# FY 2023 BUDGET SUBMISSION


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

## Medical Programs and Information Technology Programs

Volume 2 of 4

**March 2022**

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# *Medical and Information Technology Programs*

## Medical

## Joint Medical Care Special Programs



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# *Budget Overview*

## Mission Statement

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

## Budget Request

This budget request will ensure the Nation's Veterans receive high-quality health care and timely access to benefits and services. The 2023 Revised Request (RR) reflects total discretionary appropriations of $118.7 billion for Veterans Health Administration (VHA) Medical Care. This includes a $7.5 billion annual appropriations request above the 2023 enacted advance appropriations.

Medical Care is composed of four appropriations:

**Discretionary Appropriation Request**

| Dollars in Thousands ($000) Description | 2023 Advance Approp. (AA) | 2023 Revised Request (RR) | +/- 2023 AA 2023 RR | 2024 Advance Approp. (AA) | +/- 2024 AA 2023 RR |
|---|---|---|---|---|---|
| Medical Services | $70,323,116 | $70,584,116 | $261,000 | $74,004,000 | $3,419,884 |
| Medical Community Care | $24,156,659 | $28,456,659 | $4,300,000 | $33,000,000 | $4,543,341 |
| Medical Support & Compliance | $9,673,409 | $11,073,409 | $1,400,000 | $12,300,000 | $1,226,591 |
| Medical Facilities | $7,133,816 | $8,633,816 | $1,500,000 | $8,800,000 | $166,184 |
| Appropriation [Subtotal] | $111,287,000 | $118,748,000 | $7,461,000 | $128,104,000 | $9,356,000 |
| Collections | $3,909,801 | $3,909,801 | $0 | $3,967,975 | $58,174 |
| Appropriations & Collections [Total] | $115,196,801 | $122,657,801 | $7,461,000 | $132,071,975 | $9,414,174 |

- **Medical Services:** Discretionary appropriation of $70.6 billion, an increase of $261.0 million above the 2023 advance appropriation, which when combined with all other resources, funds clinical staff salaries, pharmacy, prosthetics, beneficiary travel and medical equipment.

- **Medical Community Care:** Discretionary appropriation of $28.5 billion, an increase of $4.3 billion above the 2023 advance appropriation, which when combined with all other resources, funds non-VA provided medical claims and grants for state home nursing, domiciliary and adult day care services.

- **Medical Support and Compliance:** Discretionary appropriation of $11.1 billion, an increase of $1.4 billion above the 2023 advance appropriation, which when combined with all other resources, funds 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.

- **Medical Facilities:** Discretionary appropriation of $8.6 billion, an increase of $1.5 billion above the 2023 advance appropriation, which when combined with all other resources, funds facility maintenance, leasing and energy.

The request also includes $3.9 billion in estimated medical care collections for a combined discretionary resource amount of approximately $122.7 billion.

The 2023 request supports improved patient access to and timeliness of medical care services for approximately 9.2 million enrolled Veterans. The request fully supports the provision of health care that VA projects has been deferred during the COVID-19 pandemic, in addition to providing for health care services at the pre-pandemic levels. The 2023 budget ensures that all of our veterans, including women Veterans, Veterans of color and LGBTQ+ Veterans, receive the care they have earned. The 2023 request further supports the Department's effort to address substance use disorders, prioritize Veteran suicide prevention, improve mental health care services and invest in overdose prevention and treatment programs, including those in support of the Jason Simcakoski Memorial and Promise Act. The request funds the continued expansion of our caregiver support programs, and bolsters efforts to end Veteran homelessness.

The 2023 budget also prioritizes efforts to address military environmental exposures by increasing funding for the Health Outcomes Military Exposures (HOME) program and invests in the precision oncology program to provide access to the best possible cancer care for Veterans. To improve care for Veterans, the 2023 request also includes legislative proposals that would expand eligibility for health care enrollment, lower Veterans' out-of-pocket costs for certain mental health care services and contraceptive care and enhance equity by expanding access to assisted reproductive technology, including in vitro fertilization and adoption reimbursement. The Budget also includes multiple proposals to improve VA's ability to recruit and retain the highest-quality health care workforce, a necessary component to continuing VA's ability to provide the timely, high-quality care Veterans need and have earned.

## 2024 Advance Appropriation

The Budget requests $128.1 billion in 2024 discretionary advance appropriations for medical care programs, to ensure continuity of Veterans' health care services and sustain VA's increased capacity for care following the pandemic. The Budget includes $4.0 billion in estimated medical care collections for a combined discretionary resource of approximately $132.1 billion.

## Key VA Priorities

The VA is a diverse and inclusive organization welcoming all our Veterans, including women Veterans, Veterans of color and LGBTQ+ Veterans. The 2023 request supports the following priorities:

**Providing Seamless and Coordinated Access to Integrated Veteran Care**
Providing Veterans with timely access to high quality health care is essential. Veterans are getting more care through VA than ever, in VHA facilities and through community care. While managing COVID Delta and Omicron surges and keeping Veterans as safe as possible throughout 2021, VA facilities completed more than 78 million Veteran encounters, including more than 37 million in-person, 30 million by telephone, 10 million by video and managed approximately 33 million community provided visits.

Even as Veterans return to in-person appointments for some clinical care, many clinical needs of our Veterans will continue to be delivered virtually and we are deeply appreciative of the funds Congress provided to help us do so in the American Rescue Plan (ARP) Act. ARP funding is supporting the Department's expansion of enterprise-wide technology infrastructure that is enabling VA to provide 24/7 access to virtual care from regional clinical contact centers. This access is supplemental to care offered through our VA Medical Centers and Community Based Outpatient Clinics, and for those eligible, through VA's robust community care network.

VA positions the Veteran at the center of his/her own care so he/she is the ultimate decision-maker on where to receive care. VA is taking steps to ensure timely access to the highest quality health care services while achieving the right balance of care provided in VA and the community through its Integrated Veteran Care (IVC) initiative. The benefit of IVC will be an integrated access and care coordination model that provides a simplified, Veteran-focused experience regardless of where the Veteran receives his/her care. To achieve IVC, VA is aligning staff from the Office of Community Care (OCC) and Office of Veterans Access to Care (OVAC) into a single team to oversee the design and implementation of this model.

Through the IVC initiative, VA remains committed to strengthening the direct health care system, expanding access through virtual healthcare, and pushing the boundaries of what is possible in serving our nation's Veterans. Community Care will continue to be a key component of healthcare delivery for our Veterans. With Veterans at the center of their own care, VA is working to achieve the right balance between care provided in the community and care provided at VA to ensure Veterans have timely access to the highest quality health care services.

**Delivering Timely Access to High Quality Mental Health Care and Preventing Suicide Among Veterans**
VA provides a comprehensive continuum of outpatient, residential and inpatient mental health services for the full range of mental health conditions. VA proactively screens for symptoms of depression, post-traumatic stress disorder (PTSD), problematic use of alcohol, experiences of military sexual trauma (MST) and suicide risk. VA emphasizes the use of Veterans Crisis Line (1-800-273-8255, Option 1) through multiple media continuums. In addition to the VA Crisis Line, VA is a supporter of implementing a call 988 National Suicide Prevention Lifeline.

Suicide prevention continues as a top clinical priority, and as a part of our efforts we continue to enhance our comprehensive public health approach to reach all Veterans. Suicide is a complex issue with no single cause or solution. Our commitment to a proactive, Veteran-centered Whole Health approach is integral to our mental health care efforts and includes online and telehealth access strategies. Whole Health reconnects Veterans with their mission and purpose in life as part of our comprehensive approach to reducing risk.

Maintaining the integrity of VA's mental health care system is vitally important, but it is not enough. We know some Veterans may not receive any health care services from VA, which highlights that VA alone cannot end Veteran suicide; it requires a nationwide effort. VA developed the National Strategy for Preventing Veteran Suicide with the intention of articulating how everyone can work together to prevent Veteran suicide. This national vision for preventing Veteran suicide is grounded in three major tenets that we firmly believe: (1) suicide is preventable, (2) suicide requires a public health approach, combining community-based and clinical approaches, and (3) everyone has a role to play in suicide prevention. While the development of the National Strategy was groundbreaking in defining the vision of reaching and serving Veterans within and outside VHA clinical care, VA moved to translate the vision of the 10-year National Strategy into operational plans of actions through Suicide Prevention 2.0 (SP 2.0) combined with the Suicide Prevention Now initiative.

This budget funds the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (P.L. 116-171) which authorized the new Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program to reduce Veteran suicide through a community-based grant program that provides or coordinates suicide prevention services. The 2023 budget also fully funds the provision of emergent suicide care authorized by the Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020 (P.L. 116-214).

Finally, the budget supports the Administration's efforts to expand access and lower out-of-pocket costs for mental health services, in recognition that mental health is essential to overall health, and that the United States faces a mental health crisis that has been exacerbated by the COVID-19 pandemic. To support these efforts, VA is reducing barriers to mental health access by fully implementing the 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. VA is also proposing to change the copayments for all enrolled veterans for outpatient mental health visits to $0 for the first three visits per year by modifying 38 U.S.C chapter 17.

**Supporting Cancer Moonshot and Advancements in Precision Oncology**

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

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

oncologists affiliated with National Cancer Institute-designated Cancer Centers to underserved areas.

Clinical trials are often part of standard clinical care for patients with cancer and are a second area of clinical-research integration in Precision Oncology. Together, these elements form a System of Excellence for the full spectrum of care for a particular cancer type. Systems of Excellence are established for Prostate/Genitourinary Cancers and Lung. In 2023 VA will specifically address molecular diagnostics (tumor testing, germline testing and required enhancement of genetic counseling and pharmacogenomics), complete the establishment of the Breast and Gynecologic Cancers System of Excellence, launch the Rare Cancers System of Excellence and enhance Radiation Oncology services.

The Budget invests $81.0 million within VA research programs, together with $167.0 million within the VA Medical Care program, for precision oncology to provide access to the best possible cancer care for veterans. Funds support research and programs that address cancer care, rare cancers and cancers in women, as well as genetic counseling and consultation that advance tele-oncology and precision oncology care. The combined increase in those two accounts over 2022 is $79.0 million.

**Addressing Environmental Exposures**

An estimated one in three Veterans who deploy reports an exposure to environmental hazards, and one in four believes that a major health concern has occurred because of the exposure. Military environmental exposures can result in short-term acute health outcomes and long-term chronic illnesses. Agent Orange in Vietnam and airborne hazards and open burn pits in the Southwest Asia Theater of Operations are examples of these exposures.

One of the major challenges in the field of military environmental exposures is a lack of exposure and assessment data at the individual level. VA medical care and research programs seek to enhance military exposure data collection, assessments and to improve understanding of the effects of military exposures on Veterans' health outcomes. VA programs, in collaboration with federal partners focus on obtaining a more precise determination of the types and amounts of specific environmental exposures incurred by Service members, and how they relate to specific clinical outcomes. Findings from both research and surveillance programs will inform care, policy, benefits decisions and future research protocols.

To achieve this comprehensive and integrative approach to understanding and treating Veterans exposed to environmental toxicants, VA is employing an integrative approach that leverages internal and external partnerships and combined expertise in toxicology, data science and other fields.

The VA budget increases resources for new presumptive disability compensation claims related to environmental exposures from military service. The budget also invests $51.0 million within VA research programs for the Military Exposures Research Program (MERP) and $63.0 million within the VA medical care program for HOME to increase scientific understanding of and clinical support for veterans and healthcare providers regarding the potential adverse impacts from

environmental exposures during military service. The $63.0 million investment in the 2023 HOME budget is an increase of $32.0 million above 2022 budget.

**Increasing Support to Families and Caregivers**
VA's Caregiver Support Program (CSP) empowers family caregivers to provide care and support to Veterans with a wide range of resources through the Program of General Caregiver Support Services (PGCSS) and the Program of Comprehensive Assistance for Family Caregivers (PCAFC). VA began a major expansion of PCAFC on October 1, 2020.

The PCAFC expansion is implemented in two phases. The first phase, which commenced on October 1, 2020, includes eligible Veterans who incurred or aggravated a serious injury in the line of duty on or before May 7, 1975. As of March 8, 2022, VA has received more than 139,000 unique applications for the PCAFC since October 1, 2020 and added 18,600 additional Veterans and their Family Caregivers in the program. Approximately 10,500 applications remain in process and are pending a determination of eligibility. The program office is preparing for Phase II of PCAFC expansion that is scheduled to begin on October 1, 2022; this phase of expansion will include eligible Veterans who incurred or aggravated a serious injury in the line of duty between May 7, 1975, and September 11, 2001.

In parallel to expanding the program, VA is re-examining its approach to evaluating applications. Feedback from numerous stakeholders and results of recent reassessments of legacy program (post-9/11) participants led to concerns that implementing the regulations as written was preventing some Veterans with moderate to severe caregiving needs from participating in the program. VA is currently reviewing potential modifications to achieve intended outcomes in all new and legacy cases.

In addition, CSP is responding to a recent court ruling which is expected to have notable impact to the program. On April 19, 2021, the U.S. Court of Appeals for Veterans Claims (Court), in the case of *Jeremy Beaudette & Maya Beaudette v. Denis McDonough*, Secretary of Veterans Affairs, ruled in favor of petitioners seeking review by the Board of Veterans' Appeals (Board) of decisions under VA's PCAFC. As a result of this ruling, Veterans and caregivers who disagree, in whole or in part, with a VA decision under the PCAFC now have expanded appeal options outside the VHA Clinical Appeals process. For cases that have already been adjudicated, Veterans and caregivers who disagree with a PCAFC decision have an opportunity to appeal using the following methods: Higher Level Review, Supplemental Claim or the Board of Veteran Appeals (Board).

**Continuing to Support the Growing Number of Women Veterans Who Use VA Services**
VA has seen the number of women Veterans enrolling in VA health care continue to increase, placing new demands on VA's health care system. Women make up 16.9% of today's Active-Duty military forces and 19% of National Guard and Reserves. Based on the trend, the number of women Veterans using VA health care is expected to rise rapidly. More women are choosing VA for their health care than ever before, with women accounting for over 30% of the increase in Veterans enrolled over the past 5 years. The number of women Veterans using VA health care services has more than tripled since 2001, growing from 159,810 to more than 600,000 today.

To address the growing number of women Veterans who are eligible for health care, VA is strategically enhancing services and access for women Veterans by continuing to invest in a hiring

and equipment initiatives in 2022, providing funding for a total of over 400 women's health personnel nationally: primary care providers, gynecologists, mental health providers and care coordinators. Funds are available for programs that have traditionally not been offered by VA, such as pelvic floor physical therapy, lactation support and maternity care coordination.

Enhancing capacity to support pregnant and postpartum Veterans is a VA priority. To that end, VA has provided funding to facilities to expand their maternity care coordination workforce and to increase their capacity to provide lactation support to Veterans. VA has provided funding to hire and train additional maternity care coordinators and lactation support personnel. VA is focused on improving access, services, resources and workforce capacity to make health care more accessible, more sensitive to gender-specific needs and of the highest quality for women Veterans of today and tomorrow.

Every one of the 171 VA medical centers (VAMCs) across the United States now has a full-time Women Veteran's Program Manager tasked with advocating for the health care needs of women Veterans. Mini residencies in women's health with didactic and practicum components optimize women's health clinician proficiency. Since 2008, more than 9,100 health care providers and nurses have been trained in the national, local and rural programs.

To provide the highest quality of care to women Veterans, VA offers women Veterans assignments to trained and experienced designated Women's Health Primary Care Providers (WH-PCP). We find that women assigned to WH-PCPs are twice as likely to choose to stay in VA care over time. To ensure we meet the needs for the increasing numbers of women Veterans, the VHA is rapidly increasing access to trained designated Women's Health Providers through large scale educational initiatives and has now trained over 5,561 primary care providers since 2008. VA provides many services for women Veterans, including gynecology and maternity care. VA also provides mental health services, treatment and health care related to experiences of military sexual trauma.

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

The VA budget further supports Veterans by including a legislative proposal to enhance equity by expanding access to assisted reproductive technology, in vitro fertilization and adoption reimbursement. The budget also eliminates cost-sharing for contraception-related health care and services when contraception-related services are the only care provided within the visit.

**Bolstering Efforts to End Veteran Homelessness**

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

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

VA has made significant progress to prevent and end Veteran homelessness, particularly in light of new challenges faced during the pandemic. The number of Veterans experiencing homelessness in the United States has declined by nearly half since 2010. On a single night in January 2021, there were 19,750 Veterans experiencing sheltered homelessness in the U.S. Between 2020 and 2021, the number of Veterans experiencing sheltered homelessness decreased by 10.4% (2,298 fewer people). However, COVID-19 impacted the ability of communities to conduct their counts in January 2021. The report is only able to provide national estimates on sheltered homelessness. Therefore, while an important snapshot of sheltered homelessness, the report does not provide a complete picture of homelessness in America.

Since 2010, over 938,000 Veterans and their family members have been permanently housed or prevented from becoming homeless. Efforts to end Veteran homelessness have resulted in an expansion of services available to permanently house homeless Veterans and the implementation of new programs aimed at prevention, including low-threshold care/engagement strategies and monitoring homeless outcomes. As of March 8, 2022, there were 86 areas (83 communities and 3 states: Delaware, Connecticut and Virginia) that have publicly announced an effective end to Veteran homelessness. Those communities have met the benchmarks and criteria established by the United States (U.S.) Interagency Council on Homelessness, VA and the Department of Housing and Urban Development (HUD), for declaring an end to Veteran homelessness. VA offers a wide array of interventions designed to find Veterans experiencing homelessness, engage them in services, find pathways to permanent housing and prevent homelessness from reoccurring.

The VA budget funds Medical Care costs associated with the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116-315) including Title IV, the Navy SEAL Bill Mulder Act of 2020, in support of homeless Veterans by allowing the HUD-VA Supportive Housing program (HUD-VASH) to provide assistance (such as food, shelter, clothing, blankets and hygiene items), transportation required to support stability and health, communications equipment during a covered public health emergency and for contract HUD-VASH case management. The Act increases VA's grant authority for legal services and certain per diem payments for VA's Grant and Per Diem (GPD) program.

**Addressing an Aging Medical Infrastructure:**
VA operates the largest integrated health care, benefits and cemeteries system in the Nation, with more than 1,700 hospitals, clinics and other health care facilities, a variety of benefits and service locations and 155 national cemeteries. The infrastructure portfolio consists of approximately 184 million owned and leased square feet—one of the largest in the Federal Government. While the median age of U.S. private sector hospitals is 10.8 to 11.5 years, VA's portfolio has a median age of 58 years. A full 69% of VA hospitals are over the age of 50, and VA medical facilities, on average, are nearly six times the age of private sector facilities. Health care innovation is occurring at an exponential pace, and the comparative youth of private sector facilities is informed by these trends. The architects who designed and constructed many VA facilities in the decades following World War II could not have anticipated the requirements of today's medical technology and the key enabling role that infrastructure – and technological infrastructure - now plays in delivering safe and high-quality health care. Many of VA's facilities were not designed this way and this limits our agility and ability to meet the evolving health care needs of Veterans.

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

The transformation of VA health care to achieve a safer, sustainable, greener, person-centered national health care model requires that VA leverage innovations in medical technology and clinical procedures. As technology-enabled trends in U.S. medicine bring care close to individuals and communities, there is less demand for prodigious, sprawling campuses and more emphasis on ambulatory facilities and virtual care. Many surgical, medical and diagnostic procedures that once required a hospital stay are now safely performed in the outpatient setting, and virtual health care delivery brings expertise to a patient's own home.

This evolving landscape requires VA to rebalance and recapitalize its infrastructure to optimize the mix of traditional inpatient hospitals with outpatient hospitals, multi-specialty community-based outpatient clinics, single specialty community based outpatient clinics and virtual care.

The 2023 VA budget includes a Non-Recurring Maintenance funding level of $2.5 billion, of which $505.0 million is for infrastructure projects required to support Electronic Health Record Modernization (EHRM). The Budget does not make any adjustments to the NRM request as a result of the on-going Asset and Infrastructure Review (AIR) Commission process, directed by the MISSION Act. The implementation of any changes to VA's health care infrastructure as a result of AIR may be several years away and would depend on Air Commission Presidential, and Congressional decisions. VA looks forward to collaborating with the AIR Commission as it assesses the Department's recommendations and transmits its own report to the President.

**Investing in Human Resources Modernization**
The 2023 budget is focused on investing in VA's workforce and attracting and retaining new talent by leveraging investments and improvements in VA's human capital infrastructure.

The budget supports VA's efforts to:

- continue to work with Congress on legislation such as the recently enacted RAISE Act to invest in employee wages
- maximize bonuses and retention incentives to reward employees for excellent work
- increasing opportunities to advance at VA through leadership development programs
- expediting the hiring process by simplifying the application requirements
- using all available authorities to establish a work environment that is flexible, where employees have opportunities to work outside their traditional workspace, whenever and wherever possible
- permanently raising the childcare subsidy cap for qualifying employees
- investing in employee well-being through programs such as the VHA Reduce Burnout and Optimize Organizational Thriving (REBOOT) task force
- investing in scholarship programs to offer educational opportunities to even more employees
- embedding Inclusion, Diversity, Equity and Access (IDEA) into everything we do
- continuing to focus on keeping employee and visitor safety at the forefront, as VA navigates the evolving pandemic impacts.

In addition to the overall workforce, the 2023 VA budget carves a path for optimization and innovation in the face of a growing agency needs and evolving changes in the healthcare industry. The budget invests specifically and significantly in the VHA Human Resources workforce in support of superior customer service, resulting in an improved employee and Veteran experience. These investments include:

- the standardization of staffing models to ensure adequate and appropriate allocation of resources
- use of Talent and Process Improvement Teams to further improve operational workflows and processes
- expansion of roles within the local medical centers
- enhanced training and development protocols for staff throughout the enterprise
- overall improvements to data and technical systems used by Human Resources staff.

## Change from 2023 Advance Appropriation (AA)
VA is requesting an additional $7.5 billion over the 2023 enacted Advance Appropriation amount. The table below details the activities associated with the increased appropriation request.

## Table: Update to the 2023 Advance Appropriation Request

The table on the following page displays the update to the 2023 Advance Appropriation request for Medical Care.

**Update to the 2023 Advance Appropriation Request**
**Medical Care**
(dollars in thousands)

| Description | 2023 Revised Estimate | Available Discretionary Funding: Approp. Incl. Transfers | Collections | Reimb. | Use of Unobl. Balance | Available Mand. Funding: VACAA Use of Unobl. Balance Sec. 801 | VACAA Use of Unobl. Balance Sec. 802 | ARP Act Use of Unobl. Balance Sec. 8002 1/ | Subtotal | Discretionary Annual Approp. Adjust Required |
|---|---|---|---|---|---|---|---|---|---|---|
| **Health Care Services:** | | | | | | | | | | |
| Ambulatory Care | $65,102,797 | $55,532,071 | $2,165,588 | $220,937 | $1,265,006 | $6,863 | $265,088 | $2,361,292 | $61,816,845 | **$3,285,952** |
| Dental Care | $2,291,788 | $1,942,752 | $72,433 | $0 | $41,162 | $0 | $0 | $0 | $2,056,347 | **$235,441** |
| Inpatient Care | $24,485,224 | $20,026,187 | $773,867 | $0 | $439,773 | $1,323 | $0 | $1,170,913 | $22,412,063 | **$2,073,161** |
| Mental Health Care | $13,918,915 | $12,615,868 | $439,914 | $0 | $249,994 | $0 | $0 | $0 | $13,305,776 | **$613,139** |
| Prosthetics | $4,069,980 | $4,049,331 | $20,649 | $0 | $0 | $0 | $0 | $0 | $4,069,980 | **$0** |
| Rehabilitation Care | $1,258,933 | $1,161,996 | $39,789 | $0 | $0 | $0 | $0 | $0 | $1,201,785 | **$57,148** |
| **Health Care Services [Subtotal]** | *$111,127,637* | *$95,328,205* | *$3,512,240* | *$220,937* | *$1,995,935* | *$8,186* | *$265,088* | *$3,532,205* | *$104,862,796* | ***$6,264,841*** |
| **Long-Term Services and Supports:** | | | | | | | | | | |
| Institutional Care | $8,032,757 | $6,880,810 | $253,879 | $0 | $144,274 | $0 | $0 | $0 | $7,278,963 | **$753,794** |
| Non-Institutional Care | $4,052,596 | $3,409,359 | $128,084 | $0 | $72,788 | $0 | $0 | $0 | $3,610,231 | **$442,365** |
| **VA Long-Term Services and Supports [Total]** | $12,085,353 | $10,290,169 | $381,963 | $0 | $217,062 | $0 | $0 | $0 | $10,889,194 | **$1,196,159** |
| **Other Health Care Programs:** | | | | | | | | | | |
| Camp Lejeune Families (P.L. 112-154) | $3,808 | $3,808 | $0 | $0 | $0 | $0 | $0 | $0 | $3,808 | **$0** |
| Caregivers 2/ | $1,846,210 | $1,846,210 | $0 | $0 | $0 | $0 | $0 | $0 | $1,846,210 | **$0** |
| CHAMPVA & Other Dependent Prgs | $2,164,071 | $2,164,071 | $0 | $0 | $0 | $0 | $0 | $0 | $2,164,071 | **$0** |
| Homeless Program Grants 3/ | $977,441 | $977,441 | $0 | $0 | $0 | $0 | $0 | $0 | $977,441 | **$0** |
| Readjustment Counseling | $340,041 | $340,041 | $0 | $0 | $0 | $0 | $0 | $0 | $340,041 | **$0** |
| **Other Health Care Programs [Total]** | $5,331,571 | $5,331,571 | $0 | $0 | $0 | $0 | $0 | $0 | $5,331,571 | **$0** |
| **Obligations [Total]** | $128,544,561 | $110,949,945 | $3,894,203 | $220,937 | $2,212,997 | $8,186 | $265,088 | $3,532,205 | $121,083,561 | **$7,461,000** |

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 categories may change in response to workload demand requirements throughout 2022 and 2023.

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

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

- **Health Care Services Medical Care (+$7.5 billion).** This increase is largely driven by revised actuarial trends based on the most recent data. The key drivers of these changes compared to the enacted Advance Appropriation level include:
    - $3.3 billion in ambulatory and pharmacy services
    - $2.1 billion for inpatient services
    - $1.2 billion for long term services and supports
    - $613.0 million for mental health services
    - $235.0 million for dental services
    - $57.0 million for rehabilitation services

- **Medical Services (+$261.0 million).** Funds additional medical equipment.

- **Medical Support and Compliance (+$1.4 billion).** Funds supporting supply chain modernization, regional readiness centers and increased VAMC administrative demands.

- **Medical Facilities (+$1.5 billion).** Funds a significant portion of the Non-Recurring Maintenance (NRM) budget.

- **Medical Community Care (+$4.3 billion).** Funds over 13% of the overall projected community care cost.

## Methods Used to Formulate the Budget Request

VA uses three actuarial models to support formulation of the majority of the VA health care budget, to conduct strategic and capital planning and to assess the impact of potential policy changes in a dynamic health care environment. The three actuarial models are the VA Enrollee Health Care Projection Model (EHCPM), the Civilian Health and Medical Program Veterans Affairs (CHAMPVA) Model and the Program of Comprehensive Assistance for Family Caregivers (PCAFC) Stipend Projection Model.

Activities and programs that are not projected by these models are called "non-modeled" and change annually. In general, they include NRM, state-based long-term services and supports programs (LTSS), readjustment counseling, recently enacted programs, some components of CHAMPVA programs (spina bifida, foreign medical program, children of women Vietnam Veterans) and new initiatives.

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

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

## Key Drivers of Growth in Projected Resource Requirements

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

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

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 2021 EHCPM incorporated the actual experience and projected impact of the MISSION Act, including changes to eligibility to receive

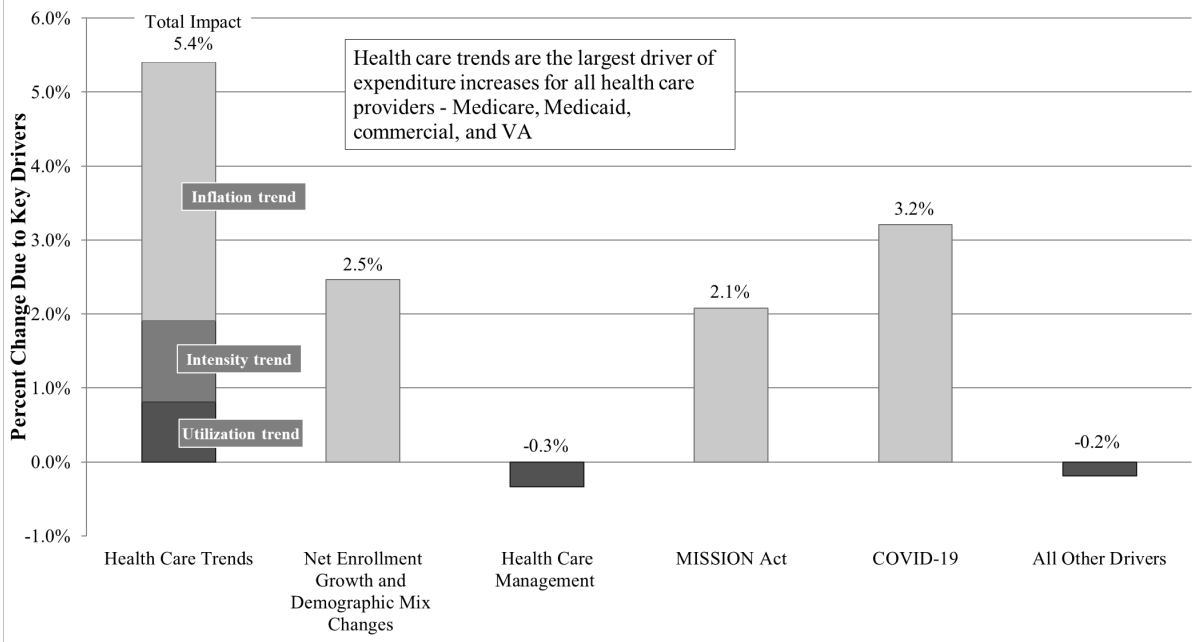
care in the community based on geographic access standards, grandfathered Veterans Choice and Accountability (Choice) Act of 2014 enrollees, wait time standards, urgent care benefits and emergency room pre-authorization.

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 to reflect higher than anticipated growth in community care workload in 2020 and 2021.

The COVID-19 pandemic continued to have a significant impact on VA health care in 2021 and is expected to impact the amount of care provided for the next few years. During the pandemic, nationwide health care utilization saw a reduced amount of care provided in 2020 and 2021 as individuals chose to defer certain care. It is anticipated that less care will be deferred in 2022 and that care previously deferred started to return in 2021 and will continue through 2023. Additionally, the stay-at-home orders and social distancing mandates have had an impact on the United States economy, which is expected to increase reliance on VA for health care. The impact of the pandemic on health care utilization in general and on mortality confounded analysis of 2020 enrollee reliance and morbidity; therefore, reliance and morbidity assumptions were not updated from 2019.

Figure A quantifies the key drivers of the projected increase in expenditure requirements for 2023 for all modeled services. Health care trends, net enrollment growth and demographic mix changes, health care management and their impact on the resources required to provide health care to enrolled Veterans are discussed in detail in the Actuarial Model Projections chapter.

## Figure A. Key Drivers of Projected Expenditure Change, 2022 – 2023




- Scenario BRD0 Modeled Services
- MISSION impacts include provisions for geographic access, wait times, urgent care, emergency room pre-authorization, and 14-day community care urgent prescription fills. Impacts for the MISSION standards for timeliness or quality and organ and bone marrow transplant policies are provided as national estimates and have not been incorporated in the 2021 EHCPM.
- The projections do not include requirements for several activities / programs that are not projected by the VA EHCPM, including administration cost for the Community Care Network contract, non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the Homeless program.

# Medical Care Budgetary Resources

The following tables display:

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

## Table: Medical Care Appropriations by Account and Medical Care Collections
(dollars in thousands)

| | | 2022 | | 2023 | 2024 | | |
|---|---|---|---|---|---|---|---|
| | 2021 | Budget | Current | Revised | Advance | +/- | +/- |
| | Actual | Estimate | Estimate | Request | Approp. | 2022-2023 | 2023-2024 |
| **Appropriations** | | | | | | | |
| **Discretionary Regular Appropriations 1/** | | | | | | | |
| Medical Services (0160) | $56,555,483 | $58,897,219 | $58,897,219 | $70,584,116 | $74,004,000 | $11,686,897 | $3,419,884 |
| Medical Community Care (0140) | $18,511,979 | $23,417,244 | $23,417,244 | $28,456,659 | $33,000,000 | $5,039,415 | $4,543,341 |
| Medical Support & Compliance (0152) | $8,199,191 | $8,403,117 | $8,403,117 | $11,073,409 | $12,300,000 | $2,670,292 | $1,226,591 |
| Medical Facilities (0162) | $6,583,265 | $6,734,680 | $6,734,680 | $8,633,816 | $8,800,000 | $1,899,136 | $166,184 |
| **Discretionary Regular Appropriations [Subtotal]** | **$89,849,918** | **$97,452,260** | **$97,452,260** | **$118,748,000** | **$128,104,000** | **$21,295,740** | **$9,356,000** |
| MCCF Collections 2/ | $3,090,673 | $4,084,952 | $3,920,671 | $3,909,801 | $3,967,975 | ($10,870) | $58,174 |
| **Discretionary Appropriations and Collections [Total]** | **$92,940,591** | **$101,537,212** | **$101,372,931** | **$122,657,801** | **$132,071,975** | **$21,284,870** | **$9,414,174** |
| **American Rescue Plan Act Mandatory Appropriations for Medical Care 4/** | | | | | | | |
| **Section 8002, the Veterans Medical Care and Health Fund (0173) 5/:** | | | | | | | |
| Medical Services Category | $9,020,443 | | | | | $0 | $0 |
| Medical Community Care Category | $1,901,196 | | | | | $0 | $0 |
| Medical Support & Compliance Category | $978,433 | | | | | $0 | $0 |
| Medical Facilities Category | $2,572,928 | | | | | $0 | $0 |
| **Veterans Medical Care and Health Fund [Subtotal]** | **$14,473,000** | | | | | **$0** | **$0** |
| **Section 8004:** | | | | | | | |
| Medical Community Care (0140) | $250,000 | | | | | $0 | $0 |
| **Section 8004 [Subtotal]** | **$250,000** | | | | | **$0** | **$0** |
| **Section 8007:** | | | | | | | |
| Medical Services (0160) | $627,900 | | | | | $0 | $0 |
| Copayment Reimbursement (5287) | $300,000 | | | | | $0 | $0 |
| Medical Community Care (0140) | $72,100 | | | | | $0 | $0 |
| **Section 8007 [Subtotal]** | **$1,000,000** | | | | | **$0** | **$0** |
| **Mandatory ARP Act Funding Available [Subtotal]** | **$15,723,000** | | | | | **$0** | **$0** |
| **Mandatory Appropriations American Families Plan** | | | | | | | |
| Medical Services (0160) | | $260,000 | | | | $0 | $0 |
| **Mandatory AFP Requested Appropriations [Subtotal]** | | **$260,000** | | | | **$0** | **$0** |
| **Mandatory Appropriations [Total]** | **$15,723,000** | **$260,000** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Discretionary and Mandatory Appropriations (**Including Discretionary Collections**) [Grandtotal]** | **$108,663,591** | **$101,797,212** | **$101,372,931** | **$122,657,801** | **$132,071,975** | **$21,284,870** | **$9,414,174** |

1/ Includes all rescissions but not transfers to the two joint Department of Defense (DoD)-VA health care 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/ Before transfers among VA accounts.

4/ Excludes $9.0 million of Medical and Prosthetics Research portion of ARP 8002. Excludes $500.0 million of Grants for Construction of State Extended Care Facilities from ARP 8004. ARP sections 8001, 8003, 8005, 8006 and 8008 are entirely excluded from the amounts in this table.

5/ 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 categories may change in response to workload demand requirements throughout 2022 and 2023.

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

| | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Obligations 1/** | | | | | | | |
| **Discretionary Obligations:** | | | | | | | |
| **Regular Obligations:** | | | | | | | |
| Medical Services (0160) | $58,047,838 | $65,070,793 | $63,334,586 | $75,277,624 | $77,079,890 | $11,943,038 | $1,802,266 |
| Medical Community Care (0140) | $17,619,094 | $23,996,704 | $25,868,933 | $29,196,966 | $33,750,756 | $3,328,033 | $4,553,790 |
| Medical Support & Compliance (0152) | $7,956,513 | $8,520,114 | $8,385,933 | $11,306,234 | $12,332,442 | $2,920,301 | $1,026,208 |
| Medical Facilities (0162) | $6,942,029 | $6,921,572 | $6,986,748 | $8,958,258 | $8,784,169 | $1,971,510 | ($174,089) |
| **Regular Obligations [Subtotal]** | **$90,565,474** | **$104,509,183** | **$104,576,200** | **$124,739,082** | **$131,947,257** | **$20,162,882** | **$7,208,175** |
| **Families First Coronavirus Response Act Obligations** | | | | | | | |
| Medical Services (0160) | $0 | | $200 | | | ($200) | $0 |
| Medical Community Care (0140) | $30,000 | | $0 | | | $0 | $0 |
| **Families First Coronavirus Response Act Appropriations [Subtotal]** | **$30,000** | | **$200** | | | **($200)** | **$0** |
| **Discretionary CARES Act Appropriations** | | | | | | | |
| Medical Services (0160) | $4,279,826 | | | | | $0 | $0 |
| Medical Community Care (0140) | $5,631,132 | | | | | $0 | $0 |
| Medical Support & Compliance (0152) | $256,511 | | | | | $0 | $0 |
| Medical Facilities (0162) | $435,462 | | | | | $0 | $0 |
| **Discretionary CARES Act Appropriations [Subtotal]** | **$10,602,931** | | | | | **$0** | **$0** |
| **Discretionary Obligations [Subtotal]** | **$101,198,405** | **$104,509,183** | **$104,576,400** | **$124,739,082** | **$131,947,257** | **$20,162,682** | **$7,208,175** |
| **Mandatory Obligations:** | | | | | | | |
| **Veterans Choice Act Section 801 2/** | | | | | | | |
| Medical Services (0160) | $4,297 | $2,365 | $3,864 | $3,980 | $4,099 | $116 | $119 |
| Medical Support & Compliance (0152) | $2,717 | $1,453 | $2,799 | $2,883 | $2,969 | $84 | $86 |
| Medical Facilities (0162) | $26,520 | $5,906 | $14,772 | $1,323 | $0 | ($13,449) | ($1,323) |
| **Veterans Choice Act Section 801 [Subtotal]** | **$33,534** | **$9,724** | **$21,435** | **$8,186** | **$7,068** | **($13,249)** | **($1,118)** |
| **Veterans Choice Fund (0172) [Subtotal] 3/** | **$25,180** | **$30,000** | **$15,465** | **$265,088** | **$0** | **$249,623** | **($265,088)** |
| **American Rescue Plan Act Mandatory Obligations for Medical Care 4/** | | | | | | | |
| **Section 8002, the Veterans Medical Care and Health Fund (0173) 5/:** | | | | | | | |
| Medical Services Category | $0 | $9,020,443 | $4,953,931 | $696,300 | | ($4,257,631) | ($696,300) |
| Medical Community Care Category | $0 | $1,901,196 | $1,901,196 | $2,098,805 | | $197,609 | ($2,098,805) |
| Medical Support & Compliance Category | $0 | $978,433 | $633,533 | $344,900 | | ($288,633) | ($344,900) |
| Medical Facilities Category | $0 | $2,572,928 | $2,180,728 | $392,200 | | ($1,788,528) | ($392,200) |
| **Veterans Medical Care and Health Fund [Subtotal]** | **$0** | **$14,473,000** | **$9,669,388** | **$3,532,205** | | **($6,137,183)** | **($3,532,205)** |
| **Section 8004:** | | | | | | | |
| Medical Community Care (0140) | $250,000 | | | | | $0 | $0 |
| **Section 8004 [Subtotal]** | **$250,000** | | | | | **$0** | **$0** |
| **Section 8007:** | | | | | | | |
| Medical Services (0160) | $0 | $627,900 | $627,900 | | | ($627,900) | $0 |
| Copayment Reimbursement (5287) | $243,610 | $0 | $56,390 | | | ($56,390) | $0 |
| Medical Community Care (0140) | $0 | $72,100 | $72,100 | | | ($72,100) | $0 |
| **Section 8007 [Subtotal]** | **$243,610** | **$700,000** | **$756,390** | | | **($756,390)** | **$0** |
| **Mandatory ARP Act Obligations [Subtotal]** | **$493,610** | **$15,173,000** | **$10,425,778** | **$3,532,205** | | **($6,893,573)** | **($3,532,205)** |
| **Mandatory Obligations American Families Plan** | | | | | | | |
| Medical Services (0160) | | $30,000 | | | | $0 | $0 |
| **Mandatory AFP Obligations [Subtotal]** | | **$30,000** | | | | **$0** | **$0** |
| **Mandatory Obligations [Subtotal]** | **$552,324** | **$15,242,724** | **$10,462,678** | **$3,805,479** | **$7,068** | **($6,657,199)** | **($3,798,411)** |
| **Discretionary and Mandatory Obligations [Total]** | **$101,750,729** | **$119,751,907** | **$115,039,078** | **$128,544,561** | **$131,954,325** | **$13,505,483** | **$3,409,764** |

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 $39.0 million of Medical and Prosthetics Research portion of ARP 8002. Excludes $500.0 million of Grants for Construction of State Extended Care Facilities from ARP 8004. ARP sections 8001, 8003, 8005, 8006 and 8008 are entirely excluded from the amounts in this table.

