source directly to educational institutions when that institution is affiliated with a VA Residency Program and the health care resource required is a commercial service, the use of medical equipment or space, or research. As a result, VA purchases medical care services from its academic affiliates, as well as other community partners, and the obligations associated with this activity are reported on the line titled Services Purchased by VA. The bulk of these contracts are for providing Veteran care through our Community Care Network (CCN), locum tenens physicians, and so forth, to fill in gaps when there are no VA physicians available, or the internal VA workload is heavy. Services procured through this program are performed by academic affiliate providers at VAMCs, as well as at the community partner's facilities through CCN. 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 titled Services Provided by VA.

This authority is a critical component of VA's education and training mission. As one of four statutory missions, VA conducts an Education and Training Program for health profession students and residents to enhance the quality of care provided to Veteran patients within the Veterans Health Administration (VHA) health care system.

Although VA relies on several title 38, United States Code authorities for procuring services outside VA, the following information discusses activities conducted by VA's Office of Acquisition Logistics and Construction and VHA Office of Procurement and Logistics pursuant to 38 U.S.C. § 8153 for activity from 2023.

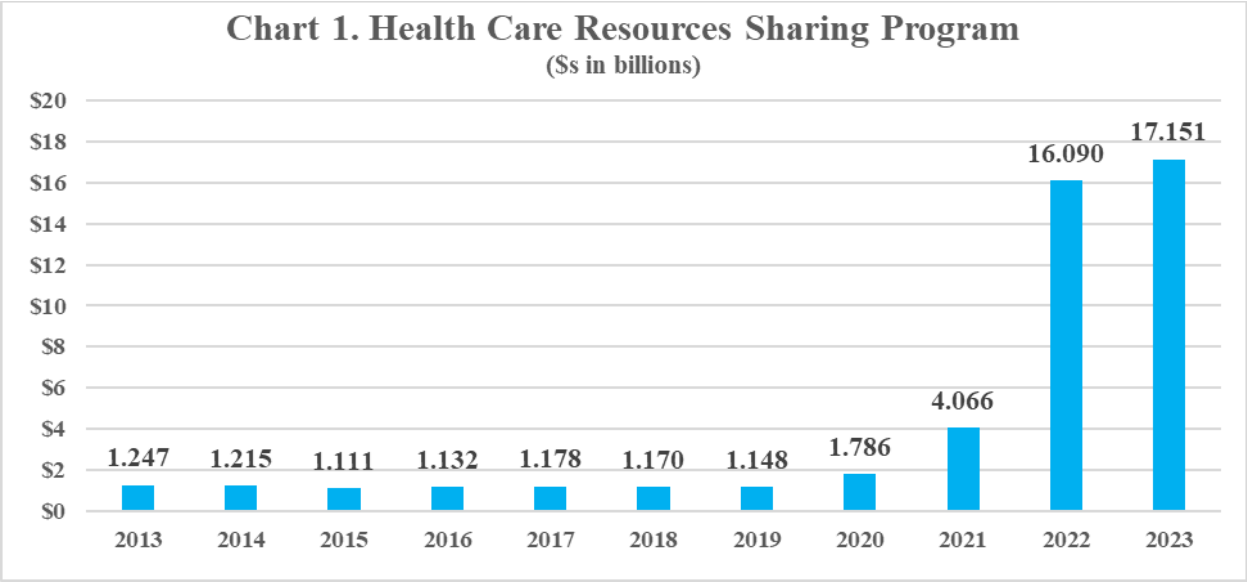
Health Care Sharing Obligations and Reimbursements

($s in thousands)	2023 Enacted	2024 Request	2024 Estimate	2025 Advance Appropriation	2025 Request	2026 Advance Appropriation	Change 2025 vs. 2024 $	Change 2025 vs. 2024 %	Change 2026 vs. 2025 $	Change 2026 vs. 2025 %
Services Purchased by VA:										
Medical Service (0160) VHA Contracting Obligations	$610,249	$779,779	$779,779	$779,779	$779,779	$779,779	$0	0%	$0	0%
Medical Service (0160) National Contracting Obligations /1	$16,479,053	$15,568,367	$17,303,006	$15,568,367	$17,303,006	$17,303,006	$0	0%	$0	0%
Medical Service (0160) Obligations Total	$17,089,302	$16,348,146	$18,082,785	$16,348,146	$18,082,785	$18,082,785	$0	0%	$0	0%
Services Provided by VA:										
Medical Service (0160) Reimbursements /2	$62,073	$64,453	$67,812	$64,453	$68,812	$68,812	$1,000	1%	$0	0%
Medical Service (0160) Obligations and Reimbursements Total	$17,151,375	$16,412,599	$18,150,596	$16,412,599	$18,151,597	$18,151,597	$1,000	0%	$0	0%

[1/] Includes Department-wide national contracting data. A new approach has been used to assess and finalize the end of year data, which enables a more accurate and comprehensive reporting of community care expenditures.
[2/] Estimated reimbursements are based on historical execution of reimbursement amounts.

The total amount of health care resource sharing for 2023 was approximately $17.2 billion. This represents procurements of approximately $17.1 billion and reimbursements totaling approximately $62.1 million.

Chart 1 presents the growth of the Health Care Resource Sharing Program since 2013. The bars represent the total health care resource services procured and revenue generated by VA contracting officers during a year.



Source: VA, Annual Report on Sharing of Health Care Resources, 2023.

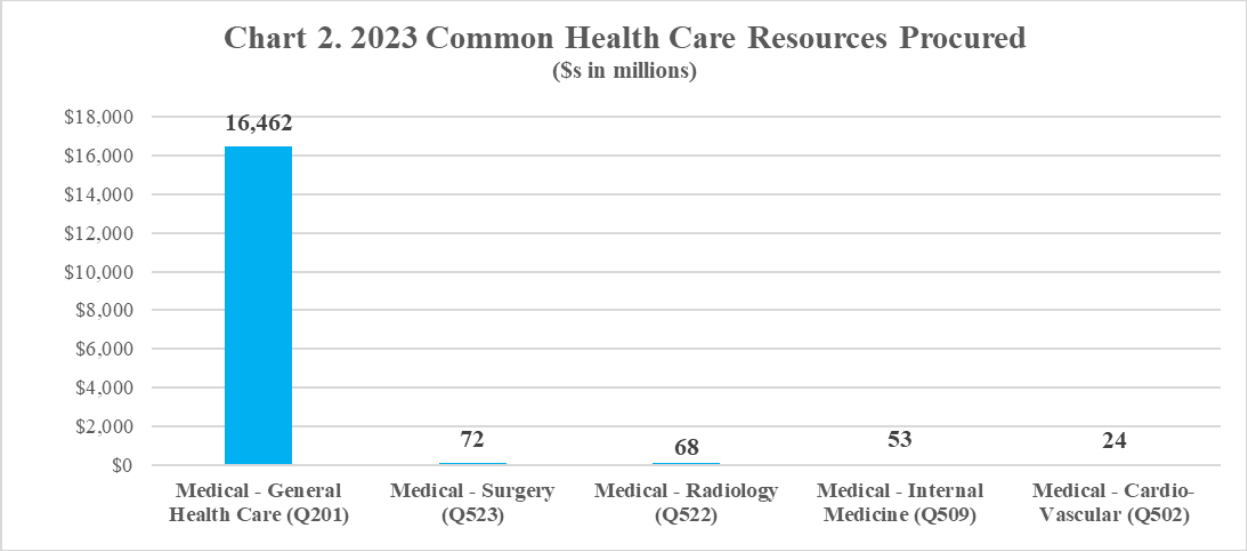
VA Health Care Facilities and Sharing

Traditionally, large VAMCs are more likely to have more extensive sharing arrangements. The referral system of medical practices enhances the size of these sharing programs as patients flow from smaller hospitals and clinics to tertiary care centers. The diversity of sharing arrangements is also influenced by the specialized capability of larger academic medical centers to manage difficult medical care problems. VAMCs in small metropolitan areas rely heavily on sharing agreements to provide health care resources not available at the VA facility.

Procurements

The procurements are primarily in the following areas: general health care, pharmacology, radiology, surgery, and internal medicine. Patients from small hospitals in need of specialty services, such as open-heart surgery, are often referred to large affiliated medical centers under this sharing authority.

Chart 2 presents the categories of services purchased by VA with the highest total obligation levels in 2023. The sum of VA purchases adds up to $16.7 billion of the total $17.2 billion in obligations that year.

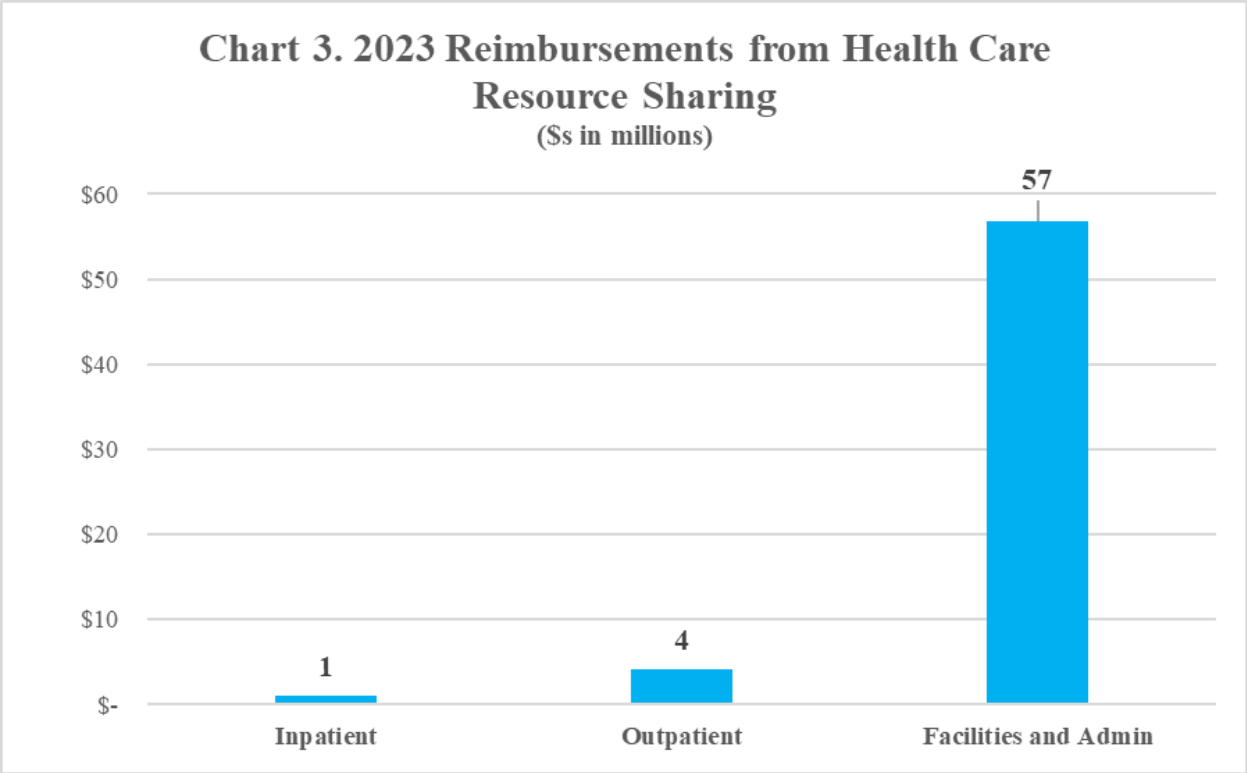


Source: VA, Annual Report on Sharing of Health Care Resources, 2023.

Reimbursements

VA provides a limited number of resources, including unused medical space, to affiliated medical colleges, community hospitals, and other sharing partners such as State Veterans Homes. VAMCs that have particular resources not fully utilized for the care of Veterans may share these resources with other community entities. Such resources are more cost effective when shared. The reimbursements received from these sharing agreements are retained by the VAMC and are used to enhance services and support.

Chart 3 presents total reimbursements in 2023 from affiliated medical colleges, community hospitals and other sharing partners.



VA / Department of Defense (DoD) Sharing

Title 38 U.S.C. § 8111 authorizes VA and DoD to enter into sharing agreements for the mutually beneficial coordination, use or exchange of health care resources, with the goal of improving access, quality, and cost effectiveness of health care services provided by VA and the Military Health System to the beneficiaries of both Departments.

VA / DoD Sharing Obligations[8] and Reimbursements

($s in thousands)	2023 Enacted [1/]	2024 Request	2024 Estimate	2025 Advance Appropriation	2025 Request	2026 Advance Appropriation	Change 2025 vs. 2024 $	Change 2025 vs. 2024 %	Change 2026 vs. 2025 $	Change 2026 vs. 2025 %
DoD-Provided Services Purchased by VA										
Medical Community Care (0140) Obligations	$62,918	$119,715	$64,806	$123,306	$66,750	$68,753	$1,944	3%	$2,003	3%
VA-Provided Services Purchased by DoD										
Medical Services (0160) Reimbursements	$79,844	$83,214	$82,239	$85,711	$84,706	$87,248	$2,467	3%	$2,541	3%

[1/] Itemized detail of DoD-Provided Services Purchased by VA in 2023 is as follows:

Obligations

(8321) Army	$22,277
(8322) Air Force	$31,496
(8323) Navy	$9,084
(8324) Defense Health Agency	$62
Obligations Total	$62,918

[1/] Itemized detail of VA-Provided Services Purchased by DoD in 2023 is as follows:

Reimbursements

DoD Sharing - All Other	$21,301
DoD Sharing - Inpatient	$0
DoD Sharing - Outpatient	$426
CHAMPUS - Inpatient	$0
CHAMPUS - Outpatient	$0
CHAMPUS - All Other	$0
TRICARE - Inpatient	$5,484
TRICARE - Outpatient	$8,011
TRICARE - All Other	$1,519
TRICARE - Pharmacy	$0
TRICARE - Active Duty Dental	$0
DoD Disability Evaluation - IDES	$10
DoD Spinal Cord Injury - Inpatient	$3,668
DoD Spinal Cord Injury - Outpatient	$29
DoD Spinal Cord Injury - Other	$962
DoD Brain Injury - Inpatient	$33,056
DoD Brain Injury - Outpatient	$392
DoD Brain Injury - Other	$4,965
DoD Blind Rehab - Inpatient	$0
DoD Blind Rehab - Outpatient	$3
DoD Blind Rehab - Other	$18
Reimbursements Total	$79,844

[8] In 2023, the VA / DoD Sharing Program experienced a lag in health care claims filed by the DoD, due to the transition of DoD medical treatment facilities to a new billing system. It is anticipated that DoD will bring the health care claims up to date. VA will continue to monitor the factors affecting the quality of data over time.

The tables that follow represent 172 active sharing agreements[9] with 2,483 services offered between 76 VA and 87 DoD facilities nationwide in 2023, an 83% increase in the number of services offered in agreements since 2022.[10]

2023 VA / DoD Health Care Resource Sharing Summary

VISN	Shared Service Type	Provider	Number of Services Offered
0 (VACO)	Administration and Support	DoD/VA	1
	Ancillary Services	DoD	1
0 (VACO) Total			**2**
1	Competency / Readiness Training	VA	1
1 Total			**1**
2	Administration and Support	DoD	2
		VA	1
	Ambulatory Care Services	DoD	10
		VA	1
	Ancillary Services	DoD	3
		VA	2
	Competency / Readiness Training	DoD/VA	1
	Inpatient Services	DoD	2
2 Total			**22**
4	Administration and Support	VA	1
	Ambulatory Care Services	DoD	57
	Ancillary Services	DoD	8
	Competency / Readiness Training	DoD/VA	1
		VA	2
	Inpatient Services	DoD	40
4 Total			**109**
5	Administration and Support	DoD	15
		DoD/VA	2
	Ambulatory Care Services	DoD	9
		DoD/VA	46
		VA	1

[9] Excluding the Health Care Sharing Fund and the Joint DoD-VA Medical Facility Demonstration Fund.

[10] The VA / DoD Sharing Program has been systematically engaged in assessing and improving the quality of fiscal data in preparation for the U.S. Treasury-mandated implementation of G-Invoicing, as well as in VA's transitions to the new Integrated Financial and Asset Management System and Electronic Health Record. In addition, VA is in the process of standardizing several VA / DoD resource sharing and fiscal processes to improve data capture and reliability, which has resulted in a more comprehensive capture of data on shared health care resources between VA and DoD. VA will continue to monitor the factors affecting the quality of data and expects to see fluctuation over the next several years.