5/ 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 categories may change in response to workload demand requirements throughout 2022 and 2023.

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

| | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary and Mandatory Obligations by Category 1/** | | | | | | | |
| Medical Services | $62,331,961 | $74,751,501 | $68,920,481 | $75,977,904 | $77,083,989 | $7,057,423 | $1,106,085 |
| Copayment Reimbursement | $243,610 | $0 | $56,390 | $0 | $0 | ($56,390) | $0 |
| Community Care | $23,555,406 | $26,000,000 | $27,857,694 | $31,560,859 | $33,750,756 | $3,703,165 | $2,189,897 |
| Medical Support & Compliance | $8,215,741 | $9,500,000 | $9,022,265 | $11,654,017 | $12,335,411 | $2,631,752 | $681,394 |
| Medical Facilities | $7,404,011 | $9,500,406 | $9,182,248 | $9,351,781 | $8,784,169 | $169,533 | ($567,612) |
| **Obligations [Grand Total]** | **$101,750,729** | **$119,751,907** | **$115,039,078** | **$128,544,561** | **$131,954,325** | **$13,505,483** | **$3,409,764** |
| **Full-Time Equivalent (FTE) 2/** | | | | | | | |
| **Discretionary Funding** | | | | | | | |
| Medical Services | 267,777 | 256,891 | 268,596 | 282,781 | 293,667 | 14,185 | 10,886 |
| Medical Support & Compliance | 57,179 | 57,725 | 59,829 | 67,351 | 69,735 | 7,522 | 2,384 |
| Medical Facilities | 25,801 | 26,654 | 25,668 | 28,626 | 29,557 | 2,958 | 931 |
| **Discretionary Funding [Subtotal]** | **350,757** | **341,270** | **354,093** | **378,758** | **392,959** | **24,665** | **14,201** |
| **Mandatory Funding** | | | | | | | |
| Veterans Medical Care and Health Fund - Medical Services 3/ | 0 | 27,900 | 0 | 0 | 0 | 0 | 0 |
| Veterans Medical Care and Health Fund - Medical Support & Compliance (0173) 3/ | 0 | 500 | 0 | 0 | 0 | 0 | 0 |
| American Families Plan | 0 | 160 | 0 | 0 | 0 | 0 | 0 |
| Veterans Choice Act, Sec. 801, FTE 4/ | 33 | 17 | 33 | 33 | 32 | 0 | (1) |
| Veterans Choice Act, Sec. 802, FTE | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Mandatory Funding [Subtotal]** | **33** | **28,577** | **33** | **33** | **32** | **0** | **(1)** |
| **FTE [Total]** | **350,790** | **369,847** | **354,126** | **378,791** | **392,991** | **24,665** | **14,200** |

[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 categories may change in response to workload demand requirements throughout 2022 and 2023.

[2/] 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.

[3/] FTEs funded by ARP Act resources in 2022 have been merged into and funded with Medical Services and Medical Support and Compliance discretionary appropriations in 2023.

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

## Medical Care Obligations by Program

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

### Table: Medical Care Total Obligations by Program
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Health Care Services:** | | | | | | | |
| Ambulatory Care | $48,092,107 | $59,651,738 | $57,658,635 | $65,102,797 | $65,242,116 | $7,444,162 | $139,319 |
| Dental Care | $1,645,894 | $1,632,271 | $1,943,308 | $2,291,788 | $2,407,174 | $348,480 | $115,386 |
| Inpatient Care | $20,274,355 | $21,843,838 | $22,147,891 | $24,485,224 | $25,559,089 | $2,337,333 | $1,073,865 |
| Mental Health Care 1/ | $11,211,279 | $13,541,352 | $12,250,840 | $13,918,915 | $14,530,920 | $1,668,075 | $612,005 |
| Prosthetic and Sensory Aids Services | $3,474,096 | $4,934,411 | $3,756,341 | $4,069,980 | $4,410,880 | $313,639 | $340,900 |
| Rehabilitation Care | $1,073,858 | $1,097,033 | $1,156,059 | $1,258,933 | $1,234,126 | $102,874 | ($24,807) |
| **Health Care Services [Subtotal]** | **$85,771,589** | **$102,700,643** | **$98,913,074** | **$111,127,637** | **$113,384,305** | **$12,214,563** | **$2,256,668** |
| **Long-Term Services & Supports (LTSS):** | | | | | | | |
| Institutional LTSS | | | | | | | |
| VA Community Living Centers (VA CLC) | $4,514,583 | $4,423,856 | $4,650,213 | $4,942,654 | $5,093,007 | $292,441 | $150,353 |
| Community Nursing Home | $1,257,935 | $1,907,731 | $1,402,472 | $1,550,526 | $1,668,076 | $148,054 | $117,550 |
| State Home Nursing | $1,503,738 | $1,707,451 | $1,403,639 | $1,490,482 | $1,496,039 | $86,843 | $5,557 |
| State Home Domiciliary | $44,096 | $56,357 | $51,632 | $49,095 | $48,729 | ($2,537) | ($366) |
| Institutional LTSS [Subtotal] | $7,320,352 | $8,095,395 | $7,507,956 | $8,032,757 | $8,305,851 | $524,801 | $273,094 |
| Non-Institutional LTSS | | | | | | | |
| State Home Adult Day Care | $1,780 | $4,734 | $1,034 | $1,286 | $1,086 | $252 | ($200) |
| Other Non-Institutional LTSS | $3,405,350 | $3,671,948 | $3,726,781 | $4,051,310 | $4,284,748 | $324,529 | $233,438 |
| Non-Institutional LTSS [Subtotal] | $3,407,130 | $3,676,682 | $3,727,815 | $4,052,596 | $4,285,834 | $324,781 | $233,238 |
| **LTSS [Subtotal]** | **$10,727,482** | **$11,772,077** | **$11,235,771** | **$12,085,353** | **$12,591,685** | **$849,582** | **$506,332** |
| **Other Health Care Programs:** | | | | | | | |
| Camp Lejeune Families (P.L. 112-154) | $6,111 | $2,909 | $3,319 | $3,808 | $3,957 | $489 | $149 |
| Caregivers 2/ | $873,177 | $1,353,133 | $1,413,133 | $1,846,210 | $2,259,305 | $433,077 | $413,095 |
| CHAMPVA & Other Dependent Prgs | $2,016,871 | $2,378,170 | $2,035,285 | $2,164,071 | $2,329,485 | $128,786 | $165,414 |
| Homeless Program Grants 3/ | $1,084,447 | $1,191,186 | $1,055,817 | $977,441 | $1,031,945 | ($78,376) | $54,504 |
| Readjustment Counseling | $281,984 | $323,789 | $326,289 | $340,041 | $353,643 | $13,752 | $13,602 |
| Copayment Reimbursement | $243,610 | $0 | $56,390 | $0 | $0 | ($56,390) | $0 |
| **Other Health Care Programs [Subtotal]** | **$4,506,200** | **$5,249,187** | **$4,890,233** | **$5,331,571** | **$5,978,335** | **$441,338** | **$646,764** |
| **Legislative Proposals 4/** | $0 | $30,000 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Subtotal]** | **$101,005,271** | **$119,751,907** | **$115,039,078** | **$128,544,561** | **$131,954,325** | **$13,505,483** | **$3,409,764** |
| Recoveries of prior year paid & unpaid obligations | $745,458 | | | | | | |
| **Obligations [Total]** | $101,750,729 | $119,751,907 | $115,039,078 | $128,544,561 | $131,954,325 | $13,505,483 | $3,409,764 |

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

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

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

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

[4/] For detail on the 2023 Legislative Proposals, please see the Legislative Proposal chapter in Volume 1.

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

**Table: Programs Included in Medical Care Obligations**
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Medical Care Programs: (Included Above)** | | | | | | | |
| Activations | $391,944 | $896,483 | $896,483 | $769,904 | $630,314 | ($126,579) | ($139,590) |
| Blind Rehabilitation Treatment | $86,000 | $159,700 | $127,400 | $126,900 | $128,600 | ($500) | $1,700 |
| Epilepsy Center of Excellence 1/ | $7,764 | $10,000 | $10,000 | $19,086 | $18,751 | $9,086 | ($335) |
| Education & Training | $2,416,353 | $2,586,956 | $2,586,687 | $2,706,082 | $2,855,500 | $119,395 | $149,418 |
| Health Professionals Educational Assistance Program | $140,822 | $205,785 | $205,785 | $248,033 | $318,758 | $42,248 | $70,725 |
| Indian Health Services | $28,010 | $30,000 | $31,196 | $32,345 | $33,606 | $1,149 | $1,261 |
| Intensive Evaluation and Treatment Program Initiative | $0 | $15,283 | $15,283 | $25,970 | $12,588 | $10,687 | ($13,382) |
| Intimate Partner Violence program | $18,309 | $30,602 | $30,602 | $24,347 | $24,585 | ($6,255) | $238 |
| Leases | $1,039,125 | $2,099,889 | $1,708,176 | $1,500,000 | $1,200,000 | ($208,176) | ($300,000) |
| Mental Health Topics: | | | | | | | |
| Opioid Prevention: | | | | | | | |
| Treatment Modalities | $384,661 | $375,668 | $400,655 | $417,051 | $433,371 | $16,396 | $16,320 |
| Opioid Prevention Programs (Include's Jason's Law) 2/ | $78,481 | $245,666 | $245,666 | $245,754 | $245,754 | $88 | $0 |
| Substance Use Disorder Initiative | $0 | $155,970 | $155,970 | $181,287 | $183,834 | $25,317 | $2,547 |
| Suicide Prevention: | | | | | | | |
| Medical Treatment | $1,932,576 | $1,741,344 | $2,162,576 | $2,385,776 | $2,456,776 | $223,200 | $71,000 |
| Outreach Programs | $297,197 | $597,997 | $597,997 | $496,598 | $500,797 | ($101,399) | $4,199 |
| National Center for Posttraumatic Stress Disorder 1/ | $39,487 | $40,000 | $40,000 | $40,000 | $40,000 | $0 | $0 |
| National Veterans Sports Program | $23,375 | $27,048 | $27,048 | $27,229 | $27,414 | $181 | $185 |
| Non-Recurring Maintenance (Lands & Structure only) 3/ | $1,994,163 | $2,263,896 | $2,654,117 | $2,505,000 | $995,000 | ($149,117) | ($1,510,000) |
| Precision Oncology Initiative | $62,695 | $100,017 | $100,017 | $167,227 | $253,433 | $67,210 | $86,206 |
| Rural Health 1/ | $267,342 | $307,455 | $307,455 | $307,455 | $307,455 | $0 | $0 |
| Spinal Cord Injury Treatment | $653,300 | $684,500 | $717,900 | $733,500 | $751,500 | $15,600 | $18,000 |
| Supply Chain Management | $113,753 | $129,514 | $129,514 | $142,404 | $139,838 | $12,890 | ($2,566) |
| Telehealth: | | | | | | | |
| Home & Clinic Based Telehealth | $3,891,077 | $2,135,182 | $4,222,841 | $4,844,912 | $5,056,418 | $622,071 | $211,506 |
| Office of Connected Care Program | $365,613 | $450,000 | $450,000 | $329,906 | $329,906 | ($120,094) | $0 |
| Veterans Homelessness Programs | $2,544,263 | $2,640,450 | $2,761,560 | $2,685,392 | $2,861,497 | ($76,168) | $176,105 |
| Whole Health | $64,501 | $73,600 | $73,600 | $75,851 | $75,874 | $2,251 | $23 |

1/ 2021 actuals are represented by allocated amounts rather than obligations.

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

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

### Table: Veteran Population Obligations in Medical Care Obligations

(Includes Veterans Choice Act Sec. 801, Veterans Choice Fund and American Rescue Plan)
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Program | $1,552,300 | $1,599,500 | $1,567,700 | $1,619,700 | $1,675,200 | $52,000 | $55,500 |
| Post Deployment Health Services: | | | | | | | |
| Gulf War Program | $5,233,200 | $5,308,700 | $5,824,300 | $6,480,200 | $7,064,400 | $655,900 | $584,200 |
| OEF/OIF/OND/OIR | $10,232,200 | $10,458,500 | $11,088,400 | $11,966,200 | $12,889,900 | $877,800 | $923,700 |
| Traumatic Brain Injury and Polytrauma System of Care: | | | | | | | |
| OEF/OIF/OND/OIR | $253,000 | $245,100 | $265,600 | $274,600 | $283,700 | $9,000 | $9,100 |
| All Veteran Care | $946,500 | $870,600 | $992,900 | $1,034,200 | $1,067,600 | $41,300 | $33,400 |
| Women Veterans Health Care: | | | | | | | |
| Program Office & Initiative Budget | $57,816 | $104,946 | $106,489 | $134,219 | $138,852 | $27,730 | $4,633 |
| Gender-Specific Care | $628,800 | $705,500 | $700,500 | $766,900 | $835,800 | $66,400 | $68,900 |
| All Care | $8,318,000 | $8,422,100 | $9,018,000 | $9,774,900 | $10,576,300 | $756,900 | $801,400 |

## Medical Care Collections Fund

VA estimates medical care collections of $3.9 billion in 2023 and $4.0 billion in 2024. The 2021 actuals reflect the copayment billing suspension that began in April 2020 and continued through the end of 2021, as included in the American Rescue Plan Act section 8007. Projected collections for 2022 through 2024 reflect recent collections trends, including the increased use of telehealth as a provision of care.

### Medical Care Collections Fund[1,2]

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Medical Care Collections Fund: | | | | | | | |
| First Party Payments: | | | | | | | |
| 1st Party Other Co-payments | $49,214 | $170,420 | $154,132 | $158,184 | $162,052 | $4,052 | $3,868 |
| Community Care Collections 1st Party | $15,119 | $21,063 | $20,018 | $20,544 | $21,047 | $526 | $503 |
| Long-Term Care Co-Payments | $714 | $2,116 | $770 | $791 | $810 | $21 | $19 |
| Pharmacy Co-payments | $212,866 | $389,924 | $322,826 | $331,314 | $339,416 | $8,488 | $8,102 |
| **First Party Payments [Subtotal]** | **$277,913** | **$583,523** | **$497,746** | **$510,833** | **$523,325** | **$13,087** | **$12,492** |
| Third Party Payments: | | | | | | | |
| 3rd Party Insurance Collections | $2,078,564 | $2,647,973 | $2,548,681 | $2,434,208 | $2,467,313 | ($114,473) | $33,105 |
| 3rd Party RX Insurance | $144,558 | $191,291 | $151,965 | $154,229 | $156,327 | $2,264 | $2,098 |
| Community Care Collections 3rd Party | $547,676 | $602,165 | $692,552 | $770,531 | $781,010 | $77,979 | $10,479 |
| **Third Party Payments [Subtotal]** | **$2,770,798** | **$3,441,429** | **$3,393,198** | **$3,358,968** | **$3,404,650** | **($34,230)** | **$45,682** |
| Other MCCF: | | | | | | | |
| Comp. & Pension Living Expenses | $1,990 | $1,635 | $810 | $1,090 | $1,090 | $280 | $0 |
| Comp. Work Therapy Collections | $34,920 | $53,961 | $26,735 | $35,974 | $35,974 | $9,239 | $0 |
| Enhanced-Use Revenue | $1,148 | $1,134 | $562 | $756 | $756 | $194 | $0 |
| Parking Fees | $3,904 | $3,270 | $1,620 | $2,180 | $2,180 | $560 | $0 |
| **Other MCCF [Subtotal]** | **$41,962** | **$60,000** | **$29,727** | **$40,000** | **$40,000** | **$10,273** | **$0** |
| **Total Collections** | **$3,090,673** | **$4,084,952** | **$3,920,671** | **$3,909,801** | **$3,967,975** | **($10,870)** | **$58,174** |
| JALFHCC amount (included above) | $12,829 | $16,602 | $15,641 | $15,598 | $15,830 | ($43) | $232 |

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

[2/] Collections of $3.1 billion were received by VA in 2021. Due to a one month lag in timing from when the funds are received and transferred from the Medical Care Collections Fund, a total of $3.1 billion was transferred from the Medical Care Collections Fund to the receiving accounts, reflecting collections received from September 2020 through August 2020: $2.5 billion to Medical Services, $564.3 million to Medical Community Care and $12.8 million to the Joint DoD-VA Medical Demonstration Fund. The funds collected in September 2020 were transferred in 2021.

## VA Staffing

The budget requests 378,791 FTE in 2023 and 392,991 FTE in 2024. The estimated staffing increase in 2023 allows VA to meet continued outpatient Relative Value Unit (RVU) growth for VA provided services, particularly due to COVID-19-related care trend fluctuations. The budget provides resources for provider growth, in a tightening provider labor market, as VA expands telehealth services and enhances suicide prevention and substance use disorder initiatives. Medical Support and Compliance staff growth is primarily driven by medical center support staff to facilitate business systems. Medical Facilities staff growth is primarily driven by the need for staff to support projects updating aging infrastructure and expanding clinical space to care for Veterans. In 2024, VA plans to realize FTE gains from 2023 onboarding in order to maintain timely access to care provided by VA facilities.

# Table: Employment Summary (FTE)

| Account | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Medical Services | 267,777 | 256,891 | 268,596 | 282,781 | 293,667 | 14,185 | 10,886 |
| Medical Community Care | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Medical Support & Compliance | 57,179 | 57,725 | 59,829 | 67,351 | 69,735 | 7,522 | 2,384 |
| Medical Facilities | 25,801 | 26,654 | 25,668 | 28,626 | 29,557 | 2,958 | 931 |
| Total Discretionary Medical Care | 350,757 | 341,270 | 354,093 | 378,758 | 392,959 | 24,665 | 14,201 |

| | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Veterans Medical Care and Health Fund - Medical Services 1/ | 0 | 27,900 | 0 | 0 | 0 | 0 | 0 |
| Veterans Medical Care and Health Fund - Medical Support & Compliance 1/ | 0 | 500 | 0 | 0 | 0 | 0 | 0 |
| Veterans Families Plan - Medical Services | 0 | 160 | 0 | 0 | 0 | | |
| Veterans Choice Act, Sec. 801, FTE 2/ | 33 | 17 | 33 | 33 | 32 | 0 | (1) |
| Veterans Choice Act, Sec. 802, FTE 3/ | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Mandatory Medical Care | 33 | 28,577 | 33 | 33 | 32 | 0 | (1) |

1/FTEs funded by ARP Act resources in 2022 have been merged into and funded with Medical Services and Medical Support and Compliance discretionary appropriations in 2023.
2/ FTEs previously funded by Section 801 resources have been merged into and funded with Medical Services, Medical Support and Compliance, and Medical Facilities discretionary appropriations. Only a small number of FTEs remain funded by Section 801, primarily to support the GME expansion in section 301.
3/ FTEs providing administrative support for the Veterans Community Care Program, including support for the Veterans Choice Program, are funded by the Medical Support and Compliance account.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Grand Total Medical Care FTE** | **350,790** | **369,847** | **354,126** | **378,791** | **392,991** | **24,665** | **14,200** |

| | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Estimate | +/- 2022-2023 |
|---|---|---|---|---|---|
| Canteen Service | 2,117 | 3,500 | 2,223 | 2,334 | 111 |
| Medical & Prosthetic Research 4/ | 4,175 | 3,585 | 4,292 | 4,523 | 231 |
| DOD-VA Health Care Sharing Fund | 82 | 15 | 87 | 98 | 11 |
| James A. Lovell Federal Healthcare Center | | | | | |
| Civilian | 2,275 | 2,308 | 2,290 | 2,324 | 34 |
| DoD Uniformed Military | 906 | 906 | 906 | 776 | (130) |
| Joint DoD-VA Med. Fac. Demo. Fund Total | 3,181 | 3,214 | 3,196 | 3,100 | (96) |

4/Includes the following FTE amounts from the American Rescue Plan Act section 8002: 40 in 2021, 8 in 2022, and 113 in 2023

## Table: FTE by Type, Medical Care

| Account | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Physicians | 23,077 | 21,594 | 23,172 | 24,450 | 25,059 | 1,278 | 609 |
| Dentists | 1,219 | 1,188 | 1,224 | 1,290 | 1,301 | 66 | 11 |
| Registered Nurses | 69,541 | 62,595 | 69,898 | 73,843 | 77,082 | 3,945 | 3,239 |
| LP Nurse/LV Nurse/Nurse Assistant | 28,649 | 26,066 | 28,738 | 30,260 | 30,598 | 1,522 | 338 |
| Non-Physician Providers | 17,570 | 18,077 | 17,635 | 18,589 | 19,455 | 954 | 866 |
| Health Technicians/Allied Health | 82,038 | 84,044 | 82,343 | 86,796 | 90,484 | 4,453 | 3,688 |
| Wage Board/Purchase & Hire | 28,094 | 28,814 | 28,069 | 30,959 | 31,824 | 2,890 | 865 |
| All Other 1/ | 100,569 | 98,892 | 103,015 | 112,572 | 117,156 | 9,557 | 4,584 |
| SubTotal | 350,757 | 341,270 | 354,094 | 378,759 | 392,959 | 24,665 | 14,200 |
| American Rescue Plan, FTE | 0 | 28,400 | 0 | 0 | 0 | 0 | 0 |
| American Families Plan, FTE | 0 | 160 | 0 | 0 | 0 | 0 | 0 |
| Veterans Choice Act, Sec. 801, FTE | 33 | 17 | 33 | 33 | 32 | 0 | (1) |
| Veterans Choice Act, Sec. 802, FTE | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 350,790 | 369,847 | 354,127 | 378,792 | 392,991 | 24,665 | 14,199 |

## Table: FTE by Type, Medical Services

| Account | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Physicians | 22,369 | 20,719 | 22,432 | 23,617 | 24,197 | 1,185 | 580 |
| Dentists | 1,205 | 1,175 | 1,209 | 1,273 | 1,283 | 64 | 10 |
| Registered Nurses | 66,211 | 59,172 | 66,416 | 69,923 | 73,023 | 3,507 | 3,100 |
| LP Nurse/LV Nurse/Nurse Assistant | 28,598 | 26,009 | 28,686 | 30,201 | 30,537 | 1,515 | 336 |
| Non-Physician Providers | 17,272 | 17,812 | 17,324 | 18,239 | 19,093 | 915 | 854 |
| Health Technicians/Allied Health | 80,639 | 82,770 | 80,888 | 85,160 | 88,791 | 4,272 | 3,631 |
| Wage Board/Purchase & Hire | 5,722 | 5,690 | 5,740 | 6,043 | 6,094 | 303 | 51 |
| All Other 1/ | 45,761 | 43,544 | 45,901 | 48,325 | 50,649 | 2,424 | 2,324 |
| SubTotal | 267,777 | 256,891 | 268,596 | 282,781 | 293,667 | 14,185 | 10,886 |
| American Rescue Plan, FTE | 0 | 27,900 | 0 | 0 | 0 | 0 | 0 |
| American Families Plan, FTE | 0 | 160 | 0 | 0 | 0 | 0 | 0 |
| Veterans Choice Act, Sec. 801, FTE | 8 | 6 | 8 | 8 | 8 | 0 | 0 |
| Total | 267,785 | 284,957 | 268,604 | 282,789 | 293,675 | 14,185 | 10,886 |

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 | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Physicians | 707 | 875 | 740 | 833 | 862 | 93 | 29 |
| Dentists | 14 | 13 | 15 | 17 | 18 | 2 | 1 |
| Registered Nurses | 3,327 | 3,423 | 3,482 | 3,920 | 4,059 | 438 | 139 |
| LP Nurse/LV Nurse/Nurse Assistant | 50 | 57 | 52 | 59 | 61 | 7 | 2 |
| Non-Physician Providers | 297 | 265 | 311 | 350 | 362 | 39 | 12 |
| Health Technicians/Allied Health | 1,228 | 1,099 | 1,285 | 1,446 | 1,497 | 161 | 51 |
| Wage Board/Purchase & Hire | 1,275 | 1,459 | 1,335 | 1,503 | 1,556 | 168 | 53 |
| All Other 1/ | 50,281 | 50,534 | 52,609 | 59,223 | 61,320 | 6,614 | 2,097 |
| SubTotal | 57,179 | 57,725 | 59,829 | 67,351 | 69,735 | 7,522 | 2,384 |
| American Rescue Plan, FTE | | 500 | | | | 0 | 0 |
| Veterans Choice Act, Sec. 801, FTE | 24 | 11 | 24 | 24 | 24 | 0 | 0 |
| Total | 57,203 | 58,236 | 59,853 | 67,375 | 69,759 | 7,522 | 2,384 |

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 | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Physicians | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Dentists | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Registered Nurses | 3 | 0 | 0 | 0 | 0 | 0 | 0 |
| LP Nurse/LV Nurse/Nurse Assistant | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-Physician Providers | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Health Technicians/Allied Health | 171 | 175 | 170 | 190 | 196 | 20 | 6 |
| Wage Board/Purchase & Hire | 21,097 | 21,665 | 20,994 | 23,413 | 24,174 | 2,419 | 761 |
| All Other 1/ | 4,527 | 4,814 | 4,505 | 5,024 | 5,187 | 519 | 163 |
| SubTotal | 25,801 | 26,654 | 25,669 | 28,627 | 29,557 | 2,958 | 930 |
| Veterans Choice Act, Sec. 801, FTE | 1 | 0 | 1 | 1 | 0 | 0 | (1) |
| Total | 25,802 | 26,654 | 25,670 | 28,628 | 29,557 | 2,958 | 929 |

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

## Table: Employment Summary, FTE by Grade (Includes Veterans Choice Act)

| | 2021 | | | |
|---|---|---|---|---|
| General Schedule Grade or Title 38 | Medical Services 0160 & 0160XA | Medical Support & Compliance 0152 & 0152XA | Medical Facilities 0162 & 0162XA | Medical Care |
| Senior Executive Service | 0 | 182 | 0 | 182 |
| Title 38 | 103,844 | 4,494 | 21 | 108,359 |
| 15 or Higher | 284 | 594 | 1 | 879 |
| 14 | 1,819 | 2,262 | 119 | 4,200 |
| 13 | 13,292 | 4,881 | 520 | 18,693 |
| 12 | 20,432 | 7,093 | 1,098 | 28,623 |
| 11 | 18,965 | 5,822 | 1,179 | 25,966 |
| 10 | 1,646 | 184 | 70 | 1,900 |
| 9 | 11,748 | 7,002 | 507 | 19,257 |
| 8 | 6,469 | 2,377 | 28 | 8,874 |
| 7 | 12,761 | 7,513 | 404 | 20,678 |
| 6 | 45,618 | 7,737 | 337 | 53,692 |
| 5 | 21,808 | 3,875 | 246 | 25,929 |
| 4 | 2,327 | 1,508 | 45 | 3,880 |
| 3 | 1,125 | 336 | 148 | 1,609 |
| 2 | 90 | 49 | 2 | 141 |
| 1 | 59 | 20 | 7 | 86 |
| Wage Board | 5,498 | 1,274 | 21,070 | 27,842 |
| FTE Total | 267,785 | 57,203 | 25,802 | 350,790 |

## Table: FTE, 2021 Actual
(Includes VACAA Section 801)

| fice of Personnel Management (OPM) Occupational Groups and Famili | Medical Services (0160 & 0160XA) | Medical Support & Compliance (0152 & 0152XA) | Medical Facilities (0162 & 0162XA) | Total Medical Care |
|---|---|---|---|---|
| 0000 –Miscellaneous Occupations Group | 797 | 5,679 | 800 | 7,276 |
| 0100 – Social Science, Psychology, And Welfare Group | 28,511 | 508 | 4 | 29,023 |
| 0200 – Human Resources Management Group | 3 | 6,037 | 0 | 6,040 |
| 0300 – General Administrative, Clerical, And Office Services Group | 11,279 | 13,645 | 982 | 25,906 |
| 0500 – Accounting And Budget Group | 402 | 6,167 | 52 | 6,621 |
| 0600 –Medical, Hospital, Dental, And Public Health Group | 216,491 | 12,919 | 621 | 230,031 |
| 0800 – Engineering And Architecture Group | 391 | 152 | 1,518 | 2,061 |
| 0900 – Legal And Kindred Group | 288 | 1,341 | 0 | 1,629 |
| 1000 – Information And Arts Group | 220 | 570 | 201 | 991 |
| 1100 – Business And Industry Group | 1,057 | 3,270 | 113 | 4,440 |
| 1300 – Physical Sciences Group | 35 | 57 | 25 | 117 |
| 1400 – Library And Archives Group | 89 | 53 | 0 | 142 |
| 1600 – Equipment, Facilities, And Services Group | 1,214 | 20 | 184 | 1,418 |
| 1700 – Education Group | 830 | 899 | 25 | 1,754 |
| 2000 – Supply Group | 410 | 3,885 | 57 | 4,352 |
| 2100 – Transportation Group | 159 | 613 | 131 | 903 |
| 2600 – Electronic Equipment Installation And Maintenance Family | 13 | 0 | 271 | 284 |
| 2800 – Electrical Installation And Maintenance Family | 23 | 0 | 826 | 849 |
| 3500 – General Services And Support Work Family | 21 | 11 | 11,337 | 11,369 |
| 4100 – Painting And Paperhanging Family | 1 | 3 | 458 | 462 |
| 4200 – Plumbing And Pipefitting Family | 0 | 0 | 650 | 650 |
| 4600 –Wood Work Family | 1 | 0 | 500 | 501 |
| 4700 – General Maintenance And Operations Work Family | 7 | 5 | 2,278 | 2,290 |
| 4800 – General Equipment Maintenance Family | 35 | 12 | 128 | 175 |
| 5000 – Plant And Animal Work Family | 3 | 2 | 228 | 233 |
| 5300 – Industrial Equipment Maintenance Family1 | 5 | 0 | 896 | 901 |
| 5400 – Industrial Equipment Operation Family | 0 | 0 | 770 | 770 |
| 5700 – Transportation/Mobile Equipment Operation Family | 91 | 297 | 1,620 | 2,008 |
| 6900 –Warehousing And Stock Handling Family | 27 | 938 | 76 | 1,041 |
| 7300 – Laundry, Dry Cleaning, And Pressing Family | 0 | 1 | 783 | 784 |
| 7400 – Food Preparation And Serving Family | 5,176 | 0 | 0 | 5,176 |
| OPM Occupational Groups and Families Not Covered Above1/ | 206 | 119 | 268 | 593 |
| Grand Total | 267,785 | 57,203 | 25,802 | 350,790 |

## 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 2023 request supports the treatment of 7.4 million patients, a 3.1% increase above 2022, and 148 million outpatient visits, an increase of 24.7% above 2022.

### Table: Unique Patients

**Unique Patients 1/**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Priority Levels** | | | | | | | |
| 1-6 | 5,315,197 | 5,340,123 | 5,403,250 | **5,423,798** | **5,454,530** | 20,548 | 30,732 |
| 7-8 | 1,092,332 | 976,936 | 1,071,785 | **1,067,737** | **1,064,647** | (4,048) | (3,090) |
| Veterans [Subtotal] | 6,407,529 | 6,317,059 | 6,475,035 | **6,491,535** | **6,519,177** | 16,500 | 27,642 |
| Non-Veterans [Subtotal] 2/ | 990,602 | 812,674 | 827,169 | **855,860** | **883,507** | 28,691 | 27,647 |
| **Unique Patients [Total]** | **7,398,131** | **7,129,734** | **7,302,204** | **7,347,395** | **7,402,684** | **45,191** | **55,289** |

**Unique Enrollees 3/**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Priority Levels** | | | | | | | |
| 1-6 | 7,248,875 | 7,414,459 | 7,373,245 | **7,466,987** | **7,552,747** | 93,742 | 85,760 |
| 7-8 | 1,885,885 | 1,801,566 | 1,811,774 | **1,747,328** | **1,689,259** | (64,446) | (58,069) |
| **Unique Enrollees [Total]** | **9,134,760** | **9,216,025** | **9,185,019** | **9,214,315** | **9,242,006** | **29,296** | **27,691** |

**Users as a Percent of Enrollees**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Priority Levels** | | | | | | | |
| 1-6 | 73.3% | 72.0% | 73.3% | **72.6%** | **72.2%** | -0.6% | -0.4% |
| 7-8 | 57.9% | 54.2% | 59.2% | **61.1%** | **63.0%** | 2.0% | 1.9% |
| **Unique Enrollees [Total]** | **70.1%** | **68.5%** | **70.5%** | **70.5%** | **70.5%** | 0.0% | 0.1% |

[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.

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

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Outpatient Visits (000):** | | | | | | | |
| Ambulatory Care: | | | | | | | |
| Staff | 92,151 | 88,321 | 99,667 | 107,751 | 108,510 | 8,084 | 759 |
| Community Care | 32,998 | 28,602 | 36,226 | 39,079 | 40,545 | 2,853 | 1,466 |
| Subtotal | 125,149 | 116,923 | 135,893 | 146,830 | 149,055 | 10,937 | 2,225 |
| Readjustment Counseling: | | | | | | | |
| Visits | 1,490 | 2,067 | 1,522 | 1,553 | 1,583 | 31 | 30 |
| Grand Total | 126,639 | 118,990 | 137,415 | 148,383 | 150,638 | 10,968 | 2,255 |
| **Patients Treated:** | | | | | | | |
| Inpatient Care | 927,318 | 749,293 | 975,008 | 1,000,986 | 1,021,162 | 25,978 | 20,176 |
| Rehabilitation Care | 9,121 | 14,842 | 14,300 | 14,865 | 15,327 | 565 | 462 |
| Mental Health Care Total | 139,015 | 144,925 | 179,057 | 177,871 | 176,667 | (1,186) | (1,204) |
| *Acute Psychiatry* | *64,123* | *82,465* | *85,375* | *85,031* | *84,668* | *(344)* | *(363)* |
| *Community Care Hospital (Psych)* | *53,330* | *24,092* | *52,910* | *52,490* | *52,070* | *(420)* | *(420)* |
| *Residential Recovery Programs* | *21,562* | *38,368* | *40,772* | *40,350* | *39,929* | *(422)* | *(421)* |
| Long-Term Care: Institutional | 87,792 | 119,965 | 113,566 | 108,192 | 116,460 | (5,374) | 8,268 |
| Subacute Care | 1,259 | 825 | 1,108 | 958 | 807 | (150) | (151) |
| Inpatient Facilities, Total | 1,164,505 | 1,029,850 | 1,283,039 | 1,302,872 | 1,330,423 | 19,833 | 27,551 |
| **Average Daily Census:** | | | | | | | |
| Inpatient Care | 13,184 | 9,856 | 14,033 | 14,733 | 15,433 | 700 | 700 |
| Rehabilitation Care | 810 | 1,101 | 1,114 | 1,120 | 1,134 | 6 | 14 |
| Mental Health Care Total | 5,580 | 5,273 | 6,684 | 6,407 | 6,281 | (277) | (126) |
| *Acute Psychiatry* | *1,742* | *1,758* | *2,032* | *1,986* | *1,951* | *(46)* | *(35)* |
| *Community Care Hospital (Psych)* | *1,168* | *174* | *1,311* | *1,382* | *1,439* | *71* | *57* |
| *Residential Recovery Programs* | *2,670* | *3,341* | *3,341* | *3,039* | *2,891* | *(302)* | *(148)* |
| Long-Term Care: Institutional | 33,403 | 41,990 | 41,952 | 42,033 | 41,949 | 81 | (84) |
| Subacute Care | 35 | 32 | 32 | 31 | 30 | (1) | (1) |
| Inpatient Facilities, Total | 53,012 | 58,252 | 63,815 | 64,324 | 64,827 | 509 | 503 |
| **Length of Stay:** | | | | | | | |
| Inpatient Care | 5.2 | 4.8 | 5.3 | 5.4 | 5.5 | 0.1 | 0.1 |
| Rehabilitation Care | 32.4 | 27.1 | 28.4 | 27.5 | 27.1 | (0.9) | (0.4) |
| Mental Health Care | 14.7 | 13.3 | 13.6 | 13.1 | 13.0 | (0.5) | (0.1) |
| Long-Term Care: Institutional | 138.9 | 127.8 | 134.8 | 141.8 | 131.8 | 7.0 | (10.0) |
| Subacute Care | 10.1 | 14.2 | 10.5 | 11.8 | 13.6 | 1.3 | 1.8 |
| **Dental Procedures (000)** | 5,430 | 6,501 | 6,827 | 7,205 | 7,584 | 378 | 379 |
| **CHAMPVA/FMP/Spina Bifida:** | | | | | | | |
| Unique Patients | 445,631 | 469,048 | 460,513 | 463,773 | 467,352 | 3,260 | 3,579 |

## Table: Global RVUs for VA and Non-VA Facilities

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

**Global RVUs Projected by the VA Enrollee Health Care Projection Model**

| Description | 2021 Projection | 2022 Projection | 2023 Projection | 2024 Projection | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|
| VA System Delivered: | | | | | | |
| Outpatient | 354,342,836 | 411,634,700 | 478,429,824 | 485,196,975 | 66,795,124 | 6,767,152 |
| Inpatient | 161,909,653 | 165,652,136 | 178,020,730 | 176,661,735 | 12,368,594 | (1,358,995) |
| All other workload | 259,740,441 | 283,275,775 | 305,086,271 | 317,726,812 | 21,810,496 | 12,640,541 |
| VA System Delivered [Subtotal] | 775,992,929 | 860,562,611 | 961,536,825 | 979,585,522 | 100,974,214 | 18,048,697 |
| Community Delivered: | | | | | | |
| Outpatient | 198,175,775 | 239,346,243 | 277,375,927 | 290,833,743 | 38,029,683 | 13,457,816 |
| Inpatient | 152,036,308 | 172,887,565 | 192,216,366 | 198,996,609 | 19,328,801 | 6,780,244 |
| All other workload | 57,274,096 | 63,220,336 | 68,527,617 | 71,625,108 | 5,307,281 | 3,097,491 |
| Community Delivered [Subtotal] | 407,486,179 | 475,454,145 | 538,119,910 | 561,455,461 | 62,665,765 | 23,335,551 |
| Total VA Delivered: | | | | | | |
| Outpatient | 552,518,611 | 650,980,943 | 755,805,750 | 776,030,719 | 104,824,807 | 20,224,968 |
| Inpatient | 313,945,961 | 338,539,701 | 370,237,095 | 375,658,344 | 31,697,395 | 5,421,249 |
| All other workload | 317,014,537 | 346,496,111 | 373,613,889 | 389,351,920 | 27,117,777 | 15,738,031 |
| **Total Delivered [Subtotal]** | **1,183,479,109** | **1,336,016,755** | **1,499,656,734** | **1,541,040,983** | **163,639,979** | **41,384,248** |

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

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

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

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

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

**Types of Resource-Based Relative Value Scales**

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

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

**Essential RBRVS**: Essential RBRVS is a licensed product developed by Optum that builds on the CMS RBRVS by filling in many (not all) gaps in the CMS schedule. The CMS RBRVS does not include RVUs for many of the professional services reimbursed by Medicare under non-physician schedules (e.g., DME, Lab). The Essential RBRVS address this by assigning RVUs to

many of these services using a process where analysts, medical coders and clinicians are consulted to determine an appropriate RVU value.

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

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

## Veteran Enrollment Priority Group Definitions

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

***Priority Group 1***

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

***Priority Group 2***

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

***Priority Group 3***

- Veterans who are Former Prisoners of War (POWs)
- Veterans awarded a Purple Heart medal
- Veterans discharged for a disability that was incurred or aggravated in the line of duty

- Veterans with VA-rated service-connected disabilities 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

***Priority Group 4***

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

***Priority Group 5***

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

***Priority Group 6***

- Compensable 0% service-connected Veterans
- Veterans exposed to Ionizing Radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki
- Project 112/SHAD participants
- Veterans who served in the Republic of Vietnam between January 9, 1962, and May 7, 1975
- Veterans of Persian Gulf War who served between August 2, 1990, and November 11, 1998
- Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953, and December 31, 1987
- Veterans who are currently or newly enrolled in VA health care
- Veterans who served in a theater of combat operations after November 11, 1998
- Veterans who were discharged from active duty less than five years ago

***Priority Group 7***

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

***Priority Group 8***

- Veterans with gross household income above the VA and the geographically-adjusted income limits for their resident location and who agrees to pay copays
    - *Veterans eligible for enrollment:*
        - Non-compensable 0% service-connected and:

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

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

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

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

***Veterans' Health Administration (VHA) Facility Non-Veterans***

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

# Table: Unique Patients 1/

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Priority Levels** | | | | | | | |
| Priority 1 | 2,635,238 | 2,736,929 | 2,784,458 | **2,823,222** | **2,883,341** | 38,764 | 60,119 |
| Priority 2 | 482,413 | 471,512 | 478,768 | **477,761** | **475,945** | (1,007) | (1,816) |
| Priority 3 | 812,944 | 802,339 | 822,848 | **825,168** | **828,159** | 2,320 | 2,991 |
| Priority 4 | 143,878 | 139,778 | 135,897 | **133,757** | **130,461** | (2,140) | (3,296) |
| Priority 5 | 994,094 | 968,403 | 938,568 | **921,895** | **895,155** | (16,673) | (26,740) |
| Priority 6 | 246,630 | 221,163 | 242,711 | **241,995** | **241,469** | (716) | (526) |
| Priority 7 | 236,747 | 226,151 | 246,412 | **248,892** | **253,851** | 2,480 | 4,959 |
| Priority 8 | 855,585 | 750,785 | 825,373 | **818,845** | **810,796** | (6,528) | (8,049) |
| Veterans [Subtotal] | 6,407,529 | 6,317,060 | 6,475,035 | **6,491,535** | **6,519,177** | 16,500 | 27,642 |
| **Non-Veterans 2/** | | | | | | | |
| CHAMPVA/SB/FMP/CW/CITI Non-Vets | 426,690 | 453,820 | 443,730 | **459,716** | **475,033** | 15,986 | 15,317 |
| N : Non-Veteran | 2,915 | 4,118 | 3,275 | **3,206** | **3,137** | (69) | (69) |
| N0: Non-Vet, Catastro Disab | 44 | 46 | 42 | **46** | **50** | 4 | 4 |
| N1: Non-Vet, CHAMPVA Ben | 13,019 | 9,335 | 10,967 | **9,902** | **8,837** | (1,065) | (1,065) |
| N2: Non-Vet, Collaterals | 98,909 | 7,492 | 18,340 | **18,283** | **18,226** | (57) | (57) |
| N3: Non-Vet, VA Employee | 256,837 | 254,678 | 259,200 | **270,424** | **281,648** | 11,224 | 11,224 |
| N4: Non-Vet, Other Federal | 88,386 | 287 | 520 | **619** | **343** | 99 | (276) |
| N5: Non-Vet, Allied Veterans | 1,815 | 1,047 | 1,211 | **1,335** | **1,459** | 124 | 124 |
| N6: Non-Vet, Humanitarian | 39,175 | 24,828 | 27,409 | **30,902** | **34,395** | 3,493 | 3,493 |
| N7: Non-Vet, Sharing Agreement | 10,834 | 6,956 | 10,834 | **9,448** | **8,062** | (1,386) | (1,386) |
| N9: Non-Vet, TRICARE/CHAMPUS | 2,761 | 1,926 | 2,116 | **2,146** | **2,176** | 30 | 30 |
| NF : FHC Active Duty 3/ | 49,217 | 48,141 | 49,525 | **49,833** | **50,141** | 308 | 308 |
| Non-Veterans [Subtotal] | 990,602 | 812,674 | 827,169 | **855,860** | **883,507** | 28,691 | 27,647 |
| **Unique Patients [Total]** | **7,398,131** | **7,129,734** | **7,302,204** | **7,347,395** | **7,402,684** | 45,191 | 55,289 |
| OEF/OIF/OND/OIR (Incl. Above) | 1,193,651 | 1,236,559 | 1,270,975 | **1,345,706** | **1,421,800** | 74,731 | 76,094 |

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/

| | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Priority Levels** | | | | | | | |
| Priority 1 | 1,605,766 | 1,690,999 | 1,727,972 | **1,760,426** | **1,811,947** | 32,454 | 51,521 |
| Priority 2 | 265,970 | 259,201 | 262,808 | **261,877** | **259,806** | (931) | (2,071) |
| Priority 3 | 368,043 | 364,313 | 369,233 | **369,636** | **369,590** | 403 | (46) |
| Priority 4 | 31,551 | 30,212 | 27,644 | **26,565** | **24,488** | (1,079) | (2,077) |
| Priority 5 | 408,717 | 411,623 | 370,829 | **359,063** | **337,476** | (11,766) | (21,587) |
| Priority 6 | 77,595 | 67,108 | 74,578 | **74,151** | **73,615** | (427) | (536) |
| Priority 7 | 99,326 | 99,106 | 104,841 | **106,108** | **108,774** | 1,267 | 2,666 |
| Priority 8 | 311,016 | 278,866 | 310,373 | **309,723** | **307,577** | (650) | (2,146) |
| Veterans [Subtotal] | 3,167,984 | 3,201,428 | 3,248,278 | **3,267,549** | **3,293,273** | 19,271 | 25,724 |
| **Non-Veterans 2/** | | | | | | | |
| CHAMPVA/SB/FMP/CW/CITI Non-Vets | 406,355 | 431,174 | 421,581 | **436,811** | **451,392** | 15,230 | 14,581 |
| N : Non-Veteran | 2,361 | 3,692 | 2,630 | **2,578** | **2,525** | (52) | (53) |
| N0: Non-Vet, Catastro Disab | 41 | 41 | 39 | **43** | **47** | 4 | 4 |
| N1: Non-Vet, CHAMPVA Ben | 11,369 | 8,826 | 10,381 | **9,326** | **8,284** | (1,055) | (1,042) |
| N2: Non-Vet, Collaterals | 71,299 | 6,305 | 15,610 | **15,609** | **15,594** | (1) | (15) |
| N3: Non-Vet, VA Employee | 245,246 | 241,128 | 248,569 | **259,850** | **271,046** | 11,281 | 11,196 |
| N4: Non-Vet, Other Federal | 73,437 | 247 | 470 | **552** | **301** | 82 | (251) |
| N5: Non-Vet, Allied Veterans | 1,485 | 874 | 1,014 | **1,116** | **1,218** | 102 | 102 |
| N6: Non-Vet, Humanitarian | 32,976 | 21,805 | 24,108 | **27,201** | **30,295** | 3,093 | 3,094 |
| N7: Non-Vet, Sharing Agreement | 9,158 | 6,292 | 9,463 | **7,665** | **5,245** | (1,798) | (2,420) |
| N9: Non-Vet, TRICARE/CHAMPUS | 2,317 | 1,693 | 1,880 | **1,908** | **1,936** | 28 | 28 |
| NF : FHC Active Duty 3/ | 49,217 | 48,141 | 49,525 | **49,833** | **50,141** | 308 | 308 |
| Non-Veterans [Subtotal] | 905,261 | 770,218 | 785,270 | **812,492** | **838,024** | 27,222 | 25,532 |
| **Unique Patients [Total]** | **4,073,245** | **3,971,646** | **4,033,548** | **4,080,041** | **4,131,297** | 46,493 | 51,256 |

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/

| | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Priority Levels** | | | | | | | |
| Priority 1 | 1,029,472 | 1,045,930 | 1,056,486 | **1,062,796** | **1,071,394** | 6,310 | 8,598 |
| Priority 2 | 216,443 | 212,311 | 215,960 | **215,884** | **216,139** | (76) | 255 |
| Priority 3 | 444,901 | 438,026 | 453,615 | **455,532** | **458,569** | 1,917 | 3,037 |
| Priority 4 | 112,327 | 109,566 | 108,253 | **107,192** | **105,973** | (1,061) | (1,219) |
| Priority 5 | 585,377 | 556,780 | 567,739 | **562,832** | **557,679** | (4,907) | (5,153) |
| Priority 6 | 169,035 | 154,055 | 168,133 | **167,844** | **167,854** | (289) | 10 |
| Priority 7 | 137,421 | 127,045 | 141,571 | **142,784** | **145,077** | 1,213 | 2,293 |
| Priority 8 | 544,569 | 471,919 | 515,000 | **509,122** | **503,219** | (5,878) | (5,903) |
| Veterans [Subtotal] | 3,239,545 | 3,115,632 | 3,226,757 | **3,223,986** | **3,225,904** | (2,771) | 1,918 |
| **Non-Veterans 2/** | | | | | | | |
| CHAMPVA/SB/FMP/CW/CITI Non-Vets | 20,335 | 22,646 | 22,149 | **22,905** | **23,641** | 756 | 736 |
| N : Non-Veteran | 554 | 426 | 645 | **628** | **612** | (17) | (16) |
| N0: Non-Vet, Catastro Disab | 3 | 5 | 3 | **3** | **3** | 0 | 0 |
| N1: Non-Vet, CHAMPVA Ben | 1,650 | 509 | 586 | **576** | **553** | (10) | (23) |
| N2: Non-Vet, Collaterals | 27,610 | 1,187 | 2,730 | **2,674** | **2,632** | (56) | (42) |
| N3: Non-Vet, VA Employee | 11,591 | 13,550 | 10,631 | **10,574** | **10,602** | (57) | 28 |
| N4: Non-Vet, Other Federal | 14,949 | 40 | 50 | **67** | **42** | 17 | (25) |
| N5: Non-Vet, Allied Veterans | 330 | 173 | 197 | **219** | **241** | 22 | 22 |
| N6: Non-Vet, Humanitarian | 6,199 | 3,023 | 3,301 | **3,701** | **4,100** | 400 | 399 |
| N7: Non-Vet, Sharing Agreement | 1,676 | 664 | 1,371 | **1,783** | **2,817** | 412 | 1,034 |
| N9: Non-Vet, TRICARE/CHAMPUS | 444 | 233 | 236 | **238** | **240** | 2 | 2 |
| NF : FHC Active Duty 3/ | 0 | 0 | 0 | **0** | **0** | 0 | 0 |
| Non-Veterans [Subtotal] | 85,341 | 42,456 | 41,899 | **43,368** | **45,483** | 1,469 | 2,115 |
| **Unique Patients [Total]** | **3,324,886** | **3,158,088** | **3,268,656** | **3,267,354** | **3,271,387** | (1,302) | 4,033 |

[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/**

| | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Priority Levels** | | | | | | | |
| 1-6 | 5,315,197 | 5,340,123 | 5,403,250 | **5,423,798** | **5,454,530** | 20,548 | 30,732 |
| 7-8 | 1,092,332 | 976,936 | 1,071,785 | **1,067,737** | **1,064,647** | (4,048) | (3,090) |
| Veterans [Subtotal] | 6,407,529 | 6,317,059 | 6,475,035 | **6,491,535** | **6,519,177** | 16,500 | 27,642 |
| Non-Veterans 2/ | 990,602 | 812,674 | 827,169 | **855,860** | **883,507** | 28,691 | 27,647 |
| **Unique Patients [Total]** | **7,398,131** | **7,129,734** | **7,302,204** | **7,347,395** | **7,402,684** | **45,191** | **55,289** |

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

| | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Priority Levels** | | | | | | | |
| 1-6 | $89,432,160 | $106,475,924 | $101,418,083 | **$113,432,776** | **$116,240,186** | $12,014,693 | $2,807,410 |
| 7-8 | $9,685,731 | $10,643,972 | $11,030,553 | **$12,420,396** | **$12,919,600** | $1,389,843 | $499,204 |
| Veterans [Subtotal] | $99,117,891 | $117,119,896 | $112,448,636 | **$125,853,172** | **$129,159,786** | $13,404,536 | $3,306,614 |
| Non-Veterans 2/ | $2,632,837 | $2,602,011 | $2,590,442 | **$2,691,389** | **$2,794,539** | $100,947 | $103,150 |
| **Obligations [Total]** | **$101,750,728** | **$119,721,907** | **$115,039,078** | **$128,544,561** | **$131,954,325** | $13,505,483 | $3,409,764 |

**Obligations Per Unique Patient**
(dollars)

| | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Priority Levels** | | | | | | | |
| 1-6 | $16,826 | $19,939 | $18,770 | **$20,914** | **$21,311** | $2,144 | $397 |
| 7-8 | $8,867 | $10,895 | $10,292 | **$11,632** | **$12,135** | $1,340 | $503 |
| Veterans [Subtotal] | $15,469 | $18,540 | $17,366 | **$19,387** | **$19,812** | $2,021 | $425 |
| Non-Veterans 2/ | $2,658 | $3,202 | $3,132 | **$3,145** | **$3,163** | $13 | $18 |
| **Obligations Per Unique Patient [Total]** | **$13,754** | **$16,792** | **$15,754** | **$17,495** | **$17,825** | **$1,741** | **$330** |

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

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

# Table: Obligations by Priority Group
# 2021-2024

| | 2021 Actual | | | 2022 Current Estimate | | | 2023 Current Estimate | | | 2024 Current Estimate | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Unique Patients | Obligations ($1,000) | Obligation per Person | Unique Patients | Obligations ($1,000) | Obligation per Person | Unique Patients | Obligations ($1,000) | Obligation per Person | Unique Patients | Obligations ($1,000) | Obligation per Person |
| **Priority Groups** | | | | | | | | | | | | |
| Priority 1 | 2,635,238 | $48,983,406 | $18,588 | 2,784,458 | $58,011,083 | $20,834 | 2,823,222 | $65,799,970 | $23,307 | 2,883,341 | $68,389,553 | $23,719 |
| Priority 2 | 482,413 | $5,441,577 | $11,280 | 478,768 | $6,063,081 | $12,664 | 477,761 | $6,722,267 | $14,070 | 475,945 | $6,828,229 | $14,347 |
| Priority 3 | 812,944 | $9,528,006 | $11,720 | 822,848 | $10,923,181 | $13,275 | 825,168 | $12,282,286 | $14,885 | 828,159 | $12,654,201 | $15,280 |
| Priority 4 | 143,878 | $6,399,801 | $44,481 | 135,897 | $6,533,531 | $48,077 | 133,757 | $7,094,910 | $53,043 | 130,461 | $7,051,725 | $54,052 |
| Priority 5 | 994,094 | $17,441,472 | $17,545 | 938,568 | $18,015,372 | $19,195 | 921,895 | $19,438,225 | $21,085 | 895,155 | $19,151,078 | $21,394 |
| Priority 6 | 246,630 | $1,637,898 | $6,641 | 242,711 | $1,871,835 | $7,712 | 241,995 | $2,095,118 | $8,658 | 241,469 | $2,165,400 | $8,968 |
| P1-6 Subtotal | 5,315,197 | $89,432,160 | $16,826 | 5,403,250 | $101,418,083 | $18,770 | 5,423,798 | $113,432,776 | $20,914 | 5,454,530 | $116,240,186 | $21,311 |
| Priority 7 | 236,747 | $2,576,475 | $10,883 | 246,412 | $3,105,595 | $12,603 | 248,892 | $3,569,292 | $14,341 | 253,851 | $3,795,530 | $14,952 |
| Priority 8 | 855,585 | $7,109,256 | $8,309 | 825,373 | $7,924,958 | $9,602 | 818,845 | $8,851,104 | $10,809 | 810,796 | $9,124,070 | $11,253 |
| P7-8 Subtotal | 1,092,332 | $9,685,731 | $8,867 | 1,071,785 | $11,030,553 | $10,292 | 1,067,737 | $12,420,396 | $11,632 | 1,064,647 | $12,919,600 | $12,135 |
| Veterans [Subtotal] | 6,407,529 | $99,117,891 | $15,469 | 6,475,035 | $112,448,636 | $17,366 | 6,491,535 | $125,853,172 | $19,387 | 6,519,177 | $129,159,786 | $19,812 |
| **Non-Veterans** | | | | | | | | | | | | |
| CHAMPVA/SB/FMP/CW Non-Vet (less CITI) | 426,690 | $2,022,982 | $4,741 | 443,730 | $2,120,417 | $4,779 | 459,716 | $2,213,954 | $4,816 | 475,033 | $2,309,221 | $4,861 |
| N: Non-Vet | 2,915 | $51,601 | $17,702 | 3,275 | $55,187 | $16,851 | 3,206 | $58,558 | $18,265 | 3,137 | $61,818 | $19,706 |
| N0: Non-Vet, Catastro Disab | 44 | $1,159 | $26,341 | 42 | $1,363 | $32,452 | 46 | $1,560 | $33,913 | 50 | $1,754 | $35,080 |
| N1: Non-Vet, CHAMPVA Ben | 13,019 | $96,017 | $7,375 | 10,967 | $91,839 | $8,374 | 9,902 | $88,155 | $8,903 | 8,837 | $84,723 | $9,587 |
| N2: Non-Vet, Collaterals | 98,909 | $95,961 | $970 | 18,340 | $28,935 | $1,578 | 18,283 | $29,435 | $1,610 | 18,226 | $29,940 | $1,643 |
| N3: Non-Vet, VA Employee | 256,837 | $190,778 | $743 | 259,200 | $135,656 | $523 | 270,424 | $138,796 | $513 | 281,648 | $141,495 | $502 |
| N4: Non-Vet, Other Federal | 88,386 | $22,694 | $257 | 520 | $1,141 | $2,194 | 619 | $1,175 | $1,898 | 343 | $1,210 | $3,528 |
| N5: Non-Vet, Allied Veterans | 1,815 | $11,781 | $6,491 | 1,211 | $12,239 | $10,107 | 1,335 | $12,709 | $9,520 | 1,459 | $13,209 | $9,053 |
| N6: Non-Vet, Humanitarian | 39,175 | $68,526 | $1,749 | 27,409 | $72,290 | $2,637 | 30,902 | $75,728 | $2,451 | 34,395 | $80,273 | $2,334 |
| N7: Non-Vet, Sharing Agreement | 10,834 | $61,034 | $5,634 | 10,834 | $60,746 | $5,607 | 9,448 | $60,469 | $6,400 | 8,062 | $59,877 | $7,427 |
| N9: Non-Vet, TRICARE/CHAMPUS | 2,761 | $10,304 | $3,732 | 2,116 | $10,629 | $5,023 | 2,146 | $10,850 | $5,056 | 2,176 | $11,019 | $5,064 |
| NF: FHC Active Duty 1/ | 49,217 | $0 | $0 | 49,525 | $0 | $0 | 49,833 | $0 | $0 | 50,141 | $0 | $0 |
| Non-Veterans [Subtotal] | 990,602 | $2,632,837 | $2,658 | 827,169 | $2,590,442 | $3,132 | 855,860 | $2,691,389 | $3,145 | 883,507 | $2,794,539 | $3,163 |
| **Total** | **7,398,131** | **$101,750,729** | **$13,754** | **7,302,204** | **$115,039,078** | **$15,754** | **7,347,395** | **$128,544,561** | **$17,495** | **7,402,684** | **$131,954,325** | **$17,825** |

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

# Tables: Funding Crosswalks 2021-2024

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

**2021 Actuals**
**Dollars in Thousands ($000)**

| Description | Discretionary | | | | |
|---|---|---|---|---|---|
| | Medical Services 0160 | Medical Community Care 0140 | Medical Support & Compl 0152 | Medical Facilities 0162 | Medical Care Total |
| **APPROPRIATION** | | | | | |
| Advance Appropriation | $56,158,015 | $17,131,179 | $7,914,191 | $6,433,265 | $87,636,650 |
| Annual Appropriation Adjustment | $497,468 | $1,380,800 | $300,000 | $150,000 | $2,328,268 |
| **Appropriation [Subtotal]** | $56,655,483 | $18,511,979 | $8,214,191 | $6,583,265 | $89,964,918 |
| **RESCISSIONS (PL 116-260 §254)** | ($100,000) | $0 | ($15,000) | $0 | ($115,000) |
| **TRANSFERS TO (-)** | | | | | |
| VA/DoD JIF (0165) | ($15,000) | $0 | $0 | $0 | ($15,000) |
| JALFHCC (0169) | ($215,945) | ($28,392) | ($30,213) | ($40,297) | ($314,847) |
| CARES Unob. Bal. to MCC (0140) (PL 116-260 §517) | ($100,000) | $0 | $0 | $0 | ($100,000) |
| CARES Unob. Bal. to VBA/GOE (PL 116-260 §515) | ($198,000) | $0 | $0 | $0 | ($198,000) |
| CARES Unob. Bal. to OI&T (PL 116-260 §515) | ($45,000) | $0 | $0 | $0 | ($45,000) |
| CARES Unob. Bal. to VBA/GOE (PL 116-260 §514) | ($140,000) | $0 | $0 | $0 | ($140,000) |
| CARES Unob. Bal. to NCA (PL 116-260 §514) | ($12,000) | $0 | $0 | $0 | ($12,000) |
| CARES Unob. Bal. to BVA (PL 116-260 §514) | ($1,000) | $0 | $0 | $0 | ($1,000) |
| CARES Unob. Bal. to Canteen (PL 116-159 §163) | ($140,000) | $0 | $0 | $0 | ($140,000) |
| **Transfers To [Subtotal]** | ($866,945) | ($28,392) | ($30,213) | ($40,297) | ($965,847) |
| **TRANSFERS FROM (+)** | | | | | |
| CARES Unob. Bal. fr. MS (0160) (PL 116-260 §517) | $0 | $100,000 | $0 | $0 | $100,000 |
| **Transfers From [Subtotal]** | $0 | $100,000 | $0 | $0 | $100,000 |
| **COLLECTIONS** | $2,513,515 | $564,329 | $0 | $0 | $3,077,844 |
| **BUDGET AUTHORITY** | $58,202,053 | $19,147,916 | $8,168,978 | $6,542,968 | $92,061,915 |
| **REIMBURSEMENTS** | $132,760 | $0 | $63,438 | $24,739 | $220,937 |
| **UNOBLIGATED BALANCE (SOY)** | | | | | |
| No-Year (Other) | $1,218,064 | $9,075 | $0 | $12,985 | $1,240,124 |
| Pre P.L. 116-260 Title XVI § 1601 1/ | $0 | ($5,007,990) | $0 | $0 | ($5,007,990) |
| Post P.L. 116-260 Title XVI § 1601 2/ | $0 | $5,007,990 | $0 | $0 | $5,007,990 |
| P.L. 115-141 § 255 (NRM) | $0 | $0 | $0 | $299,657 | $299,657 |
| P.L. 115-244 § 248 (NRM) | $0 | $0 | $0 | $512,199 | $512,199 |
| H1N1 No-Year (PL 111-32) | $7 | $0 | $111 | $5 | $123 |
| 2-Year | $853,823 | $173,389 | $98,481 | $137,079 | $1,262,772 |
| 2-Year (P.L. 116-136) | $10,388,428 | $131,132 | $172,544 | $293,204 | $10,985,308 |
| 3-Year (P.L. 116-127) | $0 | $30,000 | $0 | $0 | $30,000 |
| 4-Year Base Year 2018 | $0 | $7,699 | $0 | $0 | $7,699 |
| 4-Year Base Year 2019 | $0 | $73,988 | $0 | $0 | $73,988 |
| 5-Year Base Year 2018 | $0 | $0 | $0 | $46,071 | $46,071 |
| **Unobligated Balance (SOY) [Subtotal]** | $12,460,322 | $425,283 | $271,136 | $1,301,200 | $14,457,941 |
| **TRANSFER OF UNOBLIGATED BALANCE** | | | | | |
| CARES Unob. Bal to MCC (0140) (P.L. 116-136 §20001) | ($5,400,000) | $5,400,000 | $0 | $0 | $0 |
| CARES Unob. Bal to MSC (0152) (P.L. 116-136 §20001) | ($105,000) | $0 | $105,000 | $0 | $0 |
| CARES Unob. Bal to MF (0162) (P.L. 116-136 §20001) | ($140,000) | $0 | $0 | $140,000 | $0 |
| CARES Unob. Bal. to JALFHCC (0169) | ($10,000) | $0 | $0 | $0 | ($10,000) |
| **UNOBLIGATED BALANCE (EOY)** | | | | | |
| No-Year (Other) | ($2,350,381) | ($439,288) | $0 | ($18,489) | ($2,808,158) |
| P.L. 115-141 § 255 (NRM) | $0 | $0 | $0 | ($115,406) | ($115,406) |
| P.L. 115-244 § 248 (NRM) | $0 | $0 | $0 | ($336,087) | ($336,087) |
| H1N1 No-Year (PL 111-32) | ($7) | $0 | ($111) | ($5) | ($123) |
| 2-Year | ($837,241) | ($1,332,887) | ($149,880) | ($158,634) | ($2,478,642) |
| 2-Year (P.L. 116-136) | $0 | $0 | $0 | $0 | $0 |
| 3-Year (P.L. 116-127) | ($200) | $0 | $0 | $0 | ($200) |
| 4-Year Base Year 2018 | $0 | $0 | $0 | $0 | $0 |
| 4-Year Base Year 2019 | $0 | ($10,532) | $0 | $0 | ($10,532) |
| 5-Year Base Year 2018 | $0 | $0 | $0 | ($41,538) | ($41,538) |
| **Unobligated Balance (EOY) [Subtotal]** | ($3,187,829) | ($1,782,707) | ($149,991) | ($670,159) | ($5,790,686) |
| **LAPSE** | ($66,777) | ($2) | ($247,676) | ($4,108) | ($318,563) |
| **OBLIGATIONS [Subotal] NON-801/802** | $61,885,529 | $23,190,490 | $8,210,885 | $7,334,640 | $100,621,544 |
| **PRIOR Year Recoveries** | $442,135 | $89,736 | $2,139 | $42,851 | $576,861 |
| **OBLIGATIONS [Total] NON-801/802** | $62,327,664 | $23,280,226 | $8,213,024 | $7,377,491 | $101,198,405 |
| **FTE NON-801** | 267,777 | 0 | 57,179 | 25,801 | 350,757 |

[1/] Prior to 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and recorded obligations of $5.0 billion for 2020 in the Medical Community Care account. VA lacked sufficient funds within the account to cover the full obligations recorded in 2020 consistent with VA OGC's opinion.

[2/] Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to healthcare providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Antideficiency Act (ADA) violation that would have occurred in 2020 absent its enactment. To implement the law, VA made an accounting adjustment in 2021, the year Public Law 116-260 was enacted.

**2021 Actual**
**Dollars in Thousands ($000)**

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

| | Mandatory | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Medical | | Medical | | Information Technology | | | Section |
| | Medical | Support | Medical | Care | Minor | | | | 801 |
| Description | Services 0160XA | & Compl 0152XA | Facilities 0162XA | Total (continued) | Cons. 0111XA | Dev. 0167XD | Sustain. 0167XO | Pay & Adm 0167XZ | Grand Total |
| **UNOBLIGATED BALANCE (SOY)** | | | | | | | | | |
| No-Year | $25,089 | $13,134 | $30,437 | $68,660 | $4,296 | $218 | $1,821 | $0 | $74,995 |
| **UNOBLIGATED BALANCE (EOY)** | | | | | | | | | |
| No-Year | ($21,338) | ($10,417) | ($16,095) | ($47,850) | ($1,978) | ($1,026) | $0 | $0 | ($50,854) |
| **OBLIGATIONS [Subtotal]** | $3,751 | $2,717 | $14,342 | $20,810 | $2,318 | ($808) | $1,821 | $0 | $24,141 |
| **PRIOR Year Recoveries** | $546 | $0 | $12,178 | $12,724 | $518 | $808 | $142 | $0 | $14,192 |
| **OBLIGATIONS [Total]** | $4,297 | $2,717 | $26,520 | $33,534 | $2,836 | $0 | $1,963 | $0 | $38,333 |
| **FTE** | 8 | 24 | 1 | 33 | 0 | 0 | 0 | 0 | 33 |

**2021 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 | 8002 Research | Grants for Construction of State Extended Care Facilites | Title 38 COVID Leave 0131 | VHA ARP Sections Grand Total |
| **MANDATORY** | | | | | | | | | | | | |
| ARP Act § 8002 | $9,020,443 | $978,433 | $2,572,928 | $1,901,196 | $0 | $0 | $0 | $14,473,000 | $9,000 | $0 | $0 | $14,482,000 |
| ARP Act § 8004 | $0 | $0 | $0 | $0 | $0 | $250,000 | $0 | $250,000 | $0 | $500,000 | $0 | $750,000 |
| ARP Act § 8007 | $0 | $0 | $0 | $0 | $627,900 | $72,100 | $300,000 | $1,000,000 | $0 | $0 | $0 | $1,000,000 |
| ARP Act § 8008 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $80,000 | $80,000 |
| **Funds Available [Subtotal]** | $9,020,443 | $978,433 | $2,572,928 | $1,901,196 | $627,900 | $322,100 | $300,000 | $15,723,000 | $9,000 | $500,000 | $80,000 | $16,312,000 |
| **UNOBLIGATED BALANCE (EOY)** | | | | | | | | | | | | |
| ARP Act § 8002 - 3 year | ($9,020,443) | ($978,433) | ($2,572,928) | ($1,901,196) | $0 | $0 | $0 | ($14,473,000) | ($1,772) | $0 | $0 | ($14,474,772) |
| ARP Act § 8004 - 2 year | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ARP Act § 8004 - no year | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | ($395,596) | $0 | ($395,596) |
| ARP Act § 8007 - no year | $0 | $0 | $0 | $0 | ($627,900) | ($72,100) | ($56,390) | ($756,390) | $0 | $0 | $0 | ($756,390) |
| ARP Act § 8008 - 2 year | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | ($61,893) | ($61,893) |
| **Unobligated Balance (EOY) [Subtotal]** | ($9,020,443) | ($978,433) | ($2,572,928) | ($1,901,196) | ($627,900) | ($72,100) | ($56,390) | ($15,229,390) | ($1,772) | ($395,596) | ($61,893) | ($15,688,651) |
| **OBLIGATIONS** | $0 | $0 | $0 | $0 | $0 | $250,000 | $243,610 | $493,610 | $7,228 | $104,404 | $18,107 | $623,349 |
| **FTE ARP** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 40 | 0 | 0 | 40 |

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

**2021 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 are (Missior 0172XG | Medical Care Total (continued) | Mandatory Information Technology Dev. 0172XD | Sustain. 0172XO | Pay & Adm 0172XZ | Section 802 Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **APPROPRIATION** | | | | | | | | | | |
| Appropriation | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Appropriation [Subtotal]** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **BUDGET AUTHORITY** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **UNOBLIGATED BALANCE (SOY)** | | | | | | | | | | |
| Pre P.L. 116-260 Title XVI § 1601 1/ | $0 | ($397,400) | $0 | $0 | $0 | ($397,400) | $0 | $0 | $0 | ($397,400) |
| Post P.L. 116-260 Title XVI § 1601 2/ | $0 | $397,400 | $0 | $0 | $0 | $397,400 | $0 | $0 | $0 | $397,400 |
| No-Year | $39,231 | $89,675 | $0 | $5,389 | $15,395 | $149,690 | $0 | $0 | $0 | $149,690 |
| **Unobligated Balance (SOY) [Subtotal]** | $39,231 | $89,675 | $0 | $5,389 | $15,395 | $149,690 | $0 | $0 | $0 | $149,690 |
| **TRANSFER OF UNOBLIGATED BALANCE** | | | | | | | | | | |
| Within the Veterans Choice Fund | $0 | ($135,000) | $0 | $0 | $135,000 | $0 | $0 | $0 | $0 | $0 |
| **UNOBLIGATED BALANCE (EOY)** | | | | | | | | | | |
| No-Year | ($42,748) | ($81,706) | $0 | ($5,533) | ($150,395) | ($280,382) | ($144) | ($27) | $0 | ($280,553) |
| **Unobligated Balance (EOY) [Subtotal]** | ($42,748) | ($81,706) | $0 | ($5,533) | ($150,395) | ($280,382) | ($144) | ($27) | $0 | ($280,553) |
| **OBLIGATIONS [Subtotal]** | ($3,517) | ($127,032) | $0 | ($144) | $0 | ($130,693) | ($144) | ($27) | $0 | ($130,864) |
| **PRIOR YEAR RECOVERIES** | $5,324 | $150,392 | $0 | $156 | $0 | $155,872 | $144 | $27 | $0 | $156,043 |
| **OBLIGATIONS [Total]** | $1,807 | $23,361 | $0 | $12 | $0 | $25,180 | $0 | $0 | $0 | $25,180 |
| **FTE [Total]** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | |
|---|---|
| **Medical Care Obligations Regular** | **$101,198,405** |
| **Medical Care Obls., ARP** | **$493,610** |
| **Medical Care Obls., VACAA, Section 801** | **$33,534** |
| **Medical Care Obls., VACAA, Section 802** | **$25,180** |
| **Medical Care Obligations [Grand Total]** | **$101,750,729** |
| | |
| **Medical Care FTE, Regular** | **350,757** |
| **Medical Care FTE, ARP** | **0** |
| **Medical Care FTE, VACAA, Section 801** | **33** |
| **Medical Care FTE, VACAA, Section 802** | **0** |
| **Medical Care FTE [Grand Total]** | **350,790** |

[1/] Prior to 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and adjusted obligations upwards by $397.0 million in the Veterans Choice Fund account. VA lacked sufficient funds within the account to cover the full obligations recorded in 2020 consistent with VA OGC's opinion.

[2/] Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to healthcare providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Antideficiency Act (ADA) violation that would have occurred in 2020 absent its enactment. To implement the law, VA made an accounting adjustment in 2021, the year Public Law 116-260 was enacted.

**2022 Budget Estimate**
**Dollars in Thousands ($000)**

| Description | Discretionary | | | | |
|---|---|---|---|---|---|
| | Medical Services 0160 | Medical Community Care 0140 | Medical Support & Compl 0152 | Medical Facilities 0162 | Medical Care Total |
| **APPROPRIATION** | | | | | |
| Advance Appropriation | $58,897,219 | $20,148,244 | $8,403,117 | $6,734,680 | $94,183,260 |
| Annual Appropriation Adjustment | $0 | $3,269,000 | $0 | $0 | $3,269,000 |
| **Appropriation [Subtotal]** | $58,897,219 | $23,417,244 | $8,403,117 | $6,734,680 | $97,452,260 |
| **TRANSFERS TO (-)** | | | | | |
| VA/DoD JIF (0165) | ($15,000) | $0 | $0 | $0 | ($15,000) |
| JALFHCC (0169) | ($203,805) | ($43,768) | ($30,613) | ($92,830) | ($371,016) |
| **Transfers To [Subtotal]** | ($218,805) | ($43,768) | ($30,613) | ($92,830) | ($386,016) |
| **TRANSFERS FROM (+)** | | | | | |
| **Transfers From [Subtotal]** | $0 | $0 | $0 | $0 | $0 |
| **COLLECTIONS** | $3,445,122 | $623,228 | $0 | $0 | $4,068,350 |
| **BUDGET AUTHORITY** | $62,123,536 | $23,996,704 | $8,372,504 | $6,641,850 | $101,134,594 |
| **REIMBURSEMENTS** | $124,257 | $0 | $47,610 | $18,420 | $190,287 |
| **UNOBLIGATED BALANCE (SOY)** | | | | | |
| No-Year (Other) | $1,323,000 | $0 | $0 | $0 | $1,323,000 |
| P.L. 115-141 § 255 (NRM) | $0 | $0 | $0 | $0 | $0 |
| P.L. 115-244 § 248 (NRM) | $0 | $0 | $0 | $61,302 | $61,302 |
| P.L. 116-20 (Disaster Relief) | $0 | $0 | $0 | $0 | $0 |
| H1N1 No-Year (PL 111-32) | $0 | $0 | $0 | $0 | $0 |
| 2-Year | $1,500,000 | $0 | $100,000 | $200,000 | $1,800,000 |
| 4-Year Base Year 2017 | $0 | $0 | $0 | $0 | $0 |
| 4-Year Base Year 2018 | $0 | $0 | $0 | $0 | $0 |
| 4-Year Base Year 2019 | $0 | $0 | $0 | $0 | $0 |
| **Unobligated Balance (SOY) [Subtotal]** | $2,823,000 | $0 | $100,000 | $261,302 | $3,184,302 |
| **UNOBLIGATED BALANCE (EOY)** | | | | | |
| No-Year (Other) | $0 | $0 | $0 | $0 | $0 |
| P.L. 115-141 § 255 (NRM) | $0 | $0 | $0 | $0 | $0 |
| P.L. 115-244 § 248 (NRM) | $0 | $0 | $0 | $0 | $0 |
| P.L. 116-20 (Disaster Relief) | $0 | $0 | $0 | $0 | $0 |
| H1N1 No-Year (PL 111-32) | $0 | $0 | $0 | $0 | $0 |
| 2-Year | $0 | $0 | $0 | $0 | $0 |
| 4-Year Base Year 2017 | $0 | $0 | $0 | $0 | $0 |
| 4-Year Base Year 2018 | $0 | $0 | $0 | $0 | $0 |
| 4-Year Base Year 2019 | $0 | $0 | $0 | $0 | $0 |
| **Unobligated Balance (EOY) [Subtotal]** | $0 | $0 | $0 | $0 | $0 |
| **OBLIGATIONS [Total] NON-801/802** | $65,070,793 | $23,996,704 | $8,520,114 | $6,921,572 | $104,509,183 |
| **FTE NON-801** | 256,891 | 0 | 57,725 | 26,654 | 341,270 |

2022 Budget Estimate
Dollars in Thousands ($000)

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

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

**2022 Budget Estimate**
**Dollars in Thousands ($000)**

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

**2022 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 | Sustain. 0167XO | Pay & Adm 0167XZ | Section 801 Grand Total |
|---|---|---|---|---|---|---|---|---|---|
| **UNOBLIGATED BALANCE (SOY)** | | | | | | | | | |
| No-Year | $22,813 | $11,736 | $24,753 | $59,302 | $0 | $0 | $0 | $0 | $59,302 |
| **UNOBLIGATED BALANCE (EOY)** | | | | | | | | | |
| No-Year | ($20,448) | ($10,283) | ($18,847) | ($49,578) | $0 | $0 | $0 | $0 | ($49,578) |
| **OBLIGATIONS [Total]** | $2,365 | $1,453 | $5,906 | $9,724 | $0 | $0 | $0 | $0 | $9,724 |
| **FTE** | 6 | 11 | 0 | 17 | 0 | 0 | 0 | 0 | 17 |

**2022 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 | $2,900 | $27,000 | $0 | $100 | $0 | $30,000 | $0 | $0 | $0 | $30,000 |
| **Unobligated Balance (SOY) [Subtotal]** | $2,900 | $27,000 | $0 | $100 | $0 | $30,000 | $0 | $0 | $0 | $30,000 |
| **UNOBLIGATED BALANCE (EOY)** | | | | | | | | | | |
| No-Year | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Unobligated Balance (EOY) [Subtotal]** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **OBLIGATIONS [Total]** | $2,900 | $27,000 | $0 | $100 | $0 | $30,000 | $0 | $0 | $0 | $30,000 |
| **FTE [Total]** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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

**2022 Current Estimate**
**Dollars in Thousands ($000)**

| Description | Medical Services 0160 | Medical Community Care 0140 | Medical Support & Compl 0152 | Medical Facilities 0162 | Medical Care Total |
|---|---|---|---|---|---|
| | Discretionary | | | | |
| **APPROPRIATION** | | | | | |
| Advance Appropriation | $58,897,219 | $20,148,244 | $8,403,117 | $6,734,680 | $94,183,260 |
| Annual Appropriation Adjustment | $0 | $3,269,000 | $0 | $0 | $3,269,000 |
| **Appropriation [Subtotal]** | $58,897,219 | $23,417,244 | $8,403,117 | $6,734,680 | $97,452,260 |
| **TRANSFERS TO (-)** | | | | | |
| VA/DoD JIF (0165) | ($15,000) | $0 | $0 | $0 | ($15,000) |
| Unob. Bal. to VBA/GOE (PL 117-43 § | ($178,000) | $0 | $0 | $0 | ($178,000) |
| Unob. Bal. to BVA (PL 117-43 §151) | ($5,800) | $0 | $0 | $0 | ($5,800) |
| Unob. Bal. to OI&T (PL 117-43 §151) | ($9,700) | $0 | $0 | $0 | ($9,700) |
| JALFHCC (0169) | ($203,805) | ($43,768) | ($30,613) | ($92,830) | ($371,016) |
| **Transfers To [Subtotal]** | ($412,305) | ($43,768) | ($30,613) | ($92,830) | ($579,516) |
| **COLLECTIONS** | $3,192,280 | $712,750 | $0 | $0 | $3,905,030 |
| **BUDGET AUTHORITY** | $61,677,194 | $24,086,226 | $8,372,504 | $6,641,850 | $100,777,774 |
| **REIMBURSEMENTS** | $132,760 | $0 | $63,438 | $24,739 | $220,937 |
| **UNOBLIGATED BALANCE (SOY)** | | | | | |
| No-Year (Other) | $2,350,381 | $439,288 | $0 | $18,489 | $2,808,158 |
| P.L. 115-141 § 255 (NRM) | $0 | $0 | $0 | $115,406 | $115,406 |
| P.L. 115-244 § 248 (NRM) | $0 | $0 | $0 | $336,087 | $336,087 |
| H1N1 No-Year (PL 111-32) | $7 | $0 | $111 | $5 | $123 |
| 2-Year | $837,241 | $1,332,887 | $149,880 | $158,634 | $2,478,642 |
| 2-Year (P.L. 116-136) | $0 | $0 | $0 | $0 | $0 |
| 3-Year (P.L. 116-127) | $200 | $0 | $0 | $0 | $200 |
| 4-Year Base Year 2019 | $0 | $10,532 | $0 | $0 | $10,532 |
| 5-Year Base Year 2018 | $0 | $0 | $0 | $41,538 | $41,538 |
| **Unobligated Balance (SOY) [Subtot** | $3,187,829 | $1,782,707 | $149,991 | $670,159 | $5,790,686 |
| **UNOBLIGATED BALANCE (EOY)** | | | | | |
| No-Year (Other) | ($1,662,997) | $0 | $0 | $0 | ($1,662,997) |
| P.L. 115-141 § 255 (NRM) | $0 | $0 | $0 | $0 | $0 |
| P.L. 115-244 § 248 (NRM) | $0 | $0 | $0 | $0 | $0 |
| H1N1 No-Year (PL 111-32) | $0 | $0 | $0 | $0 | $0 |
| 2-Year | $0 | $0 | ($200,000) | ($350,000) | ($550,000) |
| 3-Year (P.L. 116-127) | $0 | $0 | $0 | $0 | $0 |
| 4-Year Base Year 2019 | $0 | $0 | $0 | $0 | $0 |
| 5-Year Base Year 2018 | $0 | $0 | $0 | $0 | $0 |
| **Unobligated Balance (EOY) [Subtot** | ($1,662,997) | $0 | ($200,000) | ($350,000) | ($2,212,997) |
| **OBLIGATIONS [Total] NON-801/802** | $63,334,786 | $25,868,933 | $8,385,933 | $6,986,748 | $104,576,400 |
| **FTE NON-801** | 268,596 | | 59,829 | 25,668 | 354,093 |