VISN	Shared Service Type	Provider	Number of Services Offered
	Ancillary Services	DoD	3
		DoD/VA	6
	Competency / Readiness Training	VA	1
	Dental Services	VA	1
	Inpatient Services	DoD	2
		DoD/VA	27
	Other and Military Unique	DoD	1
5 Total			**114**
6	Administration and Support	DoD	3
	Ambulatory Care Services	DoD	136
		DoD/VA	1
		VA	1
	Ancillary Services	DoD	48
		DoD/VA	1
	Competency / Readiness Training	DoD/VA	1
		VA	2
	Dental Services	DoD	6
		VA	1
	Inpatient Services	DoD	107
		DoD/VA	2
		VA	2
6 Total			**311**
7	Administration and Support	DoD	16
		DoD/VA	2
		VA	1
	Ambulatory Care Services	DoD	103
		DoD/VA	10
		VA	15
	Ancillary Services	DoD	34
		DoD/VA	3
		VA	6
	Competency / Readiness Training	DoD/VA	2
		VA	4
	Dental Services	DoD	4
	Inpatient Services	DoD	86
		DoD/VA	2
		VA	4

VISN	Shared Service Type	Provider	Number of Services Offered
	Other and Military Unique	DoD	2
7 Total			**294**
8	Administration and Support	DoD	8
		VA	2
	Ambulatory Care Services	DoD	72
		VA	4
	Ancillary Services	DoD	21
	Competency / Readiness Training	VA	4
	Dental Services	DoD	3
	Inpatient Services	DoD	48
8 Total			**162**
	Ambulatory Care Services	DoD/VA	4
		VA	1
	Ancillary Services	DoD	1
		DoD/VA	3
	Inpatient Services	DoD/VA	1
9 Total			**18**
10	Administration and Support	DoD	4
	Ambulatory Care Services	DoD	10
		VA	2
	Ancillary Services	DoD	3
		VA	4
	Competency / Readiness Training	DoD/VA	3
		VA	5
	Dental Services	VA	3
	Inpatient Services	DoD	58
	Other and Military Unique	VA	1
10 Total			**93**
12	Ambulatory Care Services	VA	1
	Ancillary Services	VA	1
12 Total			**2**
15	Administration and Support	DoD	2
		VA	1
	Ambulatory Care Services	DoD	24
		VA	71
	Ancillary Services	DoD	8
		VA	20

VISN	Shared Service Type	Provider	Number of Services Offered
	Competency / Readiness Training	VA	2
	Dental Services	VA	4
	Inpatient Services	DoD	24
		VA	53
15 Total			**209**
16	Administration and Support	DoD	5
		DoD/VA	2
		VA	12
	Ambulatory Care Services	DoD	56
		DoD/VA	1
		VA	6
	Ancillary Services	DoD	13
		VA	4
	Competency / Readiness Training	DoD/VA	1
		VA	4
	Dental Services	DoD	2
		VA	1
	Inpatient Services	DoD	14
	Other and Military Unique	DoD	1
		DoD/VA	1
16 Total			**123**
		VA	2
	Ambulatory Care Services	DoD	212
		VA	1
	Ancillary Services	DoD	64
		VA	1
	Competency / Readiness Training	DoD/VA	5
		VA	1
	Dental Services	DoD	13
	Inpatient Services	DoD	163
	Other and Military Unique	DoD	2
17 Total			**466**
19	Administration and Support	VA	1
	Ambulatory Care Services	DoD	1
		DoD/VA	12
		VA	13
	Ancillary Services	DoD	9

VISN	Shared Service Type	Provider	Number of Services Offered
		DoD/VA	1
	Competency / Readiness Training	DoD/VA	2
		VA	5
	Dental Services	DoD	1
	Inpatient Services	DoD	2
		DoD/VA	2
19 Total			**49**
20	Administration and Support	DoD	9
		DoD/VA	1
		VA	5
	Ambulatory Care Services	DoD	91
		DoD/VA	4
		VA	3
	Ancillary Services	DoD	34
		DoD/VA	1
		VA	1
	Competency / Readiness Training	DoD/VA	1
		VA	3
	Dental Services	DoD	7
	Inpatient Services	DoD	69
		DoD/VA	2
		VA	2
	Other and Military Unique	DoD/VA	1
20 Total			**234**
		DoD/VA	1
		VA	7
	Ambulatory Care Services	DoD	37
		DoD/VA	6
		VA	23
	Ancillary Services	DoD	7
		VA	7
	Competency / Readiness Training	DoD/VA	1
		VA	2
	Dental Services	DoD	2
	Inpatient Services	DoD	24
		DoD/VA	3
		VA	4

VISN	Shared Service Type	Provider	Number of Services Offered
21 Total			**132**
22	Administration and Support	DoD	1
		DoD/VA	2
		VA	14
	Ambulatory Care Services	DoD	45
		DoD/VA	2
	Ancillary Services	DoD	3
		DoD/VA	3
		VA	4
	Competency / Readiness Training	DoD/VA	2
		VA	4
	Dental Services	DoD/VA	1
	Inpatient Services	DoD	40
		DoD/VA	3
	Other and Military Unique	DoD/VA	2
22 Total			**126**
23	Administration and Support	DoD	1
		VA	1
	Ambulatory Care Services	DoD/VA	1
	Ancillary Services	DoD	1
		VA	4
	Competency / Readiness Training	DoD/VA	2
		VA	5
	Inpatient Services	VA	1
23 Total			**16**

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Medical and Prosthetic Research

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Medical and Prosthetic Research

Table: Appropriations and Other Federal Resources

Appropriations and Other Federal Resources (Dollars in thousands)	2023 Actuals	2024 Request	2024 Estimate[3]	2025 Request	2025 Request - 2024 Estimate
Medical and Prosthetic Research Appropriation	916,000	938,000	938,000	868,000	-70,000
American Rescue Plan Appropriation/Reallocation	30,000	0	0	0	0
Cost of War Toxic Exposure Fund (P.L. 117-168 & P.L. 117-328)	2,480	46,000	46,000	59,000	13,000
Intramural Research Total (VA Appropriations)	**948,480**	**984,000**	**984,000**	**927,000**	**-57,000**
VERA Research Support (Medical Care Support)	777,890	836,400	836,400	787,950	-48,450
Extramural Funding (Other Federal and Non-Federal Resources)	540,000	540,000	540,000	496,800	-43,200
Reimbursement Activity	61,000	61,000	61,000	61,000	0
Total Budgetary Resources	**2,327,370**	**2,421,400**	**2,421,400**	**2,272,750**	**-148,650**
Federal Employment Distribution					
Medical and Prosthetic Research Appropriation	4,537	4,716	4,649	4,626	-23
American Recovery Plan (P.L. 117-2, Section 8002) (Mandatory) [2]	123	0	0	0	0
Toxic Exposure Fund (P.L. 117-168)	6	113	113	113	(0)
Total FTE	**4,666**	**4,829**	**4,762**	**4,739**	**-23**

1. Through the Veterans Equitable Resource Allocation (VERA), Research Support includes funding from the Medical Services, Medical Support and Compliance, and Medical Facilities Appropriations to support Research.
2. Includes Direct and Reimbursable FTE.
3. A full-year 2024 appropriation for this account was not enacted at the time the Budget was prepared. Charts display the 2024 President's Budget request level for 2024 in the 2024 Estimate column.

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, $868,000,000, plus reimbursements, shall remain available until September 30, 2026: Provided, that the Secretary of Veterans Affairs shall ensure that sufficient amounts appropriated under this heading are available for prosthetic research specifically for women Veterans, and for toxic exposure research.

Medical Research Discretionary and Mandatory Appropriation Requests

To fulfill the commitment of the Department of Veterans Affairs (VA) to provide superior health care to Veterans, the Office of Research and Development (ORD) requests $927 million, a decrease of 6% or $57 million below the 2024 request, in total appropriated resources to fund the VA intramural medical research program.

This amount is comprised of the following:

Discretionary Appropriations: A request of $868 million in the Medical and Prosthetic Research Appropriation, a decrease of 8% or $70 million below the 2024 request.

Mandatory Appropriations: A request of $59 million, an increase of 28% or $13 million above the 2024 request, from the Cost of War Toxic Exposures Fund (TEF) to support medical and other research relating to exposure to environmental hazards.

Details on VA Research Funding Sources
VA Research uses a combination of VA appropriated resources and other resources to deliver on our promise to improve Veterans' health through medical research. The details below provide further explanation of the funding sources depicted in the Appropriations and Other Federal Resources table on the previous page:

- **Intramural Research:** ORD uses VA appropriations, including Medical and Prosthetics Research and the Toxic Exposures Fund, to support research merit awards (studies), research career scientist awards, career development awards, research infrastructure, and overall capacity building for the Research Enterprise. **The total 2025 intramural research estimate is $927 million.**

- **Veterans Equitable Resource Allocation (VERA), Research Support:** VA Research at VA Medical Centers (VAMCs) is further supported through VERA Research Support Allocations. Funding through the VERA model is distributed through VA Medical Care Appropriations, including Medical Service, Medical Support & Compliance, and Medical Facilities. The allocation is intended for use by the facilities in support of VAMC costs associated with research, including protected time for clinicians to conduct research, research equipment maintenance contracts, biomedical maintenance support, research infrastructure costs (both space and personnel), other general and direct administrative support for committees, and other expenses for research compliance and oversight. VERA is also used to support the Quality Enhancement Research Initiative (QUERI), which is part of the ORD organization but funded through the Medical Services Appropriation. **The 2025 VERA estimate is $788 million.**

- **Extramural Funding:** VA Researchers also independently apply for and receive extramural funding from private and federal grants. This funding is typically managed at the local level at individual VAMCs, largely through 78 VA affiliated non-profit research

corporations (NPCs) or a university affiliate. **The 2025 estimate for extramural funding is $497 million**.

- **Reimbursable Resources:** VA Research also earns collections and reimbursements. This resource includes interagency agreements with other Federal partners (within VA and outside), reimbursements from the Medical Care appropriation, and reimbursements from NPCs and University Affiliates. **The 2025 estimate for reimbursable resources is $61 million**.

Legislative Authorizations

1. **38 USC 7303: Functions of Veterans Health Administration: Research Programs:** This code is the overreaching authority for ORD to contribute to the Nation's knowledge about disease and disability among Veterans.

2. **Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022 (P.L. 117-168)**

   ORD is the designated lead for:
   - Section 501: Interagency working group on toxic exposure research, and
   - Section 805: Establishment of the Cost of War Toxic Exposures Fund.

3. **Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022 (P.L. 117-328):**

   ORD is the designated lead for:
   - Section 181. Inapplicability of Paperwork Reduction Act,
   - Section 182. Research and Development (amendments),
   - Section 183. Expansion of Hiring Authorities for certain classes of research occupations, and
   - Section 184. Comptroller general study on dedicated research time for certain personnel of the Department of Veteran Affairs.

   ORD is key support for:
   - Section 102. Department of Veteran Affairs treatment and research of prostate cancer.

4. **Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (P.L. 116-171)**

   ORD is the designated lead for:
   - Section 204(a). Department of Veterans Affairs study of all-cause mortality of veterans including by suicide. This section specifically concerns the effects of opioids and benzodiazepines;
   - Section 301. Study on connection between living at high altitude and suicide risk factors among veterans;

- Section 305. Precision medicine mental health initiative;
- Section 306. Statistical analysis and data evaluation by Department of Veterans Affairs; and
- Section 704. Use by the Department of Veterans Affairs of commercial institutional review boards in sponsored research trials.

ORD is key support for:

- Section 405. Joint mental health programs by the Department of Veterans Affairs and Department of Defense;
- Section 702. Partnerships with non-Federal Government entities to provide hyperbaric oxygen therapy for treatment of post-traumatic stress disorder and traumatic brain injury;
- Section 705. Creation of Office of Research Reviews within the VA Office of Information and Technology;
- Section 101. Strategic plan on expansion of health care coverage for Veterans transitioning from service in the Armed Forces; and
- Section 201. Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP).

VA Research Mission

For more than 95 years, VA Research has improved the lives of Veterans and all Americans through health care discovery and innovation. VA Research is part of the nation's largest integrated health care system and fosters collaboration with university affiliates, other federal agencies, nonprofit organizations and private industry.

ORD is responsible for the execution of VA's research mission, which includes the following objectives:

- Improving Veterans' health and well-being through basic, translational, clinical health services and rehabilitation, genomic and data science research, and to apply scientific knowledge to develop effective individualized care solutions for Veterans;
- Attracting, training, and retaining the highest-caliber investigators and nurture their development as leaders in their fields; and
- Assuring a culture of professionalism, collaboration, accountability, and the highest regard for research volunteers' safety and privacy.

VA Research Strategic and Cross-Cutting Clinical Priorities

VA Research leverages the input from various stakeholders to establish our Strategic and Cross Cutting Priorities. Our stakeholders include the Quality Enhancement Research Initiative (QUERI), the National Research Advisory Council (NRAC), Veterans Service Organizations (VSOs), Veterans, Congress, and the Administration.

VA Research's Five Strategic Priorities	Cross Cutting Clinical Priorities
1. Increasing Veterans' access to high-quality clinical trials 2. Increasing the substantial real-world impact of VA research 3. Putting VA data to work for Veterans 4. Actively promoting diversity, equity, and inclusion within our sphere of influence 5. Building community through VA research	1. Pain and opioid use 2. Traumatic brain injury (TBI) 3. Posttraumatic stress disorder (PTSD) 4. Military environmental exposures 5. Cancer, with a focus on precision oncology 6. Suicide prevention

Table: Total Resources Summary

(Dollars in thousands)	2023 Enacted	2024 Request	2024 Estimate[3]	2025 Request[4]	2025 Request - 2024 Estimate
APPROPIATIONS/TRANSFERS	**948,480**	**984,000**	**984,000**	**927,000**	**-57,000**
Medical and Prosthetic Research	916,000	938,000	938,000	868,000	**-70,000**
American Rescue Plan	30,000	0	0	0	**0**
Toxic Exposure Fund	2,480	46,000	46,000	59,000	**13,000**
REIMBURSMENTS	39,078	61,000	61,000	61,000	**0**
BUDGET AUTHORITY	987,558	1,045,000	1,045,000	988,000	**-57,000**
UNOBLIGATED BALANCE (SOY)	113,494	112,500	87,559	64,500	**-23,059**
UNOBLIGATED BALANCE (EOY)	-88,726	-94,500	-64,500	-44,500	**20,000**
PRIOR YEAR RECOVERIES	41,599	50,000	50,000	50,000	**0**
OBLIGATIONS	**1,053,449**	**1,113,000**	**1,118,059**	**1,058,000**	**-60,059**
Total Funding Awards[1]	2,871	3,012	3,012	2,784	**-228**
Medical and Prosthetics Research	2,860	2,840	2,840	2,612	**-228**
TEF	11	172	172	172	**0**
					0
Employment Distribution					**0**
Discretionary FTE[2]	4,410	4,716	4,649	4,626	**-23**
Mandatory (ARP, Section 8002)	109	0	0	0	**0**
Toxic Exposure Fund (P.L. 117-168)	11	113	113	113	**0**
Total	**4,530**	**4,829**	**4,762**	**4,739**	**-23**

1. For the FY 25 President's Budget, the methodology for reporting projects changed to report the total funding awards which includes Research Merit Awards (studies), Research Career Scientist Awards, infrastructure, and overall capacity building for the Research enterprise.
2. Includes Direct and Reimbursable FTE.
3. A full-year 2024 appropriation for this account was not enacted at the time the Budget was prepared. Charts display the 2024 President's Budget request level for 2024 with updates to balances, recoveries, obligations, and collections in the 2024 Estimate column.
4. Total obligations in the CJ are $70 million higher than the total obligations level reported in the 2025 Budget Appendix.

Designated Research Areas and Research Priority Areas

Designated Research Areas (DRA) represent areas where there is a prevalence of conditions within VA patient populations, uniqueness of a specific patient population, and where its disease burden or the importance of the question to health care delivery within VA. Research priority areas (RPAs) are a specialized subsection of DRAs (e.g., liver cancer RPA is part of the larger cancer DRA).

For 2025, funding is prioritized in DRAs considered to be the highest Administration priorities of Veterans' health:

Table: Designated Research Area (DRA) Chart

(Dollars in thousands)	2023 Actuals	2024 Request	2024 Estimate	2025 Request	2025 Request-2024 Estimate	
Priority Research Areas[1]					**$**	**%**
Cancer	81,295	93,822	93,822	95,069	1,247	1%
CNS Injury & Associated Disorders (e.g. TBI)	140,776	160,151	160,151	154,945	-5,206	-3%
Mental Illness (e.g. Suicide Prevention)	130,137	138,937	138,937	134,880	-4,057	-3%
Other Research Areas[1]						
Acute & Traumatic Injury	26,155	26,968	26,968	24,541	-2,427	-9%
Aging (e.g. Alzheimer's)	151,328	156,032	156,032	141,989	-14,043	-9%
Autoimmune, Allergic & Hematopoietic Disorders	39,601	40,832	40,832	37,157	-3,675	-9%
Degenerative Diseases of Bones & Joints	41,601	42,894	42,894	39,033	-3,860	-9%
Dementia & Neuronal Degeneration	42,344	43,660	43,660	39,731	-3,929	-9%
Diabetes & Major Complications	47,729	49,213	49,213	44,784	-4,429	-9%
Digestive Diseases	26,256	27,072	27,072	24,636	-2,436	-9%
Emerging Pathogens/Bio-Terrorism	2,833	2,921	2,921	2,658	-263	-9%
Health Systems	71,094	73,304	73,304	66,707	-6,597	-9%
Heart Disease/Cardiovascular Health	72,963	75,231	75,231	68,460	-6,771	-9%
Infectious Diseases	58,200	60,009	60,009	54,608	-5,401	-9%
Kidney Disorders	18,230	18,796	18,796	17,105	-1,692	-9%
Lung Disorders	28,218	29,095	29,095	26,477	-2,619	-9%
Other Chronic Diseases	7,474	7,706	7,706	7,012	-694	-9%
Prosthetics	25,569	26,363	26,363	23,991	-2,373	-9%
Sensory Loss	23,367	24,093	24,093	21,925	-2,168	-9%
Special Populations	43,280	44,625	44,625	40,609	-4,016	-9%
Substance Abuse	30,073	31,007	31,007	28,217	-2,791	-9%
Military Environmental Exposures						
Military Occupations & Environmental Exposures (e.g. Burn Pits and Agent Orange)	35,000	68,012	46,000	59,000	13,000	28%
Medical and Prosthetics Research (non-add)	*32,520*	*22,012*	-	-	-	-
Toxic Exposure Fund (non-add)	*2,480*	*46,000*	*46,000*	59,000	*13,000*	28%
Gulf War Veterans Illness (non-add)[2]	15,226	15,226	15,226	16,000	774	5%
Medical and Prosthetics Research (non-add)	*15,226*	*15,226*	-	-	-	-
Toxic Exposure Fund (non-add)	-	-	*15,226*	*16,000*	*774*	5%

1. Research projects that span multiple areas may be counted in several categories. Thus, amounts depicted within this table total to more than the VA research appropriation. This method of reporting is consistent with that of other federal agencies.
2. Gulf War Veterans Illness is included in Military Occupations & Environmental Exposures.

Funding Priorities for 2025

VA Research is uniquely positioned to address the biomedical and health ecosystem research needs of Veterans, VA, and the nation by leveraging its capabilities and resources as part of the largest integrated health care system in the country. The requested funding below is based on where VA Research's investment can make the largest impact of scientific discovery that improves Veterans' health. It also considers the relative resource needs consistent with the overall balance for all needs across the administration.