**2022 Current Estimate**
**Dollars in Thousands ($000)**

| Description | Mandatory | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Medical Care Purposes | | | | | | | | Other Purposes | | | | |
| | Veterans Medical Care and Health Fund | | | | | | | | | | | | |
| | Medical Services | Medical Support & Compliance | Medical Facilities | Community Care | Medical Services | Medical Community Care | Copay Refunds | Medical Care Total | Research | Information Technology OIT | Grants for Construction of State Extended Care Facilites | Title 38 COVID Leave 0131 | VHA ARP Sections Grand Total |
| **UNOBLIGATED BALANCE (SOY)** | | | | | | | | | | | | | |
| ARP Act § 8002 | $9,020,443 | $978,433 | $2,572,928 | $1,901,196 | $0 | $0 | $0 | $14,473,000 | $1,772 | $0 | $0 | $0 | $14,474,772 |
| ARP Act § 8004 - 2 year | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ARP Act § 8004 - no year | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $395,596 | $0 | $395,596 |
| ARP Act § 8007 | $0 | $0 | $0 | $0 | $627,900 | $72,100 | $56,390 | $756,390 | $0 | $0 | $0 | $0 | $756,390 |
| ARP Act § 8008 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $61,893 | $61,893 |
| **Unobligated Balance (SOY) [Subtotal]** | $9,020,443 | $978,433 | $2,572,928 | $1,901,196 | $627,900 | $72,100 | $56,390 | $15,229,390 | $1,772 | $0 | $395,596 | $61,893 | $15,688,651 |
| **REAPPORTIONMENT of § 8002** | | | | | | | | | | | | | |
| ARP Act § 8002 | ($3,370,212) | $0 | $0 | $2,098,805 | $0 | $0 | $0 | ($1,271,407) | $30,000 | $1,241,407 | $0 | $0 | $0 |
| ARP Act § 8007 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **UNOBLIGATED BALANCE (EOY)** | | | | | | | | | | | | | |
| ARP Act § 8002 - 3 year | ($696,300) | ($344,900) | ($392,200) | ($2,098,805) | $0 | $0 | $0 | ($3,532,205) | ($30,000) | ($630,057) | $0 | $0 | ($4,192,262) |
| ARP Act § 8004 - 2 year | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ARP Act § 8004 - no year | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ARP Act § 8007 - no year | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ARP Act § 8008 - 2 year | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Unobligated Balance (EOY) [Subtotal]** | ($696,300) | ($344,900) | ($392,200) | ($2,098,805) | $0 | $0 | $0 | ($3,532,205) | ($30,000) | ($630,057) | $0 | $0 | ($4,192,262) |
| **LAPSE** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | ($61,893) | ($61,893) |
| **OBLIGATIONS** | $4,953,931 | $633,533 | $2,180,728 | $1,901,196 | $627,900 | $72,100 | $56,390 | $10,425,778 | $1,772 | $611,350 | $395,596 | $0 | $11,434,496 |
| **FTE ARP Act** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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

**2022 Current Estimate**
**Dollars in Thousands ($000)**

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

| Description | Mandatory | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Information Technology | | | |
| | Medical Services 0160XA | Medical Support & Compl 0152XA | Medical Facilities 0162XA | Medical Care Total (continued) | Minor Cons. 0111XA | Dev. 0167XD | Sustain. 0167XO | Pay & Adm 0167XZ | Section 801 Grand Total |
| **UNOBLIGATED BALANCE (SOY)** | | | | | | | | | |
| No-Year | $21,338 | $10,417 | $16,095 | $47,850 | $1,978 | $1,026 | $0 | $0 | $50,854 |
| **UNOBLIGATED BALANCE (EOY)** | | | | | | | | | |
| No-Year | ($17,474) | ($7,618) | ($1,323) | ($26,415) | ($1,978) | ($1,026) | $0 | $0 | ($29,419) |
| **OBLIGATIONS [Total]** | $3,864 | $2,799 | $14,772 | $21,435 | $0 | $0 | $0 | $0 | $21,435 |
| **FTE** | 8 | 24 | 1 | 33 | 0 | 0 | 0 | 0 | 33 |

**2022 Current 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 | $42,748 | $81,706 | $0 | $5,533 | $150,395 | $280,382 | $144 | $27 | $0 | $280,553 |
| **Unobligated Balance (SOY) [Subtotal]** | $42,748 | $81,706 | $0 | $5,533 | $150,395 | $280,382 | $144 | $27 | $0 | $280,553 |
| **TRANSFER OF UNOBLIGATED BALANCE** | | | | | | | | | | |
| Within the Veterans Choice Fund | ($42,748) | ($81,706) | $0 | ($5,533) | $130,158 | $171 | ($144) | ($27) | $0 | $0 |
| **UNOBLIGATED BALANCE (EOY)** | | | | | | | | | | |
| No-Year | $0 | $0 | $0 | $0 | ($265,088) | ($265,088) | $0 | $0 | $0 | ($265,088) |
| **Unobligated Balance (EOY) [Subtotal]** | $0 | $0 | $0 | $0 | ($265,088) | $0 | $0 | $0 | $0 | $0 |
| **OBLIGATIONS [Total]** | $0 | $0 | $0 | $0 | $15,465 | $15,465 | $0 | $0 | $0 | $15,465 |
| **FTE [Total]** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | |
|---|---|
| **Medical Care Obligations Regular** | **$104,576,400** |
| **Medical Care Obls., ARP** | **$10,425,778** |
| **Medical Care Obls., VACAA, Section 801** | **$21,435** |
| **Medical Care Obls., VACAA, Section 802** | **$15,465** |
| **Medical Care Obligations [Grand Total]** | **$115,039,078** |
| | |
| **Medical Care FTE, Regular** | **354,093** |
| **Medical Care FTE, ARP** | **0** |
| **Medical Care FTE, VACAA, Section 801** | **33** |
| **Medical Care FTE, VACAA, Section 802** | **0** |
| **Medical Care FTE [Grand Total]** | **354,126** |

**2023 Revised Request**
**Dollars in Thousands ($000)**

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

**2023 Revised Request**
**Dollars in Thousands ($000)**

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

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

**2023 Revised Request**
**Dollars in Thousands ($000)**

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

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

**2023 Revised Request**
**Dollars in Thousands ($000)**

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

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

| | |
|---|---|
| **Medical Care Obligations Regular** | **$124,739,082** |
| **Medical Care Obls., ARP** | **$3,532,205** |
| **Medical Care Obls., VACAA, Section 801** | **$8,186** |
| **Medical Care Obls., VACAA, Section 802** | **$265,088** |
| **Medical Care Obligations [Grand Total]** | **$128,544,561** |
| | |
| **Medical Care FTE, Regular** | **378,758** |
| **Medical Care FTE, ARP** | **0** |
| **Medical Care FTE, VACAA, Section 801** | **33** |
| **Medical Care FTE, VACAA, Section 802** | **0** |
| **Medical Care FTE [Grand Total]** | **378,791** |

**2024 Advance Appropriation**
**Dollars in Thousands ($000)**

| Description | Discretionary: Medical Services 0160 | Medical Community Care 0140 | Medical Support & Compl 0152 | Medical Facilities 0162 | Medical Care Total |
|---|---|---|---|---|---|
| **APPROPRIATION** | | | | | |
| Advance Appropriation | $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 |
| **TRANSFERS TO (-)** | | | | | |
| VA/DoD JIF (0165) | ($15,000) | $0 | $0 | $0 | ($15,000) |
| JALFHCC (0169) | ($191,968) | ($51,291) | ($30,996) | ($40,570) | ($314,825) |
| **Transfers To [Subtotal]** | ($206,968) | ($51,291) | ($30,996) | ($40,570) | ($329,825) |
| **TRANSFERS FROM (+)** | | | | | |
| **Transfers From [Subtotal]** | $0 | $0 | $0 | $0 | $0 |
| **COLLECTIONS** | $3,150,098 | $802,047 | $0 | $0 | $3,952,145 |
| **BUDGET AUTHORITY** | $76,947,130 | $33,750,756 | $12,269,004 | $8,759,430 | $131,726,320 |
| **REIMBURSEMENTS** | $132,760 | $0 | $63,438 | $24,739 | $220,937 |
| **UNOBLIGATED BALANCE (SOY)** | | | | | |
| No-Year (Other) | $0 | $0 | $0 | $0 | $0 |
| P.L. 115-141 § 255 (NRM) | $0 | $0 | $0 | $0 | $0 |
| P.L. 115-244 § 248 (NRM) | $0 | $0 | $0 | $0 | $0 |
| 2-Year | $0 | $0 | $0 | $0 | $0 |
| **Unobligated Balance (SOY) [Subtotal]** | $0 | $0 | $0 | $0 | $0 |
| **UNOBLIGATED BALANCE (EOY)** | | | | | |
| No-Year (Other) | $0 | $0 | $0 | $0 | $0 |
| P.L. 115-141 § 255 (NRM) | $0 | $0 | $0 | $0 | $0 |
| P.L. 115-244 § 248 (NRM) | $0 | $0 | $0 | $0 | $0 |
| 2-Year | $0 | $0 | $0 | $0 | $0 |
| **Unobligated Balance (EOY) [Subtotal]** | $0 | $0 | $0 | $0 | $0 |
| **OBLIGATIONS [Total] NON-801/802** | $77,079,890 | $33,750,756 | $12,332,442 | $8,784,169 | $131,947,257 |
| **FTE NON-801** | 293,667 | 0 | 69,735 | 29,557 | 392,959 |

**2024 Advance Appropriation**
**Dollars in Thousands ($000)**

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

| | Mandatory | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Information Technology | | | |
| Description | Medical Services 0160XA | Medical Support & Compl 0152XA | Medical Facilities 0162XA | Medical Care Total (continued) | Minor Cons. 0111XA | Dev. 0167XD | Sustain. 0167XO | Pay & Adm 0167XZ | Section 801 Grand Total |
| **UNOBLIGATED BALANCE (SOY)** | | | | | | | | | |
| No-Year | $13,494 | $4,735 | $0 | $18,229 | $1,978 | $1,026 | $0 | $0 | $21,233 |
| **UNOBLIGATED BALANCE (EOY)** | | | | | | | | | |
| No-Year | ($9,395) | ($1,766) | $0 | ($11,161) | ($1,978) | ($1,026) | $0 | $0 | ($14,165) |
| **OBLIGATIONS [Total]** | $4,099 | $2,969 | $0 | $7,068 | $0 | $0 | $0 | $0 | $7,068 |
| **FTE** | 8 | 24 | 0 | 32 | 0 | 0 | 0 | 0 | 32 |

| | |
|---|---|
| **Medical Care Obligations Regular** | **$131,947,257** |
| **Medical Care Obls., VACAA, Section 801** | **$7,068** |
| **Medical Care Obligations [Grand Total]** | **$131,954,325** |
| **Medical Care FTE, Regular** | **392,959** |
| **Medical Care FTE, VACAA, Section 801** | **32** |
| **Medical Care FTE [Grand Total]** | **392,991** |

## American Rescue Plan Act, Section 8008: Employee Leave Fund

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

## Tables: Obligations by Object Class by Medical Care Account

The tables that follow in the remainder of this chapter show Medical Care obligations by object class. Obligations include only Medical Care obligations and exclude VACAA section 801 actual and projected obligations for information technology and minor construction, as well as American Rescue Plan Act projected obligations for the Information Technology, Grants for Construction of State Extended Care Facilities, Medical and Prosthetics Research and all other non-VHA accounts. The 2021 and 2022 mandatory and grand total obligations include the projected $300.0 million in obligations to reimburse Veterans for copayments pursuant to section 8007 of the American Rescue Plan Act.

Funding from section 8002 of American Rescue Plan Act has been included in Medical Services, Medical Support and Compliance, Medical Facilities and Medical Community Care categories as projected to be allocated from the Veterans Medical Care and Health Fund. Final funding allocations among categories may change in response to workload demand requirements throughout 2022 and 2023.

**Obligations by Object - Medical Services (MS) - Discretionary**
(dollars in thousands)

| Description | Regular Appropriations (0160 excludes 801) | | | | FAMILY FIRST & CARES ACT (0160 C3/C2) | | | | Total Medical Services Discretionary | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **10 Personnel Compensation and Benefits:** | | | | | | | | | | | | |
| Physicians | $7,916,997 | $8,464,048 | $9,283,401 | $9,943,318 | $231,785 | $0 | $0 | $0 | $8,148,782 | $8,464,048 | $9,283,401 | $9,943,318 |
| Dentists | $335,851 | $355,460 | $390,860 | $412,594 | $5,804 | $0 | $0 | $0 | $341,655 | $355,460 | $390,860 | $412,594 |
| Registered Nurses | $8,999,263 | $10,171,979 | $11,204,324 | $12,267,039 | $813,053 | $0 | $0 | $0 | $9,812,316 | $10,171,979 | $11,204,324 | $12,267,039 |
| LP Nurse/LV Nurse/Nurse Assistant | $2,127,060 | $2,403,222 | $2,662,436 | $2,840,336 | $172,662 | $0 | $0 | $0 | $2,299,722 | $2,403,222 | $2,662,436 | $2,840,336 |
| Non-Physician Providers | $2,954,772 | $3,148,166 | $3,463,110 | $3,796,107 | $86,540 | $0 | $0 | $0 | $3,041,312 | $3,148,166 | $3,463,110 | $3,796,107 |
| Health Technicians/Allied Health | $8,971,310 | $9,574,199 | $10,535,736 | $11,505,351 | $265,808 | $0 | $0 | $0 | $9,237,118 | $9,574,199 | $10,535,736 | $11,505,351 |
| Wage Board/Purchase & Hire | $374,887 | $402,859 | $444,237 | $470,180 | $13,142 | $0 | $0 | $0 | $388,029 | $402,859 | $444,237 | $470,180 |
| All Other | $3,290,379 | $3,619,721 | $3,989,792 | $4,387,243 | $197,629 | $0 | $0 | $0 | $3,488,008 | $3,619,721 | $3,989,792 | $4,387,243 |
| Permanent Change of Station | $4,095 | $4,186 | $4,271 | $4,358 | $8 | $0 | $0 | $0 | $4,103 | $4,186 | $4,271 | $4,358 |
| Employee Compensation Pay | $248,925 | $253,991 | $259,147 | $264,408 | $13 | $0 | $0 | $0 | $248,938 | $253,991 | $259,147 | $264,408 |
| Subtotal | $35,223,539 | $38,397,831 | $42,237,314 | $45,890,934 | $1,786,444 | $0 | $0 | $0 | $37,009,983 | $38,397,831 | $42,237,314 | $45,890,934 |
| **21 Travel & Transportation of Persons:** | | | | | | | | | | | | |
| Employee | $14,567 | $16,500 | $61,315 | $67,300 | $5,782 | $0 | $0 | $0 | $20,349 | $16,500 | $61,315 | $67,300 |
| Beneficiary | $1,312,850 | $1,385,278 | $1,488,378 | $1,540,378 | $15,900 | $0 | $0 | $0 | $1,328,750 | $1,385,278 | $1,488,378 | $1,540,378 |
| Other | $56,651 | $64,100 | $67,441 | $74,000 | $907 | $0 | $0 | $0 | $57,558 | $64,100 | $67,441 | $74,000 |
| Subtotal | $1,384,068 | $1,465,878 | $1,617,134 | $1,681,678 | $22,589 | $0 | $0 | $0 | $1,406,657 | $1,465,878 | $1,617,134 | $1,681,678 |
| **22 Transportation of Things** | $26,204 | $29,600 | $31,143 | $34,200 | $982 | $0 | $0 | $0 | $27,186 | $29,600 | $31,143 | $34,200 |
| **23 Rent, Communications, and Utilities:** | | | | | | | | | | | | |
| Rental of Equipment | $206,576 | $233,700 | $260,824 | $286,300 | $11,354 | $0 | $0 | $0 | $217,930 | $233,700 | $260,824 | $286,300 |
| Communications | $399,698 | $456,800 | $471,902 | $517,900 | $2,946 | $0 | $0 | $0 | $402,644 | $456,800 | $471,902 | $517,900 |
| Utilities | $230 | $0 | $0 | $0 | $1 | $0 | $0 | $0 | $231 | $0 | $0 | $0 |
| GSA Rent | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Real Property Rental | $13,755 | $0 | $0 | $0 | $2,863 | $0 | $0 | $0 | $16,618 | $0 | $0 | $0 |
| Subtotal | $620,259 | $690,500 | $732,726 | $804,200 | $17,164 | $0 | $0 | $0 | $637,423 | $690,500 | $732,726 | $804,200 |
| **24 Printing & Reproduction:** | $8,633 | $13,592 | $13,592 | $14,900 | $3,882 | $0 | $0 | $0 | $12,515 | $13,592 | $13,592 | $14,900 |
| **25 Other Contractual Services:** | | | | | | | | | | | | |
| Care in the Community Outpatient Dental Care | $6,339 | $7,200 | $7,575 | $8,300 | $0 | $0 | $0 | $0 | $6,339 | $7,200 | $7,575 | $8,300 |
| Medical and Nursing Care in the Community | $275,930 | $312,100 | $328,369 | $360,400 | $13,961 | $0 | $0 | $0 | $289,891 | $312,100 | $328,369 | $360,400 |
| Repairs to Furniture/Equipment | $335,831 | $379,900 | $399,704 | $438,700 | $1,902 | $0 | $0 | $0 | $337,733 | $379,900 | $399,704 | $438,700 |
| Maintenance & Repair Contract Services | $48,205 | $54,500 | $57,341 | $62,900 | $226 | $0 | $0 | $0 | $48,431 | $54,500 | $57,341 | $62,900 |
| Care in the Community Hospital Care | -$1,143 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | -$1,143 | $0 | $0 | $0 |
| Community Nursing Homes | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Repairs to Prosthetic Appliances | $278,134 | $300,730 | $325,840 | $353,132 | $21,534 | $0 | $0 | $0 | $299,668 | $300,730 | $325,840 | $353,132 |
| Home Oxygen | $212,021 | $229,246 | $248,387 | $269,192 | $0 | $0 | $0 | $0 | $212,021 | $229,246 | $248,387 | $269,192 |
| Organ Procurement | $18,857 | $21,300 | $22,410 | $24,600 | $0 | $0 | $0 | $0 | $18,857 | $21,300 | $22,410 | $24,600 |
| Personal Services Contracts | $51,864 | $58,700 | $61,760 | $67,800 | $68,209 | $0 | $0 | $0 | $120,073 | $58,700 | $61,760 | $67,800 |
| House Staff Disbursing Agreement | $741,977 | $839,400 | $883,157 | $969,300 | $0 | $0 | $0 | $0 | $741,977 | $839,400 | $883,157 | $969,300 |
| Scarce Medical Specialists | $192,997 | $218,300 | $229,680 | $252,100 | $64,049 | $0 | $0 | $0 | $257,046 | $218,300 | $229,680 | $252,100 |
| Other Medical Contract Services | $1,497,660 | $2,682,600 | $6,582,097 | $4,489,440 | $110,599 | $0 | $0 | $0 | $1,608,259 | $2,682,600 | $6,582,097 | $4,489,440 |
| Administrative Contract Services | $1,122,441 | $1,269,800 | $1,335,993 | $1,466,300 | $140,211 | $0 | $0 | $0 | $1,262,652 | $1,269,800 | $1,335,993 | $1,466,300 |
| Training Contract Services | $81,250 | $91,900 | $96,691 | $106,100 | $654 | $0 | $0 | $0 | $81,904 | $91,900 | $96,691 | $106,100 |
| Caregiver Stipends | $624,061 | $844,119 | $1,409,306 | $1,773,034 | $0 | $0 | $0 | $0 | $624,061 | $844,119 | $1,409,306 | $1,773,034 |
| CHAMPVA | $0 | $21,720 | $25,537 | $29,985 | $0 | $0 | $0 | $0 | $0 | $21,720 | $25,537 | $29,985 |
| Subtotal | $5,486,424 | $7,331,515 | $12,013,847 | $10,671,283 | $421,345 | $0 | $0 | $0 | $5,907,769 | $7,331,515 | $12,013,847 | $10,671,283 |

**Obligations by Object - Medical Services (MS) - Discretionary**
(dollars in thousands)

| Description | Regular Appropriations (0160 excludes 801) | | | | FAMILY FIRST & CARES ACT (0160 C3/C2) | | | | Total Medical Services Discretionary | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **26 Supplies & Materials:** | | | | | | | | | | | | |
| Provisions | $112,612 | $128,100 | $134,778 | $147,900 | $665 | $0 | $0 | $0 | $113,277 | $128,100 | $134,778 | $147,900 |
| Drugs & Medicines | $6,910,194 | $7,560,270 | $8,272,425 | $8,899,403 | $765,692 | $0 | $0 | $0 | $7,675,886 | $7,560,270 | $8,272,425 | $8,899,403 |
| Blood & Blood Products | $51,545 | $56,394 | $61,706 | $66,383 | $24 | $0 | $0 | $0 | $51,569 | $56,394 | $61,706 | $66,383 |
| Medical/Dental Supplies | $1,889,631 | $2,117,600 | $2,134,988 | $2,343,200 | $335,904 | $200 | $0 | $0 | $2,225,535 | $2,117,800 | $2,134,988 | $2,343,200 |
| Operating Supplies | $242,313 | $314,800 | $331,210 | $363,500 | $35,971 | $0 | $0 | $0 | $278,284 | $314,800 | $331,210 | $363,500 |
| Maintenance & Repair Supplies | $40,200 | $0 | $0 | $0 | $1,580 | $0 | $0 | $0 | $41,780 | $0 | $0 | $0 |
| Other Supplies | $192,590 | $346,100 | $364,142 | $399,700 | $113,357 | $0 | $0 | $0 | $305,947 | $346,100 | $364,142 | $399,700 |
| Prosthetic Appliances | $2,871,406 | $3,104,688 | $3,363,916 | $3,645,675 | $297 | $0 | $0 | $0 | $2,871,703 | $3,104,688 | $3,363,916 | $3,645,675 |
| Home Respiratory Therapy | $77,514 | $83,811 | $90,809 | $98,416 | $55 | $0 | $0 | $0 | $77,569 | $83,811 | $90,809 | $98,416 |
| Subtotal | $12,388,005 | $13,711,763 | $14,753,974 | $15,964,177 | $1,253,545 | $200 | $0 | $0 | $13,641,550 | $13,711,963 | $14,753,974 | $15,964,177 |
| **31 Equipment** | $1,837,119 | $727,811 | $2,514,904 | $602,616 | $241,762 | $0 | $0 | $0 | $2,078,881 | $727,811 | $2,514,904 | $602,616 |
| **32 Lands & Structures:** | | | | | | | | | | | | |
| Non-Recurring Maintenance | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| All Other Lands & Structures | $816 | $0 | $1,047 | $0 | $105 | $0 | $0 | $0 | $921 | $0 | $1,047 | $0 |
| Subtotal | $816 | $0 | $1,047 | $0 | $105 | $0 | $0 | $0 | $921 | $0 | $1,047 | $0 |
| **41 Grants, Subsidies & Contributions:** | | | | | | | | | | | | |
| State Home | $1,519 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $1,519 | $0 | $0 | $0 |
| Grants | $859,031 | $955,513 | $1,351,360 | $1,405,319 | $292,851 | $0 | $0 | $0 | $1,151,882 | $955,513 | $1,351,360 | $1,405,319 |
| Veteran Adoption Reimbursement | $40 | $40 | $40 | $40 | $0 | $0 | $0 | $0 | $40 | $40 | $40 | $40 |
| Subtotal | $860,590 | $955,553 | $1,351,400 | $1,405,359 | $292,851 | $0 | $0 | $0 | $1,153,441 | $955,553 | $1,351,400 | $1,405,359 |
| **42 - Insurance Claims and Indemnities** | $9,203 | $10,543 | $10,543 | $10,543 | $0 | $0 | $0 | $0 | $9,203 | $10,543 | $10,543 | $10,543 |
| **43 Imputed Interest** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $57,844,860 | $63,334,586 | $75,277,624 | $77,079,890 | $4,040,669 | $200 | $0 | $0 | $61,885,529 | $63,334,786 | $75,277,624 | $77,079,890 |
| Prior Year Recoveries | $202,978 | $0 | $0 | $0 | $239,157 | $0 | $0 | $0 | $442,135 | $0 | $0 | $0 |
| **Obligations [Total]** | **$58,047,838** | **$63,334,586** | **$75,277,624** | **$77,079,890** | **$4,279,826** | **$200** | **$0** | **$0** | **$62,327,664** | **$63,334,786** | **$75,277,624** | **$77,079,890** |

## Obligations by Object - Medical Services (MS) - Mandatory

(dollars in thousands)

| Description | VACAA Section 801 | | | | American Rescue Plan Act and American Families Plan | | | | Total Medical Services Mandatory | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **10 Personnel Compensation and Benefits:** | | | | | | | | | | | | |
| Physicians | $2,963 | $3,049 | $3,189 | $3,286 | $0 | $0 | $0 | $0 | $2,963 | $3,049 | $3,189 | $3,286 |
| Dentists | $2 | $2 | $2 | $2 | $0 | $0 | $0 | $0 | $2 | $2 | $2 | $2 |
| Registered Nurses | $45 | $46 | $48 | $49 | $0 | $0 | $0 | $0 | $45 | $46 | $48 | $49 |
| LP Nurse/LV Nurse/Nurse Assistant | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Non-Physician Providers | $223 | $229 | $240 | $247 | $0 | $0 | $0 | $0 | $223 | $229 | $240 | $247 |
| Health Technicians/Allied Health | $9 | $9 | $9 | $9 | $0 | $0 | $0 | $0 | $9 | $9 | $9 | $9 |
| Wage Board/Purchase & Hire | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| All Other | $188 | $193 | $202 | $208 | $0 | $0 | $0 | $0 | $188 | $193 | $202 | $208 |
| 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 | $3,430 | $3,528 | $3,690 | $3,801 | $0 | $0 | $0 | $0 | $3,430 | $3,528 | $3,690 | $3,801 |
| **21 Travel & Transportation of Persons:** | | | | | | | | | | | | |
| Employee | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Beneficiary | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **22 Transportation of Things** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **23 Rent, Communications, and Utilities:** | | | | | | | | | | | | |
| Rental of Equipment | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Communications | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Utilities | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| GSA Rent | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Real Property Rental | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **24 Printing & Reproduction:** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **25 Other Contractual Services:** | | | | | | | | | | | | |
| Care in the Community Outpatient Dental Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical and Nursing Care in the Community | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Repairs to Furniture/Equipment | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Maintenance & Repair Contract Services | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Care in the Community Hospital Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Community Nursing Homes | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Repairs to Prosthetic Appliances | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Home Oxygen | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Organ Procurement | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Personal Services Contracts | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| House Staff Disbursing Agreement | -$130 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | -$130 | $0 | $0 | $0 |
| Scarce Medical Specialists | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Medical Contract Services | $6 | $0 | $0 | $0 | $0 | $3,013,607 | $696,300 | $0 | $6 | $3,013,607 | $696,300 | $0 |
| Administrative Contract Services | $24 | $336 | $290 | $298 | $0 | $0 | $0 | $0 | $24 | $336 | $290 | $298 |
| Training Contract Services | $5 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $5 | $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 | -$95 | $336 | $290 | $298 | $0 | $3,013,607 | $696,300 | $0 | -$95 | $3,013,943 | $696,590 | $298 |

**Obligations by Object - Medical Services (MS) - Mandatory**
(dollars in thousands)

| Description | VACAA Section 801 | | | | American Rescue Plan Act and American Families Plan | | | | Total Medical Services Mandatory | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **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 | $174 | $0 | $0 | $0 | $0 | $400,000 | $0 | $0 | $174 | $400,000 | $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 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $4 | $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 | $178 | $0 | $0 | $0 | $0 | $400,000 | $0 | $0 | $178 | $400,000 | $0 | $0 |
| **31 Equipment** | $238 | $0 | $0 | $0 | $0 | $1,746,224 | $0 | $0 | $238 | $1,746,224 | $0 | $0 |
| **32 Lands & Structures:** | | | | | | | | | | | | |
| Non-Recurring Maintenance | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| All Other Lands & Structures | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **41 Grants, Subsidies & Contributions:** | | | | | | | | | | | | |
| State Home | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Grants | $0 | $0 | $0 | $0 | $0 | $422,000 | $0 | $0 | $0 | $422,000 | $0 | $0 |
| Veteran Adoption Reimbursement | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 | $0 | $422,000 | $0 | $0 | $0 | $422,000 | $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 | $3,751 | $3,864 | $3,980 | $4,099 | $0 | $5,581,831 | $696,300 | $0 | $3,751 | $5,585,695 | $700,280 | $4,099 |
| Prior Year Recoveries | $546 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $546 | $0 | $0 | $0 |
| **Obligations [Total]** | **$4,297** | **$3,864** | **$3,980** | **$4,099** | **$0** | **$5,581,831** | **$696,300** | **$0** | **$4,297** | **$5,585,695** | **$700,280** | **$4,099** |

**Obligations by Object - Medical Support & Compliance (MSC) - Discretionary**
(dollars in thousands)

| Description | Regular Appropriations (0152 excludes 801) | | | | CARES ACT (0152C2) | | | | Total Medical Support & Compliance Discretionary | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **10 Personnel Compensation and Benefits:** | | | | | | | | | | | | |
| Physicians | $266,728 | $301,411 | $359,383 | $385,690 | $6,968 | $0 | $0 | $0 | $273,696 | $301,411 | $359,383 | $385,690 |
| Dentists | $4,974 | $5,563 | $6,592 | $7,132 | $35 | $0 | $0 | $0 | $5,009 | $5,563 | $6,592 | $7,132 |
| Registered Nurses | $510,393 | $597,240 | $730,071 | $789,109 | $21,354 | $0 | $0 | $0 | $531,747 | $597,240 | $730,071 | $789,109 |
| LP Nurse/LV Nurse/Nurse Assistant | $4,063 | $4,737 | $5,641 | $5,958 | $333 | $0 | $0 | $0 | $4,396 | $4,737 | $5,641 | $5,958 |
| Non-Physician Providers | $54,722 | $63,260 | $76,877 | $82,569 | $1,943 | $0 | $0 | $0 | $56,665 | $63,260 | $76,877 | $82,569 |
| Health Technicians/Allied Health | $152,342 | $174,333 | $210,626 | $225,356 | $5,032 | $0 | $0 | $0 | $157,374 | $174,333 | $210,626 | $225,356 |
| Wage Board/Purchase & Hire | $87,761 | $102,353 | $124,867 | $134,817 | $3,477 | $0 | $0 | $0 | $91,238 | $102,353 | $124,867 | $134,817 |
| All Other | $4,958,713 | $5,668,246 | $6,914,165 | $7,460,356 | $98,120 | $0 | $0 | $0 | $5,056,833 | $5,668,246 | $6,914,165 | $7,460,356 |
| Permanent Change of Station | $7,614 | $7,769 | $7,927 | $8,088 | $0 | $0 | $0 | $0 | $7,614 | $7,769 | $7,927 | $8,088 |
| Employee Compensation Pay | $39,888 | $40,698 | $41,524 | $42,367 | $0 | $0 | $0 | $0 | $39,888 | $40,698 | $41,524 | $42,367 |
| Subtotal | $6,087,198 | $6,965,610 | $8,477,673 | $9,141,442 | $137,262 | $0 | $0 | $0 | $6,224,460 | $6,965,610 | $8,477,673 | $9,141,442 |
| **21 Travel & Transportation of Persons:** | | | | | | | | | | | | |
| Employee | $11,207 | $28,340 | $63,817 | $70,000 | $144 | $0 | $0 | $0 | $11,351 | $28,340 | $63,817 | $70,000 |
| Beneficiary | $6 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $6 | $0 | $0 | $0 |
| Other | $5,525 | $5,154 | $5,423 | $6,000 | $17 | $0 | $0 | $0 | $5,542 | $5,154 | $5,423 | $6,000 |
| Subtotal | $16,738 | $33,494 | $69,240 | $76,000 | $161 | $0 | $0 | $0 | $16,899 | $33,494 | $69,240 | $76,000 |
| **22 Transportation of Things** | $16,591 | $20,540 | $25,071 | $27,500 | $237 | $0 | $0 | $0 | $16,828 | $20,540 | $25,071 | $27,500 |
| **23 Rent, Communications, and Utilities:** | | | | | | | | | | | | |
| Rental of Equipment | $45,956 | $64,340 | $74,441 | $81,700 | $9,653 | $0 | $0 | $0 | $55,609 | $64,340 | $74,441 | $81,700 |
| Communications | $65,343 | $83,864 | $94,031 | $103,200 | $2,445 | $0 | $0 | $0 | $67,788 | $83,864 | $94,031 | $103,200 |
| Utilities | $8 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $8 | $0 | $0 | $0 |
| GSA Rent | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Real Property Rental | $4,696 | $0 | $0 | $0 | $52 | $0 | $0 | $0 | $4,748 | $0 | $0 | $0 |
| Subtotal | $116,003 | $148,204 | $168,472 | $184,900 | $12,150 | $0 | $0 | $0 | $128,153 | $148,204 | $168,472 | $184,900 |
| **24 Printing & Reproduction:** | $21,940 | $29,619 | $37,843 | $41,500 | $176 | $0 | $0 | $0 | $22,116 | $29,619 | $37,843 | $41,500 |
| **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 | $1,812 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $1,812 | $0 | $0 | $0 |
| Repairs to Furniture/Equipment | $4,714 | $5,333 | $5,611 | $6,200 | $0 | $0 | $0 | $0 | $4,714 | $5,333 | $5,611 | $6,200 |
| Maintenance & Repair Contract Services | $2,211 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $2,211 | $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 | $6,999 | $7,918 | $8,331 | $9,100 | $259 | $0 | $0 | $0 | $7,258 | $7,918 | $8,331 | $9,100 |
| House Staff Disbursing Agreement | $210 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $210 | $0 | $0 | $0 |
| Scarce Medical Specialists | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Medical Contract Services | $8,734 | $9,880 | $10,395 | $11,400 | $138 | $0 | $0 | $0 | $8,872 | $9,880 | $10,395 | $11,400 |
| Administrative Contract Services | $1,439,998 | $906,816 | $2,233,855 | $2,540,938 | $98,155 | $0 | $0 | $0 | $1,538,153 | $906,816 | $2,233,855 | $2,540,938 |
| Training Contract Services | $77,971 | $88,205 | $92,803 | $101,900 | $1,083 | $0 | $0 | $0 | $79,054 | $88,205 | $92,803 | $101,900 |
| Caregiver Stipends | $1 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $1 | $0 | $0 | $0 |
| CHAMPVA | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $1,542,650 | $1,018,152 | $2,350,995 | $2,669,538 | $99,635 | $0 | $0 | $0 | $1,642,285 | $1,018,152 | $2,350,995 | $2,669,538 |

**Obligations by Object - Medical Support & Compliance (MSC)**
(dollars in thousands)

| Description | Regular Appropriations (0152 excludes 801) | | | | CARES ACT (0152C2) | | | | Total Medical Support & Compliance Discretionary | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **26 Supplies & Materials:** | | | | | | | | | | | | |
| Provisions | $1,998 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $1,998 | $0 | $0 | $0 |
| Drugs & Medicines | $13 | $0 | $0 | $0 | $3 | $0 | $0 | $0 | $16 | $0 | $0 | $0 |
| Blood & Blood Products | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical/Dental Supplies | $803 | $0 | $0 | $0 | $122 | $0 | $0 | $0 | $925 | $0 | $0 | $0 |
| Operating Supplies | $38,623 | $43,692 | $45,570 | $50,000 | $1,537 | $0 | $0 | $0 | $40,160 | $43,692 | $45,570 | $50,000 |
| Maintenance & Repair Supplies | $554 | $0 | $0 | $0 | $3 | $0 | $0 | $0 | $557 | $0 | $0 | $0 |
| Other Supplies | $57,337 | $62,662 | $64,928 | $71,300 | $1,367 | $0 | $0 | $0 | $58,704 | $62,662 | $64,928 | $71,300 |
| Prosthetic Appliances | $4 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $4 | $0 | $0 | $0 |
| Home Respiratory Therapy | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $99,332 | $106,354 | $110,498 | $121,300 | $3,032 | $0 | $0 | $0 | $102,364 | $106,354 | $110,498 | $121,300 |
| **31 Equipment** | $39,007 | $43,583 | $46,065 | $47,862 | $1,991 | $0 | $0 | $0 | $40,998 | $43,583 | $46,065 | $47,862 |
| **32 Lands & Structures:** | | | | | | | | | | | | |
| Non-Recurring Maintenance | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| All Other Lands & Structures | $870 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $870 | $0 | $0 | $0 |
| Subtotal | $870 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $870 | $0 | $0 | $0 |
| **41 Grants, Subsidies & Contributions:** | | | | | | | | | | | | |
| State Home | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Grants | $60 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $60 | $0 | $0 | $0 |
| Veteran Adoption Reimbursement | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $60 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $60 | $0 | $0 | $0 |
| **42 Insurance Claims and Indemnities** | $15,852 | $20,377 | $20,377 | $22,400 | $0 | $0 | $0 | $0 | $15,852 | $20,377 | $20,377 | $22,400 |
| **43 Imputed Interest** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $7,956,241 | $8,385,933 | $11,306,234 | $12,332,442 | $254,644 | $0 | $0 | $0 | $8,210,885 | $8,385,933 | $11,306,234 | $12,332,442 |
| Prior Year Recoveries | $272 | $0 | $0 | $0 | $1,867 | $0 | $0 | $0 | $2,139 | $0 | $0 | $0 |
| **Obligations [Total]** | **$7,956,513** | **$8,385,933** | **$11,306,234** | **$12,332,442** | **$256,511** | **$0** | **$0** | **$0** | **$8,213,024** | **$8,385,933** | **$11,306,234** | **$12,332,442** |

**Obligations by Object - Medical Support & Compliance (MSC) - Mandatory**
(dollars in thousands)

| Description | VACAA Section 801 | | | | American Rescue Plan (ARP) | | | | Total Medical Support & Compliance Mandatory | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **10 Personnel Compensation and Benefits:** | | | | | | | | | | | | |
| Physicians | $162 | $167 | $175 | $180 | $0 | $0 | $0 | $0 | $162 | $167 | $175 | $180 |
| Dentists | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Registered Nurses | $196 | $202 | $211 | $217 | $0 | $0 | $0 | $0 | $196 | $202 | $211 | $217 |
| 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 | $1,950 | $2,007 | $2,099 | $2,162 | $0 | $0 | $0 | $0 | $1,950 | $2,007 | $2,099 | $2,162 |
| 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 | $2,308 | $2,376 | $2,485 | $2,559 | $0 | $0 | $0 | $0 | $2,308 | $2,376 | $2,485 | $2,559 |
| **21 Travel & Transportation of Persons:** | | | | | | | | | | | | |
| Employee | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Beneficiary | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **22 Transportation of Things** | $1 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $1 | $0 | $0 | $0 |
| **23 Rent, Communications, and Utilities:** | | | | | | | | | | | | |
| Rental of Equipment | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Communications | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Utilities | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| GSA Rent | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Real Property Rental | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **24 Printing & Reproduction:** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **25 Other Contractual Services:** | | | | | | | | | | | | |
| Care in the Community Outpatient Dental Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical and Nursing Care in the Community | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Repairs to Furniture/Equipment | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Maintenance & Repair Contract Services | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Care in the Community Hospital Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Community Nursing Homes | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Repairs to Prosthetic Appliances | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Home Oxygen | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Organ Procurement | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Personal Services Contracts | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| House Staff Disbursing Agreement | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Scarce Medical Specialists | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Medical Contract Services | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Administrative Contract Services | $84 | $423 | $398 | $410 | $0 | $633,533 | $344,900 | $0 | $84 | $633,956 | $345,298 | $410 |
| Training Contract Services | $7 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $7 | $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 | $91 | $423 | $398 | $410 | $0 | $633,533 | $344,900 | $0 | $91 | $633,956 | $345,298 | $410 |

**Obligations by Object - Medical Support & Compliance (MSC)**
(dollars in thousands)

| Description | VACAA Section 801 | | | | American Rescue Plan (ARP) | | | | Total Medical Support & Compliance Mandatory | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **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 | $10 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $10 | $0 | $0 | $0 |
| Operating Supplies | $28 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $28 | $0 | $0 | $0 |
| Maintenance & Repair Supplies | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Supplies | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Prosthetic Appliances | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Home Respiratory Therapy | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $38 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $38 | $0 | $0 | $0 |
| **31 Equipment** | $279 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $279 | $0 | $0 | $0 |
| **32 Lands & Structures:** | | | | | | | | | | | | |
| Non-Recurring Maintenance | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| All Other Lands & Structures | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **41 Grants, Subsidies & Contributions:** | | | | | | | | | | | | |
| State Home | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Grants | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Veteran Adoption Reimbursement | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **42 Insurance Claims and Indemnities** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **43 Imputed Interest** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $2,717 | $2,799 | $2,883 | $2,969 | $0 | $633,533 | $344,900 | $0 | $2,717 | $636,332 | $347,783 | $2,969 |
| Prior Year Recoveries | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Total]** | **$2,717** | **$2,799** | **$2,883** | **$2,969** | **$0** | **$633,533** | **$344,900** | **$0** | **$2,717** | **$636,332** | **$347,783** | **$2,969** |