Table: 2025 Administration Priority Areas – Discretionary Funding

2025 Administration Priority Areas					
(Dollars in thousands)	2023 Actuals	2024 Estimate[3]	2025 Estimate	2025 Request - 2024 Estimate	
				$	%
Precision Oncology	34,353	44,810	48,018	3,208	7%
Cancer Moonshot (non-add)	*28,106*	*46,654*	*44,938*	*(1,717)*	-4%
Million Veterans Program	88,743	94,298	88,430	(5,868)	-7%
Suicide Prevention	24,297	30,017	30,000	(17)	0%
ORD Enterprise and Infrastructure[1]	151,092	149,209	135,780	(13,429)	-10%
Pandemic Response and Preparedness[2]	58,200	60,009	54,608	(5,401)	-10%
Traumatic Brain Injury/Brain Health	52,570	56,930	52,000	(4,930)	-9%
National AI Institute (NAII)	10,793	10,000	10,000	-	0%

1. Program 820 total less NAII

2. Infectious Disease DRA

3. A full-year 2024 appropriation for this account was not enacted at the time the Budget was prepared. Charts display the 2024 President's Budget request level for 2024.

Precision Oncology ($48 Million Request)

Since the first Moonshot in 2016, VA established the foundations for high quality oncology care and improved care access. This effort included conducting clinical trials and overall building a learning health care system model for integrating clinical care and research. Subsequently, precision oncology is a high priority in the Veterans Health Administration (VHA). ORD has had a history of landmark trials in cancer with increased emphases on its ability to conduct and participate in large national clinical trials. Initial efforts for precision oncology targeted prostate and lung cancer, which are the two most common non-skin cancers in VA. Research is now expanded to include other cancers such as bladder, ovarian, breast, head and neck, and hematologic malignancies (B-cell).

Starting in 2021, Congressional appropriations focused on cancer clinical trials and precision oncology by establishing new studies and cancer trials networks capable of providing more access to Veterans across the nation. In collaboration with the national oncology office, VA Research established supporting infrastructure to provide a system of excellence in cancer care that incorporates clinical trials and research. The work in precision oncology maps to all ORD strategic

priorities as it systematically generates data and uses the data to establish evidence to enhance quality and value of the care while fostering innovation and impact.

2025 Planned Activities

- Apply a decentralized clinical trials model for rare cancers (prototype);
- Initiate collaborative studies in multicancer early detection;
- Develop an artificial intelligence/machine learning (AI/ML) platform to integrate genomic (e.g., Million Veteran Program, National Precision Oncology Program), phenotypic, radiomic and clinical data to inform patient stratification into cohorts for improved care, treatment and response and improved outcomes; and
- Based on feasibility:
    - Support the initiation of at least 2 new clinical trials and clinical trial sites; sustain and expand infrastructure, increase access to rural and less urban Veterans and initiate rare cancer clinical trials;
    - Sustain the 7 of Applied Proteogenomic Organizational Learning and Outcomes (APOLLO) collection sites;
    - Conduct collaborative research investigations of military exposure and cancer, such as genomic studies focused on identifying mutational signatures in tumors from Veterans associated with military exposures; and
    - Plan investigations in women's cancers, such as exploring investigations in endometrial cancer using artificial intelligence/machine learning.
- Additionally, VA will pursue activities for the Moonshot with the Department of Defense (DoD) and the National Cancer Institute (NCI) aimed at expanding the number of APOLLO biospecimen collection sites in VA.

2024 Activities

- Initiate development of the precision oncology platform that integrates AI/ML, phenotypic, clinical, genomic, and other data for clinical trials and Veteran cancer care.
- Identify and fund five clinical research hub and spokes to support prostate cancer research and care (Cleland-Dole Act).
- Stand up 12 initial sites to participate in the cancer moonshot collaborative multi-cancer early detection studies led by the National Cancer Institute.
- Initiate three or four precision oncology clinical trial/studies in the actively managed portfolio.
- Initiate at least one rare cancer clinical trial.
- Support pilot study of military toxic exposure's contribution to prostate cancer incidence, aggressiveness, and molecular features in Veterans.

2023 Accomplishments

- Expanded access to high quality, low-dose tomography lung cancer screening to 99 VA medical centers across the nation.
- Supported a mutational analysis study to identify mutational signatures associated with environmental exposure.
- Supported foundational work to early-identify Veterans with glioma and initiation of glioma treatment, identify best clinical care practices in the field to improve the coordination of care, and track cases throughout the course of care. These efforts will help set the stage for improved clinical care and research.
- Expanded clinical trial offerings at the seven genitourinary (GU) sites to provide Veterans with additional therapeutic options.
- Expanded the Phase 2/3 STARPORT trial to additional sites across the VA enterprise.
- Developed four novel therapeutic trials to address advanced non-small cell lung cancer, including one immunotherapy de-escalation trial to enhance durability and quality of life improvement while lowering toxicity.
- Expanded standardized germline sequencing for metastatic prostate cancer across the nation.
- Initiated a study to predict and characterize response to immunotherapy in stage III non-small cell lung cancer using AI/ML along with pathomic and electronic health record (EHR) data.
- Commenced work on the Precision Augmented Initiative for lung cancer screening toward refining United States Preventive Services Taskforce guidelines for lung cancer screening.
- Continued work on major national, multi-site clinical trials by the Cooperative Studies Program in the areas of colorectal cancer screening, radiation therapy for lung cancer and skin cancer.

Million Veteran Program and Precision Medicine ($88 Million Request)

The goal of the Million Veteran Program (MVP) is to improve the whole health and well-being of all Veterans equitably by understanding how genetics, lifestyle, military experience, and toxic exposures affect health and offering personalized or precision-health care approaches. To accomplish this goal, MVP has two specific aims:

- Establish a racially and ethnically diverse research cohort by expanding our over one million-strong database with more Veterans from under-represented ethnic groups. This effort will ensure illnesses and conditions seen are represented in large enough numbers to derive meaningful results, to generate the most comprehensive data possible from the blood specimens they donate, to clean and curate electronic health record and survey data and to provide genetic and health data in a secure manner for research.

- Validate scientific research findings and apply them in the clinic to provide precision health care/precision medicine to Veterans, including but not limited to precision oncology and precision mental health.

The goals of MVP align with the Congressional priorities of precision medicine, PACT Act, Hannon Act, and the Administration's priority of Cancer Moonshot. MVP goals also align with ORD's clinical priorities, including pain and opioid use, TBI, PTSD, suicide prevention, military toxic exposures, and precision oncology. As of November 2023, over one million Veterans are enrolled in MVP. However, only 10% of the enrollees are women and about 25% are racial and ethnic minorities. MVP will continue enrollment, focusing on increasing the under-represented populations.

2025 Planned Activities

- Focused recruitment/enrollment of women and Hispanic Veterans in MVP, including developing a plan for translation of MVP consent and related documents into Spanish.
- In addition to the baseline genotype data being generated on all of the one million MVP samples, whole genome sequences have been generated in a subset of over 100,000 samples, and methylation data has been generated on a subset of approximately 40,000 samples. These data have been curated and will be made available to VA researchers in in early FY 2025 within the secure Genomic Information System for Integrative Sciences (GenISIS) high performance computing environment inside the VA firewall and the associated GenISIS cloud burst in the VA enterprise Cloud..
- Continue enrollment of rural Veterans and other underrepresented populations.
- Continue establishing a back-up biorepository.
- Launch 100,000 recontact enrollment/second blood sample collection.
- Conduct new data collection, for example: images, tumor tissues, and military exposure data.
- Clinical translational projects on drug discovery and return of genetic results.

2024 Activities

- Process 100,000 whole genome sequence data and 40.000 methylation data for VA researchers.
- Begin focused recruitment and enrollment of women and Hispanic Veterans in MVP
- Prepare and pilot launch of the 100,000 recontact project.
- Begin pilot projects on toxic exposures based on recommendations from the MVP-MERP-HOME Military Exposures Task Force.
- Launch additional sites for MVP-Measures Investigating Neuropsychiatric Disorders (MVP-MIND) subject to funding availability.
- Partner with precision oncology and precision mental health initiatives and begin collection of new data types, such as, images, digital pathology, and military exposures.

- Complete eight VA-Department of Energy (DOE) projects ongoing at the Oak Ridge National Laboratory.
- Release summary results of the world largest genome-phenome association study to the broader research community through NIH's dbGaP portal.
- Initiate one or two translational pilot projects.

2023 Accomplishments

- Reached over 965,000 enrollees in MVP.
- Funded over unique 100 research projects.
- Published over 200 scientific publications.
- Completed processing over 100,000 whole genome sequence data from MVP; 40,000 methylation data.
- Launched six sites for MVP-MIND (mental health cohort); enrolled >254 Veterans.
- Established the military exposures task force in collaboration with MERP and HOME and obtained recommendations.
- Completed one year of the VA/MVP-DOE projects.
- Launched public-facing CIPHER Online – Catalog of VA Phenotype definitions.
- Completed the world's largest genome-phenome association study in collaboration with DOE. No other published study has studied the association of genetic variants from 639,969 DNA samples of diverse racial and ethnic backgrounds with 2,070 health characteristics (phenotypes).

Suicide Prevention ($30 Million Request)

The request supports mental health and suicide prevention research, including the Hannon Act, clinical trials and epidemiological studies on risk and prevention factors. The Hannon Act enhances VA programs for mental health care, suicide prevention, care for women Veterans and telehealth care for Veterans and transitioning Servicemembers. It is also advancing efforts to prevent suicide and promote mental health and general well-being among Veterans.

The Hannon Act accelerated VA's research into causes of mental health issues and to identify, improve, and expand mental health treatment protocols and health professional training. It will examine how VA manages mental health and suicide prevention resources and how it provides care in these areas. Overall, it will advance efforts by VA, other federal partners, and local communities in preventing suicide and promoting mental health and well-being among Veterans.

2025 Planned Activities

The Army Study to Assess Risk and Resilience in Servicemembers (STARRS)

Establish a researcher in residence program to provide opportunities for VA investigators to be embedded within the STARRS investigative team, which allows full access to and training on STARSS data. The VA researchers in residence will be tasked with using the data to improve understanding of risk factors associated with Veteran suicide during transition from military service. Findings from this program could be used to further refine risk identification algorithms and assist in developing interventions tailored to each suicide risk factor.

2024 Activities

A State-of-the-Art Conference held in September 2023 provided a foundation for researchers in the field to begin collaboration and project planning based on the strategic framework developed at the conference. In January 2024, the VA released a special Request for Applications (RFA) that aligns with the goals of the meeting. This RFA will provide funding for research projects, including multi-site clinical trials dedicated to building the evidence base for the use of psychedelic medication to treat Veterans' mental health conditions while also gathering information to support future implementation efforts.

2023 Accomplishments

There is a rapidly expanding evidence base of preclinical studies and clinical trials supporting the use of psychedelic treatments for mental health conditions prevalent in the Veteran population, including depression, post-traumatic stress disorder (PTSD), and addiction. Several psychedelic treatments (e.g., MDMA and psilocybin) are in the pipeline with potential to be FDA-approved within the next two to five years. The evidence to date was generated by non-governmental, non-VA, private sponsors. VA seeks to further evaluate the efficacy of these treatments and the potential to effectively deliver this care to our Veterans and potentially, to other groups.

- Hosted a State of the Art (SOTA) stakeholder conference with two major objectives: (1) to better understand the current state of scientific evidence and to identify a strategic framework to conduct future psychedelic treatment research for select mental health conditions; and (2) for agents where FDA-approval may be anticipated, to determine the necessary steps for potential VA system-wide clinical implementation. As a result of this conference, VA will develop: (1) a strategic framework for future VA research questions based upon SOTA recommendations and (2) a strategic framework for clinical implementation and addressing infrastructure needs.

- ORD is currently supporting 105 separate suicide prevention research projects. In addition, QUERI national implementation of the Caring Letters for suicide prevention program reached over 300,000 Veterans with over 2.25 million letters and contacts. QUERI also supported the national implementation of the suicide risk screening (RISK ID) initiative in 138 sites, enabling 115,011 VA providers/staff to provide suicide risk screening to 6,136,626 Veterans.

ORD Enterprise and Infrastructure ($136 Million Request)

The goal of the VA research enterprise initiative is to improve the well-being of Veterans through research while respecting the investment of taxpayer dollars. This initiative is achieved by equipping our system to function as a coordinated whole rather than independent VA medical centers. We defined the VA research enterprise as the entire set of people, tools, and processes committed to a whole-of-VA approach for fulfilling our mission and supporting researchers, clinicians, and Veterans.

This initiative also focuses on creating an infrastructure that provides support to quality research and access to knowledge through tools developed in-house, as well as leveraging software as a service. This infrastructure is a force multiplier to reducing start-up time as well as back-end analytics to help translate results to clinical practice. An example of such infrastructure investment is the ORD Office for Sustainment and Implementation of Research Electronic Health Record (EHR) Solutions (OSIRES). OSIRES addresses the requirements for VA research continuity, success, and growth throughout the years-long EHR Modernization (EHRM) process (additional information available in Volume V – Information Technology Programs and electronic Health Record Modernization). OSIRES' primary objectives are to represent and support research's transition to the new EHR by leading the National Research EHR Council and to work across all aspects of the EHR implementation for research to maintain the highest standards of cutting-edge patient care, patient safety, regulatory compliance, and scientific integrity. Another example is the investments in scientific computing platforms, such as the VA Informatics and Computing Infrastructure (VINCI) Prospect, and the Research Analytics Super Platform (RASP). These in-house platforms allow for oversight of spending and sharing of analytic tools through enterprise software licenses. As the scientific computing program matures, more data analytic software is added to cloud environments and more MVP genome-phenome based studies, as well as other high impact oncology and other research studies, requiring increased budgetary support. Sustaining and enhancing this infrastructure will support VA research leadership technologically, enhance cooperation, and will continue to make the VA inviting to extramural sponsors, researchers, and employees.

Previous sections also described scientific enterprise infrastructure related to ORD excellence in clinical trials and genomics research. The VA clinical research enterprise provided opportunities for Veterans to participate in clinical trials across a range of disease areas targeted at prevention, diagnosis and treatments. Through the Cooperative Studies Program, investments in networks, scientific, and technological capabilities resulted high impact, landmark clinical trials while also making VA an attractive partner in other federal, academic and industry studies. Furthermore, the Million Veteran Program created a data-rich environment that advances innovation tied to clinical data to provide greater insights into Veteran health.

2025 Planned Activities

- Organizational realignment with an established policy for periodic organizational alignment review to ensure future strides in functional realignment.

- Focus on maturing existing actively managed portfolios and establishing new portfolios based on VA and Veteran needs and begin advancing repeatable processes to ensure integration with VHA decision making.
- Identify research functional requirements for using the new EHR and its data and work with the EHRM Integration Office and the Oracle Cerner implementation and deployment teams to meet requirements.
- Facilitate research functionality and successful workflows within the new EHR, including functional integration, research roles and permissions, training needs, workflow design, and data access, governance, and provisioning through user-functional testing.
- Continue to expand and modernize the existing VA computing infrastructures, such as VINCI,GenISIS, and GenISIS Cloud Burst (GCB), to enable use of AI/ML and high-performance computing with VA and MVP data by the large number of VA researchers.
- Enhance cloud-based analytic tools in the VA Enterprise Cloud (VAEC) VINCI Prospect and the RASP and Software-as-a-Service (SaaS) systems to better support VA research.
- Expand the number of analyses with a focus on piloting external, non-VA researcher access within the VA Data Commons, a system that expands the number of qualified researchers who can analyze curated de-identified EHR and genetic data from MVP.
- Advance real-world evidence/data and causal inference methodologies that can use original (e.g., clinical trials) or existing (e.g., EHR) data to conduct analyses to provide additional insights for clinicians and scientists on treatment effectiveness and/or other pathways for improvements in care.
- Pilot a biospecimen and data registry catalog to make data and specimen access for accelerated secondary research.
- Implement a Clinical Trials Management System to offer more standardized and streamlined data collection to support future research data use.
- Pilot a prototype of the Research Volunteer Registry in support of the VA research enterprise.

2024 Activities

- Continue to fill essential positions based on the assessment of the organizational alignment.
- In collaboration with HR's workforce management, we are developing a national, specialized human resource support for research hiring. Once the Central Research HR initiative is completed, activities will shift to monitoring, quality improvement, and sustainment. Clinical and operations partners will establish an agreement and procedures on the protection of time for research for clinician investigators to support their research projects and required research committee work.
- Launch and sustainment of research in the Oracle Health System at Federal Health Clinical Center - Lovell.
    - Enhance Partnered Research Program (PRP) to develop processes to more efficiently assess industry-sponsored, large, multi-site

clinical trial feasibility based on medical center data and data regarding ongoing and planned research from the VA Innovation and Research Review System (VAIRRS).

- Continue to provide limited field contract support by identifying areas that would benefit from enterprise-wide contracts rather than individual site contracts and increase ORD's contracting team to manage the scale of the work.
- Complete the requirements review of the 17 IT systems/applications maintained primarily in Falling Waters, West Virginia, identify the systems to sunset or modernize and incorporate existing data and/or processes with VAIRRS.
- Launch the Research Enterprise Dashboard for oncology to allow a broad understanding of the location of patients and clinical trial sites.
- Identify all existing research data registries and research biospecimen repositories and create a catalog for access by researchers.
- Expand the use of high-performance computing and cloud analytics to enhance the processing of data results for translation.
- Obtain and implement the upgraded servers from the American Rescue Plan (ARP) 2022 IT reallocation.
- Contract for a Clinical Trials Management System for more streamlined data collection and future research data use.
- Launch a research application hosting environment to allow access to ORD created applications for VA employees when they are at the academic affiliate.
- Establish an implementation plan for the Research Volunteer Registry, hire staff, and develop a statement of work to award a contract for the external Veteran–facing portal for the Volunteer Registry.