**Obligations by Object - Medical Facilities (MF) - Discretionary**
(dollars in thousands)

| Description | Regular Appropriations (0162 excludes 801) | | | | CARES ACT (0162C2) | | | | Total Medical Facilities Discretionary | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **10 Personnel Compensation and Benefits:** | | | | | | | | | | | | |
| Physicians | $325 | $0 | $0 | $0 | $72 | $0 | $0 | $0 | $397 | $0 | $0 | $0 |
| Dentists | $0 | $0 | $0 | $0 | $3 | $0 | $0 | $0 | $3 | $0 | $0 | $0 |
| Registered Nurses | $38 | $0 | $0 | $0 | $420 | $0 | $0 | $0 | $458 | $0 | $0 | $0 |
| LP Nurse/LV Nurse/Nurse Assistant | -$32 | $0 | $0 | $0 | $195 | $0 | $0 | $0 | $163 | $0 | $0 | $0 |
| Non-Physician Providers | $104 | $0 | $0 | $0 | $101 | $0 | $0 | $0 | $205 | $0 | $0 | $0 |
| Health Technicians/Allied Health | $10,513 | $12,570 | $14,719 | $15,759 | $1,204 | $0 | $0 | $0 | $11,717 | $12,570 | $14,719 | $15,759 |
| Wage Board/Purchase & Hire | $1,482,636 | $1,679,511 | $1,955,054 | $2,085,910 | $77,114 | $0 | $0 | $0 | $1,559,750 | $1,679,511 | $1,955,054 | $2,085,910 |
| All Other | $517,264 | $576,467 | $673,374 | $721,636 | $16,652 | $0 | $0 | $0 | $533,916 | $576,467 | $673,374 | $721,636 |
| Permanent Change of Station | $151 | $154 | $157 | $160 | $0 | $0 | $0 | $0 | $151 | $154 | $157 | $160 |
| Employee Compensation Pay | $37,515 | $38,277 | $39,054 | $39,847 | $0 | $0 | $0 | $0 | $37,515 | $38,277 | $39,054 | $39,847 |
| Subtotal | $2,048,514 | $2,306,979 | $2,682,358 | $2,863,312 | $95,761 | $0 | $0 | $0 | $2,144,275 | $2,306,979 | $2,682,358 | $2,863,312 |
| **21 Travel & Transportation of Persons:** | | | | | | | | | | | | |
| Employee | $2,905 | $2,905 | $3,056 | $3,200 | $116 | $0 | $0 | $0 | $3,021 | $2,905 | $3,056 | $3,200 |
| Beneficiary | -$20 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | -$20 | $0 | $0 | $0 |
| Other | $43,131 | $43,131 | $47,005 | $48,900 | $19 | $0 | $0 | $0 | $43,150 | $43,131 | $47,005 | $48,900 |
| Subtotal | $46,016 | $46,036 | $50,061 | $52,100 | $135 | $0 | $0 | $0 | $46,151 | $46,036 | $50,061 | $52,100 |
| **22 Transportation of Things** | $18,229 | $19,622 | $20,445 | $21,300 | $27 | $0 | $0 | $0 | $18,256 | $19,622 | $20,445 | $21,300 |
| **23 Rent, Communications, and Utilities:** | | | | | | | | | | | | |
| Rental of Equipment | $12,127 | $12,127 | $12,759 | $13,300 | $2,641 | $0 | $0 | $0 | $14,768 | $12,127 | $12,759 | $13,300 |
| Communications | $52,926 | $52,926 | $55,685 | $58,000 | $6 | $0 | $0 | $0 | $52,932 | $52,926 | $55,685 | $58,000 |
| Utilities | $529,279 | $574,279 | $620,215 | $645,600 | $273 | $0 | $0 | $0 | $529,552 | $574,279 | $620,215 | $645,600 |
| GSA Rent | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Real Property Rental | $781,408 | $898,727 | $1,110,465 | $957,022 | $2,711 | $0 | $0 | $0 | $784,119 | $898,727 | $1,110,465 | $957,022 |
| Subtotal | $1,375,740 | $1,538,059 | $1,799,124 | $1,673,922 | $5,631 | $0 | $0 | $0 | $1,381,371 | $1,538,059 | $1,799,124 | $1,673,922 |
| **24 Printing & Reproduction:** | $101 | $114 | $120 | $125 | $3 | $0 | $0 | $0 | $104 | $114 | $120 | $125 |
| **25 Other Contractual Services:** | | | | | | | | | | | | |
| Care in the Community Outpatient Dental Care | $8 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $8 | $0 | $0 | $0 |
| Medical and Nursing Care in the Community | -$30 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | -$30 | $0 | $0 | $0 |
| Repairs to Furniture/Equipment | $22,676 | $22,676 | $23,858 | $24,800 | $251 | $0 | $0 | $0 | $22,927 | $22,676 | $23,858 | $24,800 |
| Maintenance & Repair Contract Services | $277,972 | $321,115 | $342,854 | $856,900 | $4,163 | $0 | $0 | $0 | $282,135 | $321,115 | $342,854 | $856,900 |
| Care in the Community Hospital Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Community Nursing Homes | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Repairs to Prosthetic Appliances | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Home Oxygen | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Organ Procurement | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Personal Services Contracts | $2,818 | $2,818 | $2,965 | $3,100 | $107 | $0 | $0 | $0 | $2,925 | $2,818 | $2,965 | $3,100 |
| House Staff Disbursing Agreement | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Scarce Medical Specialists | $256 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $256 | $0 | $0 | $0 |
| Other Medical Contract Services | $12,364 | $0 | $0 | $0 | $70 | $0 | $0 | $0 | $12,434 | $0 | $0 | $0 |
| Administrative Contract Services | $520,373 | $584,439 | $214,357 | $1,291,630 | $59,766 | $0 | $0 | $0 | $580,139 | $584,439 | $214,357 | $1,291,630 |
| Training Contract Services | $1,351 | $1,351 | $1,421 | $1,500 | $4 | $0 | $0 | $0 | $1,355 | $1,351 | $1,421 | $1,500 |
| 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 | $837,788 | $932,399 | $585,455 | $2,177,930 | $64,361 | $0 | $0 | $0 | $902,149 | $932,399 | $585,455 | $2,177,930 |

**Obligations by Object - Medical Facilities (MF) - Discretionary**
(dollars in thousands)

| Description | Regular Appropriations (0162 excludes 801) | | | | CARES ACT (0162C2) | | | | Total Medical Facilities Discretionary | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **26 Supplies & Materials:** | | | | | | | | | | | | |
| Provisions | $9 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $9 | $0 | $0 | $0 |
| Drugs & Medicines | $112 | $0 | $0 | $0 | $10 | $0 | $0 | $0 | $122 | $0 | $0 | $0 |
| Blood & Blood Products | $4 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $4 | $0 | $0 | $0 |
| Medical/Dental Supplies | $2,201 | $0 | $0 | $0 | $474 | $0 | $0 | $0 | $2,675 | $0 | $0 | $0 |
| Operating Supplies | $143,382 | $239,743 | $248,520 | $258,700 | $19,173 | $0 | $0 | $0 | $162,555 | $239,743 | $248,520 | $258,700 |
| Maintenance & Repair Supplies | $178,402 | $274,763 | $285,365 | $297,000 | $5,226 | $0 | $0 | $0 | $183,628 | $274,763 | $285,365 | $297,000 |
| Other Supplies | $48,227 | $48,227 | $50,741 | $52,800 | $3,180 | $0 | $0 | $0 | $51,407 | $48,227 | $50,741 | $52,800 |
| Prosthetic Appliances | $7 | $0 | $0 | $0 | $4 | $0 | $0 | $0 | $11 | $0 | $0 | $0 |
| Home Respiratory Therapy | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $372,344 | $562,733 | $584,626 | $608,500 | $28,067 | $0 | $0 | $0 | $400,411 | $562,733 | $584,626 | $608,500 |
| **31 Equipment** | $100,039 | $134,072 | $160,110 | $166,354 | $47,147 | $0 | $0 | $0 | $147,186 | $134,072 | $160,110 | $166,354 |
| **32 Lands & Structures:** | | | | | | | | | | | | |
| Non-Recurring Maintenance | $1,825,112 | $881,565 | $2,505,000 | $995,000 | $179,823 | $0 | $0 | $0 | $2,004,935 | $881,565 | $2,505,000 | $995,000 |
| All Other Lands & Structures | $278,855 | $562,733 | $568,423 | $223,026 | $8,608 | $0 | $0 | $0 | $287,463 | $562,733 | $568,423 | $223,026 |
| Subtotal | $2,103,967 | $1,444,298 | $3,073,423 | $1,218,026 | $188,431 | $0 | $0 | $0 | $2,292,398 | $1,444,298 | $3,073,423 | $1,218,026 |
| **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** | $2,339 | $2,436 | $2,536 | $2,600 | $0 | $0 | $0 | $0 | $2,339 | $2,436 | $2,536 | $2,600 |
| **43 Imputed Interest** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $6,905,077 | $6,986,748 | $8,958,258 | $8,784,169 | $429,563 | $0 | $0 | $0 | $7,334,640 | $6,986,748 | $8,958,258 | $8,784,169 |
| Prior Year Recoveries | $36,952 | $0 | $0 | $0 | $5,899 | $0 | $0 | $0 | $42,851 | $0 | $0 | $0 |
| **Obligations [Total]** | **$6,942,029** | **$6,986,748** | **$8,958,258** | **$8,784,169** | **$435,462** | **$0** | **$0** | **$0** | **$7,377,491** | **$6,986,748** | **$8,958,258** | **$8,784,169** |

**Obligations by Object - Medical Facilities (MF) - Mandatory**
(dollars in thousands)

| Description | VACAA Section 801 | | | | American Rescue Plan (ARP) | | | | Total Medical Facilities Mandatory | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **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 | $111 | $114 | $119 | $0 | $0 | $0 | $0 | $0 | $111 | $114 | $119 | $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 | $111 | $114 | $119 | $0 | $0 | $0 | $0 | $0 | $111 | $114 | $119 | $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 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **22 Transportation of Things** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **23 Rent, Communications, and Utilities:** | | | | | | | | | | | | |
| Rental of Equipment | $3 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $3 | $0 | $0 | $0 |
| Communications | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Utilities | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| GSA Rent | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Real Property Rental | -$316 | $14,616 | $1,160 | $0 | $0 | $408,176 | $0 | $0 | -$316 | $422,792 | $1,160 | $0 |
| Subtotal | -$313 | $14,616 | $1,160 | $0 | $0 | $408,176 | $0 | $0 | -$313 | $422,792 | $1,160 | $0 |
| **24 Printing & Reproduction:** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **25 Other Contractual Services:** | | | | | | | | | | | | |
| Care in the Community Outpatient Dental Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical and Nursing Care in the Community | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Repairs to Furniture/Equipment | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Maintenance & Repair Contract Services | $99 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $99 | $0 | $0 | $0 |
| Care in the Community Hospital Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Community Nursing Homes | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Repairs to Prosthetic Appliances | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Home Oxygen | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Organ Procurement | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Personal Services Contracts | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| House Staff Disbursing Agreement | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Scarce Medical Specialists | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Medical Contract Services | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Administrative Contract Services | $435 | $42 | $44 | $0 | $0 | $0 | $392,200 | $0 | $435 | $42 | $392,244 | $0 |
| Training Contract Services | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Caregiver Stipends | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| CHAMPVA | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $534 | $42 | $44 | $0 | $0 | $0 | $392,200 | $0 | $534 | $42 | $392,244 | $0 |

**Obligations by Object - Medical Facilities (MF) - Mandatory**
(dollars in thousands)

| Description | VACAA Section 801 | | | | American Rescue Plan (ARP) | | | | Total Medical Facilities Mandatory | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **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 | $150 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $150 | $0 | $0 | $0 |
| Maintenance & Repair Supplies | $117 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $117 | $0 | $0 | $0 |
| Other Supplies | $22 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $22 | $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 | $289 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $289 | $0 | $0 | $0 |
| **31 Equipment** | $419 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $419 | $0 | $0 | $0 |
| **32 Lands & Structures:** | | | | | | | | | | | | |
| Non-Recurring Maintenance | -$10,772 | $0 | $0 | $0 | $0 | $1,772,552 | $0 | $0 | -$10,772 | $1,772,552 | $0 | $0 |
| All Other Lands & Structures | $24,074 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $24,074 | $0 | $0 | $0 |
| Subtotal | $13,302 | $0 | $0 | $0 | $0 | $1,772,552 | $0 | $0 | $13,302 | $1,772,552 | $0 | $0 |
| **41 Grants, Subsidies & Contributions:** | | | | | | | | | | | | |
| State Home | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Grants | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Veteran Adoption Reimbursement | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **42 - Insurance Claims and Indemnities** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **43 Imputed Interest** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $14,342 | $14,772 | $1,323 | $0 | $0 | $2,180,728 | $392,200 | $0 | $14,342 | $2,195,500 | $393,523 | $0 |
| Prior Year Recoveries | $12,178 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $12,178 | $0 | $0 | $0 |
| **Obligations [Total]** | **$26,520** | **$14,772** | **$1,323** | **$0** | **$0** | **$2,180,728** | **$392,200** | **$0** | **$26,520** | **$2,195,500** | **$393,523** | **$0** |

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

| Description | Regular Appropriations (0140 excludes 801) | | | | FAMILY FIRST & CARES ACT (0140C3/C2) | | | | Total Medical Community Care Discretionary | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **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 | $12,015 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $12,015 | $0 | $0 | $0 |
| Other | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $12,015 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $12,015 | $0 | $0 | $0 |
| **22 Transportation of Things** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **23 Rent, Communications, and Utilities:** | | | | | | | | | | | | |
| Rental of Equipment | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Communications | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Utilities | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| GSA Rent | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Real Property Rental | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **24 Printing & Reproduction:** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **25 Other Contractual Services:** | | | | | | | | | | | | |
| Care in the Community Outpatient Dental Care | $434,213 | $871,525 | $1,118,905 | $1,186,326 | $0 | $0 | $0 | $0 | $434,213 | $871,525 | $1,118,905 | $1,186,326 |
| Medical and Nursing Care in the Community | $5,549,102 | $9,275,629 | $10,602,256 | $12,968,669 | $2,483,437 | $0 | $0 | $0 | $8,032,539 | $9,275,629 | $10,602,256 | $12,968,669 |
| 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 | $4,425,034 | $7,710,705 | $9,017,489 | $10,779,363 | $3,028,225 | $0 | $0 | $0 | $7,453,259 | $7,710,705 | $9,017,489 | $10,779,363 |
| Community Nursing Homes | $1,131,646 | $1,305,367 | $1,443,170 | $1,552,581 | $0 | $0 | $0 | $0 | $1,131,646 | $1,305,367 | $1,443,170 | $1,552,581 |
| Repairs to Prosthetic Appliances | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Home Oxygen | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Organ Procurement | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Personal Services Contracts | $1,036 | $1,078 | $1,120 | $1,164 | $0 | $0 | $0 | $0 | $1,036 | $1,078 | $1,120 | $1,164 |
| House Staff Disbursing Agreement | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Scarce Medical Specialists | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Medical Contract Services | $3,278,974 | $3,413,412 | $3,546,535 | $3,684,850 | $49,470 | $0 | $0 | $0 | $3,328,444 | $3,413,412 | $3,546,535 | $3,684,850 |
| Administrative Contract Services | $11,877 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $11,877 | $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 | $1,102,159 | $1,456,351 | $1,519,123 | $1,636,307 | $0 | $0 | $0 | $0 | $1,102,159 | $1,456,351 | $1,519,123 | $1,636,307 |
| Subtotal | $15,934,041 | $24,034,067 | $27,248,598 | $31,809,260 | $5,561,132 | $0 | $0 | $0 | $21,495,173 | $24,034,067 | $27,248,598 | $31,809,260 |

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

| Description | Regular Appropriations (0140 excludes 801) | | | | FAMILY FIRST & CARES ACT (0140C3/C2) | | | | Total Medical Community Care Discretionary | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **26 Supplies & Materials:** | | | | | | | | | | | | |
| Provisions | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Drugs & Medicines | $365,286 | $378,561 | $407,505 | $395,642 | $0 | $0 | $0 | $0 | $365,286 | $378,561 | $407,505 | $395,642 |
| 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 | $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 | -$1 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | -$1 | $0 | $0 | $0 |
| Prosthetic Appliances | $15,250 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $15,250 | $0 | $0 | $0 |
| Home Respiratory Therapy | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $380,535 | $378,561 | $407,505 | $395,642 | $0 | $0 | $0 | $0 | $380,535 | $378,561 | $407,505 | $395,642 |
| **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 | $1,201,528 | $1,456,305 | $1,540,863 | $1,545,854 | $100,000 | $0 | $0 | $0 | $1,301,528 | $1,456,305 | $1,540,863 | $1,545,854 |
| 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 | $1,201,528 | $1,456,305 | $1,540,863 | $1,545,854 | $100,000 | $0 | $0 | $0 | $1,301,528 | $1,456,305 | $1,540,863 | $1,545,854 |
| **42 - Insurance Claims and Indemnities** | $1,239 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $1,239 | $0 | $0 | $0 |
| **43 Imputed Interest** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $17,529,358 | $25,868,933 | $29,196,966 | $33,750,756 | $5,661,132 | $0 | $0 | $0 | $23,190,490 | $25,868,933 | $29,196,966 | $33,750,756 |
| Prior Year Recoveries | $89,736 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $89,736 | $0 | $0 | $0 |
| **Obligations [Total]** | **$17,619,094** | **$25,868,933** | **$29,196,966** | **$33,750,756** | **$5,661,132** | **$0** | **$0** | **$0** | **$23,280,226** | **$25,868,933** | **$29,196,966** | **$33,750,756** |

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

| | American Rescue Plan (ARP) | | | |
|---|---|---|---|---|
| **Description** | **FY 2021** | **FY 2022** | **FY 2023** | **FY 2024** |
| **10 Personnel Compensation and Benefits:** | | | | |
| Physicians | $0 | $0 | $0 | $0 |
| Dentists | $0 | $0 | $0 | $0 |
| Registered Nurses | $0 | $0 | $0 | $0 |
| LP Nurse/LV Nurse/Nurse Assistant | $0 | $0 | $0 | $0 |
| Non-Physician Providers | $0 | $0 | $0 | $0 |
| Health Technicians/Allied Health | $0 | $0 | $0 | $0 |
| Wage Board/Purchase & Hire | $0 | $0 | $0 | $0 |
| All Other | $0 | $0 | $0 | $0 |
| Permanent Change of Station | $0 | $0 | $0 | $0 |
| Employee Compensation Pay | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 |
| **21 Travel & Transportation of Persons:** | | | | |
| Employee | $0 | $0 | $0 | $0 |
| Beneficiary | $0 | $0 | $0 | $0 |
| Other | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 |
| **22 Transportation of Things** | $0 | $0 | $0 | $0 |
| **23 Rent, Communications, and Utilities:** | | | | |
| Rental of Equipment | $0 | $0 | $0 | $0 |
| Communications | $0 | $0 | $0 | $0 |
| Utilities | $0 | $0 | $0 | $0 |
| GSA Rent | $0 | $0 | $0 | $0 |
| Other Real Property Rental | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 |
| **24 Printing & Reproduction:** | | | | |
| **25 Other Contractual Services:** | | | | |
| Care in the Community Outpatient Dental Care | $0 | $0 | $0 | $0 |
| Medical and Nursing Care in the Community | $0 | $979,415 | $1,041,709 | $0 |
| Repairs to Furniture/Equipment | $0 | $0 | $0 | $0 |
| Maintenance & Repair Contract Services | $0 | $0 | $0 | $0 |
| Care in the Community Hospital Care | $0 | $993,881 | $1,057,096 | $0 |
| Community Nursing Homes | $0 | $0 | $0 | $0 |
| Repairs to Prosthetic Appliances | $0 | $0 | $0 | $0 |
| Home Oxygen | $0 | $0 | $0 | $0 |
| Organ Procurement | $0 | $0 | $0 | $0 |
| Personal Services Contracts | $0 | $0 | $0 | $0 |
| House Staff Disbursing Agreement | $0 | $0 | $0 | $0 |
| Scarce Medical Specialists | $0 | $0 | $0 | $0 |
| Other Medical Contract Services | $0 | $0 | $0 | $0 |
| Administrative Contract Services | $0 | $0 | $0 | $0 |
| Training Contract Services | $0 | $0 | $0 | $0 |
| Caregiver Stipends | $0 | $0 | $0 | $0 |
| CHAMPVA | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $1,973,296 | $2,098,805 | $0 |

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

| | American Rescue Plan (ARP) | | | |
|---|---|---|---|---|
| **Description** | **FY 2021** | **FY 2022** | **FY 2023** | **FY 2024** |
| **26 Supplies & Materials:** | | | | |
| Provisions | $0 | $0 | $0 | $0 |
| Drugs & Medicines | $0 | $0 | $0 | $0 |
| Blood & Blood Products | $0 | $0 | $0 | $0 |
| Medical/Dental Supplies | $0 | $0 | $0 | $0 |
| Operating Supplies | $0 | $0 | $0 | $0 |
| Maintenance & Repair Supplies | $0 | $0 | $0 | $0 |
| Other Supplies | $0 | $0 | $0 | $0 |
| Prosthetic Appliances | $0 | $0 | $0 | $0 |
| Home Respiratory Therapy | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 |
| **31 Equipment** | $0 | $0 | $0 | $0 |
| **32 Lands & Structures:** | | | | |
| Non-Recurring Maintenance | $0 | $0 | $0 | $0 |
| All Other Lands & Structures | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 |
| **41 Grants, Subsidies & Contributions:** | | | | |
| State Home | $250,000 | $0 | $0 | $0 |
| Grants | $0 | $0 | $0 | $0 |
| Veteran Adoption Reimbursement | $0 | $0 | $0 | $0 |
| Subtotal | $250,000 | $0 | $0 | $0 |
| **42 - Insurance Claims and Indemnities** | $0 | $0 | $0 | $0 |
| **43 Imputed Interest** | $0 | $0 | $0 | $0 |
| Subtotal | $250,000 | $1,973,296 | $2,098,805 | $0 |
| Prior Year Recoveries | $0 | $0 | $0 | $0 |
| **Obligations [Total]** | **$250,000** | **$1,973,296** | **$2,098,805** | **$0** |

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

| Description | Medical Services Total All Funding Sources (Discretionary & Mandatory) | | | | Medical Support & Compiance Total All Funding Sources (Discretionary & Mandatory) | | | | Medical Facilities Total All Funding Sources (Discretionary & Mandatory) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **10 Personnel Compensation and Benefits:** | | | | | | | | | | | | |
| Physicians | $8,151,745 | $8,467,097 | $9,286,590 | $9,946,604 | $273,858 | $301,578 | $359,558 | $385,870 | $397 | $0 | $0 | $0 |
| Dentists | $341,657 | $355,462 | $390,862 | $412,596 | $5,009 | $5,563 | $6,592 | $7,132 | $3 | $0 | $0 | $0 |
| Registered Nurses | $9,812,361 | $10,172,025 | $11,204,372 | $12,267,088 | $531,943 | $597,442 | $730,282 | $789,326 | $458 | $0 | $0 | $0 |
| LP Nurse/LV Nurse/Nurse Assistant | $2,299,722 | $2,403,222 | $2,662,436 | $2,840,336 | $4,396 | $4,737 | $5,641 | $5,958 | $163 | $0 | $0 | $0 |
| Non-Physician Providers | $3,041,535 | $3,148,395 | $3,463,350 | $3,796,354 | $56,665 | $63,260 | $76,877 | $82,569 | $205 | $0 | $0 | $0 |
| Health Technicians/Allied Health | $9,237,127 | $9,574,208 | $10,535,745 | $11,505,360 | $157,374 | $174,333 | $210,626 | $225,356 | $11,717 | $12,570 | $14,719 | $15,759 |
| Wage Board/Purchase & Hire | $388,029 | $402,859 | $444,237 | $470,180 | $91,238 | $102,353 | $124,867 | $134,817 | $1,559,861 | $1,679,625 | $1,955,173 | $2,085,910 |
| All Other | $3,488,196 | $3,619,914 | $3,989,994 | $4,387,451 | $5,058,783 | $5,670,253 | $6,916,264 | $7,462,518 | $533,916 | $576,467 | $673,374 | $721,636 |
| Permanent Change of Station | $4,103 | $4,186 | $4,271 | $4,358 | $7,614 | $7,769 | $7,927 | $8,088 | $151 | $154 | $157 | $160 |
| Employee Compensation Pay | $248,938 | $253,991 | $259,147 | $264,408 | $39,888 | $40,698 | $41,524 | $42,367 | $37,515 | $38,277 | $39,054 | $39,847 |
| Subtotal | $37,013,413 | $38,401,359 | $42,241,004 | $45,894,735 | $6,226,768 | $6,967,986 | $8,480,158 | $9,144,001 | $2,144,386 | $2,307,093 | $2,682,477 | $2,863,312 |
| **21 Travel & Transportation of Persons:** | | | | | | | | | | | | |
| Employee | $20,349 | $16,500 | $61,315 | $67,300 | $11,351 | $28,340 | $63,817 | $70,000 | $3,021 | $2,905 | $3,056 | $3,200 |
| Beneficiary | $1,328,750 | $1,385,278 | $1,488,378 | $1,540,378 | $6 | $0 | $0 | $0 | -$20 | $0 | $0 | $0 |
| Other | $57,558 | $64,100 | $67,441 | $74,000 | $5,542 | $5,154 | $5,423 | $6,000 | $43,150 | $43,131 | $47,005 | $48,900 |
| Subtotal | $1,406,657 | $1,465,878 | $1,617,134 | $1,681,678 | $16,899 | $33,494 | $69,240 | $76,000 | $46,151 | $46,036 | $50,061 | $52,100 |
| **22 Transportation of Things** | $27,186 | $29,600 | $31,143 | $34,200 | $16,829 | $20,540 | $25,071 | $27,500 | $18,256 | $19,622 | $20,445 | $21,300 |
| **23 Rent, Communications, and Utilities:** | | | | | | | | | | | | |
| Rental of Equipment | $217,930 | $233,700 | $260,824 | $286,300 | $55,609 | $64,340 | $74,441 | $81,700 | $14,771 | $12,127 | $12,759 | $13,300 |
| Communications | $402,644 | $456,800 | $471,902 | $517,900 | $67,788 | $83,864 | $94,031 | $103,200 | $52,932 | $52,926 | $55,685 | $58,000 |
| Utilities | $231 | $0 | $0 | $0 | $8 | $0 | $0 | $0 | $529,552 | $574,279 | $620,215 | $645,600 |
| GSA Rent | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Real Property Rental | $16,618 | $0 | $0 | $0 | $4,748 | $0 | $0 | $0 | $783,803 | $1,321,519 | $1,111,625 | $957,022 |
| Subtotal | $637,423 | $690,500 | $732,726 | $804,200 | $128,153 | $148,204 | $168,472 | $184,900 | $1,381,058 | $1,960,851 | $1,800,284 | $1,673,922 |
| **24 Printing & Reproduction:** | $12,515 | $13,592 | $13,592 | $14,900 | $22,116 | $29,619 | $37,843 | $41,500 | $104 | $114 | $120 | $125 |
| **25 Other Contractual Services:** | | | | | | | | | | | | |
| Care in the Community Outpatient Dental Care | $6,339 | $7,200 | $7,575 | $8,300 | $0 | $0 | $0 | $0 | $8 | $0 | $0 | $0 |
| Medical and Nursing Care in the Community | $289,891 | $312,100 | $328,369 | $360,400 | $1,812 | $0 | $0 | $0 | -$30 | $0 | $0 | $0 |
| Repairs to Furniture/Equipment | $337,733 | $379,900 | $399,704 | $438,700 | $4,714 | $5,333 | $5,611 | $6,200 | $22,927 | $22,676 | $23,858 | $24,800 |
| Maintenance & Repair Contract Services | $48,431 | $54,500 | $57,341 | $62,900 | $2,211 | $0 | $0 | $0 | $282,234 | $321,115 | $342,854 | $856,900 |
| Care in the Community Hospital Care | -$1,143 | $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 | $299,668 | $300,730 | $325,840 | $353,132 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Home Oxygen | $212,021 | $229,246 | $248,387 | $269,192 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Organ Procurement | $18,857 | $21,300 | $22,410 | $24,600 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Personal Services Contracts | $120,073 | $58,700 | $61,760 | $67,800 | $7,258 | $7,918 | $8,331 | $9,100 | $2,925 | $2,818 | $2,965 | $3,100 |
| House Staff Disbursing Agreement | $741,847 | $839,400 | $883,157 | $969,300 | $210 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Scarce Medical Specialists | $257,046 | $218,300 | $229,680 | $252,100 | $0 | $0 | $0 | $0 | $256 | $0 | $0 | $0 |
| Other Medical Contract Services | $1,608,265 | $5,696,207 | $7,278,397 | $4,489,440 | $8,872 | $9,880 | $10,395 | $11,400 | $12,434 | $0 | $0 | $0 |
| Administrative Contract Services | $1,262,676 | $1,270,136 | $1,336,283 | $1,466,598 | $1,538,237 | $1,540,772 | $2,579,153 | $2,541,348 | $580,574 | $584,481 | $606,601 | $1,291,630 |
| Training Contract Services | $81,909 | $91,900 | $96,691 | $106,100 | $79,061 | $88,205 | $92,803 | $101,900 | $1,355 | $1,351 | $1,421 | $1,500 |
| Caregiver Stipends | $624,061 | $844,119 | $1,409,306 | $1,773,034 | $1 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| CHAMPVA | $0 | $21,720 | $25,537 | $29,985 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $5,907,674 | $10,345,458 | $12,710,437 | $10,671,581 | $1,642,376 | $1,652,108 | $2,696,293 | $2,669,948 | $902,683 | $932,441 | $977,699 | $2,177,930 |

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

(dollars in thousands)

| Description | Medical Services Total All Funding Sources (Discretionary & Mandatory) | | | | Medical Support & Compiance Total All Funding Sources (Discretionary & Mandatory) | | | | Medical Facilities Total All Funding Sources (Discretionary & Mandatory) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **26 Supplies & Materials:** | | | | | | | | | | | | |
| Provisions | $113,277 | $128,100 | $134,778 | $147,900 | $1,998 | $0 | $0 | $0 | $9 | $0 | $0 | $0 |
| Drugs & Medicines | $7,675,886 | $7,560,270 | $8,272,425 | $8,899,403 | $16 | $0 | $0 | $0 | $122 | $0 | $0 | $0 |
| Blood & Blood Products | $51,569 | $56,394 | $61,706 | $66,383 | $0 | $0 | $0 | $0 | $4 | $0 | $0 | $0 |
| Medical/Dental Supplies | $2,225,709 | $2,517,800 | $2,134,988 | $2,343,200 | $935 | $0 | $0 | $0 | $2,675 | $0 | $0 | $0 |
| Operating Supplies | $278,284 | $314,800 | $331,210 | $363,500 | $40,188 | $43,692 | $45,570 | $50,000 | $162,705 | $239,743 | $248,520 | $258,700 |
| Maintenance & Repair Supplies | $41,780 | $0 | $0 | $0 | $557 | $0 | $0 | $0 | $183,745 | $274,763 | $285,365 | $297,000 |
| Other Supplies | $305,951 | $346,100 | $364,142 | $399,700 | $58,704 | $62,662 | $64,928 | $71,300 | $51,429 | $48,227 | $50,741 | $52,800 |
| Prosthetic Appliances | $2,871,703 | $3,104,688 | $3,363,916 | $3,645,675 | $4 | $0 | $0 | $0 | $11 | $0 | $0 | $0 |
| Home Respiratory Therapy | $77,569 | $83,811 | $90,809 | $98,416 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $13,641,728 | $14,111,963 | $14,753,974 | $15,964,177 | $102,402 | $106,354 | $110,498 | $121,300 | $400,700 | $562,733 | $584,626 | $608,500 |
| **31 Equipment** | $2,079,119 | $2,474,035 | $2,514,904 | $602,616 | $41,277 | $43,583 | $46,065 | $47,862 | $147,605 | $134,072 | $160,110 | $166,354 |
| **32 Lands & Structures:** | | | | | | | | | | | | |
| Non-Recurring Maintenance | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $1,994,163 | $2,654,117 | $2,505,000 | $995,000 |
| All Other Lands & Structures | $921 | $0 | $1,047 | $0 | $870 | $0 | $0 | $0 | $311,537 | $562,733 | $568,423 | $223,026 |
| Subtotal | $921 | $0 | $1,047 | $0 | $870 | $0 | $0 | $0 | $2,305,700 | $3,216,850 | $3,073,423 | $1,218,026 |
| **41 Grants, Subsidies & Contributions:** | | | | | | | | | | | | |
| State Home | $1,519 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Grants | $1,151,882 | $1,377,513 | $1,351,360 | $1,405,319 | $60 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Veteran Adoption Reimbursement | $40 | $40 | $40 | $40 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $1,153,441 | $1,377,553 | $1,351,400 | $1,405,359 | $60 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **42 Insurance Claims and Indemnities** | $9,203 | $10,543 | $10,543 | $10,543 | $15,852 | $20,377 | $20,377 | $22,400 | $2,339 | $2,436 | $2,536 | $2,600 |
| **43 Imputed Interest** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $61,889,280 | $68,920,481 | $75,977,904 | $77,083,989 | $8,213,602 | $9,022,265 | $11,654,017 | $12,335,411 | $7,348,982 | $9,182,248 | $9,351,781 | $8,784,169 |
| Prior Year Recoveries | $442,681 | $0 | $0 | $0 | $2,139 | $0 | $0 | $0 | $55,029 | $0 | $0 | $0 |
| **Obligations [Total]** | **$62,331,961** | **$68,920,481** | **$75,977,904** | **$77,083,989** | **$8,215,741** | **$9,022,265** | **$11,654,017** | **$12,335,411** | **$7,404,011** | **$9,182,248** | **$9,351,781** | **$8,784,169** |

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

| Description | Medical Community Care Total All Funding Sources (Discretionary & Mandatory) except VCF | | | | Veterans Choice Fund Total (Mandatory) | | | | Medical Community Care & Veterans Choice Total (Discretionary & Mandatory) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **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 | $12,015 | $0 | $0 | $0 | $1,493 | $0 | $0 | $0 | $13,508 | $0 | $0 | $0 |
| Other | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $12,015 | $0 | $0 | $0 | $1,493 | $0 | $0 | $0 | $13,508 | $0 | $0 | $0 |
| **22 Transportation of Things** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **23 Rent, Communications, and Utilities:** | | | | | | | | | | | | |
| Rental of Equipment | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Communications | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Utilities | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| GSA Rent | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Real Property Rental | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **24 Printing & Reproduction:** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **25 Other Contractual Services:** | | | | | | | | | | | | |
| Care in the Community Outpatient Dental Care | $434,213 | $871,525 | $1,118,905 | $1,186,326 | $322 | $0 | $0 | $0 | $434,535 | $871,525 | $1,118,905 | $1,186,326 |
| Medical and Nursing Care in the Community | $8,032,539 | $10,255,044 | $11,643,965 | $12,968,669 | -$9,597 | $15,465 | $265,088 | $0 | $8,022,942 | $10,270,509 | $11,909,053 | $12,968,669 |
| Repairs to Furniture/Equipment | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Maintenance & Repair Contract Services | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Care in the Community Hospital Care | $7,453,259 | $8,704,586 | $10,074,585 | $10,779,363 | $1,025 | $0 | $0 | $0 | $7,454,284 | $8,704,586 | $10,074,585 | $10,779,363 |
| Community Nursing Homes | $1,131,646 | $1,305,367 | $1,443,170 | $1,552,581 | -$1 | $0 | $0 | $0 | $1,131,645 | $1,305,367 | $1,443,170 | $1,552,581 |
| Repairs to Prosthetic Appliances | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Home Oxygen | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Organ Procurement | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Personal Services Contracts | $1,036 | $1,078 | $1,120 | $1,164 | $0 | $0 | $0 | $0 | $1,036 | $1,078 | $1,120 | $1,164 |
| House Staff Disbursing Agreement | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Scarce Medical Specialists | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Medical Contract Services | $3,328,444 | $3,413,412 | $3,546,535 | $3,684,850 | -$118,811 | $0 | $0 | $0 | $3,209,633 | $3,413,412 | $3,546,535 | $3,684,850 |
| Administrative Contract Services | $11,877 | $0 | $0 | $0 | -$3,495 | $0 | $0 | $0 | $8,382 | $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 | $1,102,159 | $1,456,351 | $1,519,123 | $1,636,307 | -$32,812 | $0 | $0 | $0 | $1,069,347 | $1,456,351 | $1,519,123 | $1,636,307 |
| Subtotal | $21,495,173 | $26,007,363 | $29,347,403 | $31,809,260 | -$163,369 | $15,465 | $265,088 | $0 | $21,331,804 | $26,022,828 | $29,612,491 | $31,809,260 |

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

| Description | Medical Community Care Total All Funding Sources (Discretionary & Mandatory) except VCF | | | | Veterans Choice Fund Total (Mandatory) | | | | Medical Community Care & Veterans Choice Total (Discretionary & Mandatory) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **26 Supplies & Materials:** | | | | | | | | | | | | |
| Provisions | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Drugs & Medicines | $365,286 | $378,561 | $407,505 | $395,642 | $31,328 | $0 | $0 | $0 | $396,614 | $378,561 | $407,505 | $395,642 |
| 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 | $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 | -$1 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | -$1 | $0 | $0 | $0 |
| Prosthetic Appliances | $15,250 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $15,250 | $0 | $0 | $0 |
| Home Respiratory Therapy | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $380,535 | $378,561 | $407,505 | $395,642 | $31,328 | $0 | $0 | $0 | $411,863 | $378,561 | $407,505 | $395,642 |
| **31 Equipment** | $0 | $0 | $0 | $0 | -$144 | $0 | $0 | $0 | -$144 | $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 | $1,551,528 | $1,456,305 | $1,540,863 | $1,545,854 | $0 | $0 | $0 | $0 | $1,551,528 | $1,456,305 | $1,540,863 | $1,545,854 |
| 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 | $1,551,528 | $1,456,305 | $1,540,863 | $1,545,854 | $0 | $0 | $0 | $0 | $1,551,528 | $1,456,305 | $1,540,863 | $1,545,854 |
| **42 Insurance Claims and Indemnities** | $1,239 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $1,239 | $0 | $0 | $0 |
| **43 Imputed Interest** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $23,440,490 | $27,842,229 | $31,295,771 | $33,750,756 | -$130,692 | $15,465 | $265,088 | $0 | $23,309,798 | $27,857,694 | $31,560,859 | $33,750,756 |
| Prior Year Recoveries | $89,736 | $0 | $0 | $0 | $155,872 | $0 | $0 | $0 | $245,608 | $0 | $0 | $0 |
| **Obligations [Total]** | **$23,530,226** | **$27,842,229** | **$31,295,771** | **$33,750,756** | **$25,180** | **$15,465** | **$265,088** | **$0** | **$23,555,406** | **$27,857,694** | **$31,560,859** | **$33,750,756** |