2023 Accomplishments

- Launched and leveraged the GCB in the VA Enterprise Cloud. ORD completed over 300 genome-wide association analyses through 2024 first quarter. The number of analyses is expected to increase by 50% in 2025.
- Launched and leveraged ORD VINCI Prospect a VA Enterprise Cloud data analytics and storage environment that supported 40+ projects.
- Moved copies of deidentified MVP genetic and health data to the VA Data Commons to support the Open Science Initiatives, which is to make VA research data publicly available, and completed operational testing. Began the first set of 13 approved analyses for beta testing.

- Continued to build on models of centralized data cores that coordinated across research and operations groups to curate and validate EHR and genetic test data, such as the Prostate Cancer data core, the Genetic and Molecular Diagnostic Test (GDx) data core and the Pharmacogenomics Action for Cancer Survivorship (PHASeR) data core in VINCI.
- Built out the dashboards for the VA Innovation and Research Review System (VAIRRS) to ensure transparency of the research being conducted and planned in the VA. This transparency supports the actively managed portfolios and the partnered research program office in their efforts to make strategic investments in research and ensure mutually beneficial partnerships within the industry.
- Performed system enhancements to GenISIS and VINCI with the American Rescue Plan (ARP)OIT Reallocation.

Infectious Diseases and Pandemic Preparedness ($55 Million Request)

During the COVID pandemic, VA contributed to clinical trials, biospecimen collection, and data analytics/informatics research to address several issues impacting Veterans and the nation at large. This work included several treatment trials and internationally recognized work in Long COVID or Post-COVID conditions as well as publications on the use of treatments within the VA health care system. Under the White House Office of Science and Technology Policy, VA began work to prepare a national infrastructure and readiness plan for future infectious disease outbreaks and pandemics.

2025 Planned Activities

- Complete for the majority of COVID-specific research. This work includes a joint effort with DoD to understand the factors and patterns related to COVID infection among facility patients.
- Complete analytical work of VA's electronic health records to provide practical evidence.
- Continue research in Long COVID. This will include infrastructure development related to the ability to provide an enterprise resource for biospecimen collection (VA SHIELD) and analysis (VA SeqCURE). VA will also continue to establish a real-world evidence capability to utilize VA and other data sources to provide more in-depth understanding of the impact of treatments and risk factors for disease. VA will seek to leverage these capabilities where possible. While VA will evaluate its ability to support a clinical trials network by leveraging existing capabilities, it would redirect efforts centered on readiness for future pandemics. VA would shift from current plans to be an active partner as an established infrastructure to a cost model dependent on external sources of funding.

2024 Activities

In 2024, the Cooperative Studies Program (CSP) 2028 (EPIC^3) cohort expects to complete some initial analyses being conducted. ORD's investments in a national biorepository and activities aimed at improving knowledge and the standard of care in the treatment of COVID-19 have created a comprehensive infrastructure that will use its expertise to expand research into other infectious diseases of major consequence to Veterans. Activities such as VA Sequencing Collaborations United for Research and Epidemiology (VA SeqCURE) and VA Science and Health Initiative to Combat Infectious and Emerging Life-Threatening Diseases (VA SHIELD) are also expanding

into oncogenomic efforts that complement VA's push for improvements in precision oncology. VA SHIELD's maturation of its biorepository to accept and provide research access to a wider range of sample types will greatly increase efficiencies in VA investigators' abilities to research COVID-19 and other disease areas, resulting in a swifter contribution to research knowledge.

The narrower focus in activities Current funding availability led to a narrower focus in activities (e.g., VA SHIELD) to ensures initial COVID goals were reached while plans for future scope will be evaluated further.

2023 Accomplishments

- Published 525 VA-authored or VA-affiliated papers related to COVID-19.
- Expanded VA SeqCure to six VA medical centers and expanded to sequence other high consequence infectious diseases that impact the Veteran population (e.g., monkeypox, C. difficile, E. coli) and assess trends of these diseases. VA SeqCURE is a research component to genomic sequencing of infectious diseases. This program was initiated in 2021 with five VA medical centers and focused on sequencing SARS-CoV-2 variants.
- Expanded the VA Science and Health Initiative to Combat Infectious and Emerging Life-Threatening Diseases (VA SHIELD) infrastructure to include twelve collection sites, two biobanks and a bioinformatics core. VA SHIELD is a comprehensive, secure biorepository of specimens and associated data. In addition, VA SHIELD was approved for collection of remainder clinical specimens and the prospective collection of specimens, for which VA SHIELD identified over 45,000 specimens into the effort. VA SHIELD also continues to facilitate research projects involving COVID, anti-microbial resistance, cancer, vector-borne illnesses, and epidemiology and sequencing research.
- COVID-19 Pharmacotherapy Effectiveness in the VA Health care System (COPE-VA), a VHA study partnered with FDA and Biomedical Advanced Research and Development Authority (BARDA), informs clinical, operational and research partners on strategies for optimizing use of pharmacotherapies for the treatment of mild to moderate COVID-19. A recent publication in 2023 identified key findings associated with receipt of outpatient COVID-19 pharmacotherapies in VHA, including limited and under-prescription of pharmacotherapies in VA. Many Veterans with risk factors for severe COVID-19 did not receive treatment and minority racial and ethnic groups were less likely to receive any pharmacotherapy.
- Developed and implemented a national program for VA Facilities to participate in the Center for Disease Control and Prevention's (CDC) Tecovirimat expanded access program for monkeypox.

Traumatic Brain Injury (TBI) and Brain Health ($52 Million Request)

TBI can lead to lifelong disabilities that vary in severity, which is determined by the characteristics of the event or events that caused the injury and the number of exposures. Due to the nature of combat and previously unknown injuries that may have occurred from training, TBIs are frequently not recognized at the time of injury. This delay in diagnosis and associated care can magnify neurobehavioral conditions that negatively impact Veterans' quality of life.

Each year, VA sees roughly 100,000 patients who have a TBI diagnosis. TBI symptoms include headaches, irritability, sleep disorders, visual and balance deficits, memory lapses, slowed thinking, and depression. TBI manifests not only in cognitive deficits, but also with problems in behavioral health, sensory perception, and motor, endocrine, and autonomic nervous system function. Potential consequences of TBI include neurodegenerative disease, prolonged sensory processing deficits, substance misuse, and mental health issues. Most TBI cases are mild and difficult to diagnose. VA investigators are examining various approaches to detect, monitor, and treat Veterans with TBI.

The Scott Hannon Initiative for Precision Brain and Mental Health (SHIPBMH) will identify and validate brain and mental health biomarkers specifically for depression, anxiety, post-traumatic stress disorder, bipolar disorder, and traumatic brain injury. SHIPBMH will integrate this wide range of biomarkers to provide clinically actionable diagnostics, including neuroimaging, biofluids, electroencephalography and genetic and neurobehavioral assessments. This effort will leverage discoveries from ongoing research programs such as MVP, LIMBIC-CENC, the Translational Research Center for TBI and Stress Disorders TRACTS and newly launched programs such MVP-MIND.

In addition, SHIPBMH will expand the public availability of rich, deidentified data with respect to the large-scale collection of standardized data and open data sharing through both the Federal Interagency TBI Research (FITBIR) informatics system and the VA data commons. The third goal of SHIPBMH is to execute the clinical translation of SHIPBMH identified targets. The first target will focus on cytochrome P450 (CYP450) pharmacogenomic markers of gene variants responsible for the differential metabolism of commonly prescribed opioids. All activities under SHIPBMH are coordinated by a coordinating center funded and established in the field.

ORD continues to focus on developing objective tools and resources to improve the diagnosis and monitoring of brain health in Veterans who have sustained TBI. ORD will also focus on the needs of Veterans with a lifetime history of one or more TBIs. This study includes success in their community, understanding TBI-related mental health conditions, and exploring ways for improving self-management of their TBI symptoms.

2025 Planned Activities

- Establish a Brain Health Coordinating Center and Clinical Research Sites, a collaboration between ORD and key Clinical Programs to improve research relevancy, clinical involvement, and implementation across range-of-brain health conditions.
- Fund the first of four two-year Proof-of-Concept projects to develop machine learning algorithms to integrate multi-modal biomarkers for TBI and other brain health conditions.
- Conduct a Cooperative Studies Program (CSP) clinical trial examining growth hormone replacement therapy in Veterans with mild TBI and adult growth hormone deficiency.
- Will complete the translational development of novel TBI/Brain Health positron emission tomography (PET) Ligands at our Missouri Open Field Blast Core and the Columbia VAMC PET ligand development team’s initiative to assess chronic TBI/brain health conditions.

- Continue to study the impact of TBI on multiple sensory systems (e.g., Veteran centric impairments of vision, hearing, balance, and sense of smell).
- Develop brain stimulation (e.g., magnetic, electrical, and electromagnetic modalities) standards for clinical trials in treatment of TBI and brain health conditions. The field of brain stimulation outside of transcranial magnetic stimulation for treatment resistant depression lacks standards for reproducibility in both application and hardware.
- Conduct 3studies on the impact of TBI on multiple sensory systems (e.g., Veteran-centric impairments of vision, hearing, balance, and sense of smell).
- Upgrade technology for TBI-specific laboratory animal major equipment and the Shared Equipment Evaluation Program to increase research capacity and improve infrastructure.
- Continue support for the Long-term Impact of Military-relevant Brain Injury Consortium (LIMBIC), the VA-DoD jointly funded longitudinal cohort of up to 3,000 post-9/11 Veterans and Service members with TBI and other brain health conditions. In 2025, the consortium will be in its extension year of its current five-year funding period.

2024 Activities

- Release RFAs to investigate multi-sensory impairments after TBI.
- Initiate funding for Joint Outcomes and Biorepositories in Neurologic Studies of TBI (JOIN). The longitudinal TBI research for moderate to severe TBI, including Veterans with TBI-related disorders of consciousness and/or dystonia.
- Release a joint RFA with the National Institute of Aging regarding the effects of lifetime history of TBI on aging and the effects of age on TBI outcomes.

  Completing the five-year funding of the Long-term Impact of Military Consortium (LIMBIC), a VA-DOD jointly funded initiative, with a new RFA for a competitive renewal of the consortium.

2023 Activities and Accomplishments

- Initiated funding of four Proof-of-Concept Proposals to fulfill the Precision Brain and Mental Health requirement of the Commander John Scott Hannon Act, Section 305. These projects will develop machine learning algorithms to integrate multi-modal biomarkers for greater accuracy in diagnosis and tracking of brain health.
- Renewed the Translational Research Center for TBI and Stress Disorders (TRACTS) for another five years beginning in 2025.

Investing in Artificial Intelligence (AI) ($10 Million Request)

The National Artificial Intelligence Institute (NAII) is an initiative that began in VA's Office of Research and Development in 2019. NAII expertise informs efforts outside of the scope of research and development. The $10 Million reflected in the MPR Chapter is for AI efforts impacting research which are funded through the NAII which is part of ORD.

The NAII advances R&D and translational priorities in key areas such as:

- Assisting with identifying R&D projects where the use of AI/ML could make significant improvements in outcomes in the areas of prediction, prevention, diagnosis, and treatment of diseases across the continuum of care, which enhances the overall health outcomes for our Veterans.
- Providing subject matter expertise to directly translate new evidence into practice and by pilot testing novel tools and solutions that can be used to revolutionize clinical care.
- Developing tools and infrastructure to support AI/ML research and development. Creating tools that will ultimately improve Veteran health care and operations.
- Utilization of AI Networks, consisting of VA medical centers with cross functional skills and infrastructure to support prototyping and testing AI driven solutions, to foster greater collaboration and enhance shared insights and lessons learned.
- Providing subject matter expertise in collaboration with other researchers and universities to support the use of AI in specialty areas such as Precision Brain Health and radiology imaging studies. NAII subject matter experts seek to bridge early lifecycle development into pilots and provide verification of readiness for operational usage.

The NAII supports increasing the real-world impact of VA research by providing a mechanism for directly translating new evidence into practice and by pilot testing novel tools and solutions that can be used to revolutionize clinical care. Data architecture and analytic support developed and maintained by the NAII can be used to realize the potential of real-time data for improving bedside clinical care delivery, to support the transformation of the VA into a Learning Health System. DEI is a core feature of the Trustworthy AI Framework being developed by the NAII to support research and operations in their mission to implement AI/ML solutions within the VA. In the future, the NAII may provide support for AI/ML based tools to improve identification of patients for clinical trials to enhance clinical trial enrollment and outreach of Veterans potentially eligible for participation.

NAII created specific pilots and coordinated projects to ensure regulatory compliance and provide support to research personnel to support their understanding of what is and how to ensure Trustworthy Artificial Intelligence (TAI) standards are met in any ongoing AI/ML research. Examples of these projects include the creation of a TAI playbook and implementation toolkit, and the creation of vignettes for visual aide support. One such pilot, the AI/ML Mobile Digital Health Pilot, exemplifies our mission to support AI/ML research and development while creating a bridge into operationalizing the product. TAI develops guidelines and frameworks to ensure the ethical, safe, and effective implementation of AI, while AI/ML technologies with the goal of providing personalized care to Veterans suffering from long-term health conditions.

NAII further seeks to accelerate the trustworthy adoption of AI in ways that best serve the Office of Research and Development and our Veterans, improving our ability to fulfill our mission.

2025 Planned Activities

- Create and maintain infrastructure for pilot testing of promising new AI/ML technologies.
- Develop example protocols and consent documents to support VA research investigations into AI/ML solutions in Veteran health care.
- Pilot the All Services Personnel and Institutional Readiness Engine (ASPIRE) across the VA Research workforce. Training encompasses trustworthy AI principles, data ethics, equity, bias, and discrimination.
- Leverage infrastructure supported by ORD to pilot/test promising interventions, such as the application of real-time risk-prediction modeling to improve uptake of evidence-based medical interventions to improve Veteran health.
- Utilize data science professionals to mine and evaluate VA's datasets to identify potential areas of AI aligned research and to support existing hypotheses.
- Continue to advance pivotal research and guidance in the Trustworthy AI domain, ensuring ORD's commitment to responsible AI practices in R&D. A primary focus will remain on ensuring trustworthy AI and compliance with Executive Orders 13960 and 14110 requirements as well as any additional Executive Orders that are issued.
- Provide feasibility studies and early piloting of AI and ML solutions.
- Utilize VA's AI Network (i.e., VA Medical Centers) to test, operationalize and disseminate successful AI and ML innovations and continue to monitor field performance until the product is deemed viable for operations, providing an evidenced based path into real-world clinical practice.

2024 Activities

- NAII aims to advance pivotal research and guidance in the Trustworthy AI domain, fortifying ORD's commitment to responsible AI practices in R&D. A primary focus will be on scaling the AI IRB Supplementary Module across all IRB-approved projects to support an agency-wide commitment to trustworthy AI and compliance with Executive Orders 13960 and 14110 requirements. NAII continues to support:
    - Infrastructure – this includes both the (1) computing infrastructure/software/storage to support the VA- and non-VA funded AI research[; (2) organizational components necessary to support AI projects and processes/policies associated with trustworthy AI that are specific to research (e.g., additional institutional review board processes, review of cooperative research and development agreements with industry); (3) data curation associated with AI research; and (4) security concerns related to research on AI, such as insider threats.
    - Workforce Development – (1) Assess and enhance research AI workforce capacity, including recruiting, hiring, training, and retaining AI practitioners. (2) Provide training on AI literacy for non-practitioners involved in AI research, including institutional review boardIRB members, contracting officers, privacy officers, Office of General Counsel Special Team Advising Research (STAR), technology transfer specialists, research information security.

- Use Cases – (1) Funding AI research that contributes to our mission of improving Veterans' well-being through research; and (2) Creating, maintaining, and reporting use case inventory for both ORD-funded research and research funded by other sources. This will involve modifying data collected in the VA Innovation and Research Review System (VAIRRS).
- Governance – Staffing with adequate expertise to engage on behalf of research with VA's AI governance process, including when it is appropriate to apply exclusions from minimum practices for research and development*

- Development and dissemination of a trustworthy AI/ML toolkit to support research and development across the enterprise.
- Create training tools to assist with research and regulatory compliance about trustworthy AI policies.
- Facilitate the effective implementation of latest requirements, Trustworthy AI Support system and the NAII Digital Command Center (DCC).
- Completion of phase I of the AI/ML Mobile Digital Health Pilot project, along with other pilot programs like the Digital Command Center and ASPIRE, a multi-agency initiative aimed at improving workforce upskilling.
- Aligning with Investigators, Scientific Review and Management (ISRM) within ORD to provide AI subject matter expertise and technical support for the portfolio.
- Expanding our groundbreaking AI/ML Mobile Digital Health Pilot. This platform passes the highest security standards, has read-write integration capabilities into the electronic health record (EHR) and enables a scalable advanced analytics and artificial intelligence platform to advance AI in mobile and digital health technologies through a mobile cell phone application.
- Enhance the All Services Personnel and Institutional Readiness Engine (ASPIRE), by integrating the assessment component and preparing to pilot the system within ORD. Training will also encompass trustworthy AI principles, data ethics, equity, bias, and discrimination.
- Evaluate the impact of promising technologies, such as Ambient dictation, on key priority areas, such as physician burnout, and provide support to ensure that novel AI-based solutions are safe and effective.

2023 Accomplishments

- Accelerated Trustworthy AI by standing up the VA Data Governance Council's AI Working Group.
- Planned and executed comprehensive contractor support to the entire NAII program to support the creation of a research network capable of pilot testing AI/ML, solutions in health care and to manage an ever-growing demand to respond to AI initiatives, which included communications support, website and project support, and development of the ServiceNow Project Management module and executing an AI Summit.

- Made significant advancements in developing and initiating the TAI Playbook as part of our EO 13960 TAI Support initiative.
- Launched the Digital Command Center and realized a return on that investment in improved access to care at pilot centers.
- Produced concrete benefits in the form of Veteran protections from the AI IRB pilot and AI oversight committee pilot. NAII is currently in the process of scaling these pilots across the NAII AI Network.
- Developed ASPIRE, a collaborative interagency project (NAII, Department of the Navy, Department of Labor, Department of Air Force, and Department of Health & Human Services), to develop a scalable, interoperable, interagency platform that can assess, educate, and enable an agile government workforce skilled in AI, data science, and cybersecurity. ASPIRE is currently equipped with a learning management system (LMS). The assessment system is developed but has not been integrated into the LMS. Integration will occur in FY 2024.
- Created the first agency AI website to communicate information about the US Department of Veterans Affairs' use of AI and AI governance to a public audience in a transparent manner. Key audience segments include Veterans; their families, caregivers, and survivors; the general public; government partners; industry partners; academic partners; the media; and more.

Table: 2025 Administration Priority Areas – Mandatory Funding

(Dollars in thousands)	2023 Actuals	2024 Request	2024 Estimate	2025 Request	2025 Request-2024 Estimate	
					$	%
Military Occupations & Environmental	**35,000**	**68,012**	**46,000**	**59,000**	**13,000**	**28%**
Medical and Prosthetics Research (non-add)	*32,520*	*22,012*	*0*	0	*0*	-
Toxic Exposure Fund (non-add)	*2,480*	*46,000*	*46,000*	59,000	*13,000*	28%
Gulf War Veterans Illness (non-add)	**15,226**	**15,226**	**15,226**	**16,000**	**774**	**5%**
Medical and Prosthetics Research (non-add)	*15,226*	*15,226*	*0*	*0*	*0*	-
Toxic Exposure Fund (non-add)	*0*	*0*	*15,226*	*16,000*	*774*	5%

Military Environmental Exposures (MEE)

Military toxic exposures research addresses a range of diseases and conditions that may have arisen during active duty. This is one of most significant growth areas for VA Research. The importance of this topic is a key focus in many Congressional hearings, media outlets, and department communications. Examples of key exposures include those related to burn pits, Agent Orange, and other toxic substances. Health conditions associated with disability claims include hypertension, asthma, and genitourinary malignancies. The PACT Act further highlighted the priority for VA to address toxic exposures, not only in research, but in its health care and benefits activities. VHA has two complementary offices with different strengths to generate evidence and inform policy on military exposures: Health Outcomes Military Exposures (HOME) and ORD Military Exposure Research Program (MERP).

One of these major efforts is continued implementation of Section 501 of the PACT Act. The interagency workgroup consists of members from the VA, DoD, Health and Human Services

(HHS), Environment Protection Agency (EPA), and other federal partners involved in research activities regarding the health consequences of toxic exposures experienced during active military, naval, air, or space service.

This interagency workgroup provides guidance on new research related to health consequences of toxic exposure during military service by developing a five-year strategic plan for collaborative research activities and opportunities for advancing the field. Timely reports to Congress are submitted as outlined in PACT Act Section 501, with an initial report submitted to Congress in late summer of 2023. Development of the five-year strategic plan and roadmap will be submitted in the late summer of 2024.

Exposure assessment at the individual level was identified as the major gap in the military exposures field. Therefore, identifying and ideally quantifying the toxicant(s) a Service member or Veteran was exposed to will inform health outcomes, clinical care, and policy (e.g., prevention, detection, presumption, and clinical practice guidelines). There are numerous potential sources of data, such as the Individual Longitudinal Exposure Record (ILER), a Veteran's own recollections, and markers of the exposure left on the Veteran, such as genetic markers of particular exposures. The mission of a relatively new ORD MERP is to establish a system-wide capability to advance military exposure assessments and understand the effects of military exposures on Veterans' health outcomes. Recently, ORD also funded a Military Exposures Research Innovation Center focused on constrictive bronchiolitis, which often is difficult to diagnose but could have significant consequences, especially in respiratory health. Additionally, these capabilities, coupled with those in the Gulf War Veterans Illness Program, have resulted in a growing set of enterprise capabilities and understanding of different exposures and their impact on Veterans' health and related outcomes.

2025 Planned Activities

- Continue implementation of Section 501 of the PACT Act. The interagency workgroup consists of members from the VA, DoD, HHS, EPA and other federal partners involved in research activities regarding the health consequences of toxic exposures experienced during active military, naval, air, or space service.
- Military Exposure requests for funding applications will be updated to align with the new ORD organizational structure. This will leverage cross-cutting fund announcements established during the ORD restructuring.
- Leverage research use of the Vietnam Veteran Air Force Health Study (Ranch Hand Study) to evaluate generational, cancer and other health concerns of this cohort, in consultation with Vietnam Veterans of America and other stakeholders.

2024 Planned Activities

- Continue full activation of ORD MERP's Exposure Assessment Core to support toxicologists with a nucleus of collaborators and resources to develop, test, and validate exposure assessments to support the broader VA research enterprise that works on military environmental exposures. These efforts serve as an enterprise resource for a broader set of field investigators. Hiring additional biorepository regulatory and policy expertise. ORD will build on the progress of VA SHIELD, the enterprise-wide biobank initially established

by ORD in response to COVID, and data/biobanking subject matter experts to collect trusted specimens for wide use. Additionally, ORD will leverage the Million Veterans Program (MVP) to shed light on how a Service member's genes may impact the effect of MEE on their health.

- Establish an ORD MERP military toxic exposures biospecimen repository leveraging an MOU with VA SHIELD. This repository will be the first ever military exposure biorepository. Biospecimens are a precious resource for both developing and validating exposure assessments, as well as understanding the health effects of these exposures.
- Further explore the relationship between military exposures and rare cancers. Studies show that exposure to environmental contaminants and toxic chemicals can lead to a higher risk of certain types of cancer. MERP will complement the work being done by ORD's Precision Oncology Program by focusing on the mechanisms by which military environmental and toxic carcinogenic factors may give rise to rare cancers, a poorly understood area. Shedding light on how military exposures lead to disease can help to identify preventive, diagnostic, and treatment strategies. The ORD MERP environmental- and toxic-exposure biospecimen repository and outside federal and academic partnerships will be leveraged to catalyze progress.
- Complete a systematic program review for the Military Exposure Research Program initiated in December 2023. Participants included the three Consortia of Research (Cores) and ORD leadership and stakeholders. Primary areas identified for improvement were pre-applications and instructions for future funding applications. New elements for a communication plan were also identified and will be further developed in 2024.
- Expand the workforce in military exposures research and training, with an emphasis on finding Veterans and descendants of Veterans who are enrolled with VA academic affiliates and want to pursue a career in environmental and military exposure research. In addition to benefiting the research, it will open new career opportunities for these Veterans and military family members.
- Through QUERI's Partnered Evidence-based Policy Resource Center (PEPReC), we will undertake a national evaluation on the impact of legislative initiatives related to military exposures on access to, and demand for, VA care over time. To support VA's efforts to increase access to care for Veterans with military toxic exposures as part of the PACT Act, PEPReC is working with human resources to develop an evidence-based approach for estimating ideal staffing levels for achieving VHA access goals (e.g., wait time targets) at VA medical centers.
- QUERI and the VHA Evidence-based Policy Subcommittee will work with VA clinical operational partners to conduct evaluation plans under development, including plans focused on military exposures for the VA 2024 Evidence Act. An example evaluation topic under development is examining the extent military exposures may have harmed Veterans, particularly latent or chronic health effects of exposures (e.g., toxins at Camp Lejeune).
- Continue the congressionally mandated Gulf War Program, which is overseen by the Research Advisory Committee (RAC) on Gulf War Veterans' Illnesses. The goal of this program is to improve the health of Gulf War Veterans experiencing debilitating symptoms, such as persistent headaches, joint and muscle pain, fatigue and sleep

disturbances, attention and memory problems, gastrointestinal symptoms, and skin abnormalities. Continue outreach engagement sessions with Gulf War Veterans to better understand their health concerns as they age and reinforce the value of participating in research.

- Continue the "In-Depth" project to systematically document the health characteristics of Veterans living with Gulf War Illness in collaboration with NIH National Institute of Neurological Disorders and Stroke (NINDS) clinical services.
- Continue study of Collaborative Specialty Care for Gulf War Illness to examine the best model of care to deliver treatments to Gulf War Veterans with Gulf War Illness and to examine the under-recognition of medically unexplained symptom conditions among Veterans with Gulf War Illness.
- Analyze differences in mortality between Vietnam War era Veterans and civilians for conditions potentially related to military service in that era.
- Continue to test the research usability of the Individual Longitudinal Exposure RecordILER (ILER), a VA-DoD collaboration to track in-service exposures. Progress in this area was made by adding subject matter experts from our Exposure Assessment Core to the ILER user interface. Their training and usage of ILER will facilitate important capabilities for future users of the research and help mitigate potential barriers.
- Continue a large observational study run by the CSP to assess impacts of deployment on respiratory health, particularly in context of burn pit exposures, while using data from NASA to provide insights into how particulate matter was distributed regions of the Middle East.

Funding policies and funding protocols will be finalized for the Toxic Exposure Fund.

2023 Accomplishments

- Completed an analysis of the MEE portfolio to identify gaps in capabilities, technologies and resources. This included holding a planning meeting where resource, process, and expertise gaps were articulated by researchers in the field. ORD then identified gaps for trusted data and biospecimens, toxicology expertise and technologies for exposure assessment, and agency agreements for efficient and timely execution of research.
- Developed and posted MEE information for investigator-initiated funding applications.
- Continued full activation of ORD MERP's Exposure Assessment Core to support toxicologists with a nucleus of collaborators and resources to develop, test, and validate exposure assessments to support the broader VA research enterprise that works on military environmental exposures. Partial activation of this Core took place Fall 2022 where a strategic planning meeting was executed, and goals and objectives were developed.

Areas of Continued Interest

Addressing the Needs of Veterans with Tinnitus

Auditory system injuries, which include tinnitus, hearing loss, and balance problems, occur often after military-related noise and blast exposures. Tinnitus and hearing loss are among the ten most prevalent service-connected disabilities of new compensation recipients. Research in auditory

system injuries remains a VA priority to ensure the development of novel intervention treatments, self-management tools to alleviate auditory system injuries, and diagnostic tests to identify tinnitus and other auditory related injuries. Funding for tinnitus is reported under the Sensory Loss DRA.

ORD has a dedicated, funded, hearing research center: the National Center for Rehabilitative Auditory Research (NCRAR), which was established 26 years ago by the VA Rehabilitation Research and Development Service. In addition to this center, ORD funds research investigators in other VA Medical Centers working to resolving issues of auditory system injuries in our Veterans.

Several investigators also obtain funding from agencies such as the National Institutes of Health: National Institute of Deafness and Other Communication Disorders (NIDCD), the DoD, and academic institutions to cohesively leverage funding to address tinnitus outcomes. ORD scientific staff serve on various Federal agencies (e.g., NIH, DoD) committees, councils, and panels, which fosters collaboration in research related to auditory system injuries and accelerates advances in solutions for Service members and Veterans.

Recent and future activities:

- Post Request for Applications (RFAs) for a study addressing the effects of blast, noise, and/or TBI on one or multiple sensory systems and communication disorders (e.g., tinnitus, vestibular, vision, speech, and related disorders) and another study to evaluate the impact of TBI on multiple sensory systems is planned to be released.
- VA and DoD Consortium of researchers, clinicians, and leaders are developing a Clinical VA Evidence Based Practice Program Practice Guideline (CPG) for tinnitus clinical management. CPGs developed by the VA and DoD improve care by reducing variation in practice and promoting best practices throughout these two health care systems. Work is ongoing that involves conducting a systematic review of all randomized controlled trials performed on different methods of tinnitus management. The overall purpose is to ensure Service members and Veterans have access to high value evidence-based clinical tinnitus services.

Pain and Opioid Use

Chronic pain is more prevalent and of a greater intensity in the Veteran population than in the general population according to the National Health Interview Survey (NHIS). It is often accompanied by coexisting mental health problems and overlapping painful conditions. This places Veterans at risk for harm from opioid medication, especially opioid use disorder (OUD). VA Research supports the generation of new knowledge to improve the prevention, diagnosis, and treatment of OUD, as well as the development and testing of innovative approaches for chronic pain management for Veterans. This work is guided by the requirements of the Comprehensive Addiction and Recovery Act (CARA), the Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand, VHA's Opioid Safety Initiative and the Hannon Act.

Recent and future activities:

- The CYP2D6 gene modifies the response to opioids by altering drug metabolism. Several VA studies have demonstrated the effects of this mutation in the Veteran population

prescribed opioids, resulting in an undesirable response due to poor metabolism or rapid metabolism of opioids. As a result, the CYP2D6 genetic testing is included on the VA Stratification Tool for Opioid Risk Mitigation Dashboard to allow for a precision medicine approach to pain management.

- VA expects to fund a national study on use of Whole Health services to improve Veteran-centered pain management through the DoD/NIH/VA Pain Collaboratory. The study was selected based on a competitive review of studies to conduct efficient, large-scale pragmatic clinical trials and/or implementation science demonstration projects within the infrastructure of the NIH-DoD-VA Pain Management Collaboratory (PMC) on nonpharmacologic approaches to pain management and other comorbid conditions in U.S. Veterans, military personnel and their families.
    - Veterans recovering from opioid use disorder (OUD) struggle with obtaining and sustaining meaningful employment that provides identity, structure, income, daily activity, and socialization, which are foundational in promoting occupational functioning, participation in community and full recovery. Individual Placement and Support (IPS) is an evidence-based model of supported employment and a means for Veterans with OUD to get back to work in steady, competitive jobs. This clinical trial compares IPS to usual vocational rehabilitation with the hopes of sustaining employment in competitive jobs, while decreasing the odds of a relapse.

Spinal Cord Injury and Disorders (SCI/D)
Approximately 17,000 new cases of spinal cord injury occur each year, of which several hundred involve Veterans. The VA Healthcare System provides care for up to 27,000 Veterans living with Spinal Cord Injury and Disorders (SCI/D), such as Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS). These various conditions can result in permanent neurologic changes leading to paralysis. ORD supports innovative research on SCI/D to repair and/or replace damaged and lost tissue, restore lost function, and mitigate secondary consequences, in order to maximize function, independence, and social reintegration for the Veterans.

Recent and future activities:

- Powered Exoskeletons for Persons with Spinal Cord Injury study could help Veterans restore, replace, and rehabilitate for functional recovery. The study provided Veterans with SCI exoskeletons for overground ambulation and was the first take-home study of its kind. Due to the promising study findings, the VA developed a clinical protocol for the use of powered exoskeletons, as well as offering exoskeleton training to eligible Veterans.

- VA funded a consortium of investigators to develop a cell-based therapy to repair the injured spinal cord and thereby restore function (e.g., hand grasp, pincer movement). This project is unique to the VA and to date, restoration of function has been achieved in the animal studies. The study is now in the process of obtaining Food and Drug Administration guidance to perform necessary long-term safety studies in animals, which is a major milestone for the VA. This study is the first step towards a future clinical trial to help repair the spinal cord and to restore upper limb function.

Addressing Women Veterans Health

In conjunction with the priority to ensure disabled Veterans who require a prosthesis can access the most modern prosthetics technology available and to support the growing number of women Veterans who use VA services, VA Research continues to encourage the development and translation of prosthetic devices for women. As directed by Congress in HR 115-673, ORD has emphasized and prioritized funding for projects in this area. Prosthetic components are typically designed for men, as most prosthetic users are male. However, the number of female Veterans is growing, and VA must be able to meet their prosthetic needs as well.

ORD added a statement to our RFAs that prosthetic and other assistive technology needs of women Veterans are an area of special emphasis. This request 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 were selected for funding based on the results of rigorous scientific peer review.

Recent and future activities:

- To improve virtual care for Women Veterans, VA will continue to collect feedback from Women Veterans who receive care within the VA and from VA clinical team members about their experiences delivering synchronous virtual care to women. Information will be used to develop a definition and implementation blueprint of optimized virtual care delivery for Women Veterans.
- Published a supplement on "Moving Women Veterans' Health Research Forward" in JGIM with 25 peer-reviewed papers and two editorials included, spanning reproductive health, mental health, sexual violence and innovative clinical services for Women Veterans.
- ORD supports a Women's Health Practice Based Research Network, which has been a leader in advancing not only Women's Veteran Health, but health for all women with key partners such as the NIH Office of Research on Women's Health. In addition to the research findings specific to women, it has advance novel approaches to welcoming, including and supporting women in clinical trials.

ORD Operational Units

As described earlier in the Investment in the VA Research Enterprise section, ORD will continue the implementation to undertake a major effort to align the organizational structure of the office with its functions, with the goal of more effectively and efficiently fulfilling our mission. We aligned our structure to serve as funders of research and as the strategic headquarters of the largest integrated biomedical research organization in the nation. This effort will involve seven units reporting to the Chief Research and Development Officer (CRADO).

Strategy, Partnerships, Outreach, and Communications (SPOC)
This unit is charged with creating forward-looking strategies, governance processes for establishing priorities and programs, and measuring the impact of serving Veterans. It will develop and maintain ORD's long-term strategy by anticipating future trends in strategic health care priorities and maintaining a proactive stance, to ensure the effective communication of ORD's

strategy and vision and build a community among ORD's stakeholders, to enforce organizational alignment with strategic priorities and measure the success of ORD. SPOC will support centralized functions within ORD, such as Communications.

Enterprise Protections, Regulatory, and Outreach Systems (EPROS)
EPROS is charged with ensuring the appropriate policies for the protection of human participants and animal subjects in VA conducted research as well as with developing and managing VHA's research regulatory policies and associated education and training. It is developing, coordinating, and managing enterprise-wide access to central research repositories and digital research systems and ensuring the protection of VA's intellectual property and commercialization efforts. EPROS is responsible for championing and solving the impacts on research for the transition to the EHR, encouraging the disclosure of inventions, supporting the review of multi-site research through the Central IRB, providing a centralized core for ethical, regulatory and educational programs for human and animal research, and providing key central systems for data and biospecimen management. The following sub-units are currently housed under EPROS: Technology Transfer Program (TTP), Central IRB, Central Policy and Regulatory, Research Education and Training, Research IT and Data Governance, Research Education and Training, Central Veterinary Medical Office, and the OSIRES team.