**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 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **10 Personnel Compensation and Benefits:** | | | | | | | | | | | | |
| Physicians | $8,422,875 | $8,765,459 | $9,642,784 | $10,329,008 | $3,125 | $3,216 | $3,364 | $3,466 | $8,426,000 | $8,768,675 | $9,646,148 | $10,332,474 |
| Dentists | $346,667 | $361,023 | $397,452 | $419,726 | $2 | $2 | $2 | $2 | $346,669 | $361,025 | $397,454 | $419,728 |
| Registered Nurses | $10,344,521 | $10,769,219 | $11,934,395 | $13,056,148 | $241 | $248 | $259 | $266 | $10,344,762 | $10,769,467 | $11,934,654 | $13,056,414 |
| LP Nurse/LV Nurse/Nurse Assistant | $2,304,281 | $2,407,959 | $2,668,077 | $2,846,294 | $0 | $0 | $0 | $0 | $2,304,281 | $2,407,959 | $2,668,077 | $2,846,294 |
| Non-Physician Providers | $3,098,182 | $3,211,426 | $3,539,987 | $3,878,676 | $223 | $229 | $240 | $247 | $3,098,405 | $3,211,655 | $3,540,227 | $3,878,923 |
| Health Technicians/Allied Health | $9,406,209 | $9,761,102 | $10,761,081 | $11,746,466 | $9 | $9 | $9 | $9 | $9,406,218 | $9,761,111 | $10,761,090 | $11,746,475 |
| Wage Board/Purchase & Hire | $2,039,017 | $2,184,723 | $2,524,158 | $2,690,907 | $111 | $114 | $119 | $0 | $2,039,128 | $2,184,837 | $2,524,277 | $2,690,907 |
| All Other | $9,078,757 | $9,864,434 | $11,577,331 | $12,569,235 | $2,138 | $2,200 | $2,301 | $2,370 | $9,080,895 | $9,866,634 | $11,579,632 | $12,571,605 |
| Permanent Change of Station | $11,868 | $12,109 | $12,355 | $12,606 | $0 | $0 | $0 | $0 | $11,868 | $12,109 | $12,355 | $12,606 |
| Employee Compensation Pay | $326,341 | $332,966 | $339,725 | $346,622 | $0 | $0 | $0 | $0 | $326,341 | $332,966 | $339,725 | $346,622 |
| Subtotal | $45,378,718 | $47,670,420 | $53,397,345 | $57,895,688 | $5,849 | $6,018 | $6,294 | $6,360 | $45,384,567 | $47,676,438 | $53,403,639 | $57,902,048 |
| **21 Travel & Transportation of Persons:** | | | | | | | | | | | | |
| Employee | $34,721 | $47,745 | $128,188 | $140,500 | $0 | $0 | $0 | $0 | $34,721 | $47,745 | $128,188 | $140,500 |
| Beneficiary | $1,340,751 | $1,385,278 | $1,488,378 | $1,540,378 | $1,493 | $0 | $0 | $0 | $1,342,244 | $1,385,278 | $1,488,378 | $1,540,378 |
| Other | $106,250 | $112,385 | $119,869 | $128,900 | $0 | $0 | $0 | $0 | $106,250 | $112,385 | $119,869 | $128,900 |
| Subtotal | $1,481,722 | $1,545,408 | $1,736,435 | $1,809,778 | $1,493 | $0 | $0 | $0 | $1,483,215 | $1,545,408 | $1,736,435 | $1,809,778 |
| **22 Transportation of Things** | $62,270 | $69,762 | $76,659 | $83,000 | $1 | $0 | $0 | $0 | $62,271 | $69,762 | $76,659 | $83,000 |
| **23 Rent, Communications, and Utilities:** | | | | | | | | | | | | |
| Rental of Equipment | $288,307 | $310,167 | $348,024 | $381,300 | $3 | $0 | $0 | $0 | $288,310 | $310,167 | $348,024 | $381,300 |
| Communications | $523,364 | $593,590 | $621,618 | $679,100 | $0 | $0 | $0 | $0 | $523,364 | $593,590 | $621,618 | $679,100 |
| Utilities | $529,791 | $574,279 | $620,215 | $645,600 | $0 | $0 | $0 | $0 | $529,791 | $574,279 | $620,215 | $645,600 |
| GSA Rent | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Real Property Rental | $805,485 | $898,727 | $1,110,465 | $957,022 | -$316 | $422,792 | $1,160 | $0 | $805,169 | $1,321,519 | $1,111,625 | $957,022 |
| Subtotal | $2,146,947 | $2,376,763 | $2,700,322 | $2,663,022 | -$313 | $422,792 | $1,160 | $0 | $2,146,634 | $2,799,555 | $2,701,482 | $2,663,022 |
| **24 Printing & Reproduction:** | $34,735 | $43,325 | $51,555 | $56,525 | $0 | $0 | $0 | $0 | $34,735 | $43,325 | $51,555 | $56,525 |
| **25 Other Contractual Services:** | | | | | | | | | | | | |
| Care in the Community Outpatient Dental Care | $440,560 | $878,725 | $1,126,480 | $1,194,626 | $322 | $0 | $0 | $0 | $440,882 | $878,725 | $1,126,480 | $1,194,626 |
| Medical and Nursing Care in the Community | $8,324,212 | $9,587,729 | $10,930,625 | $13,329,069 | -$9,597 | $994,880 | $1,306,797 | $0 | $8,314,615 | $10,582,609 | $12,237,422 | $13,329,069 |
| Repairs to Furniture/Equipment | $365,374 | $407,909 | $429,173 | $469,700 | $0 | $0 | $0 | $0 | $365,374 | $407,909 | $429,173 | $469,700 |
| Maintenance & Repair Contract Services | $332,777 | $375,615 | $400,195 | $919,800 | $99 | $0 | $0 | $0 | $332,876 | $375,615 | $400,195 | $919,800 |
| Care in the Community Hospital Care | $7,452,116 | $7,710,705 | $9,017,489 | $10,779,363 | $1,025 | $993,881 | $1,057,096 | $0 | $7,453,141 | $8,704,586 | $10,074,585 | $10,779,363 |
| Community Nursing Homes | $1,131,646 | $1,305,367 | $1,443,170 | $1,552,581 | -$1 | $0 | $0 | $0 | $1,131,645 | $1,305,367 | $1,443,170 | $1,552,581 |
| Repairs to Prosthetic Appliances | $299,668 | $300,730 | $325,840 | $353,132 | $0 | $0 | $0 | $0 | $299,668 | $300,730 | $325,840 | $353,132 |
| Home Oxygen | $212,021 | $229,246 | $248,387 | $269,192 | $0 | $0 | $0 | $0 | $212,021 | $229,246 | $248,387 | $269,192 |
| Organ Procurement | $18,857 | $21,300 | $22,410 | $24,600 | $0 | $0 | $0 | $0 | $18,857 | $21,300 | $22,410 | $24,600 |
| Personal Services Contracts | $131,292 | $70,514 | $74,176 | $81,164 | $0 | $0 | $0 | $0 | $131,292 | $70,514 | $74,176 | $81,164 |
| House Staff Disbursing Agreement | $742,187 | $839,400 | $883,157 | $969,300 | -$130 | $0 | $0 | $0 | $742,057 | $839,400 | $883,157 | $969,300 |
| Scarce Medical Specialists | $257,302 | $218,300 | $229,680 | $252,100 | $0 | $0 | $0 | $0 | $257,302 | $218,300 | $229,680 | $252,100 |
| Other Medical Contract Services | $4,958,009 | $6,105,892 | $10,139,027 | $8,185,690 | -$118,805 | $3,013,607 | $696,300 | $0 | $4,839,204 | $9,119,499 | $10,835,327 | $8,185,690 |
| Administrative Contract Services | $3,392,821 | $2,761,055 | $3,784,205 | $5,298,868 | -$2,952 | $634,334 | $737,832 | $708 | $3,389,869 | $3,395,389 | $4,522,037 | $5,299,576 |
| Training Contract Services | $162,313 | $181,456 | $190,915 | $209,500 | $12 | $0 | $0 | $0 | $162,325 | $181,456 | $190,915 | $209,500 |
| Caregiver Stipends | $624,062 | $844,119 | $1,409,306 | $1,773,034 | $0 | $0 | $0 | $0 | $624,062 | $844,119 | $1,409,306 | $1,773,034 |
| CHAMPVA | $1,102,159 | $1,478,071 | $1,544,660 | $1,666,292 | -$32,812 | $0 | $0 | $0 | $1,069,347 | $1,478,071 | $1,544,660 | $1,666,292 |
| Subtotal | $29,947,376 | $33,316,133 | $42,198,895 | $47,328,011 | -$162,839 | $5,636,702 | $3,798,025 | $708 | $29,784,537 | $38,952,835 | $45,996,920 | $47,328,719 |

**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 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
| **26 Supplies & Materials:** | | | | | | | | | | | | |
| Provisions | $115,284 | $128,100 | $134,778 | $147,900 | $0 | $0 | $0 | $0 | $115,284 | $128,100 | $134,778 | $147,900 |
| Drugs & Medicines | $8,041,310 | $7,938,831 | $8,679,930 | $9,295,045 | $31,328 | $0 | $0 | $0 | $8,072,638 | $7,938,831 | $8,679,930 | $9,295,045 |
| Blood & Blood Products | $51,573 | $56,394 | $61,706 | $66,383 | $0 | $0 | $0 | $0 | $51,573 | $56,394 | $61,706 | $66,383 |
| Medical/Dental Supplies | $2,229,135 | $2,117,800 | $2,134,988 | $2,343,200 | $184 | $400,000 | $0 | $0 | $2,229,319 | $2,517,800 | $2,134,988 | $2,343,200 |
| Operating Supplies | $480,999 | $598,235 | $625,300 | $672,200 | $178 | $0 | $0 | $0 | $481,177 | $598,235 | $625,300 | $672,200 |
| Maintenance & Repair Supplies | $225,965 | $274,763 | $285,365 | $297,000 | $117 | $0 | $0 | $0 | $226,082 | $274,763 | $285,365 | $297,000 |
| Other Supplies | $416,057 | $456,989 | $479,811 | $523,800 | $26 | $0 | $0 | $0 | $416,083 | $456,989 | $479,811 | $523,800 |
| Prosthetic Appliances | $2,886,968 | $3,104,688 | $3,363,916 | $3,645,675 | $0 | $0 | $0 | $0 | $2,886,968 | $3,104,688 | $3,363,916 | $3,645,675 |
| Home Respiratory Therapy | $77,569 | $83,811 | $90,809 | $98,416 | $0 | $0 | $0 | $0 | $77,569 | $83,811 | $90,809 | $98,416 |
| Subtotal | $14,524,860 | $14,759,611 | $15,856,603 | $17,089,619 | $31,833 | $400,000 | $0 | $0 | $14,556,693 | $15,159,611 | $15,856,603 | $17,089,619 |
| **31 Equipment** | $2,267,065 | $905,466 | $2,721,079 | $816,832 | $792 | $1,746,224 | $0 | $0 | $2,267,857 | $2,651,690 | $2,721,079 | $816,832 |
| **32 Lands & Structures:** | | | | | | | | | | | | |
| Non-Recurring Maintenance | $2,004,935 | $881,565 | $2,505,000 | $995,000 | -$10,772 | $1,772,552 | $0 | $0 | $1,994,163 | $2,654,117 | $2,505,000 | $995,000 |
| All Other Lands & Structures | $289,254 | $562,733 | $569,470 | $223,026 | $24,074 | $0 | $0 | $0 | $313,328 | $562,733 | $569,470 | $223,026 |
| Subtotal | $2,294,189 | $1,444,298 | $3,074,470 | $1,218,026 | $13,302 | $1,772,552 | $0 | $0 | $2,307,491 | $3,216,850 | $3,074,470 | $1,218,026 |
| **41 Grants, Subsidies & Contributions:** | | | | | | | | | | | | |
| State Home | $1,303,047 | $1,456,305 | $1,540,863 | $1,545,854 | $250,000 | $0 | $0 | $0 | $1,553,047 | $1,456,305 | $1,540,863 | $1,545,854 |
| Grants | $1,151,942 | $955,513 | $1,351,360 | $1,405,319 | $0 | $422,000 | $0 | $0 | $1,151,942 | $1,377,513 | $1,351,360 | $1,405,319 |
| Veteran Adoption Reimbursement | $40 | $40 | $40 | $40 | $0 | $0 | $0 | $0 | $40 | $40 | $40 | $40 |
| Subtotal | $2,455,029 | $2,411,858 | $2,892,263 | $2,951,213 | $250,000 | $422,000 | $0 | $0 | $2,705,029 | $2,833,858 | $2,892,263 | $2,951,213 |
| **42 Insurance Claims and Indemnities** | $28,633 | $33,356 | $33,456 | $35,543 | $0 | $0 | $0 | $0 | $28,633 | $33,356 | $33,456 | $35,543 |
| **43 Imputed Interest** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $100,621,544 | $104,576,400 | $124,739,082 | $131,947,257 | $140,118 | $10,406,288 | $3,805,479 | $7,068 | $100,761,662 | $114,982,688 | $128,544,561 | $131,954,325 |
| Prior Year Recoveries | $576,861 | $0 | $0 | $0 | $168,596 | $0 | $0 | $0 | $745,457 | $0 | $0 | $0 |
| ARP Act 8007 Compayment Reimbursement | $0 | $0 | $0 | $0 | $243,610 | $56,390 | $0 | $0 | $243,610 | $56,390 | $0 | $0 |
| **Obligations [Total]** | **$101,198,405** | **$104,576,400** | **$124,739,082** | **$131,947,257** | **$308,714** | **$10,406,288** | **$3,805,479** | **$7,068** | **$101,750,729** | **$115,039,078** | **$128,544,561** | **$131,954,325** |

## Medical Care Areas of Focus

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

**Table: Total Medical Care Obligations by Program**
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate 5/ | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Health Care Services:** | | | | | | | |
| Ambulatory Care | $48,092,107 | $59,651,738 | $57,658,635 | $65,102,797 | $65,242,116 | $7,444,162 | $139,319 |
| Dental Care | $1,645,894 | $1,632,271 | $1,943,308 | $2,291,788 | $2,407,174 | $348,480 | $115,386 |
| Inpatient Care | $20,274,355 | $21,843,838 | $22,147,891 | $24,485,224 | $25,559,089 | $2,337,333 | $1,073,865 |
| Mental Health Care 1/ | $11,211,279 | $13,541,352 | $12,250,840 | $13,918,915 | $14,530,920 | $1,668,075 | $612,005 |
| Prosthetic and Sensory Aids Services | $3,474,096 | $4,934,411 | $3,756,341 | $4,069,980 | $4,410,880 | $313,639 | $340,900 |
| Rehabilitation Care | $1,073,858 | $1,097,033 | $1,156,059 | $1,258,933 | $1,234,126 | $102,874 | ($24,807) |
| **Health Care Services [Subtotal]** | **$85,771,589** | **$102,700,643** | **$98,913,074** | **$111,127,637** | **$113,384,305** | **$12,214,563** | **$2,256,668** |
| **Long-Term Services & Supports (LTSS):** | | | | | | | |
| Institutional LTSS | | | | | | | |
| VA Community Living Centers (VA CLC) | $4,514,583 | $4,423,856 | $4,650,213 | $4,942,654 | $5,093,007 | $292,441 | $150,353 |
| Community Nursing Home | $1,257,935 | $1,907,731 | $1,402,472 | $1,550,526 | $1,668,076 | $148,054 | $117,550 |
| State Home Nursing | $1,503,738 | $1,707,451 | $1,403,639 | $1,490,482 | $1,496,039 | $86,843 | $5,557 |
| State Home Domiciliary | $44,096 | $56,357 | $51,632 | $49,095 | $48,729 | ($2,537) | ($366) |
| Institutional LTSS [Subtotal] | $7,320,352 | $8,095,395 | $7,507,956 | $8,032,757 | $8,305,851 | $524,801 | $273,094 |
| Non-Institutional LTSS | | | | | | | |
| State Home Adult Day Care | $1,780 | $4,734 | $1,034 | $1,286 | $1,086 | $252 | ($200) |
| Other Non-Institutional LTSS | $3,405,350 | $3,671,948 | $3,726,781 | $4,051,310 | $4,284,748 | $324,529 | $233,438 |
| Non-Institutional LTSS [Subtotal] | $3,407,130 | $3,676,682 | $3,727,815 | $4,052,596 | $4,285,834 | $324,781 | $233,238 |
| **LTSS [Subtotal]** | **$10,727,482** | **$11,772,077** | **$11,235,771** | **$12,085,353** | **$12,591,685** | **$849,582** | **$506,332** |
| **Other Health Care Programs:** | | | | | | | |
| Camp Lejeune Families (P.L. 112-154) | $6,111 | $2,909 | $3,319 | $3,808 | $3,957 | $489 | $149 |
| Caregivers 2/ | $873,177 | $1,353,133 | $1,413,133 | $1,846,210 | $2,259,305 | $433,077 | $413,095 |
| CHAMPVA & Other Dependent Prgs | $2,016,871 | $2,378,170 | $2,035,285 | $2,164,071 | $2,329,485 | $128,786 | $165,414 |
| Homeless Program Grants 3/ | $1,084,447 | $1,191,186 | $1,055,817 | $977,441 | $1,031,945 | ($78,376) | $54,504 |
| Readjustment Counseling | $281,984 | $323,789 | $326,289 | $340,041 | $353,643 | $13,752 | $13,602 |
| Copayment Reimbursement | $243,610 | $0 | $56,390 | $0 | $0 | ($56,390) | $0 |
| **Other Health Care Programs [Subtotal]** | **$4,506,200** | **$5,249,187** | **$4,890,233** | **$5,331,571** | **$5,978,335** | **$441,338** | **$646,764** |
| **Legislative Proposals 4/** | $0 | $30,000 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Subtotal]** | **$101,005,271** | **$119,751,907** | **$115,039,078** | **$128,544,561** | **$131,954,325** | **$13,505,483** | **$3,409,764** |
| Recoveries of prior year paid & unpaid obligations | $745,458 | | | | | | |
| **Obligations [Total]** | $101,750,729 | $119,751,907 | $115,039,078 | $128,544,561 | $131,954,325 | $13,505,483 | $3,409,764 |

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

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

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

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

[4/] For detail on the 2023 Legislative Proposals, please see the Legislative Proposals chapter in Volume 1.

[5/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, together with updated estimates for transfers, reimbursements and medical care collections.

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

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Medical Care Programs: (Included Above)** | | | | | | | |
| Activations | $391,944 | $896,483 | $896,483 | $769,904 | $500,000 | ($126,579) | ($269,904) |
| Blind Rehabilitation Treatment | $86,000 | $159,700 | $127,400 | $126,900 | $128,600 | ($500) | $1,700 |
| Epilepsy Center of Excellence 1/ | $7,764 | $10,000 | $10,000 | $19,086 | $18,751 | $9,086 | ($335) |
| Education & Training | $2,416,353 | $2,586,956 | $2,586,687 | $2,706,082 | $2,855,500 | $119,395 | $149,418 |
| Health Professionals Educational Assistance Program | $140,822 | $205,785 | $205,785 | $248,033 | $318,758 | $42,248 | $70,725 |
| Indian Health Services | $28,010 | $30,000 | $31,196 | $32,345 | $33,606 | $1,149 | $1,261 |
| Intensive Evaluation and Treatment Program Initiative | $0 | $15,283 | $15,283 | $25,970 | $12,588 | $10,687 | ($13,382) |
| Intimate Partner Violence program | $18,309 | $30,602 | $26,602 | $24,347 | $24,585 | ($2,255) | $238 |
| Leases | $1,039,125 | $2,099,889 | $1,708,176 | $1,500,000 | $1,200,000 | ($208,176) | ($300,000) |
| Mental Health Topics: | | | | | | | |
| Opioid Prevention: | | | | | | | |
| Treatment Modalities | $384,661 | $375,668 | $400,655 | $417,051 | $433,371 | $16,396 | $16,320 |
| Opioid Prevention Programs (Include's Jason's Law) 2/ | $78,481 | $245,666 | $245,666 | $245,754 | $245,754 | $88 | $0 |
| Substance Use Disorder Initiative | $0 | $155,970 | $155,970 | $181,287 | $183,834 | $25,317 | $2,547 |
| Suicide Prevention: | | | | | | | |
| Medical Treatment | $1,932,576 | $1,741,344 | $2,162,576 | $2,385,776 | $2,456,776 | $223,200 | $71,000 |
| Outreach Programs | $297,197 | $597,997 | $597,997 | $496,598 | $500,797 | ($101,399) | $4,199 |
| National Center for Posttraumatic Stress Disorder 1/ | $39,487 | $40,000 | $40,000 | $40,000 | $40,000 | $0 | $0 |
| National Veterans Sports Program | $23,375 | $27,048 | $27,048 | $27,229 | $27,414 | $181 | $185 |
| Non-Recurring Maintenance (Lands & Structure only) 3/ | $1,994,163 | $2,263,896 | $2,654,117 | $2,505,000 | $995,000 | ($149,117) | ($1,510,000) |
| Precision Oncology Initiative | $62,695 | $100,017 | $100,017 | $167,227 | $253,433 | $67,210 | $86,206 |
| Rural Health 1/ | $267,342 | $307,455 | $307,455 | $307,455 | $307,455 | $0 | $0 |
| Spinal Cord Injury Treatment | $653,300 | $684,500 | $717,900 | $733,500 | $751,500 | $15,600 | $18,000 |
| Supply Chain Management | $113,753 | $129,514 | $129,514 | $142,404 | $139,838 | $12,890 | ($2,566) |
| Telehealth: | | | | | | | |
| Home & Clinic Based Telehealth | $3,891,077 | $2,135,182 | $4,222,841 | $4,844,912 | $5,056,418 | $622,071 | $211,506 |
| Office of Connected Care Program | $365,613 | $450,000 | $450,000 | $329,906 | $329,906 | ($120,094) | $0 |
| Veterans Homelessness Programs | $2,544,263 | $2,636,454 | $2,761,560 | $2,685,392 | $2,861,497 | ($76,168) | $176,105 |
| Whole Health | $64,501 | $73,600 | $73,600 | $75,851 | $75,874 | $2,251 | $23 |

[1/] 2021 Actuals reflect allocated amounts rather than obligations.

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

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

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

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Program | $1,552,300 | $1,599,500 | $1,567,700 | $1,619,700 | $1,675,200 | $52,000 | $55,500 |
| Post Deployment Health Services: | | | | | | | |
| Gulf War Program | $5,233,200 | $5,308,700 | $5,824,300 | $6,480,200 | $7,064,400 | $655,900 | $584,200 |
| OEF/OIF/OND/OIR | $10,232,200 | $10,458,500 | $11,088,400 | $11,966,200 | $12,889,900 | $877,800 | $923,700 |
| Traumatic Brain Injury and Polytrauma System of Care: | | | | | | | |
| OEF/OIF/OND/OIR | $253,000 | $245,100 | $265,600 | $274,600 | $283,700 | $9,000 | $9,100 |
| All Veteran Care | $946,500 | $870,600 | $992,900 | $1,034,200 | $1,067,600 | $41,300 | $33,400 |
| Women Veterans Health Care: | | | | | | | |
| Program Office & Initiative Budget | $57,816 | $104,946 | $106,489 | $134,219 | $138,852 | $27,730 | $4,633 |
| Gender-Specific Care | $628,800 | $705,500 | $700,500 | $766,900 | $835,800 | $66,400 | $68,900 |
| All Care | $8,318,000 | $8,422,100 | $9,018,000 | $9,774,900 | $10,576,300 | $756,900 | $801,400 |

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

**FFCRA**: Families First Coronavirus Response Act (Public Law 116-127)

**CARES:** Coronavirus Aid, Relief, and Economic Security Act (Public Law 116-136)

**VACAA**: Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146)

# Ambulatory Care

**Ambulatory Care with Pharmacy**
*(dollars in thousands)*

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $29,456,466 | $35,292,090 | $33,429,917 | $41,089,652 | $41,004,952 | $7,659,735 | ($84,700) |
| Discretionary FFCRA/CARES Act Obligations | $2,108,548 | $0 | $200 | $0 | $0 | ($200) | $0 |
| **Discretionary Obligations [Subtotal]** | **$31,565,014** | **$35,292,090** | **$33,430,117** | **$41,089,652** | **$41,004,952** | **$7,659,535** | **($84,700)** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $6,310,467 | $7,911,245 | $10,025,289 | $11,252,219 | $13,646,543 | $1,226,930 | $2,394,324 |
| Discretionary FFCRA/CARES Act Obligations | $2,519,306 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$8,829,773** | **$7,911,245** | **$10,025,289** | **$11,252,219** | **$13,646,543** | **$1,226,930** | **$2,394,324** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $4,190,463 | $4,664,392 | $4,299,329 | $5,831,080 | $6,372,870 | $1,531,751 | $541,790 |
| Discretionary CARES Act Obligations | $159,702 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$4,350,165** | **$4,664,392** | **$4,299,329** | **$5,831,080** | **$6,372,870** | **$1,531,751** | **$541,790** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $3,273,977 | $3,575,961 | $3,356,058 | $4,296,603 | $4,210,683 | $940,545 | ($85,920) |
| Discretionary CARES Act Obligations | $208,544 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$3,482,522** | **$3,575,961** | **$3,356,058** | **$4,296,603** | **$4,210,683** | **$940,545** | **($85,920)** |
| **Discretionary Total** | **$48,227,473** | **$51,443,688** | **$51,110,793** | **$62,469,554** | **$65,235,048** | **$11,358,761** | **$2,765,494** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $4,194,321 | $2,941,104 | $68,400 | $0 | ($2,872,704) | ($68,400) |
| American Rescue Plan Act, Section 8007 (0160) | $0 | $627,900 | $0 | $627,900 | $0 | $627,900 | ($627,900) |
| VACAA, Section 801 (0160) | $2,015 | $1,172 | $3,864 | $3,980 | $4,099 | $116 | $119 |
| **Mandatory Obligations [Subtotal]** | **$2,015** | **$4,823,393** | **$2,944,968** | **$700,280** | **$4,099** | **($2,244,688)** | **($696,181)** |
| Medical Community Care Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $1,478,166 | $979,415 | $969,609 | $0 | ($9,806) | ($969,609) |
| American Rescue Plan Act, Section 8004 (0140) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 (0140) | $0 | $72,100 | $0 | $72,100 | $0 | $72,100 | ($72,100) |
| Veterans Choice Fund (0172) | -$139,446 | $24,300 | $15,465 | $265,088 | $0 | $249,623 | ($265,088) |
| **Mandatory Obligations [Subtotal]** | **-$139,446** | **$1,574,566** | **$994,880** | **$1,306,797** | **$0** | **$311,917** | **($1,306,797)** |
| Medical Support and Compliance Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $359,352 | $424,467 | $231,083 | $0 | ($193,384) | ($231,083) |
| VACAA, Section 801 (0152) | $1,473 | $221 | $2,799 | $2,883 | $2,969 | $84 | $86 |
| **Mandatory Obligations [Subtotal]** | **$1,473** | **$359,573** | **$427,266** | **$233,966** | **$2,969** | **($193,300)** | **($230,997)** |
| Medical Facilities Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $1,447,256 | $2,180,728 | $392,200 | $0 | ($1,788,528) | ($392,200) |
| VACAA, Section 801 (0162) | $591 | $3,262 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$591** | **$1,450,518** | **$2,180,728** | **$392,200** | **$0** | **($1,788,528)** | **($392,200)** |
| **Mandatory Total** | **-$135,366** | **$8,208,050** | **$6,547,842** | **$2,633,243** | **$7,068** | **($3,914,599)** | **($2,626,175)** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $31,567,029 | $40,115,483 | $36,375,085 | **$41,789,932** | **$41,009,051** | $5,414,847 | ($780,881) |
| Medical Community Care | $8,690,327 | $9,485,811 | $11,020,169 | **$12,559,016** | **$13,646,543** | $1,538,847 | $1,087,527 |
| Medical Support and Compliance | $4,351,638 | $5,023,965 | $4,726,595 | **$6,065,046** | **$6,375,839** | $1,338,451 | $310,793 |
| Medical Facilities | $3,483,113 | $5,026,479 | $5,536,786 | **$4,688,803** | **$4,210,683** | ($847,983) | ($478,120) |
| **Obligations [Grand Total]** | **$48,092,107** | **$59,651,738** | **$57,658,635** | **$65,102,797** | **$65,242,116** | **$7,444,162** | **$139,319** |

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.

## Overview

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. Community care is provided to eligible beneficiaries when VA cannot provide the care needed in accordance with the MISSION Act access standards.

## Types of Services Provided / Method of Delivery

### Primary Care

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

All 18 Veteran Integrated Service Networks (VISNs) have a Clinical Resource Hub (CRH) which is a virtual repository of clinicians, that provide team-based primary care and mental health services, primarily via telehealth, to underserved sites across the enterprise improving Veteran access to care. In 2018 VA expanded CRH through the creation of Mobile Deployment Teams (MDT) as required by title IV section 402 of the MISSION ACT. The expansion of CRH between 2020 and 2021 resulted in 660 sites supported by CRH clinical services–a 23% increase with over 150,000 Veterans receiving care from a CRH clinician. Sixteen of the 18 CRHs are expanding to provide specialty care service by the end of 2022. Planned expansion of services in CRH in 2023 include additional specialty care, pain management, substance use disorder, surgical services, and rehabilitation services. The 2023 budget request is required to support and expand CRH clinical offerings and increase access to clinical services for Veterans in underserved areas.

### Nutrition and Food Services

Nutrition and Food Service (NFS) develops and provides comprehensive evidence-based nutrition services through a modernized, Veteran-centric Nutrition and Food Services program that empowers and engages a diverse workforce, educates future nutrition professionals, and advances nutrition practice through research and continuous quality improvement. Most recently NFS has been focused on addressing food security within our Veteran population as in 2021, 2.6 million Veterans were screened. NFS provides group classes, individual sessions, via in-person appointments or virtual modalities. In the past year, NFS virtual appointments increased from 45,000 (2020) to 120,000 (2021), including 83 facilities offering Healthy Teaching Kitchens programs virtually.

**Podiatry**

Podiatry includes medical and surgical foot and ankle care and the Prevention of Amputation in Veterans Everywhere (PAVE) program. This includes the amputation/ulcer databased and the High-Risk Amputation Pyramid Cubes. The National Podiatry Program provides clinical guidance, policy, and oversight who provided nearly 72,000 in-person and over 25,000 CVT encounters in 2021.

**Emergency Medicine**

Emergency Medicine Services (EM) provides acute, emergent and urgent care on-demand through our 110 VHA emergency departments (ED) and 30 Urgent Care Centers (UCC). Tele-Emergent and Tele-Urgent Care services are under development at several VAMCs.

**Nursing Services**

Nurses play a vital role in primary care (PC) delivery as part of the Veterans Health Administration (VHA) multidisciplinary Patient Aligned Care Teams (PACT). Through in-person and virtual (video, secure messaging & telephone) encounters, both Registered Nurses (RN) and License Practical Nurse (LPN) 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 PACT 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. Strong practices during COVID-19 include population management for high-risk Veterans who delayed preventive care (e.g., diabetes) during the pandemic with proactive outreach to contact and manage care and treatment of substance use disorder (SUD). 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.

**Recent Trends**

In 2021, VA continued to make the most of its legal and operational authority and business processes to integrate virtual care to Veterans at home. Due to social distancing requirements brought on by the COVID-19 pandemic, there were significant increases in utilization of these modalities to maintain connections with Veterans.

- More than 10.0 million video telehealth visits were conducted in 2021; 96 % of these video visits (9.5 million +) were completed with Veterans at home or some other non-VA location;
- Over 95 % of VHA PC and Mental health (MH) providers have completed at least one VA video connect encounter;

- Use of virtual care is also an industry standard and offers comparable outcomes, outstanding customer service for our Veterans and their caregivers who may experience difficulty or hardship with traveling to a facility. The opportunity to provide care virtually, when clinically appropriate, is also an effective tool to increase recruitment and retention of our scarce resources of PC and MH providers;
- In June 2021, a virtual collaborative conference was hosted by the Office of Patient Centered Care and Cultural Transformation (OPCC& CT) the Office of Primary Care (OPC), and the Office of Mental Health and Suicide Prevention (OMHSP) sharing VA's cutting-edge approach to health care, 'Transforming Healthcare Delivery: Whole Health Integration with Primary Care and Mental Health'. In response to COVID-19, this conference was transitioned from a 600-person face to face event to a virtual conference reaching nearly 3,000 clinicians;
- In September 2021, the fourth annual national 'Veterans in Pain: Pain care, Opioid safety and Substance abuse Treatment (VIP POST)' was held virtually over three days in September. The conference brought together over 1200 attendees (clinicians and non-clinicians) from all disciplines, including the VISN and Facility Primary Care Pain Champions, to learn about pain care transformation, opioid safety and substance use disorder/opioid use disorder (SUD/OUD) treatment;
- In 2018, MISSION Act established regulatory authority to assert federal supremacy for VA providers and authorized delegates to access the network of state and regional Prescription Drug Monitoring Programs (PDMPs). Led by VHA's Pain Management, Opioid Safety, and PDMP office (PMOP), VA modernized the legacy CPRS electronic health record by successfully developing an integrated PDMP solution and deploying that enterprise-wide in November 2020. As of October 30th, 2021, the solution is connected to 50 of 54 individual state, regional, and Military Health System PDMPs. It enables simultaneous querying of the participating PDMPs directly from within the Veteran's electronic health record, providing greater efficiency and satisfaction for providers while supporting safe prescribing of controlled substances;
- The US is confronted with a rise in OUD, opioid misuse, and opioid-associated harms. Medication treatment for opioid use disorder (MOUD), including methadone, buprenorphine and naltrexone, are the gold standard treatments for OUD. MOUD reduces illicit opioid use, mortality, criminal activity, healthcare costs, and high-risk behaviors. In the Spring of 2018, the VHA initiated the Stepped Care for Opioid Use Disorder, Train the Trainer (SCOUTT) Initiative to facilitate access to MOUD in VHA non-SUD care settings. The SCOUTT Initiative's primary goal is to increase MOUD prescribing in VHA primary care, mental health, and pain clinics by training providers working in those settings on how to provide MOUD and to facilitate implementation by providing an ongoing learning collaborative. Phase 1 of the SCOUTT Initiative is engaged in over 35 clinics in over 18 facilities across the VHA providing MOUD through a variety of clinical models of MOUD care (including pharmacy and nurse collaborative care models). In the first three years of the SCOUTT Initiative, results indicate the number of patients receiving MOUD has tripled and the number of clinicians prescribing MOUD has nearly tripled within SCOUTT clinics. Over 2,000 Veterans have been provided MOUD within SCOUTT Initiative clinics;

- Team based education is an essential element for implementing stepped pain care, stepped OUD care and effective care for Veterans with deployment related health concerns, including impacts of toxic environmental exposures. In collaboration with Specialty Pain Care, Mental Health, Whole Health and Pharmacy, the Office of Primary Care/Ambulatory Care has taken the lead in team-based, multidisciplinary education on topics related to pain care, SUD/OUD care and Deployment Health/Exposure concerns through the weekly the National Pain VA-ECHO series of education/training calls as well as the monthly Integrated Pain Community of Practice call and the Post-Deployment Integrated Care Initiative Community of Practice calls. There are routinely over 225-250 clinicians from over a dozen disciplines/programs attending these calls;
- Providing collaborative Primary Care-Mental Health (PCMHI) care to approximately 8% of Veterans enrolled at all primary care sites across 1.4 million encounters, which represents 108% of the encounter volume compared to the year prior and demonstrates ongoing resilience of PACT clinical functions despite the COVID-19 pandemic;
- Total PC nursing encounters for 2021: 165,151 VVC; 579,250 telephone, and 3,328,175 face to face visits covering the urban, rural and highly rural Veteran populations. PC nursing staff also provided nursing support for 14.8 million PC provider face to face, VVC, and telephone clinic visits;
- In 2021, PACT CPP completed 1,731,620 visits; 86% of these visits were virtual in response to the COVID-19 pandemic. Specific to VA Video Connect (VVC) a 455% increase in utilization of compared to the previous year was seen;

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

- VA Health Care demonstrated significantly better performance than commercial Health Maintenance Organizations (HMOs) and Medicaid HMOs for all 16-outpatient effectiveness measures and was significantly better for 14 measures compared with Medicare HMOs. (Price et al, 2018);
- Veterans generally rate the VA outpatient experience more highly than care received through purchased community care. Implementation of the Choice Act was largely successful in expanding veterans' choices of outpatient care sites without compromising their care experiences. As purchased care further expands under the MISSION Act, monitoring of meaningful differences between settings should continue, with the results used to inform both VA purchasing decisions and patients' care choices. (Vanneman et al, 2020);
- VHA primary care clinics with the most Patient Centered Medical Home (PCMH) PACT components had greater improvements in control and care for several chronic diseases than the lowest PCMH implementation clinics. In adjusted models across 808 VHA clinics, the 77 clinics with the most PACT components in place had significantly larger improvements in five of seven chronic disease outcome measures (e.g., glycemic control in diabetes, blood pressure control in hypertension), ranging from 1.3 % to 5.2 % more of the patient population meeting measures, than the 69 clinics with the least PACT components. (Rosland et al, 2017);

- Veterans with multiple chronic conditions (i.e., 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 et al., 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 PACT 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);
- Interdisciplinary intensive primary care programs are associated with improved quality of care for high-utilization, high-cost patients. Key program elements include comprehensive patient assessments, weekly interdisciplinary team meetings, social workers and mental health providers, all of which are valuable to improving population management efforts of high-risk patients in primary care (VHA);
- A national strategy to focus efforts on catching Veterans up with their preventative health care screens was established in March 2021. After field testing, the collaborative effort between NCP, OPC, ONS & OVAC launched the Preventative Health Inventory Note. This note assists in the completion of ten clinical reminders that represent health care screening efforts which have lapsed during the pandemic. Facilities that are high utilizers of the note are seeing as much of a 2% absolute increase in performance measures;
- In 2021, all ambulatory clinical staff contributed to implementation of a streamlined suicide screening process, which resulted in 94% screening performance in the fourth quarter, 62% performance on subsequent same-day evaluation, and consolidated tools and methods for sustained collaborative improvement in this area consistent with a high-performing learning health system;
- Ambulatory Care Nurses supported VHA's COVID-19 response by providing clinical support for drive up testing centers, mobile clinics and as facility entry screeners for real time access to diagnostic lab, treatment and acute care admission needs. Clinical Resource Hub (CRH) Ambulatory Care nurses provided virtual RN coverage to PACT teams at facilities impacted by COVID, enabling those facilities to shift local PACT RN Care Managers and aided Clinical Contact Centers during the COVID surge;
- All nursing roles in primary care, specialty and other ambulatory care practice settings rapidly updated their clinical competence in acute and long-term care and were deployed across the VA health system as well as in support of the VA's 4th Mission to the civilian sector;

- Among Veterans with COPD CPP integration of the COPD CARE program at 13 VA facilities with a CPP seeing patients as part of the achieved:
    - Increase of CPP encounters for COPD management by 890%
    - Readmission rates reduced for COPD to 6-8% compared to ~20% for the national average
    - Increased access with 92% of Veterans receiving follow-up post discharge compared to 49% that received standard care for COPD management;
- Healthy Teaching Kitchens are hands-on or virtual demonstrations that teach Veterans and their care givers learn to prepare healthy dishes. There is also an Healthy Teaching Kitchens YouTube playlist for on-demand learning. VHA also has developed a national food insecurity screen that has screened over 6 million Veterans since October 2017. Over 50 VA facilities host food pantries that distribute to those in need;
- Close collaboration with Office of Mental Health and Suicide Prevention to conduct aggressive suicide screening, risk mitigation, and safety planning in emergency departments in our EDs and UCs;
- ED/UC sites at high operational risk have been reduced by 67% from 16-20.

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# Dental Care

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $792,766 | $886,171 | $789,983 | $802,383 | $836,948 | $12,400 | $34,565 |
| Discretionary FFCRA/CARES Act Obligations | $25,662 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$818,428** | **$886,171** | **$789,983** | **$802,383** | **$836,948** | **$12,400** | **$34,565** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $552,140 | $378,057 | $871,525 | $1,118,905 | $1,186,326 | $247,380 | $67,421 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$552,140** | **$378,057** | **$871,525** | **$1,118,905** | **$1,186,326** | **$247,380** | **$67,421** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $131,656 | $126,588 | $139,100 | $187,500 | $204,500 | $48,400 | $17,000 |
| Discretionary CARES Act Obligations | $67 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$131,722** | **$126,588** | **$139,100** | **$187,500** | **$204,500** | **$48,400** | **$17,000** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $142,566 | $130,524 | $142,700 | $183,000 | $179,400 | $40,300 | ($3,600) |
| Discretionary CARES Act Obligations | $397 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$142,963** | **$130,524** | **$142,700** | **$183,000** | **$179,400** | **$40,300** | **($3,600)** |
| **Discretionary Total** | **$1,645,253** | **$1,521,340** | **$1,943,308** | **$2,291,788** | **$2,407,174** | **$348,480** | **$115,386** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $110,205 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 (0160) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0160) | $63 | $63 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$63** | **$110,268** | **$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) | $16 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$16** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $10 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0152) | $45 | $12 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$45** | **$22** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $465 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0162) | $517 | $176 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$517** | **$641** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Mandatory Total** | **$642** | **$110,931** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $818,491 | $996,439 | $789,983 | **$802,383** | **$836,948** | $12,400 | $34,565 |
| Medical Community Care | $552,156 | $378,057 | $871,525 | **$1,118,905** | **$1,186,326** | $247,380 | $67,421 |
| Medical Support and Compliance | $131,767 | $126,610 | $139,100 | **$187,500** | **$204,500** | $48,400 | $17,000 |
| Medical Facilities | $143,480 | $131,165 | $142,700 | **$183,000** | **$179,400** | $40,300 | ($3,600) |
| **Obligations [Grand Total]** | **$1,645,894** | **$1,632,271** | **$1,943,308** | **$2,291,788** | **$2,407,174** | **$348,480** | **$115,386** |

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 VA provides oral health services to eligible Veterans specified under U.S.C. §1710(c) and 1712. VA implements its statutory authority through regulations that establish the Dental Program,

such as Title 38 CFR § §17.160 – 17.166. The mission of VA Dentistry is to Honor America's Veterans by contributing to their whole health through the provision of exceptional oral health care. Due to the high cost of dental care in the private sector, VA dentistry is highly visible. The statutory authority limits dental eligibility for comprehensive (routine) dental care to certain qualifying Veterans.

**Population Covered**

There are 9.1 million Veterans enrolled in VA healthcare. Approximately 1.4 million enrolled Veterans are eligible for comprehensive dental care. In 2021, VA dental services managed the care of 453,000 Veterans eligible for comprehensive dental care. An additional 85,000 were eligible and provided dental care due to medical necessity (20% above eligibility for comprehensive dental care), for a total of 538,000 Veterans.

**Types of Services Provided**

The scope of dental care provided to Veterans varies based on eligibility. Services received by Veterans eligible for comprehensive dental care include examinations, hygiene services (cleanings), dental radiology, restorative (fillings), endodontics (root canals), periodontal care, fixed, removable and 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 surgery procedures.