Office of Finance
Finance is charged with managing all aspects of budget, finance and accounting for ORD and the field and evaluating the strategic use of ORD's financial resources. This unit works to ensure ORD is operating with fiscal responsibility in supporting the VA Research Enterprise's mission of improving Veterans' lives through research. Finance supports centralized functions within ORD, such as budgeting and operations, and the Non-Profit Program Office.

Operations and Workplace Culture (OWC)
The OWC unit is responsible for centralizing internal ORD operations functions. It provides ORD staff with dedicated resources such as HR, contracting, leadership development, talent management, and employee engagement that are rooted in solving problems efficiently and effectively so that the day-to-day ORD processes run smoothly. The OWC unit also strives to continually improve the efficiency of internal operations and ensure timely responses to external requests and requirements. The following sub-units are housed under OWC: Central Administration, Contracting, and Operations.

National Artificial Intelligence Institute (NAII)
As described earlier, The NAII seeks to develop AI research and development capabilities in VA to support Veterans and their families, survivors, and caregivers. NAII designs and collaborates on AI R&D initiatives, national AI policy, and partnerships across agencies, industries, and academia. NAII is dedicated to advancing AI research and development for practical impact and outcomes to ensure Veteran health and well-being.

Investigators, Scientific Review, and Management (ISRM)
ISRM contributes to the VA Research Enterprise mission of improving Veterans lives through research by funding research originating out of the VA clinical setting and patient-provider care experience, management of research portfolios, collaboration with stakeholders and the

recruitment and retention of a diverse set of investigators. Sub-units withing ISRM include Biomedical Laboratory Research and Development (BLR&D), Rehabilitation Research and Development (RR&D), Clinical Science Research and Development (CSR&D), Health Services Research and Development (HSR&D) and a number of Actively Manages Portfolios focusing on specific areas of Veteran need (e.g., Precision Oncology, Pain and Opioid Use, TBI, Suicide Prevention).

Biomedical Laboratory Research and Development Service (BLR&D)
BLR&D supports and conducts pre-clinical 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, which will ultimately contribute to new and better preventive measures and medical treatments.

Rehabilitation Research and Development Service (RR&D)
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.

Clinical Science Research and Development Service (CSR&D)
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, epidemiology, and infrastructure needs.

Health Systems Research and Development Service (HSR&D)
HSR&D pursues research that addresses all aspects of VA health care, including patient care practices, models of care delivery (including telehealth), access to care, quality, safety, and costs of care, health equity, patient and provider experience and implementation of evidence-based clinical interventions into practical practice. HSR&D also addresses critical issues for Veterans who have returned from Iraq and Afghanistan with conditions that may require care over their lifetimes, most notably PTSD, pain, and risk of suicide. Major scientific contributions include novel methods that promote Veteran, provider, and caregiver engagement in health care, data science (making VA data work for Veterans), and improvement science (how to get effective treatments into the hands of Veterans faster).

HSR&D oversees and facilitates VA's QUERI program, which leverages scientifically supported quality improvement methods, paired with a deep understanding of Veterans' preferences and needs, to implement research discoveries and evidence-based practices rapidly into routine care to improve the quality and safety of care delivered to Veterans. The QUERI program is funded by the VERA Model and does not receive funding from the Medical and Prosthetics Research apropriation. QUERI's national network of programs and partnered evaluation initiatives include more than 200 VA scientists and ORD supported experts in health services research who collaborate with VA leaders, administrators, and providers. QUERI is also managing VHA's

fulfillment of the Evidence Act, including the Evidence-based Policy Subcommittee, fostering cross-VHA operational partnership and VA Research collaborations on annual evaluations addressing VA strategic priorities. In partnership with more than 70 VISN and VA national program office leaders, QUERI disseminated over 200 research-informed strategies and products, supporting over 27,000 VA employees across the U.S. in delivering evidence-based care to over 5.7 million Veterans and their families.

Also, HSR&D's Evidence Synthesis Program (ESP) provides timely, targeted, thorough, unbiased, and innovative syntheses of the medical literature for VA to translate into evidence-based clinical practice and policy. ESP reports are made available to clinicians, managers, and policymakers in a timely way as they work to improve the health and health care of Veterans. In addition to helping to guide quality-improvement efforts, ESP reports help guide future research. In 2023, ESP released a report based on a national evidence review showing that VA health care was comparable or better than care provided in non-VA community settings.

Enterprise Optimization (EO)
EO is charged with supporting the execution of ORD's agenda, particularly as it relates to a national enterprise-wide approach toward planning for, coordinating, and managing the VA Research Enterprise resources and producing impactful scientific findings that translate to the health care system, such as Field Support, so that the field may execute the VA research strategy efficiently and successfully. It supports centralizing existing field resources and developing them to provide researchers with effective and accessible tools and resources. It will also work towards increasing the accessibility of VA scientific resources and products to ensure a cooperative approach and facilitation of innovative scientific research. Sub-units within EO that support centralized functions within ORD include Field Operations, the Partnered Research Program, the Cooperative Studies Program, and the Million Veteran Program.

Cooperative Studies Program (CSP)
CSP is responsible for planning and conducting large multicenter clinical trials and epidemiological studies. It serves as a foundational part of the VA national clinical research enterprise and seeks to advance the health and health care of Veterans through cooperative research studies that produce innovative, definitive, and effective solutions to Veteran and national health care problems.

Million Veteran Program (MVP)
MVP is a national voluntary research program that partners with Veterans receiving their care in the VA health care system to study how genes affect health. To do this, MVP is building one of the world's largest databases of genes and health by safely collecting blood samples and health information from over one million Veteran volunteers. With over one million Veterans enrolled, MVP is also one of the most comprehensive and racially and ethnically diverse cohorts in the world with over 180,000 Veterans of African descent and over 80,000 Hispanic Veterans.

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 strategies to improve life for Veterans and all Americans.

VA and DoD share a commitment to honor those who served our nation by providing them with the best health care available. In addition to ones described earlier, our other collaborative research projects cover a wide range of topics, including the long-term health effects of military service on Service Members, Veterans and family, military environmental exposure, TBI, polytrauma, prosthetics and amputation care, PTSD and other mental health issues, suicide prevention, and pain management. VA and DoD have agreements allowing for the transfer of medical record data to support research, among other activities, which is stored in a joint database maintained by ORD as the DoD/VA Infrastructure for Clinical Intelligence (DaVINCI). VA and DoD are partnering in several development tasks to support research using Cerner tools.

VA also is a formal partner with DoD, the Department of the Army, and the National Institute of Mental Health (NIMH) in the third phase of the STARRS-LS. As study participants continue to transition out of the military, this collaboration seeks to link DoD and VA data to better study the pathways military Service Members take as they leave the military, with an overall goal of reducing military and Veteran suicide.

VA and DOE are collaborating in the VA-DOE Big Data Science Initiative, a partnership focused on the secure analysis of large amounts of digital health and genomic data (so-called "big data") from VA, including MVP and other federal sources to help advance health care for Veterans and others, while also driving DOE's next generation supercomputing designs. Current collaborative projects include developing risk-prediction tools for suicide, lethal prostate cancer, and cardiovascular disease, as well as assessing the relationship between altitude and suicide. Eight new joint projects have been selected and will be launched in 2023. The topics include improving treatment for heart failure, improving the risk prediction of suicide, predicting negative side effects of antipsychotic medications for better management of care, Long COVID, enabling precision care for sleep disorders, improving lung cancer screening, improving precision treatment for lung cancer, and improving risk prediction and management of complications from diabetes.

VA and HHS are collaborating on diabetes management, patient safety, the use of health information data, the identification of strategies and designs for military environmental exposures research, characterization of Gulf War illness, cancer clinical trials and research on COVID-19 preventives, diagnostics, and therapeutics.

VA Research also collaborates with the Indian Health Service, part of HHS, to improve access to care for American Indian Veterans. VA collaborates with other components of HHS, such as the National Cancer Institute (NCI) and the National Institute on Aging (NIA), as described below. Through the Pain Management Collaboratory, VA collaborates with NIH and DoD on a series of trials of non-opioid treatments for chronic pain in Veterans and active-duty military members.
NCI and VA Interagency Group to Accelerate Trials Enrollment (NAVIGATE) sites enrolled more Veterans into NCI trials than sites that did not received dedicated funding for local clinical trials infrastructure, which highlighting the success of the program.

VA ORD through its Cooperative Studies Program has an interagency agreement with the U.S. Food and Drug Administration to use real-world evidence/data to better inform medical policy on the use of treatments. Efforts focus on leveraging the CSP Point of Care methodology which allows greater reach of Veterans in various settings (including rural ones) to evaluate therapies that are already available and to examine their comparative effectiveness.

ORD, through QUERI, actively collaborates with the NIH to provide national training in implementation research and health system science methods to promote translation of research findings into real-world health care settings through the Implementation Research Institutes sponsored by NIMH and NCI.

VA and NIA are collaborating on the VA-NIA Alzheimer's Disease Veteran-Centric Alliance Network for Health Care Excellence (AD-VANCE) Initiative. That partnership is aimed at fast-tracking the development of new treatments and cures for Alzheimer's disease and related dementias (AD/ADRD) and to improve the care of Veterans with AD/ADRD and the well-being of their caregivers.

VA also fosters dynamic collaborations with its university affiliates and with nonprofit organizations and private industry.

Appendix

Designated Research Area (DRA) Descriptions

The areas of research below represent areas where VA has a particularly strong strategic interest because of the prevalence of conditions within VA patient populations, the uniqueness of a specific patient population, and its disease burden to the VA system or the importance of the question to health care delivery within VA.

Acute & Combat-Related Injury (Acute and Traumatic Injury): Research focuses on surgical approaches and post-operative care of injuries or chronic conditions prevalent in Veterans. This focus includes amputation, burn treatment, fracture repair strategies, shock, wound repair/healing, sepsis, and polytrauma.

Aging, Older Veterans' Health and Care (e.g., Alzheimer's): Research focuses on the physiological aspects of the aging process, geriatric syndromes, disease prevention in the elderly, geriatric pharmacology (polypharmacy), and care of elderly Veterans, which includes delivery and outcome measures of geriatric care in outpatient facilities, hospitals, long term care settings, caregiver issues, and questions about the financing of health care for Medicare-eligible Veterans. Funding also supports projects focused on diseases or issues that are the most common or more prevalent in older Veterans (e.g., cardiovascular disease, stroke, Alzheimer's Disease, Parkinson's Disease, certain cancers, Type II diabetes, chronic lung disease, age-related sensory loss, end of life issues), as well as projects involving a study population that is 60+ years old or has research results likely to contribute to the health care of older Veterans.

Autoimmunity, Allergy, and Inflammation (Autoimmune, Allergic & Hematopoietic Disorders): Focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, health care utilization and delivery of care for autoimmune diseases,

immunodeficiency, immune-complex disorders, and diseases related to allergic or delayed hypersensitivity reactions and the effects of aging on these functions, such as immunosenescence, systemic inflammation, gut microbiome dependent effects on immune function, and sexual dimorphism of immune inflammatory responses. This focus also includes Lupus, Long COVID, immunotherapy, cells of the immune system, and immunology of organ transplantation.

Brain and Spinal Cord Injuries and Disorders (incl. TBI) (CNS Injury & Associated Disorders): Focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, health care utilization and delivery of care for brain and spinal cord injuries sustained during active-duty military service and subsequently. Neurotrauma may be the result of a blast, penetrating or crush injury, blunt force trauma, ischemic event, or hemorrhage. This focus also includes Epilepsy, neuropathic pain, Multiple Sclerosis, neural plasticity, peripheral nerve injury, and chronic traumatic encephalopathy.

Cancer: Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, prognosis, treatment and prevention of cancer as well as health care utilization and delivery of care to cancer patients. This focus includes the delivery, efficacy, and effectiveness of therapies (including chemotherapy, radiation, gene therapy, bone marrow transplants, etc.) for the treatment of adult leukemia/lymphoma, solid tumors, and cancer pain.

Precision oncology studies focus on the characterization of a patient tumor or other biospecimen using next generation sequencing (i.e., NGS profiling) or other histologies for diagnosis, treatment, prediction, or prognosis. Studies may include the use of targeted therapies (or in combination with immunotherapy) aimed at treating cancer cells, use of biomarker(s) to test for cancer or clinical/treatment response, outcome, screening or patient stratification, use of NGS profiling to understand resistance to therapy in a patients tumor and/or molecular characteristics of resistant samples derived from patient biopsies (e.g., patients enrolled in clinical trials) or to understand the molecular drivers of response to immunotherapy. Studies may use data analytics such as artificial intelligence/machine learning/neural networks/algorithms to interrogate pathomic and radiomic images or genomic/transcriptomic/proteomic data for cancer diagnosis, prognosis, risk stratification and prediction of treatment response.

Cardiovascular Disease: Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, health care utilization and delivery of care for disease and disorders of the heart, central and peripheral vasculature. Includes studies on heart failure, coronary artery disease, pacemakers, defibrillators, idiopathic hypertension, peripheral artery disease, aneurysms, and atherosclerosis. This focus also includes studies on the cellular and non-cellular constituents of blood (e.g., hemostasis, blood coagulation, hematopoiesis, anemia), and stroke.

Diabetes and Other Endocrine Disorders: Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, health care utilization and delivery of care for diseases associated with the regulation of glucose, insulin, and metabolism.

Digestive Diseases: Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, health care utilization and delivery of care for diseases associated with the

gastrointestinal system and associated organs, such as liver, spleen, gallbladder, and pancreas. This focus includes GI motility, acid reflux (GERD), inflammatory bowel disease (IBD), irritable bowel syndrome (IBS), digestion, nutrition, and liver transplants.

Emerging Pathogens and Bioterrorism: Funds research on new or re-emerging pathogenic agents and those that are expanding into hosts and areas where they have not previously been reported. The category includes any pathogen reported with high incidence in an epidemic or pandemic outbreak and includes proposals on microbes, vector-borne pathogens, or Select Agents with potential for use in bioterrorism.

Gulf War Veterans Illness: Research aims to better understand and treat health problems experienced by some Veterans following exposures to toxic substances and environmental hazards during the Gulf War. These efforts are guided by a strategic plan by the Research Advisory Committee on Gulf War Veterans' Illnesses, a committee created by Congress in 1998 (Public Law 105-368) and first appointed by the VA Secretary in January 2002. The committee directs VA to commit at least $15 million to Gulf War research annually.

Health Systems: Research focuses on a systematic study of organizational structures, design, and delivery methods to improve Veteran health, with a particular focus on the Quintuple Aim outcomes (e.g., efficiency, equity, and quality of care for). This includes studying gaps in the care process and implementation, developing innovations and best practices in existing care delivery systems (both human and systems design), performance and quality of care, human safety issues, resource utilization, cost-benefit, management and human resource factors affecting care, Veteran and community engagement methods, and developing models to improve the overall efficiency of the health care organization and the care delivery process.

Infectious Diseases: Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, and prevention of infectious diseases of humans and relevant animal infection models, including studies of effects of aging on infectious diseases and health care utilization and delivery of care for Veterans infected with SARS-CoV, Hepatitis A, B & C, HIV, TB, Flu (H5N1), bacteria, fungi, parasites and vector-borne agents.

Kidney Disorders: Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, health care utilization and delivery of care for diseases and disorders of the kidney, including the effect of aging. This focus also includes end-stage renal diseases, dialysis and renal function after transplantation.

Lung Disorders: Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, health care utilization and delivery of care for diseases and disorders of the lung. Also includes effect of toxic exposure, autoimmunity, infectious diseases, effect of transplantation on pulmonary function, ventilator studies, and Chronic Obstructive Pulmonary Disease (COPD).

Mental, Cognitive and Behavioral Disorders Mental Illness: This DRA is used for proposals which focus on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, health care utilization, and delivery of mental health services for psychiatric and behavioral disorders

including psychotic disorders, depression, mood and anxiety disorders, adjustment disorders, post-traumatic stress disorder (PTSD), behavioral and cognitive disorders, vascular dementia, and frontotemporal dementia. It also includes studies of sleep disorders, memory loss, or other neuro-cognitive impairments that occur due to an aging-related disease or following brain injury (such as a TBI or stroke).

Military and Environmental Exposures: Research focuses on chronic health effects of conditions or substances encountered during military service and the health care utilization and delivery of care to Veterans with these exposures. This DRA emphasizes repeated or long-term exposures and includes studies on Agent Orange, dioxins, industrial chemicals, industrial materials, oil fires, insecticides/pesticides, burn pits, micro-particulates, jet fuel, radiation, and electromagnetic and acoustic exposures. It also includes studies of novel animal or organoid/tissue chip exposure models.

Musculoskeletal Disorders: Focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, health care utilization, and delivery of care for musculoskeletal disorders common in Veterans either as a result of a combat-related injury or the result of a progressive disease affecting the body's muscles, joints, tendons, ligaments, bones, or normal aging. This focus includes chronic low back pain, osteoarthritis, osteoporosis, muscular dystrophy, fracture healing, osteomyelitis, degenerative disc disease, and joint replacement as a treatment.

Neurodegenerative Diseases: Focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, health care utilization and delivery of care for neurodegenerative diseases of the central and peripheral nervous system (including progressive loss of structure or function of neurons, death of neurons), which are prevalent in Veteran populations. This focus includes Alzheimer's Disease, amyotrophic lateral sclerosis, Huntington's Disease, Parkinson's Disease, and prion diseases.

Other Conditions: This DRA is used to code dental research and other conditions that cannot be classified under any other DRA.