**Recent Trends**

Veterans eligible for comprehensive dental care increased at an average 7.3% annually during the last ten years. Over the previous five years, the number of dental treatment rooms increased by 1.9% per year. The total number of dental staff decreased by 0.8%, led by dental hygienists down 2.7%, dental assistants down 1.2% and dentists down 1.0%. In 2021, the 247 VA dental clinics managed the care of 535,000 Veterans. 465,000 Veterans received dental care on-site in a VA clinic. 3.9 million procedures were completed during 1.4 million visits. The remaining 70,000 Veterans received dental care exclusively through Community Care.

**Projections for the Future**

The VA defines market share as the number of Veterans provided care during the fiscal year 2021 that are eligible for comprehensive dental care (450,000) divided by the number of Veterans eligible for comprehensive dental care (1.38 million). This gives a market share of 32%.

Dental care provided to unique Veterans grew by an average of 1.2% per year from 2011 to 2020, including the time during the pandemic. The care provided through the community had the highest growth of 24% for 2019, which was the year following full implementation of the MISSION Act and just before the impact of the Covid-19 pandemic. 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 1-hour drive time requirements will lead to further increased Community Care dental costs. The cost of community care per unique Veteran has historically been approximately 20% higher than that of in-house care. Procedure workload has increased by an average of 1.5% per year. During the last five years, dental treatment rooms increased by 1.9% and dental staffing decreased by 0.8% per year. The Office of Dentistry projects a target market share of 47% within five years. Given the historical annual growth rate of 7.3% for Veterans eligible for comprehensive dental care, the VA Office of Dentistry forecasts about 2.26 million Veterans will be eligible for comprehensive care by 2028. The number of unique Veterans to serve in 2025 is projected at 767,000 for comprehensive dental care and 145,000 for focused care due to medical necessity, for a total of 1,022,000.

Studies by the American Dental Association[1] (ADA) and the Centers for Disease Control and Prevention[2] (CDC) show yearly dental service utilization up to 65% for those with third-party payor coverage in the U.S. population. These studies show there is significant potential for growth in VA dentistry.

| Year | Unique Veterans Seen | Market Share |
|---|---|---|
| Actuals | | |
| 2016 | 480,950 | 52% |
| 2017 | 493,900 | 50% |
| 2018 | 512,790 | 48% |
| 2019 | 541,291 | 46% |
| 2020 | 462,823 | 36% |
| 2021 | 442,104 | 32% |
| Projection | | |
| 2022 | 537,981 | 39% |
| 2023 | 606,856 | 41% |
| 2024 | 682,920 | 43% |
| 2025 | 766,856 | 45% |
| 2026 | 859,407 | 47% |

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

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

# Inpatient Care

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $8,654,500 | $5,734,460 | $7,753,651 | $10,211,983 | $10,496,939 | $2,458,332 | $284,956 |
| Discretionary FFCRA/CARES Act Obligations | $1,144,187 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$9,798,687** | **$5,734,460** | **$7,753,651** | **$10,211,983** | **$10,496,939** | **$2,458,332** | **$284,956** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $4,556,699 | $8,070,496 | $8,019,194 | $9,223,705 | $11,013,950 | $1,204,511 | $1,790,245 |
| Discretionary FFCRA/CARES Act Obligations | $2,851,317 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$7,408,016** | **$8,070,496** | **$8,019,194** | **$9,223,705** | **$11,013,950** | **$1,204,511** | **$1,790,245** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $1,568,409 | $1,577,316 | $1,657,500 | $2,234,700 | $2,437,500 | $577,200 | $202,800 |
| Discretionary CARES Act Obligations | $70,884 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,639,292** | **$1,577,316** | **$1,657,500** | **$2,234,700** | **$2,437,500** | **$577,200** | **$202,800** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $1,279,634 | $1,267,966 | $1,281,100 | $1,642,600 | $1,610,700 | $361,500 | ($31,900) |
| Discretionary CARES Act Obligations | $138,484 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,418,118** | **$1,267,966** | **$1,281,100** | **$1,642,600** | **$1,610,700** | **$361,500** | **($31,900)** |
| **Discretionary Total** | **$20,264,114** | **$16,650,238** | **$18,711,445** | **$23,312,988** | **$25,559,089** | **$4,601,543** | **$2,246,101** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $3,416,368 | $2,218,727 | $0 | $0 | ($2,218,727) | $0 |
| American Rescue Plan Act, Section 8007 (0160) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0160) | $754 | $443 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$754** | **$3,416,811** | **$2,218,727** | **$0** | **$0** | **($2,218,727)** | **$0** |
| Medical Community Care Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $400,453 | $993,881 | $1,057,096 | $0 | $63,215 | ($1,057,096) |
| 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) | $3,803 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$3,803** | **$400,453** | **$993,881** | **$1,057,096** | **$0** | **$63,215** | **($1,057,096)** |
| Medical Support and Compliance Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $551,650 | $209,066 | $113,817 | $0 | ($95,249) | ($113,817) |
| VACAA, Section 801 (0152) | $554 | $84 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$554** | **$551,734** | **$209,066** | **$113,817** | **$0** | **($95,249)** | **($113,817)** |
| Medical Facilities Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $823,368 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0162) | $5,129 | $1,234 | $14,772 | $1,323 | $0 | ($13,449) | ($1,323) |
| **Mandatory Obligations [Subtotal]** | **$5,129** | **$824,602** | **$14,772** | **$1,323** | **$0** | **($13,449)** | **($1,323)** |
| **Mandatory Total** | **$10,241** | **$5,193,600** | **$3,436,446** | **$1,172,236** | **$0** | **($2,264,210)** | **($1,172,236)** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $9,799,442 | $9,151,271 | $9,972,378 | **$10,211,983** | **$10,496,939** | $239,605 | $284,956 |
| Medical Community Care | $7,411,819 | $8,470,949 | $9,013,075 | **$10,280,801** | **$11,013,950** | $1,267,726 | $733,149 |
| Medical Support and Compliance | $1,639,847 | $2,129,050 | $1,866,566 | **$2,348,517** | **$2,437,500** | $481,951 | $88,983 |
| Medical Facilities | $1,423,248 | $2,092,568 | $1,295,872 | **$1,643,923** | **$1,610,700** | $348,051 | ($33,223) |
| **Obligations [Grand Total]** | **$20,274,355** | **$21,843,838** | **$22,147,891** | **$24,485,224** | **$25,559,089** | **$2,337,333** | **$1,073,865** |

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.

# Overview

VA delivers inpatient acute and critical care in its medical centers and through referral to hospitals in the community. Facilities partner with local hospitals to transfer Veterans back into the VA system to safeguard continuity of care.

## Types of Services Provided / Method of Delivery

### Anesthesia

Anesthesia service provides sedation/anesthesia, homeostatic support, physiologic monitoring and pain management during surgical, therapeutic, and diagnostic procedures for over 400,000 Operating Room (OR) procedures and about 200,000 non-OR procedures. Anesthesia service provides expert consultation and management for critical care surgical and non-surgical patients and oversight of surgical patients requiring interventional postoperative pain management. Further, anesthesia pain specialists participate in diagnosis and treatment of chronic pain conditions and syndromes, often in a multidisciplinary fashion with germane VA specialties (neurology, addiction medicine, physiatry, *etc*.) to provide the best possible outcomes to 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-Critical Care

The National TeleCritical Care Program (TCC) is comprised of a Program Office with two regional hubs. The East hub is based in Cincinnati and the West hub is based in Minneapolis. The TCC Program currently has 11 sub-hubs placed nationwide which stations intensivists, APRNs, registered nurses, and medical support assistants. The program serves 880 beds in 61 hospitals in various ICU units nationwide. After the Enterprise TCC expansion, services will be available at 89 hospitals and over 1450 ICU beds. The units are in combination of medical, surgical, cardio, cardiovascular, and stepdown. In 2021, approximately 21,575 patients received TCC care for over 106,320 bed days of care.

### Quality, Safety, and Efficiency

VA's Inpatient Evaluation Center (IPEC) works closely with the Centers for Medicare and Medicaid Services (CMS) Center for Clinical Standards and Quality (CCSQ) to calculate standard measures of Veteran outcomes during a VA hospital stay. These outcomes include risk-adjusted 30-day mortality and readmission rates; rates of potentially preventable complications (Patient Safety Indicators - PSIs); and Health Care Associated Infections (HAIs).

By using the same methodology that CMS applies to hospitals, health systems, and providers participating in Medicare, VA can directly compare its performance with the private sector and provide assurance to Veterans and the nation about the value of VA care. The comparisons listed in the table below are based on the most recent VA data sent to CMS for posting on their Hospital Compare website[3] and the most current published national non-VA benchmarks.

The following overall trends are noted:

- After adjusting for patient characteristics, VA mortality is lower than the private sector for the four disease processes reported.
- 30-day readmission rates are slightly higher for VA, reflecting psychosocial risk factors that are more prevalent among Veterans but not accounted for in CMS risk adjustment methods.
- Adverse events, as measured using patient safety indicators (PSIs), are generally similar or lower, with one exception.[4]
- Rates of health care associated infection are similar to the prior year and comparable to or lower than the private sector (not shown due to differing reporting methodology[15]).

CMS data, including hospital-specific data, for VA and the private sector is available for public download[5], which allows other groups to conduct independent analyses of VA care. Three recent studies published in prominent medical journals confirm VA outcomes are superior to the private sector across a broad range of measures.[6,7,8]

[3] Link: www.medicare.gov/hospitalcompare

[4] PSI 03 – Pressure Ulcer Rate – is higher, a difference attributable to the higher proportion of Veterans with spinal cord injury and related diseases that are served in VA hospitals, compared to non-VA hospitals. This difference is not accounted for in statistical adjustment.

[5] https://data.medicare.gov/

[6] Blay E, DeLancey, JO, Hewitt, DB. Initial public reporting of quality at Veterans Affairs vs Non–Veterans Affairs hospitals. *JAMA Internal Medicine*. 2017;177:882-5.

[7] Price RA, Sloss EM, Cefalu M et al. Comparing quality of care in Veterans Affairs and non-Veterans Affairs settings. *J Gen Intern Med* 2018;33:1631-8.

[8] Weeks WB, West AN. Veterans Health Administration Hospitals outperform non-Veterans Health Administration hospitals in most health care markets. *Ann Intern Med* 2018; 11 December 2018 doi: 10.7326/M18-1540

## Quality Outcomes (Mortality and Readmission) Table

| Quality Outcomes (Mortality & Readmission) [9] | VA [10] July 1, 2017 – Dec 1, 2019 | CMS [11] July 1, 2017 - Dec 1, 2019 |
|---|---|---|
| **Mortality** | **Rate** | **Rate** |
| 30-day risk standardized mortality rate - Congestive Heart Failure | 8.7 | 11.2 |
| 30-day risk standardized mortality rate - Pneumonia | 12.5 | 15.3 |
| 30-day risk standardized mortality rate – Acute Myocardial Infarction | 11.6 | 12.3 |
| 30-day risk standardized mortality rate – Chronic Obstructive Pulmonary Disease | 7.4 | 8.1 |
| **Readmission** | **Rate** | **Rate** |
| 30-day risk standardized readmission rate - Congestive Heart Failure | 23.1 | 21.9 |
| 30-day risk standardized readmission rate - Pneumonia | 17.4 | 16.7 |
| 30-day risk standardized readmission rate - Acute Myocardial Infarction | 17.1 | 15.8 |
| 30-day risk standardized readmission rate – Chronic Obstructive Pulmonary Disease | 20.7 | 19.7 |
| 30-day Hospital Wide readmission rate | 17.3 | 15.5 |

| Patient Safety Indicators (PSIs) | VA Risk Adjusted Rate per 1,000 Discharges from July 1, 2019 – June 30, 2021 [12] | CMS Reported Medicare FFS Discharges Risk Adjusted Mean Rate per 1,000 Discharges from July 1, 2017 – June 30, 2019 [13] |
|---|---|---|
| Pressure Ulcer Rate | 0.99 | 0.49 |
| Inpatient Surgical Deaths | 146.99 | 156.54 |
| Collapsed lung due to medical treatment | 0.37 | 0.21 |
| Postoperative Hip Fracture | 0.16 | 0.14 |
| Perioperative Bleeding/Bruise | 2.32 | 2.11 |
| Postoperative Kidney & Diabetic Complications | 1.09 | 0.97 |
| Postoperative Respiratory Failure | 4.15 | 5.70 |
| Perioperative Blood Clot/Embolism | 3.11 | 3.19 |
| Postoperative Sepsis | 3.58 | 4.43 |
| A wound that splits open after surgery on the abdomen or pelvis | 0.60 | 0.73 |

[9] Measures of readmissions and mortality show how often patients who are hospitalized for certain conditions experience serious problems soon after they are discharged. Measures of readmission show when patients who have had a recent hospital stay need to go back into a hospital again for unplanned care within 30 days of leaving the hospital.

[10] VA National Average Risk Standardized Rate calculated by CMS.

[11] CMS National Observed Rate (Hospital Compare)

[12] Rates in this column calculated using International Classification of Diseases – 10th Edition (ICD-10) diagnoses and CMS PSI Software Version 11 and are ***risk adjusted rates***.

[13] Data presented in this column are nationwide comparative ***risk adjusted mean rates*** with parameter estimates derived from Medicare FFS discharges from 3,293 IPPS hospitals, July 1, 2017 – June 30, 2019.

| Patient Safety Indicators (PSIs) | VA Risk Adjusted Rate per 1,000 Discharges from July 1, 2019 – June 30, 2021[12] | CMS Reported Medicare FFS Discharges Risk Adjusted Mean Rate per 1,000 Discharges from July 1, 2017 – June 30, 2019[13] |
|---|---|---|
| Accidental puncture or laceration from medical treatment | 1.23 | 1.09 |
| PSI 90 Composite | 0.99 | 0.99 |

| Healthcare-Associated Infections (HAIs) | VA Oct 1, 2020-Sept 30, 2021 | VA[14] Oct 1, 2019-Sept 30, 2020 |
|---|---|---|
| | Mean | Mean |
| 1. Central Line Associated Bloodstream Infection Rate per 1,000-line days | | |
| Acute Care | 0.69 | 0.72 |
| ICU | 1.80 | 1.24 |
| 2. Catheter Associated Urinary Tract Infection per 1,000 catheter days | | |
| Acute Care | 0.68 | 1.01 |
| ICU | 0.83 | 0.63 |
| 3. Total Bloodstream (BSI) Infection rates per 100 patient months | | |
| Outpatient Dialysis Treatment Center | 0.65 | 0.56 |
| 4. Access-Related Bloodstream Infection rates per 100 patient months | | |
| Outpatient Dialysis Treatment Center | 0.35 | 0.26 |
| 5. Total Bloodstream Standardized Infection Ratio | | |
| Outpatient Dialysis Treatment Center | 0.82 | 1.05 |

**Impact of COVID-19**

As a result of the global COVID-19 pandemic, most VA facilities have seen wide fluctuation in the numbers of admitted patients, most notably during community surge events. In response, healthcare providers have volunteered to travel to sites in need to provide direct inpatient care. VA facilities have provided inpatient care to residents of State Veterans Homes and to civilian patients through activation of VA's Fourth Mission. Within facilities, healthcare providers have moved from outpatient to inpatient positions, as needed, to meet clinical demands. The following Table provides an overview of inpatient utilization and outcomes related to the pandemic, within VA healthcare facilities.

| **COVID-19 Summary** | | |
|---|---|---|
| **All patients cared for in VA Medical Centers** | | |
| **Feb 28, 2020–Nov 2, 2021** | Total Patients Hospitalized for COVID-19 | 60,075 |
| | Total ICU Admissions* | 25,395 (42.3% of Total Patients Hospitalized) |
| | Mechanical Ventilation | 3,302 (13.0% of ICU Admissions*) |
| | In-Hospital Mortality | 5,591 (9.3% of Total Patients Hospitalized for COVID-19) |
| | State Veterans Home Patients Hospitalized in VA | 1,539 |
| | 4th Mission Civilian Patients Hospitalized in VA | 485 |
| **Veteran patients cared for in VA Medical Centers** | | |
| **Subset Feb 28, 2020–Nov 2, 2021[15]** | Veterans Hospitalized for COVID-19 | 59,185 |
| | Length of Stay, days (IQR) | 11.4 (6-16) |
| | Veteran ICU Admissions* | 24,956 (42.2% of Veterans Hospitalized for COVID-19) |
| | In-Hospital Mortality | 5,461 (9.2% of Veterans Hospitalized for COVID-19) |
| *ICU beds at some facilities have been used for non-critically ill COVID-19 patients, for example, to provide adequate isolation precautions and availability of nursing staff. | | |

[14] Rates are based on incomplete reporting directly related to suspense of reporting data from March through June.

[15] National Healthcare Safety Network (NHSN) – Centers for Disease Control and Prevention (CDC). National and State Healthcare-Associated Infection Progress Report, March 2020 www.cdc.gov/hai/progress-report/index.html; https://www.cdc.gov/hai/surveillance/progress-report/index.html

# Mental Health

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $8,247,161 | $10,642,464 | $9,286,484 | $10,248,343 | $10,706,715 | $961,859 | $458,372 |
| Discretionary FFCRA/CARES Act Obligations | $157,587 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$8,404,748** | **$10,642,464** | **$9,286,484** | **$10,248,343** | **$10,706,715** | **$961,859** | **$458,372** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $445,088 | $579,327 | $709,156 | $775,972 | $827,605 | $66,816 | $51,633 |
| Discretionary FFCRA/CARES Act Obligations | $181,979 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$627,066** | **$579,327** | **$709,156** | **$775,972** | **$827,605** | **$66,816** | **$51,633** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $1,007,734 | $948,628 | $1,065,000 | $1,435,900 | $1,566,200 | $370,900 | $130,300 |
| Discretionary CARES Act Obligations | $13,171 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,020,905** | **$948,628** | **$1,065,000** | **$1,435,900** | **$1,566,200** | **$370,900** | **$130,300** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $1,136,480 | $1,006,242 | $1,137,700 | $1,458,700 | $1,430,400 | $321,000 | ($28,300) |
| Discretionary CARES Act Obligations | $16,437 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,152,917** | **$1,006,242** | **$1,137,700** | **$1,458,700** | **$1,430,400** | **$321,000** | **($28,300)** |
| **Discretionary Total** | **$11,205,637** | **$13,176,661** | **$12,198,340** | **$13,918,915** | **$14,530,920** | **$1,720,575** | **$612,005** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $248,901 | $52,500 | $0 | $0 | ($52,500) | $0 |
| American Rescue Plan Act, Section 8007 (0160) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0160) | $530 | $380 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$530** | **$249,281** | **$52,500** | **$0** | **$0** | **($52,500)** | **$0** |
| Medical Community Care Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $20,170 | $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) | $597 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$597** | **$20,170** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $16,661 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0152) | $345 | $72 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$345** | **$16,733** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $77,449 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0162) | $4,170 | $1,058 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$4,170** | **$78,507** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Mandatory Total** | **$5,642** | **$364,691** | **$52,500** | **$0** | **$0** | **($52,500)** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $8,405,278 | $10,891,745 | $9,338,984 | **$10,248,343** | **$10,706,715** | $909,359 | $458,372 |
| Medical Community Care | $627,663 | $599,497 | $709,156 | **$775,972** | **$827,605** | $66,816 | $51,633 |
| Medical Support and Compliance | $1,021,251 | $965,361 | $1,065,000 | **$1,435,900** | **$1,566,200** | $370,900 | $130,300 |
| Medical Facilities | $1,157,087 | $1,084,749 | $1,137,700 | **$1,458,700** | **$1,430,400** | $321,000 | ($28,300) |
| **Obligations [Grand Total]** | **$11,211,279** | **$13,541,352** | **$12,250,840** | **$13,918,915** | **$14,530,920** | **$1,668,075** | **$612,005** |

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

- 38 CFR 17.38 Medical Benefits Package; 38 CFR 17.98 Mental Health Services

- 38 U.S.C. §1712A, §1720H, §1720I
- Public Law 114-2, *Clay Hunt Suicide Prevention for American Veterans Act*
- Executive Order (EO) 13822, issued on January 9, 2018

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

**Treatment Modality (Continuum of Care)**

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

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

**Suicide Prevention Treatment in Non-MH Setting.** Suicide prevention is everyone's business, everyone has a role to play, and suicide prevention services are available throughout the continuum of VA healthcare. These are services documented for patients at risk of suicide that do not take place in one of the previously described Mental Health Treatment Modalities. This will be care for patients at risk of suicide who present at the Emergency Room or may be managed in another setting like Primary Care.

**Major Characteristics of Program.** The major characteristics in this section break out the care provided to Veterans with serious mentally illness (SMI) by sub-specialty such as PTSD, Substance Use and General Mental Health Services. In addition, it shows the care associated with

Suicide Prevention efforts and a default category which contains all the other mental health specialty care not provided to the SMI population, all community care mental health and all mental health provided in a non-Mental Health specialty setting, such as primary care clinic.

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

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Treatment Modality ($000):** | | | | | | | |
| VA Inpatient Hospital | $1,857,166 | $1,910,186 | $1,987,642 | $2,205,292 | $2,287,686 | $217,649 | $82,395 |
| Contract Inpatient Hospital | $696,988 | $627,759 | $762,557 | $834,975 | $890,942 | $72,419 | $55,966 |
| Psychiatric and VA Dom Res. Rehab. Trmt | $792,658 | $1,020,739 | $889,212 | $973,259 | $990,285 | $84,047 | $17,026 |
| VA Outpatient Clinics | $6,275,594 | $7,649,043 | $6,601,757 | $7,868,910 | $8,261,734 | $1,267,153 | $392,823 |
| Non-VA Outpatient | $165,037 | $237,924 | $180,563 | $197,710 | $210,962 | $17,148 | $13,252 |
| Subtotal Direct Mental Health | $9,787,444 | $11,445,652 | $10,421,731 | $12,080,147 | $12,641,610 | $1,658,416 | $561,463 |
| *Non-Add included above:* | | | | | | | |
| *Suicide Prevention Treatment in MH setting* | *$1,395,600* | *$1,219,755* | *$1,546,600* | *$1,662,360* | *$1,714,282* | *$115,760* | *$51,922* |
| Suicide Prevention Outreach 1/: | | | | | | | |
| Suicide Prevention Direct Program, SP | $236,757 | $535,686 | $535,686 | $431,857 | $433,531 | ($103,829) | $1,674 |
| Suicide Prevention Coordinators, GP | $60,440 | $62,311 | $62,311 | $64,741 | $67,266 | $2,430 | $2,525 |
| Subtotal Suicide Prevention Program Subtotal | $297,197 | $597,997 | $597,997 | $496,598 | $500,797 | ($101,399) | $4,199 |
| Suicide Prevention Treatment in Non MH Setting | $536,976 | $448,289 | $595,076 | $639,616 | $659,594 | $44,540 | $19,978 |
| Contract Homeless | $186,222 | $472,644 | $195,188 | $201,680 | $206,022 | $6,492 | $4,342 |
| VA - Mental Health in non MH Setting | $403,439 | $576,770 | $440,848 | $500,874 | $522,897 | $60,026 | $22,023 |
| Total Mental Health | **$11,211,279** | **$13,541,352** | **$12,250,840** | **$13,918,915** | **$14,530,920** | $1,668,075 | $612,005 |
| **Major Characteristics of Program ($000):** | | | | | | | |
| SMI - PTSD | $296,000 | $363,230 | $369,500 | $379,900 | $385,300 | $10,400 | $5,400 |
| SMI - Substance Abuse | $581,600 | $666,745 | $663,500 | $697,700 | $715,100 | $34,200 | $17,400 |
| SMI - Other Than PTSD & SA | $5,283,500 | $5,156,379 | $5,209,900 | $5,290,500 | $5,404,200 | $80,600 | $113,700 |
| Subtotal, SMI | $6,161,100 | $6,186,354 | $6,242,900 | $6,368,100 | $6,504,600 | $125,200 | $136,500 |
| Suicide Prevention Outreach | $297,197 | $597,997 | $597,997 | $496,598 | $500,797 | ($101,399) | $4,199 |
| Other Mental Health (Non-SMI) | $4,752,981 | $6,757,001 | $5,409,943 | $7,054,217 | $7,525,523 | $1,644,274 | $471,306 |
| **Total Mental Health** | **$11,211,279** | **$13,541,352** | **$12,250,840** | **$13,918,915** | **$14,530,920** | $1,668,075 | $612,005 |
| Included Above: | | | | | | | |
| **OEF/OIF/OND POPULATION *ONLY*:** | | | | | | | |
| SMI - PTSD | $146,604 | $179,370 | $166,754 | $197,162 | $210,543 | $30,408 | $13,381 |
| SMI - Substance Abuse | $160,253 | $171,853 | $182,279 | $215,518 | $230,144 | $33,239 | $14,626 |
| SMI - Other Than PTSD & SA | $1,243,706 | $1,291,986 | $1,414,648 | $1,672,611 | $1,786,128 | $257,963 | $113,517 |
| Subtotal, SMI | $1,550,563 | $1,643,209 | $1,763,681 | $2,085,291 | $2,226,815 | $321,610 | $141,524 |
| Other Mental Health (Non-SMI) | $867,935 | $769,645 | $987,228 | $1,167,251 | $1,246,470 | $180,023 | $79,219 |
| Total OEF/OIF/OND | $2,418,497 | $2,412,854 | $2,750,909 | $3,252,542 | $3,473,285 | $501,633 | $220,743 |
| **Average Daily Census:** | | | | | | | |
| Acute Psychiatry | 1,742 | 1,758 | 2,032 | 1,986 | 1,951 | 1,951 | (35) |
| Contract Hospital (Psych) | 1,168 | 174 | 1,311 | 1,382 | 1,439 | 71 | 57 |
| Psy Residential Rehab | 2,670 | 3,341 | 3,341 | 3,039 | 2,891 | (302) | (148) |
| Total | 5,580 | 5,273 | 6,684 | 6,407 | 6,281 | (277) | (126) |
| **Outpatient Visits:** | | | | | | | |
| VA Care - Mental Health | 16,220,549 | 17,479,350 | 17,962,766 | 19,531,243 | 19,656,267 | 1,568,477 | 125,024 |
| Non-VA Care - Mental Health | 891,075 | 1,015,849 | 942,446 | 1,009,087 | 1,046,949 | 66,641 | 37,862 |
| Not Included Above: | | | | | | | |
| VA - Mental Health in non MH Setting | 1,431,605 | 2,237,272 | 1,564,350 | 1,777,352 | 1,855,501 | 213,002 | 78,149 |

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

## Population Covered

Mental health care at VA comprises an unparalleled system of comprehensive treatments and services to meet the needs of each Veteran and the family members involved in the Veteran's care. Veteran demand for VHA mental health care continues to grow, with approximately 1.8 million

Veterans (30% of all VHA users) receiving mental health services in a VHA specialty mental health setting in 2021.

Across VA settings of care, more than 520,000 Veterans were seen in 2021 for a substance use disorder diagnosis. The proportions of VHA health-service users who receive mental health treatment are highest among younger Veterans and decline with age. The proportions are also slightly higher for women as compared to men in older age groups with the gap declining in Veterans younger than age 35. Reflecting the size of the cohort of male Veterans over age 65, 61% of all users of VHA services in specialty mental health settings in 2020 were men over age 50.

**Type of Services Provided**

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

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

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

- Availability of same-day mental health services at every VA health care facility;
- Robust use of technology such as tele-mental health resources, mobile apps and web-based self-help courses;
- Integration of mental health care within primary care, geriatric and specialty medical care programs and clinics;

- Leading the nation in training mental health providers in evidence-based mental health treatments; and
- VA's mental health Centers of Excellence conduct cutting edge research, provide education and implement clinical innovations across the VA system.

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

**Recent Trends**

- In 2019, the Mental Health Hiring Initiative completed hiring of over 1,000 additional mental health providers. VA is currently undertaking a Mental Health Hiring Sustainability Initiative (begun in 2019), which is providing targeted planning and human resources support for the facilities struggling the most with having adequate mental health staffing. In 2021, VA saw a net increase of 770 staff.
- The number of outpatient mental health encounters or treatment visits more than doubled between 2006 and 2019 (from 10.7 million to 21.8 million), and during the COVID-19 pandemic VA provided 19.7 million in-person and telephone encounters in 2020 and 18.5 million in 2021.[14]
- Between 2006 and 2021, the number of Veterans who received mental health care from the VHA grew by 49%. This rate of increase is almost twice the rate for VHA users overall. The proportion of Veterans served by VHA who receive mental health services has also increased. In 2006, 19% of VHA users received mental health services, and in 2021, the figure was 23%.
- Since 2006, there has been more than threefold increase in the number of women Veterans accessing VHA mental health services. In 2021, 225,000 women Veterans received VHA mental health care, representing approximately 38% of all women VHA patients.
- Introduction of Peer Specialists to the mental health workforce provides unique opportunities for engaging Veterans in care and supporting a Veteran-centric approach to mental health. Currently, there are 1,185 peer support staff members working in outpatient, residential and inpatient mental health services, as well as in homelessness programs, primary care patient-aligned care teams (PACT), and the Veterans Crisis Line's Peer

[14]The Office of Mental Health and Suicide Prevention has two restrictions on using mental health telephone encounters to determine workload. These two restrictions lowered mental health workload counts during the pandemic period as telephone encounters were increasingly relied on to deliver mental health services. The two relevant restrictions are as follows:

1) Mental health telephone contacts should not be used to increase the count of mental health unique patients if an individual only received mental health telephone encounters.

2) Mental health telephone contacts should only increase the mental health encounter count if a veteran with a telephone encounter received inpatient, domiciliary, residential, or in-person outpatient care.

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. As of March 2022, VHA has trained over 17,570 providers in one or more of these EBPs.
- Between 2016 and 2020, initial Primary Care Mental Health Integration (PCMHI) encounters occurring the same day as appointments with Primary Care Providers increased from approximately 36% to about 55%. From 20 to 2021, there was a decline to 32%, which is largely attributed to the Covid-19 pandemic.
- In 2017, VA began offering emergent mental health services to former Service members with Other than Honorable administrative discharges. In 2021, 12,016 Service members with an "other than honorable" discharge received mental health services.
- The scale of the shift to telehealth in response to COVID-19 was dramatic. In 2020, nearly 550,000 Veterans received telemental health services during more than 2.4 million sessions. In 2021, VA provided telemental health services to more than 873,000 Veterans during more than 5.6 million visits (surpassing the 20 annual total by more than 3.2 million visits). In 2021, of the Veterans receiving telemental health care, 98% of all telemental health visits were into the Veteran's home or other preferred location. Nearly 13,000 VA outpatient mental health providers (98%) had completed a clinical video visit to a Veteran's home as of September 2021.
- In 2021, work continued to establish integrated Clinical Resource Hubs (including both Primary Care and Mental Health) to support telehealth in all VA regional networks.
- VA has used big data from its electronic medical record and predictive analytics to target clinical attention and outreach to Veterans estimated to be at highest risk of suicide and overdose.
- The Recovery Engagement and Coordination for Health - Veterans Enhanced Treatment (REACH VET) uses a statistical algorithm to identify patients at the highest risk of suicide in the next month. Once identified, a facility's REACH VET Coordinator identifies a clinician who knows the Veteran best. This clinician reviews the care the Veteran is receiving and reaches out to the Veteran. During this contact, clinical risk is assessed and collaborative discussions regarding care enhancement occur. The REACH VET program has identified more than 87,000 Veterans since it began in 2017. Furthermore, data suggest that in comparison to control groups, Veterans identified by REACH VET exhibited:
    - More health care appointments
    - More mental health appointments

    - Decreases in the % of missed appointments
    - Greater completion of suicide prevention safety plans
- VA's Stratification Tool for Opioid Risk Mitigation (STORM) uses VHA administrative data and predictive modeling to help improve opioid safety by identifying patients at the highest risk for overdose or suicide-related events and assigning them a risk score. STORM is updated nightly and provides risk scores and risk mitigation strategies for patients being considered for opioid prescriptions, who have an active or recently discontinued outpatient opioid prescription, or who have an opioid use disorder. A well-controlled evaluation in VHA of outcomes associated with a mandate that "very high" risk STORM patients receive an interdisciplinary risk review found that being mandated for review was associated with a significant reduction in all-cause mortality risk over the next four months.
- The VA Opioid Overdose Education and Naloxone Distribution (OEND) program aims to decrease opioid-related overdose deaths among VHA patients by providing education on opioid overdose prevention, recognition of opioid overdose, and training on the rescue response, including provision of naloxone. Since implementation of the OEND program in 2014, VHA prescribers, representing all VHA facilities, have prescribed naloxone, and more than 698,700 naloxone prescriptions have been dispensed to over 345,000 VHA patients with over 2,600 overdose reversals with naloxone reported, with an additional 146 reversals reported from naloxone in AED Cabinets and carried by VA Police.

**Projections for the Future**

- VA projects demand for services, not the number of patients consuming services. VA projects a 30% growth in inpatient and outpatient mental health care during the period from 2017 through 2030 (an increase from 17.8 million to 25.4 million). In 2019, VA already provided 21.8 million outpatient mental health encounters or treatment visits. The projection for 2024, demonstrating high demand for mental health services. During the same period, the inpatient-bed-days-of-care measurement is expected to be stable at about 3,450,000.
- Rapid growth in demand poses challenges for maintaining adequate mental health staffing to continue providing timely access to high quality, evidence-based mental health services. The Mental Health Hiring Initiative launched in 2017 successfully met the goal of increasing mental health providers by adding 1,045 additional net providers to the current VHA workforce by December 2018. VA embarked on a Mental Health Hiring Sustainability Initiative in 2019 to facilitate hiring and retention at facilities with severe shortages of mental health staff (provides targeted support to facilities struggling the most with having adequate mental health staffing).
- Continue to increase Veterans' access to care through increased mental health staff hiring and ongoing expansion of telehealth services.
- Continue national outreach efforts to increase awareness of mental health services and resources, reduce negative perceptions about seeking mental health care and improve mental health literacy among Veterans, their families and friends.
- Proactively support transitioning service members' mental health.

- Advance national implementation of measurement-based care (MBC) in mental health.
- Continue expansion of open access to care, ensuring access for urgent mental health care needs as well as sustained access to meet ongoing care needs.
- Work with the Congress to enact the Administration's legislative proposal that would lower out-of-pocket costs for certain mental health care services.

## Opioid Prevention, Treatment, and Program

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Treatment Modality ($000): | | | | | | | |
| MH Inpatient | $88,887 | $66,033 | $92,583 | $96,372 | $100,143 | $3,789 | $3,771 |
| MH Clinics | $126,481 | $126,347 | $131,740 | $137,131 | $142,497 | $5,391 | $5,366 |
| MH Dom/RRT | $63,280 | $67,352 | $65,911 | $68,608 | $71,293 | $2,697 | $2,685 |
| Methadone | $38,910 | $42,591 | $40,528 | $42,187 | $43,838 | $1,659 | $1,651 |
| Other Inpatient | $9,400 | $8,601 | $9,791 | $10,192 | $10,591 | $401 | $399 |
| Other OPC | $37,853 | $37,563 | $39,427 | $41,040 | $42,646 | $1,613 | $1,606 |
| Subtotal Treatment | $364,811 | $348,487 | $379,980 | $395,530 | $411,008 | $15,550 | $15,478 |
| Pharmacy | $19,850 | $27,181 | $20,675 | $21,521 | $22,363 | $846 | $842 |
| **Total Treatment** | **$384,661** | **$375,668** | **$400,655** | **$417,051** | **$433,371** | **$16,396** | **$16,320** |
| Jason Simcakoski Memorial and Promise Act (*Jason's Law*) 1/ 2/ 3/: | | | | | | | |
| Pain and Opioid Management Services | $50,833 | $207,197 | $207,197 | $207,197 | $207,197 | $0 | $0 |
| Pain and Opioid Management Administration | $0 | $5,500 | $5,500 | $5,588 | $5,588 | $88 | $0 |
| Patient Centered Care Services | $24,782 | $29,857 | $29,857 | $29,857 | $29,857 | $0 | $0 |
| Patient Centered Care Administration | $2,866 | $3,112 | $3,112 | $3,112 | $3,112 | $0 | $0 |
| Program [Subtotal] | **$78,481** | **$245,666** | **$245,666** | **$245,754** | **$245,754** | **$88** | **$0** |
| **Total Opioid Prevention, Treatment and Program Cost** | **$463,142** | **$621,334** | **$646,321** | **$662,805** | **$679,125** | **$16,484** | **$16,320** |

[1/] Included in the Comprehensive Addiction and Recovery Act of 2016 (CARA)

[2/] Patient Centered Care Services and Administration is included with the Whole Budget request shown later in the chapter.

[3/] Office of Patient Advocacy's annual budget of $11.0 million is no longer reflected in this table

### Authority for Action

- 38 U.S.C. §§ 1701,1730B, 7301(b), 5701(l), 7332.
- 38 C.F.R. §§ 1.483, 1.515, 17.419.
- Jason Simcakoski Memorial and Promise Act, P.L. 114-198 § 901-933
- VA Prescription Data Accountability Act, P. L. 115-86
- SUPPORT for Patients and Communities Act, P.L. 115-271

VA continues to pursue a comprehensive strategy to promote safe prescribing of opioids when indicated for effective pain management and to directly address treatment of opioid use disorder (OUD) and prevention of opioid overdose. VA is addressing these three strategic priorities with funding established by the enactment of P.L. 114-198, title XI, the Jason Simcakoski Memorial and Promise Act[15], also referred to as *Jason's Law*. Concerning safe opioid prescribing, the Pain

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

Management Program in Specialty Care Services (SCS) expanded to form the Pain Management, Opioid Safety Program (PMOP) office. In the 2023, $213.0 million in allocated funds will provide targeted support of pain management and opioid safety programs primarily at the facility level with national support to ensure successful implementation and increase access to care, especially in rural areas.

**Purpose:**

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

Naloxone is a medication used to block the effects of a potentially fatal opioid overdose and VA is a national and international leader in naloxone distribution to healthcare patients (Oliva et al., 2017).

A portion of the requested budget for 2023 will support continued growth and replenishment of VHA's Opioid Overdose Education and Naloxone Distribution (OEND). Naloxone is a medication used to block the effects of a potentially fatal opioid overdose. OEND consists of: 1) providing naloxone and education to VA patients at-risk for opioid overdose; 2) Rapid Naloxone Initiative effort to distribute naloxone to VA Police; and 3) Rapid Naloxone Initiative to deploy naloxone to Automated External Defibrillator (AED) cabinets. This includes continuing to fund naloxone free to high risk VHA patients (as is legislatively required by Jason's Law) and free to facilities (to reduce barriers to distribution), development and delivery of new educational and training materials (for Academic Detailing and field use) and providing support to the expansion of naloxone to first responders (VA Police) and in AED cabinets. 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).

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

- dispensing naloxone medication without charge to over 341,000 patients with over 2,600 reported opioid overdose reversals from the start of the program in 2014;
- equipping 3,552 VA Police Officers and 1,087 AED Cabinets with naloxone (as of April 2021); and
- Academic Detailers (specially trained VA pharmacists) also promoted OEND through individualized, evidence-based educational outreach visits and consultation for clinicians by clinicians. Through the first quarter of 2022, academic detailers had completed more than 28,600 such visits with more than 20,500 health care professionals nationwide.

VA's requested pain management and opioid safety budget will ensure VA continues to expand its efforts to ensure the rapid availability of lifesaving naloxone to patients and staff.

2. **Opioid Stewardship**

The budget will support Facility and VISN pain and opioid safety leadership positions to support *Jason's Law*, including mandated expansion of the Opioid Safety Initiative (OSI). Allocated funds expand capacity for pain management and opioid safety efforts in the field, including:

- Beginning in 2021, funds were provided to VISNs and Facilities to be used for dedicated staffing to ensure oversight, reporting, and coordination of pain and opioid initiatives.
    - PMOP established VISN and Facility PMOP Coordinator (1.0 FTE) positions, a dedicated program manager who provides oversight and support for quality monitoring, adherence to policy requirements, and other programmatic responsibilities. This role is critical to continue opioid stewardship, assessment of OSI effectiveness, addressing new and evolving evidence-based best practices and trends as seen in the opioid epidemic, and establishing opioid safety leadership at facilities as required by The Joint Commission. 2022 efforts include collaborations with the following Offices:
        - Office of Community Care: collaboration focuses on opioid stewardship and community care prescribers, as is mandated by MISSION Act Section 131 legislation and OIG recommendations.
        - Office of Information Technology (OIT) and Office of Electronic Health Record Modernization (OEHRM): collaborations are being established to integrate a network of state Prescription Drug Monitoring Program (PDMP) into VHA's electronic health record (EHR), as recommended in ONDCP's National Drug Control Strategy and in compliance with the MISSION Act Section 134.
- In 2022, PMOP began expanding communication to the field hosting the inaugural Community of Practice Calls for Behavioral Pain Management and PMOP Coordinators. There are currently over 350 VHA staff actively participating in these channels.
- PMOP will fund the Capstone projects for the newly created VA Addiction Scholars Program.
- PMOP created the TelePain Neuromodulation program across the enterprise as part of the development of the Specialty Care Program Office-National Virtual Specialty Care Services Program (SCPO-VSCS).
- PMOP is assisting with resolving issues presented in the GAO 2021 High-Risk List, which is a list of programs and operations that are 'high risk' due to their vulnerabilities to fraud, waste, abuse, and mismanagement, or that need transformation.
- Under PMOP, the Enterprise Opioid Strategy Team has convened a subgroup devoted to the HRL, working towards outcomes and gap analysis for the Federal-wide efforts under the direction of ONDCP.
- PMOP is commencing several evaluative efforts including a VHA 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, and legacy measures, and a partnership with OMHSP and Oak Ridge National Laboratory (Department of Energy) to work towards data-driven computation modeling projects. Curated data could be integrated into existing VA platforms for clinician support.