Prosthetics, Orthotics, and Assistive Technology: Research focuses on the studies of new devices or the improvement of existing devices to replace missing body parts or to supplement defective body parts. This focus includes research on the engineering design, development, implementation, prototype testing or fitting of an artificial limb, orthotics research, neural prostheses, assistive technology, restorative devices, and rehabilitation services for improving Veteran's prognosis and functioning (e.g., communication, ambulation, mobility, cognition, vision, bowel/bladder function, etc.). This focus includes research into the delivery and quality of care for patients requiring prosthetics, orthotics, neural prostheses, or assistive technology. Implanted devices for specific health conditions such as pacemakers (e.g., cardiac or deep brain stimulators), heart valves and total joint replacements would not fall under this DRA.

Sensory Loss: Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, health care utilization, and delivery of care for sensory loss common in Veterans either as a result of a combat-related injury or military environmental exposure, the result of a progressive disease process, or normal aging. This focus includes tinnitus and rehabilitation

for sensory and other communication disorders. Sensory loss research may double code with the Aging DRA (e.g., macular degeneration), Diabetes DRA (e.g., diabetic retinopathy), Cancer DRA (e.g., chemotherapy-related ototoxicity), or Prosthetics DRA (e.g., cochlear and retinal implants) as appropriate.

Special Populations: Research focuses on VA, VHA, and Administration strategic goals related to improving care and outcomes for underserved, marginalized, and at-risk Veteran populations across the life journey (VA Strategic Plan Goal 2), includes a special emphasis on innovative research focused on equity, experience, value, quality, and outcomes. Also focuses on Veterans experiencing, or who are at risk of, homelessness, suicide, and other adverse events and those experiencing adverse social determinants and/or gaps in quality and access to care. In 2025, ORD QUERI plans to launch a national study of the risk and resilience factors affecting Veteran housing and economic security in response to the VA Strategic Plan Learning Agenda supplement on homelessness.

Substance Use Disorders: Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, and prevention of abuse of alcohol, nicotine, and drugs, individually and/or in combination. Includes studies of specialized VA health care services provided to substance-abusing and substance-addicted Veterans. Studies include mechanistic studies of diseases caused by substance abuse, substance abuse in patients with PTSD, anxiety disorders, depression, schizophrenia, and studies on pain management or anesthetics.

Table: Obligations by Object Class

Medical and Prosthetic Research Direct Obligations			
(dollars in thousands)	2023 Actuals	2024 Estimate[1]	2025 Estimate[2]
11 Personnel Compensation and Benefits	357,910	386,070	358,257
13 Other compensation	148	160	149
12 Civilian personnel benefits	147,671	159,289	147,814
21 Travel	5,524	5,959	5,530
22 Transportation of Things	752	812	753
23 Rent, Communications, & Utilities	10,404	11,223	10,415
24 Printing & Reproduction	282	304	282
25 Other Services	329,182	355,082	329,501
26 Supplies & Materials	55,509	59,876	55,563
31 Equiptment	29,493	31,813	29,521
32 Land & Structures	215	232	216
42 Insurance Claims & Indemnities	0	0	0
Total	937,091	1,010,821	938,000

Medical and Prosthetic Research Reimbursable Obligations			
(Dollars in thousands)	2023 Actuals	2024 Estimate[1]	2025 Estimate[2]
11 Personnel Compensation and Benefits	23,070	33,319	33,319
13 Other compensation	-	-	-
12 Civilian personnel benefits	1,197	1,729	1,729
21 Travel	-	-	-
22 Transportation of Things	14	21	21
23 Rent, Communications, & Utilities	7	10	10
24 Printing & Reproduction	4	5	5
25 Other Services	17,461	25,218	25,218
26 Supplies & Materials	440	635	635
31 Equiptment	44	63	63
Total	42,237	61,000	61,000

1. A full-year 2024 appropriation for this account was not enacted at the time the Budget was prepared. Charts display the 2024 President's Budget request level for 2024 with updates to balances, recoveries, obligations, and collections in the 2024 Estimate column.
2..The total obligations in the CJ are $70 million higher than the total obligations level reported in the 2025 Budget Appendix.

Table: Medical Research Obligations and Budgetary Resources

Medical Research Obligations and Budgetary Resources					
	(Dollars in thousands)				
Description	2023 Enacted	2024 Request	2024 Estimate[1]	2025 Request2	2025 Request - 2024 Estimate
DISCRETIONARY RESOURCES					
Medical and Prosthetic Research Annual Appropriation	916,000	938,000	938,000	868,000	-70,000
APPROPRIATION [Subtotal]	916,000	938,000	938,000	868,000	-70,000
REIMBURSEMENTS	39,078	61,000	61,000	61,000	0
BUDGET AUTHORITY	**916,000**	**938,000**	**938,000**	**868,000**	**-70,000**
UNOBLIGATED BALANCE (SOY)					
No-year	4,334	4,500	4,305	4,500	195
2-year	96,380	100,000	83,016	60,000	-23,016
5-year	12,500	8,000	0	0	0
Unobligated Balance (SOY) [Subtotal]	113,214	112,500	87,321	64,500	-22,821
UNOBLIGATED BALANCE (EOY)					
No-year	-4,305	-4,500	-4,500	-4,500	0
2-year (Annual Appropriation)	-83,016	-90,000	-60,000	-40,000	20,000
Lapse (Two Year)	-1,643	0	0	0	0
Unobligated Balance (EOY) [Subtotal]	-88,964	-94,500	-64,500	-44,500	20,000
PRIOR YEAR RECOVERIES	41,599	50,000	50,000	50,000	0
OBLIGATIONS	**1,020,927**	**1,067,000**	**1,071,821**	**999,000**	**-72,821**
Full-Time Equivalents (FTE):					
Direct FTE	4,272	4,536	4,536	4,514	-22
Reimbursable FTE	112	180	113	112	-1
Total FTE	4,384	4,716	4,649	4,626	-23
MANDATORY RESOURCES					
American Rescue Plan § 8002 (ARP)					
REALLOCATION	30,000	0	0	0	**0**
BUDGET AUTHORITY	**0**	**0**	**0**	**0**	**0**
UNOBLIGATED BALANCE (SOY)					
ARP section 8002 - 3 year	280	0	0	0	0
UNOBLIGATED BALANCE (EOY)					0
ARP section 8002 - 3 year	0	0	0	0	0
PRIOR YEAR RECOVERY	0	0	0	0	0
OBLIGATIONS	**30,280**	**0**	**0**	**0**	**0**
Total FTE	109	0	0	0	-109
Cost of War Toxic Exposure Fund (TEF)					
TEF (P.L 117-168, Section 806) - 3 year	650	0	0	0	0
TEF (P.L 117-328) - 5 year	1,830	0	0	0	0
TEF (Request)	0	46,000	46,000	59,000	13,000
APPROPRIATION [Subtotal]	2,480	46,000	46,000	59,000	13,000
BUDGET AUTHORITY	2,480	46,000	46,000	59,000	13,000
UNOBLIGATED BALANCE (SOY)	0	0	238	0	-238
UNOBLIGATED BALANCE (EOY)	238	0	0	0	0
PRIOR YEAR RECOVERY	0	0	0	0	0
OBLIGATIONS	**2,242**	**46,000**	**46,238**	**59,000**	**12,762**
Total FTE	6	113	113	113	0

1. A full-year 2024 appropriation for this account was not enacted at the time the Budget was prepared. Charts display the 2024 President's Budget request level for 2024 with updates to balances, recoveries, obligations, and collections in the 2024 Estimate column.
2.. The total obligations in the CJ are $70 million higher than the total obligations level reported in the 2025 Budget Appendix.

Revolving and Trust Activities

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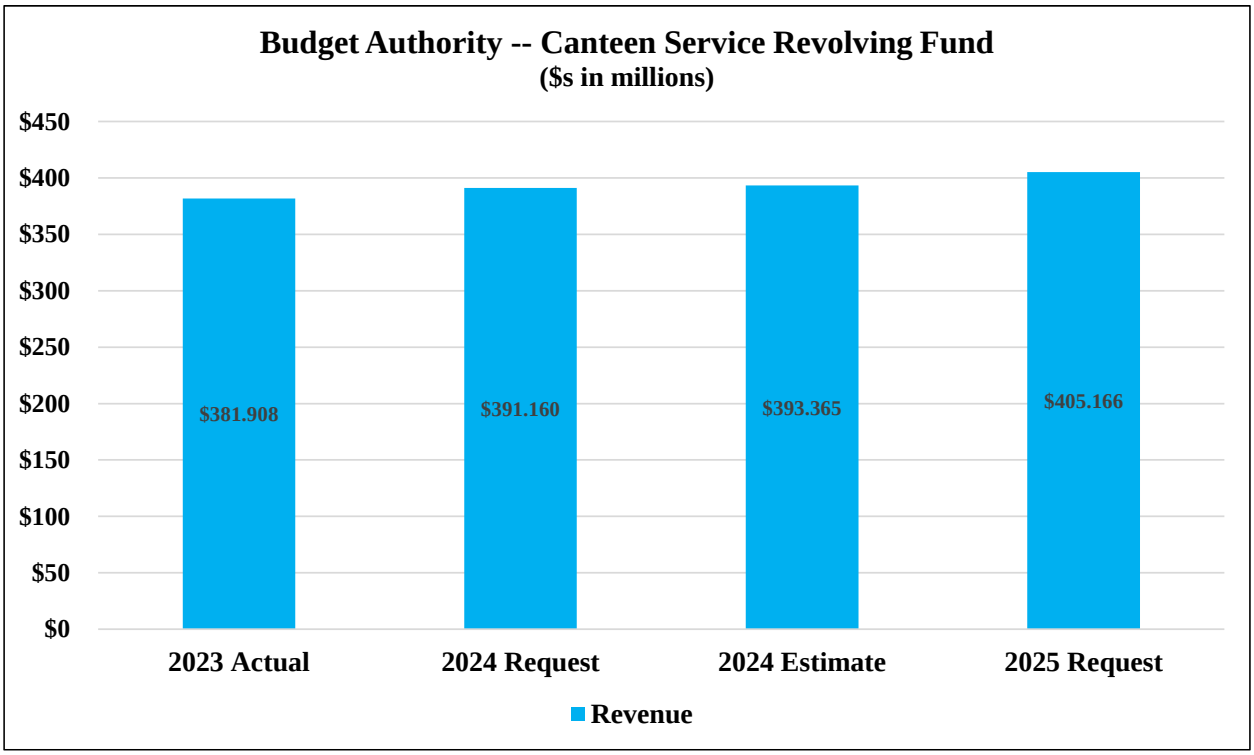
Veterans Canteen Service Revolving Fund



The 2024 Current Estimate is based on updated projections for the Canteen Service

Program Description

The Veterans Canteen Service (VCS) was established by Congress in 1946 to furnish, at reasonable prices, meals, merchandise, and services necessary for the comfort and well-being of Veterans in hospitals and domiciliaries operated by the VA (38 U.S.C. § 7801-10). It has since expanded to provide reasonably priced merchandise and services to America's Veterans enrolled in VA's health care system, their families, caregivers, VA employees, volunteers, and visitors.

Congress originally appropriated a total of $5.0 million for the operation of the VCS. Funds exceeding VSC needs, or $12.1 million, have been returned to the U.S. Treasury. In May 1988, Congress enacted the Veterans' Benefits Act of 1988 (Public Law 100-322) which 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. The Continuing Appropriations Act, 2021, (Public Law 116-159), Division A, Section 163, signed on October 1, 2020, authorized the transfer of $140,000,000 from funding provided to the Medical Services account in title X of division B of the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act", Public Law 116-136) to the Veterans Canteen Service Revolving Fund to provide sufficient operating funds to offset the

loss of revenue resulting from the coronavirus pandemic. 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 2025 and beyond.

Fund Highlights /1
(dollars in thousands)

Description	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Estimate	+/- 2024-2025
Total revenue.....	$381,908	$391,160	$393,365	$405,166	$11,801
Obligations.....	$411,370	$402,895	$405,697	$410,398	$4,701
FTE.....	2,215	2,065	2,210	2,200	(10)

[1/] The numbers in the chart above reflect an estimate of the activity during the Federal fiscal year (October – September), as the Veterans Canteen Service uses a retail industry fiscal year (February – January) used by similar private sector retailers to enhance their ability to compare their operations to their private sector peers.

The retail-calendar-fiscal-year reporting cycle has been adopted to better align VCS operations with the financial reporting structure of the retail industry. The calendar uses a (4-5-4) weekly cycle for the monthly reporting schedule. The 4-5-4 retail accounting calendar divides the year, beginning with the month of February, into quarters with the first and last month of each quarter consisting of four weeks each and the middle month of each quarter consisting of five weeks. Although the retail accounting calendar is used for management purposes, VCS will continue to report on a Federal fiscal year basis.

Summary of Budget Request

No appropriation by Congress will be required for VCS to operate during 2025. Disbursements are currently greater than collections; however, the remaining balances from the authorized CARES Act funds transfer is sufficient to maintain operations through 2025. VCS is a self-sustaining, revolving fund activity that obtains its revenues from non-Federal sources; therefore, no Congressional action is required. VCS is an independent agency within VA with control over its major activities, including collections, procurement, finance, and personnel management. VCS is implementing operational changes to return to self-sustainment where collections are sufficient to cover operating expenses and capital improvements. The operational changes include right-sizing staff expenses to current revenue levels, controlling costs by reducing inventory levels, and implementing targeted price increases. Operational adjustments will continue to be made until collections are sufficient to cover obligations.

Changes From 2024 Budget Request (dollars in thousands)			
	2024		
Description	Budget Estimate	Current Estimate	Increase/ Decrease
Total revenue.....	$391,160	$393,365	$2,205
Obligations.....	$402,895	$405,697	$2,802
FTE.....	2,065	2,210	145

Summary of Employment

For personnel management, VCS uses techniques generally applied in commercial retail chain stores, food, and vending operations. The key performance indicator (KPI) is salary expenses as a percent of revenue. Budgets for canteens and central office staff are established for this KPI annually. The KPI is monitored monthly through financial reports provided to the central office and canteen leadership, and it is benchmarked against the same period from the previous year and the budget targets. Contractors are an essential component of human capital required to maintain operations during the onboarding process. As such, contractor cost is part of this KPI.

The following chart reflects the full-time equivalent (FTE) employment for 2023 through 2025:

Summary of Employment					
		2024			
	2023 Actual	Budget Estimate	Current Estimate	2025 Estimate	+/- 2024-2025
FTE.....	2,215	2,065	2,210	2,200	(10)

Revenues and Expenses
(dollars in thousands)

	2023 Actual	2024 Budget Estimate 2/	2024 Current Estimate	2025 Estimate
Sales Program:				
Revenue	$381,908	$391,160	$393,365	$405,166
Less Cost of Sales	($236,783)	N/A	($237,986)	($239,048)
Gross Income	$145,125	N/A	$155,379	$153,963
Less Operating Expenses	($141,306)	($363,349)	($140,825)	($135,731)
Operating Income	$3,819	N/A	$14,555	$18,232
Non-operating Expenses/Income	($18,523)	($924)	($18,488)	($17,827)
Net income for the year 1/	($14,703)	$26,887	($3,934)	$405

1/ A net loss will be covered by the Reserve in the Canteen revolving fund which is shown in the Financial Conditions chart below on the line titled: *Cash with Treasury, in banks, in transit*

2/ The 2024 Congressional Justification did not display information in this format. This column displays only those rows that were shown in the 2024 Congressional Justification. A new display is presented in this Congressional Justification to provide additional detail on Revenue, Cost of Sales, and Operating Expenses.

Financial Condition

The schedule below reflects the anticipated financial condition of the VCS through 2025. Changes from year to year are the result of anticipated changes in revenues, obligations, and outlays previously portrayed.

Financial Condition
(dollars in thousands)

	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Estimate	+/- 2024-2025
Assets:					
Cash with Treasury, in banks, in transit	$92,000	$77,000	$70,946	$58,614	($12,332)
Accounts receivable (net)	$34,689	$40,102	$35,112	$36,165	$1,053
Inventories	$18,603	$15,812	$15,812	$16,286	$474
Real property and equipment (net)	$38,448	$26,250	$39,278	$40,456	$1,178
Other assets	$500	$525	$525	$541	$16
Total assets	$184,240	$159,689	$161,673	$152,063	($9,610)
Liabilities:					
Accounts payable including funded accrued liabilities	$44,281	$26,509	$42,010	$44,372	$2,363
Unfunded annual leave and coupons books	$6,426	$6,747	$6,747	$7,085	$337
Total liabilities	$50,707	$33,257	$48,757	$51,457	$2,700
VHA equity:					
Unexpended balance:					
Unobligated balance	$8,742	$9,179	$9,201	$437	($8,764)
Undelivered orders	$0	$0		$0	$0
Invested capital	$124,791	$117,254	$103,715	$100,168	($3,547)
Total Government equity (end-of-year)	$133,533	$126,433	$112,916	$100,605	($12,311)

Retained Income
(dollars in thousands)

	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Estimate	+/- 2024-2025
Retained Income:					
Opening Balance	$33,150	($7,949)	$18,447	$14,513	($3,934)
Transactions:					
Net Operating Income	($14,703)	($10,583)	($3,934)	$405	$4,339
Net Non-Operating Gain	$0	$0	$0	$0	$0
Closing Balance	$18,447	($18,532)	$14,513	$14,918	$405

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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 VA Medical Centers (VAMC). These nonprofit corporations (NPCs) provide flexible funding mechanisms for the conduct of VA-approved research and educational activities. They administer funds from non-VA Federal and private sources to operate various research and educational activities in VA. These corporations are private, state-chartered entities. They are self-sustaining and funds are not received into a government account. No appropriation is required to support these activities.

Prior to June 1, 2004, 93 VAMCs had received approval for the formation of nonprofit research corporations. Presently, 78 are active. Most of the corporations have indefinite, ongoing operations. However, the law permits NPC mergers, which may result in a decrease in the number of NPCs overall.

All 78 NPCs have received their authority from the Internal Revenue Service Code of 1986, under Article 501(c)(3) or similar Code Sections. The fiscal years for these organizations vary, with most having year-ends on September 30 or December 31. The table below reflects estimated revenues and expenses from 2023 to 2025.

Table: Contribution Highlights

Contribution Highlights
(dollars in thousands)

	2022 Actual 1/	2023 Estimated 2/	2024 Budget Estimate	2024 Current Estimate	2025 Estimate	+/- 2023-2024
Contributions.....	$310,832	$312,711	$309,430	$319,181	$327,034	$7,853
Expenses.....	$307,083	$305,084	$293,011	$306,798	$313,417	$6,619

The 2024 Current Estimate is based on an updated estimate of contributions and expenses.
1/ The actual amounts for 2022 were reported by the NPCs in June and July 2023
2/ The FY 2023 actuals will be reported by the NPCs in July 2024 as part of the annual reporting requirement in conjunction with the NPC Annual Report to Congress (ARC)

The following table is a list of research corporations that have received approval for formation along with their actual 2022 contribution from the non-VA Federal and private sources. In addition, NPCs with no contributions have been approved for operation. Some have received contributions in the past, others have not received any contributions to date:

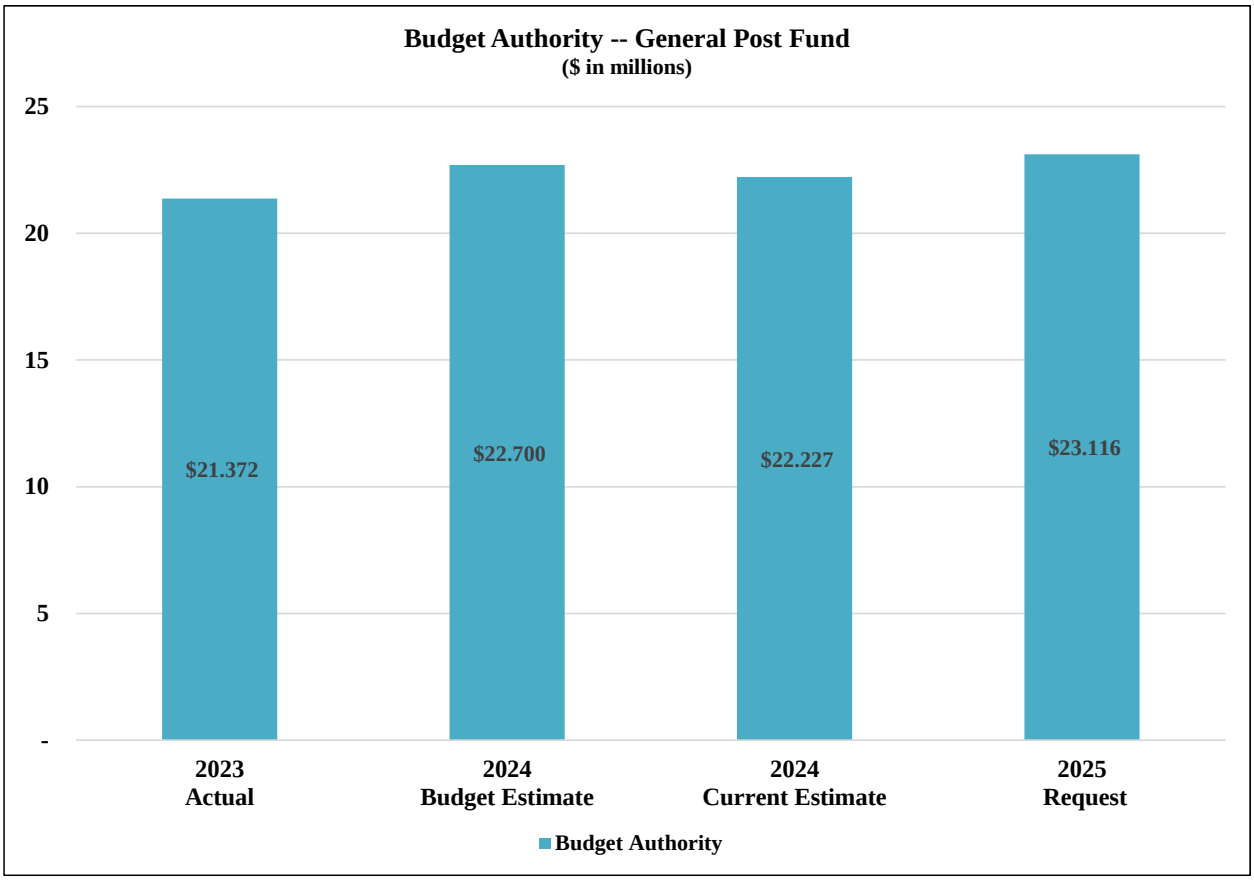
Table: Nonprofit Corporations

Nonprofit Corporations	City	State	Actual Revenues (Contributions) 2022	Estimated Revenues (Contributions) 2023	Estimated Revenues (Contributions) 2024	Estimated Revenues (Contributions) 2025
1. Albany Research Institute, Inc.	Albany	NY	2,406,000	1,876,000	670,000	19,000
2. Arizona Veterans Research and Education Foundation	Phoenix	AZ	1,796,000	1,507,000	1,800,000	1,950,000
3. Asheville Medical Research and Education Corporation	Asheville	NC	84,000	137,000	150,000	160,000
4. Augusta Biomedical Research Corporation	Augusta	GA	80,000	101,000	105,000	110,000
5. Baltimore Research and Education Foundation	Baltimore	MD	8,554,000	6,000,000	6,300,000	6,615,000
6. Bedford VA Research Corporation, Inc.	Bedford	MA	922,000	200,000	180,000	150,000
7. Biomedical Research and Education Foundation of Southern Arizona	Tucson	AZ	272,000	450,000	650,000	750,000
8. Biomedical Research Foundation	Little Rock	AR	1,219,000	1,400,000	1,600,000	1,600,000
9. Biomedical Research Institute of New Mexico	Albuquerque	NM	6,553,000	7,190,000	7,400,000	7,450,000
10. Boston VA Research Institute, Inc.	Boston	MA	13,305,000	13,000,000	13,000,000	13,000,000
11. Bronx Veterans Medical Research Foundation, Inc.	Bronx	NY	4,591,000	4,500,000	5,000,000	5,500,000
12. Buffalo Institute for Medical Research, Inc.	Buffalo	NY	922,000	600,000	400,000	400,000
13. Center for Veterans Research and Education	Minneapolis	MN	8,878,000	6,768,000	7,106,000	7,462,000
14. Chicago Association for Research and Education in Science	Hines	IL	5,695,000	7,000,000	7,000,000	7,000,000
15. Cincinnati Education & Research for Veterans Foundation	Cincinnati	OH	1,534,000	2,287,000	2,516,000	2,712,000
16. Clinical Research Foundation, Inc.	Louisville	KY	388,000	300,000	350,000	325,000
17. Dallas VA Research Corporation	Dallas	TX	1,996,000	2,500,000	2,525,000	2,550,000
18. Dayton VA Research and Education Foundation	Dayton	OH	195,000	110,000	120,000	130,000
19. Denver Research Institute, Inc.	Denver	CO	7,809,000	10,158,000	10,361,000	10,568,000
20. Dorn Research Institute, Inc.	Columbia	SC	488,000	500,000	550,000	605,000
21. East Bay Institute for Research and Education	Sacramento	CA	1,200,000	3,067,000	3,500,000	4,000,000
22. Foundation for Advancing Veterans' Health Research, Inc.	San Antonio	TX	3,793,000	5,579,000	5,612,000	4,403,000
23. Foundation for Atlanta Veterans Education and Research, Inc.	Atlanta	GA	11,962,000	9,551,000	5,458,000	5,500,000
24. Great Plains Veterans Research Foundation	Sioux Falls	SD	53,000	100,000	125,000	140,000
25. Greater Los Angeles Research and Education Foundation	Los Angeles	CA	7,243,000	8,012,000	8,075,000	8,139,000
26. Houston VA Research and Education Foundation	Houston	TX	1,020,000	500,000	600,000	700,000
27. Idaho Veterans Research and Education Foundation, Inc.	Boise	ID	1,248,000	600,000	650,000	700,000
28. Indiana Institute for Medical Research, Inc.	Indianapolis	IN	1,489,000	1,601,000	1,761,000	1,937,000

Nonprofit Corporations	City	State	Actual Revenues (Contributions) 2022	Estimated Revenues (Contributions) 2023	Estimated Revenues (Contributions) 2024	Estimated Revenues (Contributions) 2025
29. Institute for Clinical Research, Inc.	Washington	DC	6,536,000	5,500,000	5,600,000	6,000,000
30. Institute for Medical Research, Inc.	Durham	NC	7,876,000	11,000,000	12,000,000	13,000,000
31. Iowa City VA Medical Research Foundation	Iowa City	IA	941,000	400,000	450,000	450,000
32. Lexington Biomedical Research Institute, Inc.	Lexington	KY	421,000	300,000	300,000	300,000
33. Loma Linda Veterans Association for Research and Education, Inc.	Loma Linda	CA	3,909,000	4,000,000	4,300,000	4,500,000
34. Louisiana Veterans Research and Education Corporation	New Orleans	LA	83,000	286,000	314,000	345,000
35. Lowcountry Center for Veterans Research	Charleston	SC	2,683,000	3,210,000	4,014,000	5,017,000
36. McGuire Research Institute, Inc.	Richmond	VA	5,239,000	4,300,000	4,500,000	4,600,000
37. Middle Tennessee Research Institute, Inc.	Nashville	TN	749,000	750,000	750,000	750,000
38. Midwest Veterans' Biomedical Research Foundation	Kansas City	MO	2,142,000	1,700,000	2,000,000	2,000,000
39. Truman VA Medical Research Foundation	Columbia	MO	964,000	838,000	875,000	900,000
40. Mountain Home Research and Education Corporation	Mountain Home	TN	551,000	800,000	800,000	800,000
41. Narrows Institute for Biomedical Research, Inc.	Brooklyn	NY	2,873,000	200,000	200,000	20,000
42. Nebraska Educational Biomedical Research Association	Omaha	NE	1,137,000	400,000	400,000	400,000
43. North Florida Foundation for Research and Education, Inc.	Gainesville	FL	1,470,000	3,250,000	4,250,000	4,250,000
44. Northern California Institute for Research and Education, Inc.	San Francisco	CA	54,120,000	62,409,000	62,000,000	62,000,000
45. Ocean State Research Institute, Inc.	Providence	RI	5,112,000	1,253,000	1,303,000	1,355,000
46. Overton Brooks Research Corporation	Shreveport	LA	151,000	330,000	340,000	335,000
47. Pacific Health Research and Education Institute	Honolulu	HI	540,000	230,000	500,000	1,500,000
48. Palo Alto Veterans Institute for Research	Palo Alto	CA	29,923,000	29,508,000	30,983,000	31,913,000
49. Philadelphia Research and Education Foundation	Philadelphia	PA	2,330,000	200,000	220,000	240,000
50. Portland VA Research Foundation, Inc.	Portland	OR	8,307,000	8,835,000	9,454,000	9,927,000
51. Research! Mississippi, Inc.	Jackson	MS	204,000	116,000	200,000	250,000
52. Research, Inc.	Memphis	TN	1,063,000	880,000	900,000	920,000
53. Salem Research Institute, Inc.	Salem	VA	1,369,000	1,500,000	1,800,000	2,000,000
54. Salisbury Foundation for Research and Education, Inc.	Salisbury	NC	528,000	674,000	761,000	898,000
55. Seattle Institute for Biomedical and Clinical Research	Seattle	WA	19,540,000	19,340,000	19,000,000	19,000,000

Nonprofit Corporations	City	State	Actual Revenues (Contributions) 2022	Estimated Revenues (Contributions) 2023	Estimated Revenues (Contributions) 2024	Estimated Revenues (Contributions) 2025
56. Sierra Veterans Research and Education Foundation	Reno	NV	211,000	350,000	400,000	400,000
57. Sociedad de Investigacion Cientificas, Inc	San Juan	PR	344,000	430,000	538,000	672,000
58. South Florida Veterans Affairs Foundation for Research and Education, Inc	Miami	FL	2,522,000	275,000	275,000	275,000
59. Southern California Institute for Research and Education	Long Beach	CA	2,655,000	3,000,000	3,250,000	3,250,000
60. Tampa VA Research and Education Foundation, Inc	Tampa	FL	3,317,000	3,500,000	3,700,000	4,000,000
61. Central Texas Veterans Research Foundation	Temple	TX	969,000	1,006,000	600,000	600,000
62. The Bay Pines Foundation, Inc	Bay Pines	FL	1,296,000	1,100,000	1,200,000	1,200,000
63. The Cleveland VA Medical Research and Education Foundation	Cleveland	OH	3,836,000	4,028,000	4,229,000	4,441,000
64. The Research Corporation of Long Island, Inc	Northport	NY	161,000	196,000	225,000	225,000
65. Tuscaloosa Research and Education Advancement Corporation	Tuscaloosa	AL	1,160,000	1,153,000	1,122,000	889,000
66. VA Black Hills Research and Education Foundation	Fort Meade	SD	4,000	0	0	0
67. VA Connecticut Research and Education Foundation, Inc.	West Haven	CT	1,464,000	1,600,000	1,800,000	1,900,000
68. Veterans Bio-Medical Research Institute, Inc	East Orange	NJ	2,396,000	2,367,000	2,367,000	2,367,000
69. Veterans Education and Research Ass'n. of Northern New England, Inc	White River Junction	CT	3,387,000	4,966,000	5,066,000	5,167,000
70. Veterans Education and Research Association of Michigan	Ann Arbor	MI	1,916,000	2,000,000	2,200,000	2,420,000
71. Metropolitan Detroit Research and Education Foundation	Detroit	MI	90,000	150,000	200,000	250,000
72. Veterans Health Foundation	Pittsburgh	PA	2,631,000	2,318,000	2,388,000	2,460,000
73. Veterans Health Research Institute of Central New York, Inc	Syracuse	NY	1,568,000	1,734,000	2,100,000	2,100,000
74. Veterans Medical Research Foundation of San Diego	San Diego	CA	16,368,000	16,400,000	17,000,000	17,000,000
75. Veterans Research and Education Foundation	Oklahoma City	OK	329,000	386,000	415,000	450,000
76. Veterans Research and Education Foundation of St. Louis	St. Louis	MO	1,777,000	1,892,000	1,949,000	2,008,000
77. VISTAR, Inc	Birmingham	AL	477,000	350,000	400,000	450,000
78. Western Institute for Veterans Research	Salt Lake City	UT	5,097,000	5,352,000	5,619,000	5,900,000
79. Wisconsin Corporation for Biomedical Research	Milwaukee	WI	401,000	355,000	360,000	365,000
Total			**310,832,000**	**312,711,000**	**319,181,000**	**327,034,000**

General Post Fund



The 2024 Current Estimate is based on an updated projection of receipts to the General Post Fund

Program Description

This trust fund consists of gifts, bequests, and proceeds from the sale of property left in the care of VA facilities by former beneficiaries who die leaving no heirs or without having otherwise disposed of their estate. Such funds are used to promote the comfort and welfare of Veterans at hospitals and other facilities for which no general appropriation is available. Donations from pharmaceutical companies, non-profit corporations, and individuals to support VA medical research can also be deposited into this fund (title 38 U.S.C., Ch. 83, Acceptance of Gifts and Bequests, and Ch. 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 Veterans Health Administration Directive 4721, General Post Fund. In

addition, P.L. 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

Description (dollars in thousands)	2023 Actual	2024 Budget Estimate	2024 Current Estimate	2025 Estimate	+/- 2024-2025
Budget Authority (permanent, indefinite).....	$21,372	$22,700	$22,227	$23,116	$889
Projected Receipts :					
Trust Fund and Donation.....	$19,422	$16,600	$20,200	$21,000	$800
Therapeutic Residences.....	$688	$800	$700	$700	$0
Total Projected Receipts.....	$20,110	$17,400	$20,900	$21,700	$800

Table 2: Changes from 2024 Budget Estimate

Description (dollars in thousands)	2024 Budget Estimate	2024 Current Estimate	Increase/ Decrease
Budget Authority (permanent, indefinite).....	$22,700	$22,227	($473)
Projected Receipts:			
Trust Fund and Donation.....	$16,600	$20,200	$3,600
Therapeutic Residences.....	$800	$700	($100)
Total Projected Receipts.....	$17,400	$20,900	$3,500

Program Activity

Trust Fund and Donations

Estimates of trust fund obligations for 2024 and 2025 are $22.2 million and $23.1 million respectively. The obligations are consistent with the purposes for which proceeds from this fund may legally be expended (Comptroller General's Decision B 125715, November 10, 1955) and the intent of the donors. Donors usually specify that their donations be used for designated recreational or religious purposes, research projects, or equipment purchases (for example, televisions, medical equipment, and physical therapy equipment).

Compensated Work Therapy - Therapeutic Residences (CWT-TR)

Under 38 U.S.C. § 2032, funds received through the operation of the Therapeutic Housing Program are to be deposited in the General Post Fund. The Secretary has the discretionary authority to

expend up to an additional $500 thousand from the fund above the amount credited to the fund in a fiscal year from proceeds of this program.

Table 3: Financial Actions and Conditions

Description (dollars in thousands)	2023 Actual
Balance beginning of year: 1/	
Cash	$19,423
Investments	$117,791
Property, Plant, Equipment & Other Assets	$44,529
Total	$181,743
Increase during period:	
Cash	$165,581
Investments	$99,875
Property, Plant, Equipment & Other Assets	$2
Total	$265,458
Decrease during period:	
Cash	$183,386
Investments	$77,774
Property, Plant, Equipment & Other Assets	$2,261
Total	$263,421
Balance at end of year:	
Cash	$1,618
Investments	$139,892
Property, Plant, Equipment & Other Assets	$42,270
Total	$183,780

1/ There is a slight difference between the 2022 Balance end of year as reported in the Total 2024 Budget and the Total 2023Balance beginning of year due to irregularities that occurred over the years. Beginning in 2023, actual data will be based on a new accounting report.

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Department of Veterans Affairs
Office of the Assistant Secretary for Management
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