- PMOP has initiated funding of Medication Take-Back mailing envelopes for Veterans, ensuring Veterans have a means of safely disposing of expired or unwanted prescription and over-the-counter drugs. The envelopes are free to Veterans and do not require postage.
- PMOP has initiated funding of a Sterile Syringe Program to provide preventative and treatment services to Veterans who inject drugs and preventative services like vaccinations, naloxone to prevent overdose, and Pre-Exposure prophylaxis (PrEP), a medication that prevents HIV.
- PMOP provides 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.
- In 2022, the integrated Prescription Drug Monitoring Programs (PDMP) CPRS solution reached its one-year milestone. The solution enables querying the network of PDMPs from within the Veteran's electronic health record, providing greater efficiency and satisfaction for providers while supporting safe prescribing of controlled substances.
    - During the first 12 months, over two (2) million queries were executed using the PDMP button with roughly 96.5% of those being successful.
- VA staff are now executing approximately 100,000 queries every two weeks with the PDMP Query button in CPRS. The solution now connects to 50 of the 54-individual state/regional/DoD PDMPs making it the largest existing network of PDMPs.

### 3. Tele-Pain (including prevention and treatment of Opioid Use Disorder)

2023 funding for TelePain is an outgrowth of the $23.5 million spent in 2022. VA efforts in 2023 will include expanding TelePain models to provide opioid, chronic-pain, opioid use disorder (OUD) prevention and treatment (such as Medication for OUD, MOUD), and related care via telehealth technology, including:

- Staffing both at the program and field levels, training, supplies, equipment, and other tools needed to support the program.
- Implementing pain and opioid-related care using existing tele-hub structure established by VISN-based "Clinical Resource Hubs" with additional specialists in the areas of chronic pain, opioid use disorder treatment, and pharmacy added to each VISN hub site.
- Expanding and complementing existing telehealth efforts by offering new care for complex pain and opioid safety that aligns with the VA goals for addressing the opioid epidemic as outlined to the White House Office of National Drug Control Policy (ONDCP).
- Funding from PMOP to support the Clinical Resource Hub (CRH) TelePain services in the field. Funding has been accepted by 11 VISNs to support the expansion of TelePain services.
- Expanding the PMOP Office to include neuromodulation to support evidence-based interventions for pain management following appropriate biopsychosocial evaluation and determination of benefit.

### 4. Pain Management Team/Pain Clinic staffing

VA's allocated budget is utilized to initiate and establish positions that support *Jason's Law*-mandated interdisciplinary Pain Management Teams (PMTs) through field funding to staff an active PMT at all sites.

- Beginning in 2021, funds were provided to be used for dedicated staffing at VISNs and Facilities to ensure oversight, reporting, and coordination of pain and opioid initiatives.
    - In addition to PMOP Coordinator positions (see Opioid Stewardship), sustained funds were used to support Pain Points of Contact/Consultants (0.25 FTE), and Primary Care Pain Champions (0.25 FTE).
- PMOP field funding for expansion of clinical care: Pain Clinics/Pain Management Teams to provide access to comprehensive specialty care.
    - In 2022, PMOP's funding effort to expand PMTs and Pain clinic staffing totals $126.6 million and anticipates this stream of funding to expand to $152.6 million in 2023.
- PMOP field funding to support CARF-accredited Interdisciplinary Pain Rehabilitation Programs (IPRPs) in all VISNs.
- PMOP has initiated four new Request for Applications (RFAs) for five-year seed funding to the field focused on staffing in pain clinics which include:
    - The Active Management of Pain (AMP) 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 focuses on safe opioid prescribing in pain specialty care clinics and integrated access to M-OUD prescribing (CARA mandate).
    - The Whole Health Coaches in Pain Management Teams 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 seeks to hire mental health providers to be integrated into pain clinics to provide mental health care.

### 5. OUD Treatment

VA makes available a broad continuum of care for Veterans with opioid use disorder (OUD) that includes inpatient, residential, and general outpatient settings as well its 33 accredited and certified opioid treatment programs (OTPs). Approximately 67,000 Veterans with an opioid use disorder (OUD) diagnosis were seen in VHA in 2021. The evidence-based treatment of opioid use disorder are medications including methadone, buprenorphine, and extended-release naltrexone (M-OUD). In 2018, VA launched the Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT) initiative to support the expansion of M-OUD in Level 1 clinics (primary care, general mental health, and pain management). Phase 1 sites in each VISN implemented this expansion during 2019. From August 2018 through September 2021, there was a 211% increase in the number of patients receiving buprenorphine in Phase 1 level clinics and 194% increase in the number of providers prescribing buprenorphine in these clinics. Furthermore, Veterans are remaining engaged in care with 71% of Veterans retained on buprenorphine for more than 90 days. A

National Virtual SCOUTT conference for Phase 1 sites took place in 2021 with over 300 attendees. Phase 2 of the SCOUTT initiative was launched in 2020 and three regional conferences occurred in 2021 attracting over 500 participants. Since the launch of Phase 2 in 2020, there has been a 29% increase in the number of patients receiving buprenorphine and a 20% increase in the number of providers prescribing buprenorphine. Additionally, the infrastructure developed to support Phase 1 of the SCOUTT initiative also supports Level 1 clinics at facilities that were not formally involved in the SCOUTT initiative. In 2021 of the 67,548 patients with an OUD treated throughout the VA, 45.8% received MOUD compared to 11.1% outside the VA as reported by the Substance Abuse and Mental Health Services Administration.

The number of providers with a Drug Enforcement Administration (DEA) X-waiver also has continued to increase since the 4th quarter 2020. Over 6,500 X-waivered providers who have written prescriptions for M-OUD issued to the VHA pharmacy (VA employed and community providers serving Veterans) as of December 2021. This reflects an increase of 19% from the end of 2020.

In addition, in support of interprofessional team-based models of care, VA is leveraging Clinical Pharmacy Specialist (CPS) providers to deliver comprehensive medication management services and improve Veterans' access to care for substance use disorder (SUD), including OUD. In partnership with the VA Office of Rural Health, the VA Pharmacy Benefits Management (PBM) Clinical Pharmacy Practice Office launched a nationwide initiative in 2020 to expand the CPS provider workforce focused on SUD care. Since initiation, 51 VA facilities have been awarded funding to hire 64 CPS providers across Mental Health, Pain Management, Primary Care and Specialty Care settings with a primary focus of expanding access to OUD for rural Veterans. As part of this project, three regional train the trainer, clinical pharmacy boot camps were held virtually in June and July 2020 and trained 234 VA CPS providers. The training focused on advancing CPS provider practice in SUD, including OUD, care, and risk mitigation across Level 1 clinics, in alignment with the SCOUTT initiative, and offered subsequent office hours to further support growth in CPS practice of SUD care. As of the fourth quarter of 2021, 212 VA CPS providers were routinely delivering OUD care with 47,150 encounters in 2021. This represents a 76.8% growth in CPS provider practice in OUD care delivery since the implementation of the SCOUTT initiative; significant CPS practice growth in SUD care is expected in 2022.

**Evidence Supporting VA's Opioid Prevention, Treatment and Program**:

VA's Opioid Safety Initiative (OSI), OEND, and opioid stewardship related efforts are supported by the following published articles and best practices:


- Oliva EM, Richardson J, Harvey M, Bellino P (2021). Saving Lives: The Veterans Health Administration (VHA) Rapid Naloxone Initiative. Journal on Quality ad Patient Safety. 2021 Jun; 47(8):469-480
- Sandbrink F, Oliva EM, McMullen TL, Aylor AR, Harvey MA, Christopher ML, Cunningham F, Minegishi T, Emmendorfer T, Perry JM (2020). Opioid Prescribing and Opioid Risk Mitigation Strategies in the Veterans Health Administration. J Gen Intern Med. 2020 Dec;35(Suppl 3):927-934
- Sandbrink F, Uppal R (2019). The Time for Opioid Stewardship Is Now. Jt Comm J Qual Patient Saf. 2019 Jan;45(1):1-2. doi: 10.1016/j.jcjq.2018.10.004. Epub 2018 Dec 3.

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- Ghafoor, VL, et al. Implementation of a pain medication stewardship program. Am J Health-Syst Pharm—Vol 70 Dec 1, 2013, 2010; 2074-2075.
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- Rizk, E, et al. Quality indicators to measure the effect of opioid stewardship interventions in hospital and emergency department settings. Am J Health-Syst Pharm. 2019; 76:225-35
- Thompson, CA. VA's pharmacists manage patients' opioid use via education, interdisciplinary care. Am J Health-Syst Pharm. 2018; 75(15): 1087-1088.
- Harden, P, et al. Clinical Implications of Tapering Chronic Opioids in a Veteran Population. Pain Medicine 2015; 16: 1975–1981.
- Dole, E, et al. Provision of pain management by a pharmacist with prescribing authority. Am J Health-Syst Pharm. 2007; 64:85-9
- Seckel, E, et al. Meeting the National Need for Expertise in Pain Management with Clinical Pharmacist Advanced Practice Providers. The Joint Commission Journal on Quality and Patient Safety 2019; 45:387–392
- National Quality Partners Playbook: Opioid Stewardship (https://www.qualityforum.org/National_Quality_Partners_Opioid_Stewardship_Action_Team.aspx)
- The Joint Commission Standards including pain assessment and management standards as updated in 2018: r3_report_issue_11_2_11_19_rev.pdf (jointcommission.org)

VA's TelePain efforts are supported by the following published articles and best practices:

- Chen, J.A., DeFaccio, R.J., Gelman, H.M., Thomas, E.R., Indresano, J.A. Dawson, T.C., Glynn, L.H., Sandbrink, F. & Zeliadt, S.B. (2021). Telehealth and rural-urban differences in receipt of pain care in the Veterans Health Administration. *Pain Medicine*. https://doi.org/10.1093/pm/pnab194
- Silvestrini, M., Indresano, J., Zeliadt, S.B., & Chen, J.A. (2021) "There's a huge benefit just to know that someone cares": A qualitative examination of rural veterans' experiences with TelePain. *BMC Health Services Research*, *21*, 1111. https://doi.org/10.1186/s12913-021-07133-5
- Glynn, L. H., Chen, J. A., Dawson, T. C., Gelman, H., & Zeliadt, S. B. Bringing Chronic-Pain Care to Rural Veterans: A Telehealth Pilot Program Description. Psychological Services. 2021 Aug;18(3):310-318. doi: 10.1037/ser0000408. Epub 2020 Jan 16
- Anne Roberts, Lorna Philip, Margaret Currie & Alasdair Mort (2015) Striking a balance between in-person care and the use of eHealth to support the older rural population with

chronic pain, International Journal of Qualitative Studies on Health and Well-being, 10:1, DOI: 10.3402/qhw.v10.27536

- Carey EP, et al. "Implementation of Telementoring for Pain Management in Veterans Health Administration: Spatial Analysis," *Journal of Rehabilitation Research and Development* 2016; 53(1):147-56.
- Nanda U, Luo J, Wonders Q, Pangarkar S. Telerehabilitation for Pain Management. Phys Med Rehabil Clin N Am. 2021 May;32(2):355-372.
- VA Office of Rural Health Fact Sheets: Office of Rural Health Overview and Clinical Resource Hubs. Available from Rural Veteran Health Background - Office of Rural Health (va.gov)
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VA's Pain Management efforts are supported by the following published articles and best practices:

- Sandbrink F, What Is Special About Veterans in Pain Specialty Care?, *Pain Medicine*. 2017; 18(4): 623–625, https://doi.org/10.1093/pm/pnx054
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- Demidenko M, Dobscha S, Morasco B, et al. Suicidal ideation and suicidal self-directed violence following clinician-initiated prescription opioid discontinuation among long-term opioid users. *General Hospital Psychiatry*. 2017; 47:29-35.
- Gallagher, Rollin M. Advancing the Pain Agenda in the Veteran Population. *Anesthesiology Clinics*, Volume 34, Issue 2, 357 - 378.
- Kerns RD, Philip EJ, Lee AW, Rosenberger PH. Implementation of the veterans' health administration national pain management strategy. *Transl Behav Med*. 2011;1(4):635–643. doi:10.1007/s13142-011-0094-3.
- Bohnert, A. S., and M. A. Ilgen. 2019. Understanding links among opioid use, overdose, and suicide. *N Engl J Med.* 2019; 380, no. 1:71–9.
- Oquendo, M., and Volkow, N. Suicide: A Silent Contributor to Opioid-Overdose Deaths, *N Engl J Med*. 2018; 378:1567-1569. DOI: 10.1056/NEJMp18014.
- Pain Management Best Practices Inter-Agency Task Force Report https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf

Efforts related to supporting federal initiatives to address the opioid crisis are supported by the following published articles and best practices:

- Executive Office of the President (2021). The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One. Whitehouse.gov.
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- VA Health Care: Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed: VA Health Care: Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed | U.S. GAO
- High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas, GAO-19-157SP (Washington, D.C. Mar. 6, 2019).
- High Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas, GAO-21-119SP (Washington, D.C.: March 2, 2021).
- Centers For Disease Control And Prevention Public Health Service U S Department Of Health And Human Services. Guideline for Prescribing Opioids for Chronic Pain. J Pain Palliat Care Pharmacother. 2016, Jun;30(2):138-40
- VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders. https://www.healthquality.va.gov/guidelines/MH/sud/

Efforts related to pain mini-residencies in Primary Care are supported by the following published articles and best practices:

- Kligler B, Bair MJ, Banerjea R, DeBar L, Ezeji-Okoye S, Lisi A, Murphy JL, Sandbrink F, Cherkin DC (2018). Clinical Policy Recommendations from the VHA State-of-the-Art

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- Chang ET, Raja PV, Stockdale SE, Katz ML, Zulman DM, Eng JA, Hedrick KH, Jackson JL, Pathak N, Watts B, Patton C, Schectman G, Asch SM. What are the key elements for implementing intensive primary care? A multisite Veterans Health Administration case study. Healthc (Amst). 2018 Dec;6(4):231-237. doi: 10.1016/j.hjdsi.2017.10.001. Epub 2017 Nov 6.
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- Kerns RD, Philip EJ, Lee AW, Rosenberger PH. Implementation of the veterans health administration national pain management strategy. *Transl Behav Med*. 2011;1(4):635–643. doi:10.1007/s13142-011-0094-3
- VA Office of Primary Care's Patient Aligned Care Team (PACT) Roadmap for Managing Pain https://www.va.gov/PAINMANAGEMENT/Providers/Providers_docs/2018-Pain-Roadmap-Final.pdf
- VA/DOD Clinical Practice Guideline for Management of Opioid Therapy (OT) for Chronic Pain (2017). https://www.healthquality.va.gov/guidelines/Pain/cot/
- Pain Management Best Practices Inter-Agency Task Force Report https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf

Efforts related to expansion of medication treatment for opioid use disorder are supported by the following published articles and best practices:

- Gellad W, Zhao X, Thorpe C, et all. Overlapping buprenorphine, opioid, and benzodiazepine prescriptions among Veterans dually enrolled in Department of Veterans Affairs and Medicare Part D. *Substance Abuse.* January – March 2017; 38(1):22-25.
- Fiellin, David A., et al. "Primary care–based buprenorphine taper vs maintenance therapy for prescription opioid dependence: a randomized clinical trial." *JAMA internal medicine* 174.12 (2014): 1947-1954.
- Weiss, Roger D., et al. "Adjunctive counseling during brief and extended buprenorphine-naloxone treatment for prescription opioid dependence: a 2-phase randomized controlled trial." *Archives of general psychiatry* 68.12 (2011): 1238-1246.
- National Academies of Science, Engineering and Medicine with support from the nation Institute on Drug Abuse and the Substance Abuse and Mental Health Services Administration polished the report, Medications for Opioid Use Disorder Save Lives which reinforces that OUD Medication saves lives and the need to make this life-saving treatment more accessible. http://www.nationalacademies.org/hmd/Reports/2019/medications-for-opioid-use-disorder-save-lives.aspx
- VA/DOD Clinical Practice Guideline for Management of Substance Use Disorder (SUD) (2015). https://www.healthquality.va.gov/guidelines/MH/sud/

# Substance Use Disorder Program

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary Obligations** | | | | | | | |
| Medical Services (0160): | $0 | $0 | $0 | $179,681 | $182,180 | $179,681 | $2,499 |
| Medical Community Care (0140): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance (0152): | $0 | $0 | $0 | $1,606 | $1,654 | $1,606 | $48 |
| Medical Facilities (0162): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$181,287** | **$183,834** | **$181,287** | **$2,547** |
| **Mandatory Obligations** | | | | | | | |
| Veterans Medical Care and Health Fund (0173) Category 1/: | | | | | | | |
| Medical Services | $0 | $104,418 | $104,418 | $0 | $0 | ($104,418) | $0 |
| Medical Community Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance | $0 | $1,552 | $1,552 | $0 | $0 | ($1,552) | $0 |
| Medical Facilities | $0 | $50,000 | $50,000 | $0 | $0 | ($50,000) | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$155,970** | **$155,970** | **$0** | **$0** | **($155,970)** | **$0** |
| **Discretionary & Mandatory Obligations by Category:** | | | | | | | |
| Medical Services | $0 | $104,418 | $104,418 | $179,681 | $182,180 | $75,263 | $2,499 |
| Medical Community Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance | $0 | $1,552 | $1,552 | $1,606 | $1,654 | $54 | $48 |
| Medical Facilities | $0 | $50,000 | $50,000 | $0 | $0 | ($50,000) | $0 |
| Discretionary & Mandatory Obligations [Total] | **$0** | **$155,970** | **$155,970** | **$181,287** | **$183,834** | **$25,317** | **$2,547** |

[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

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

While the Department of Veterans Affairs (VA) is a national leader in the prevention and treatment of substance use disorder (SUD), gaps exist. In its 2019 National Survey on Drug Use and Health survey the Substance Abuse Mental Health and Services Administration (SAMHSA) estimated less than 15% of Veterans with SUD receive treatment for their SUD. Among Veterans receiving care within the Veterans Health Administration (VHA), over 540,000 had an SUD diagnosis in 2021 with less than 30% receiving SUD specialty services.

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

- Over 25 Internal & External Workgroups / Governance Councils

- Three Federal Workgroups responsive to the Office of National Drug Control Strategy (ONDCP) supporting/informing policy development and the development of the National Drug Control Strategy (NDCS) and the National Treatment Plan for Substance Use Disorders (NDCS-NTP)
- Member - Interdepartmental SUD Coordinating Committee established under PL 115-271 §7022, *SUPPORT for Patients and Communities Act*
- Federal Liaison representing VA on "Opioids and Behavioral Health Project" coordinated by the National Quality Forum
- Two Research Advisory Boards
- Multiple Conference/Education Planning Committees

*Statutory or Congressional Requirements*

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

*Office of National Drug Control Policy Reporting Requirements*

- National Drug Control Program Agency Budgets
- National Drug Control Assessment, National Drug Control Strategy, Performance Reporting System (New)
- NDCS-NTP action plan and performance updates

*Audit and Oversight Activities*

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

SUD treatment services are currently funded through existing appropriations that support the Veterans Equitable Resource Allocation (VERA) provided to the Veteran Integrated Service Networks (VISN). Additional resources are required to comply with the ONDCP NDCS, the NDCS-NTP, and congressional and statutory requirements. Funding is also closely aligned with the priorities outlined in "The Biden-Harris Administration's Statement of Drug Policy Priorities," which will largely be the basis for this year's National Drug Control Strategy.

Substance Use Disorder (SUD) commonly involves the use of multiple substances. The number of Veterans served within VHA with amphetamine, cannabis, cocaine, and alcohol use disorders

is rising. The number of Veterans with an amphetamine use disorder has increased by 52% since 2016 and the number with cannabis use disorder has increased almost 28%. Table 1 details the top five SUD diagnoses among Veterans served within VHA.

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

| Substance | 2016 | 2017 | 2018 | 2019 | 2020[16] | 2021 | % Change 2016 –2021 |
|---|---|---|---|---|---|---|---|
| Alcohol | 363,763 | 388,933 | 393,531 | 416,590 | 397,986 | 405,850 | 11.6% |
| Cannabis | 103,815 | 112,910 | 123,754 | 135,766 | 128,732 | 132,776 | 27.9% |
| Cocaine | 69,524 | 70,407 | 72,258 | 73,272 | 66,419 | 61,754 | -11.2% |
| Opioid | 66,851 | 69,142 | 71,471 | 71,327 | 68,773 | 67,548 | 1% |
| Amphetamine | 25,549 | 30,085 | 37,290 | 43,720 | 39,889 | 38,852 | 52.1% |

**Overdose Deaths: Opioid and Stimulant Use Disorders**

While there was a slight decline in the number of overdose deaths during 2018, review of overdose death data for 2019 and 2020 suggest a reversal of those trends with rising overdose rates. (https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#dashboard). The CDC estimates that overdose fatalities during the pandemic increased by over 30%, and approximately 104,000 people died from a drug-related overdose in the 12-month period that ended in September 2021..

As detailed in the Opioid Prevention, Treatment, and Program Budget narrative; VHA has made significant progress with efforts targeted towards prevention of opioid use disorder (OUD) and opioid overdose deaths.[17] Emerging data suggest that the opioid crisis is evolving. Among Veterans receiving treatment within VHA, the rate of overdose mortality increased from 14.5-per-100,000 person years in 2010 to 21.1-per-100,000 person years in 2016 (Lin et al., 2019).[18] The increases in opioid overdoses were largely driven by non-methadone synthetic opioids (e.g., fentanyl) and heroin overdoses. More recent data documents increases in the number of opioid overdose deaths among Veterans receiving VHA care, from 807 in 2010 to 1,410 in 2019 (VA OMHSP, unpublished findings). This suggests the need to target future efforts more directly to address opioid use disorders and use of illicit substances.

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

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

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

There is also a significant concern with rising rates of stimulant overdoses, specifically methamphetamine. VHA is therefore planning efforts to launch a stimulant safety initiative in 2022 aimed in part at increasing the percentage of Veterans with stimulant use disorder who receive evidence-based contingency management or cognitive behavioral therapy.

**National Drug Control Strategy - National Treatment Plan (NDCS-NTP)/ The Biden-Harris Administration's Statement of Drug Policy Priorities**

The NDCS-NTP was developed by ONDCP as required by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act) and outlines 22 areas of focus across three pillars (early intervention, improved services for individuals with SUD, and improved quality of treatment). The Biden Harris Administration Drug Policy Priorities were released in April 2021 and include, expanding access to evidence-based treatment, advancing racial equity issues in our approach to drug policy, enhancing evidence-based harm reduction efforts, advancing recovery-ready workplace, expanding the addiction workforce, and expanding access to recovery support services.

VHA's response in support of the NDCS-NTP and The Biden-Harris Administration's Statement of Drug Policy Priorities includes strategic engagement across multiple program offices (e.g., Clinical Pharmacy Practice Office, Public Health, Primary Care, Community Care, Academic Affiliations, and the Homeless Program Office) and requires collaboration with other Federal partners including the Department of Defense. Initiatives to support NDCS-NTP and The Biden-Harris Administration's Statement of Drug Policy Priorities as part of the 2023 SUD request are responsive to congressional expectations outlined in 2019 and 2020 appropriations conference reports (e.g., SUD services for women Veterans, universal screening for opioid use disorder, access to residential treatment for SUD, and use of technology to provide access to SUD services). Furthermore, the actions supported by the budget would directly address VA priorities of access and suicide prevention.

In addition, it is anticipated that the 2022 National Drug Control Strategy will emphasize The Biden-Harris Administration's Statement of Drug Policy Priorities which include, expanding access to evidence-based treatment, advancing racial equity issues in our approach to drug policy, enhancing evidence-based harm reduction efforts, advancing recovery-ready workplaces and expanding the addiction workforce, and expanding access to recovery support services.

The SUD Budget for 2023 outlined below closely aligns with The Biden-Harris Administration's Statement of Drug Policy Priorities 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; and 3) supporting ongoing education and training to ensure Veterans continue to have access to state of the art, evidence-based treatment for substance use concerns.

***Access to Care***

**Stepped Care for SUD.**

Of the more than 540,000 Veterans receiving SUD care within VHA during 2021, less than 25% received specialty SUD treatment with less than 4% receiving intensive SUD services.

Current efforts to expand access to medications for OUD and alcohol use disorder (AUD) have had an impact; however, the historical focus on providing SUD services through specialty care has limited the amount of growth that is possible with only 45.8% of Veterans diagnosed with OUD and 11% of Veterans with AUD receiving clinical practice guideline recommended medications during 2021.

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

| Substance | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|
| Alcohol Use | 26,680 (7.02%) | 31,905 (8.2%) | 37,651 (9.45%) | 42,305 (10.2%) | 42,530 (10.8%) | 45,038 (11%) |
| Opioid Use | 22,606 (34.1%) | 24,069 (34.8%) | 24,696 (34.9%) | 26,415 (40.4%) | 27,571 (44.4%) | 27,358 (45.8%) |

To address evidence-based medication for opioid use disorder (M-OUD) treatment, VHA launched the Stepped Care for Opioid Use Disorder – Train the Trainer (SCOUTT) initiative in May 2018. Eighteen of our Phase One clinic-based teams comprised of staff from primary care, general mental health, and pain management participated in the training. Between August 2018 and December 2020, the teams evidenced a 211% increase in the number of Veterans receiving buprenorphine for the treatment of OUD and a 194% increase in the number of providers with a Drug Enforcement Administration (DEA) X-waiver who are prescribing medication treatment for opioid use disorder with buprenorphine. Since the initiative launch, over 2,000 patients have been started on buprenorphine.

Provision of treatment for SUD in settings outside of specialty care is not fully captured in the current VAMC budgets. The SCOUTT initiative has demonstrated that M-OUD can be successfully provided outside of specialty care and that a stepped care approach to treatment provides opportunities to address the broader spectrum of SUD treatment needs. The SUD budget therefore requests support to expand access to SUD services outside of the specialty care setting, specifically targeting general mental health and primary care clinics[19]. There will also be additional support for the CRH in each VISN to address gaps in access to SUD services for Veterans who primarily receive care in Community Based Outpatient Clinics. The plan would provide for at least two Full-time Equivalent (FTE) per CRH in 2022 and sustained in 2023 and 2024, as well as staff targeted to VAMCs to support provision of SUD treatment within Behavioral Health Interdisciplinary Program (BHIP) teams or through Primary Care Mental Health Integration. The resources request would support:

- Expansion of approximately 330 staff hired in 2022 with sustainment in 2023 and 2024 to provide SUD services with capacity for each CRH to provide medications for OUD and AUD as well as SUD counseling.

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

- Partnered research to evaluate implementation of the stepped care model which expands SUD care beyond specialty care and into primary care, pain management and general mental health clinics.
- Expansion of Pharmacy infrastructure from 2022 through 2024 for in-clinic medication administration.
- Developing mobile methadone clinic capacity to treat Veterans with OUD in underserved/rural communities
- VA Central Office infrastructure to support facilitated implementation, training, and evaluation.

Metrics:

- SUD16: % of Veterans with OUD receiving guideline indicated medication
- % of Veterans with AUD receiving guideline indicated medication
- % of Veterans screened annually for drug use *(To be proposed/New)*
- Number of providers within VHA with DEA X-waiver

These efforts are responsive to the following recommendations and requirements:

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

**Access to Residential Treatment and Post-stabilization Engagement.**

VHA provides two types of 24-hour care to Veterans with severe, complex, or acute substance use disorders. This includes inpatient withdrawal management and stabilization in numerous medical and general mental health units and provision of care in Mental Health Residential Rehabilitation Treatment Programs (MH RRTP), otherwise referred to as Domiciliary beds. Treatment provided within Specialty Domiciliary SUD programs is equivalent to standards specified by the American Society of Addiction Medicine Patient Placement Criteria, specifically Level 3.7, Medically Monitored Intensive Inpatient Services. At the end of 2021, seventy Domiciliary SUD programs were in operation with over 1,850 official operational beds focused specifically on intensive, medically monitored residential SUD treatment. The NDCS requires access to SUD treatment within forty-eight hours of referral. The average time between screening for residential treatment and admission to a SUD residential bed within VHA was 21 days through second quarter of 2020, significantly longer than the target defined by the NCDS. Further, the wait time does not include the time between referral and screening which in some cases may be a few weeks. The pandemic has had a significant and sustained impact on residential operations with waits for residential treatment increasing during 2021 to 31 days on average. Increased waits for residential treatment in large part were related to reduction in capacity necessary to safely operate residential units.

Results from the 2020 MH RRTP Annual Program review identified deficiencies impacting access for Veterans needing SUD treatment. Areas of concern identified were inadequate resources to support regular admissions, staffing challenges, concerns related to COVID-19 mitigation, and beds not being available. Historical concerns related to appropriateness of referrals and medical needs have also impacted access and often are related to the need for withdrawal management services. The residential treatment programs in VHA can provide medically monitored withdrawal management, comparable to ambulatory withdrawal management, which would facilitate more timely access to care and further address concerns with post-stabilization engagement in treatment. However, implementation of withdrawal management in the residential programs historically has been limited.

During 2019, each VISN completed a detailed market assessment for MH RRTP services as a subcomponent of a broader review of healthcare services. Review of information provided by facilities as part of that assessment identified that less than half of the VA medical centers reported the ability to access residential admission for SUD treatment within seventy-two hours and only slightly more than 61% were able to access admission within thirty days. Twelve of eighteen VISNs identified the need for additional SUD services that would require medical facilities funding. At the end of 2021 there were six Domiciliary SUD programs under development. These programs are critical to meeting requirements for reducing current wait times and providing admission within forty-eight hours.

Beyond the specific need for expansion of bed-based services for SUD treatment, the NDCS-NTP and congressional stakeholders have specifically identified a need for services for women. At the current time there are only two Domiciliary SUD programs that offer a dedicated track for women Veterans. The 2023 - 2024 SUD budget would build on planned 2022 efforts and provide the necessary funds to meet the national benchmarks established by the NDCS and the expectations of stakeholders. This will require:

- Sustained expansion of approximately 300 staff to increase access within existing Domiciliary SUD programs and SUD-Track programs within General Domiciliary to support admission within 48 hours including expansion of medically monitored withdrawal management. Hiring efforts began in 2022 with current funds requested to support sustainment while services are established.
- National SUD program office infrastructure to support development of clinical informatic tools to facilitate referral and admission processes (e.g., real-time report with bed availability, number pending admission, and projected waits).
- Medical facility and activation funds to continue support for the expansion of Domiciliary SUD services initiated during 2022.

Metrics:

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

These efforts are responsive to the following recommendations and requirements:

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

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

To close the treatment gap as required by the NDCS-NTP and to provide a recovery environment as detailed in the Biden-Harris priorities, services specific to Veteran engagement are required. The NDCS-NTP specifically requires VA "support peer recovery support services" and "continue peer and paraprofessional outreach, engagement, and intervention efforts." Since 2005, peer support staff have been working in the VA health care system. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics (2008) mandated the availability of peer support services for Veterans stating, "Peer support is one of the 10 fundamental components of recovery according to the National Consensus Statement on Mental Health Recovery" (p. 4) and "All Veterans with *SMI (Serious Mental Illness)* must have access to peer support services, either on-site or within the community" (p.

28). That same year, P.L. 110-387, *The Veterans' Mental Health and Other Care Improvements Act Of 2008* established the requirement for the use of peer specialists and their qualifications in VHA. Through this legislation, peer specialists in VHA became defined as Veterans discharged under other than dishonorable conditions who are in recovery from a mental health and/or SUD and who are certified to provide peer support services.

Studies have found improvements in treatment engagement, treatment retention, reduction in symptoms of mental illness, improvements in abstinence from addictive substances, and improvements on quality-of-life measures (Bassuk et al., 2016; Chinman et al., 2015; Druss et al., 2018; Fortuna et al., 2018; Ashford et al., 2019; McCarthy et al., 2019; Fortuna et al., 2020) for individuals who received peer support services as part of their mental health care services.

VHA has hired hundreds of Veterans providing such support as peer specialists and is now the single largest employer of peer specialists in the United States. The current 1,197 peer support staff work throughout the VA health care system in inpatient and outpatient mental health and SUD programs, intensive community mental health recovery services (formerly Mental Health Intensive Case Management (MHICM)), Psychosocial Rehabilitation and Recovery Centers (PRRC), vocational rehabilitation services, and residential treatment programs. However, apart from the Domiciliary SUD programs, utilization of peer specialists to support SUD treatment within VHA is not required and there is not capacity within the current infrastructure to support expansion of services or to target SUD services.

***Homeless Population***

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

The SUD budget will directly address the requirements of The Biden-Harris Administration's Statement of Drug Policy Priorities and NDCS-NTP through the expansion of peer support services to SUD treatment services with a targeted focus on engagement in treatment using a stepped care approach. Peer specialists hired by facilities to work as members of the SUD treatment team would prioritize treatment engagement for those Veterans presenting on inpatient units and in emergency departments with substance-related concerns. In addition, working in collaboration with the Homeless Program Office, the budget will provide additional support for SUD case managers to work with the Supportive Services for Veterans and their Families (SSVF) program. The principal objective of the proposal is to link a VA medical center SUD case manager to each SSVF grantee to coordinate MH and SUD care for VHA-eligible homeless Veterans, ensuring prompt access for this high-risk population. Once

enrolled in SSVF, VHA-eligible Veterans identified as needing behavioral health services will be referred by grantees to a designated case manager who will assist in providing an initial screening and then linking the Veteran to appropriate follow-up appointments. It is expected that SSVF grantees and the case manager will review care coordination during regularly scheduled case conferences.

Currently, there are 260 SSVF grantees serving communities through the country and US territories. SSVF served 114,175 Veterans and their family members in 2021, 80,049 of whom were Veterans. As approximately 85% of the Veterans served are VHA-eligible (68,000) and 60% of these Veterans will need assistance from a VA MH provider, potentially 41,000 Veterans would be linked to care.

Details of Peer Support Services – Health Navigators plan:

- Expansion of approximately 300 peer specialists to work in SUD specialty care.
- National Program office support for training and certification of Peer Support Specialists consistent with current requirements. Monitoring of scope of SUD services provided by peer specialists with intention to identify strong practices that can be shared with current peer specialists working in other settings of care to meet the needs of Veterans with co-occurring SUD and mental health concerns.
- Partnered research to evaluate implementation of SUD specific peer support services.
- Expansion of approximately 380 FTE SUD case managers to work directly with SSVF grantees and homeless program staff with the goal of engaging or re-engaging Veterans in SUD treatment.

Metrics:

- Post-discharge engagement with or receipt of SUD services following acute inpatient admission.
- Utilization of high-cost emergency services post inpatient discharge with an SUD admitting diagnosis

These efforts are responsive to the following recommendations and requirements:

- NDCS-NTP and The Biden-Harris Administration's Statement of Drug Policy Priorities:
    - Increase access to treatment for homeless populations with increased outreach and mobile opioid mobile treatment units.
    - Continue peer and paraprofessional outreach, engagement, and intervention efforts.
    - Support peer recovery support services.

        Increase addiction and recovery workforce, including peer recovery specialists, addiction nurses, social workers, MSWs, psychologists, addiction psychiatrists and addiction medicine specialists.

**Responding to Emerging Drug Threats**

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

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

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

Metrics:

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

These efforts are supported by clinical practice guidelines and recommendations outlined in:

- SAMHSA. Treatment of Stimulant Use Disorders. SAMHSA Publication No. PEP20-06-01-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2020

These efforts are responsive to the following recommendations and requirements:

- *Fentanyl Use and Urine Drug Screening Practices in a Domiciliary Residential Rehabilitation Treatment Program at the Bath VA Medical Center (September 12, 2018)*, Office of the Inspector General
- HSR&D State of the Art Conference, *Effective Management of Pain and Addiction*, Policy Recommendation, OUD Sub-group
- NDCS-NTP: Increase access to treatment programs, especially for stimulants, benzodiazepines, and other non-opioid substances requiring management during the acute withdrawal process.

**Use of Technology**

Individuals experiencing SUDs often face barriers to care such as lack of access to transportation necessary to access services. The NDCS-NTP outlines specific requirements for the expansion mobile technologies and mobile units to support access to SUD treatment. The CESATEs have completed pilot work exploring the feasibility of implementing mobile apps for the treatment of SUD within VHA (https://www.blogs.va.gov/VAntage/75258/help-hand-phone-apps-provide-veteran-support-24-7/).

National implementation of mobile technologies for the treatment of SUD will require support to train providers and facilitate implementation, provide technical assistance, and support for use of existing mobile app solutions. The SUD budget seeks a phased deployment of mobile apps to support treatment of substance use disorders. Initial implementation will target implementation of pilots during 2022 with continued expansion in 2023 and sustainment in 2024. The budget would align resources within the CESATEs responsible for identifying the mobile app solution(s) that will be made available and developing the necessary infrastructure to support implementation. The budget seeks support for: Partnered research to evaluate implementation of the stepped care model and CESATE infrastructure to support facilitated implementation, training, and evaluation.

Metrics:

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

These efforts are responsive to the following recommendations and requirements:

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

**Enhancement of Employment Opportunities for Veterans in Recovery**

During 2019, 65.8% (8,872) of Veterans newly enrolled in VHA Vocational services had a SUD diagnosis. However, research has shown that Veterans are frequently not assessed for, or if assessed, not referred to vocational services suggesting the number of Veterans in need of vocational support may be higher. The NDCS-NTP requires VA explore opportunities to support expanded access to employment for those in recovery. VA Supported employment (SE) is currently available to Veterans diagnosed with a Serious Mental Illness. Expansion would require additional staff at VA medical centers to provide the necessary vocational supports as well as support for implementation to include mechanisms for monitoring fidelity to the SE model of care. Review of the literature suggests the SE has the potential to significantly improve employment outcomes for those Veterans experiencing SUD concerns, particularly those Veterans with other co-occurring conditions (Lones et al., 2017; Rosenheck & Mares, 2007; Mueser et al., 2011). Considering the current pandemic and impact on unemployment rates nationally, the budget seeks to increase access to SE services for Veterans diagnosed with a SUD with support for one FTE per VISN during 2022 (targeted to a single VA medical center) with anticipated expansion during 2023 to support at least 156 new staff.

Metrics:

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

These efforts are responsive to the following recommendations and requirements:

- The Biden-Harris Administration's Statement of Drug Policy Priorities and NDCS-NTP:
    - Expand access to employment opportunities and support for people in treatment and recovery.

***Education, Training, and Consultation***

**Evidence-Based Treatment for SUD**

Improving Veteran outcomes by providing evidence-based psychotherapy (EBP) is the primary focus of this effort. The budget seeks to bring together experts in clinical training, program development, SUD, program evaluation, quality assurance and quality improvement, and implementation specialists. This will be a collaborative effort between the CESATEs and EBP subject matter experts in OMHSP. The intent of this effort is to ensure Veterans have ready access to evidence-based psychotherapies for SUD to include therapies recommended by the current clinical practice guidelines. At this time four EBPs for SUD have been implemented or partially implemented in VHA: Cognitive-Behavioral Therapy for SUD (CBT-SUD), Motivational Enhancement Therapy (MET), Motivational Interviewing (MI), and Behavioral Couples Therapy for SUD (BCT-SUD). *(NOTE: This list does not include contingency management which is considered an evidence-based practice, but not a psychotherapy).*

Implementation of MI and BCT-SUD have been limited. At the current time the EBPs that have been deployed do not address the full scope of recommended treatments defined by the VA/DoD Clinical Practice Guidelines for the Management of SUD. In addition, the current EBPs can only be delivered by licensed providers and via individual psychotherapy. This excludes a notable fraction of the SUD workforce within VA – Addiction Therapists (approximately 360). Further, most of the care within VHA is provided in group settings particularly in intensive outpatient and residential settings. The SUD budget would address this treatment and training gap through the development, expansion, and implementation of at least six (6) evidence-based psychotherapies (pending any changes in the forthcoming update of the VA/DoD CPG for the Management of Substance Use Disorders) beginning in 2022:

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

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

The SUD budget would provide the resources necessary for the development of needed training materials, validation that the materials reliably equip providers to deliver the most likely effective interventions in the manner intended, and validation that providing the interventions as intended reliably produces expected patient outcomes. All activities will occur within a framework of continuous quality improvement focusing on training outcomes, numbers of Veterans reached, and Veteran outcomes. A current capability to locate previously trained providers will allow for targeted dissemination and implementation based on gaps in needed evidence-based psychotherapy competencies.

Metrics:

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

These efforts are responsive to the following recommendations / requirements:

- The Biden-Harris Administration's Statement of Drug Policy Priorities including increasing access to evidence-based care as well as the NDCS-NTP: Increase rural access to evidence-based SUD care through outreach, primary care screening, telehealth, distance learning, and mobile units.

**Expanding the Addictions Workforce**

The NDCS-NTP defines a current gap in the number of trained addiction treatment professionals. VHA is a leader in training healthcare professionals, including those working in SUD treatment settings. The VA Office of Academic Affiliations (OAA) currently provides support for the Interdisciplinary Advanced Addiction Professional Fellowship Coordinating Center. The Coordinating Center currently provides support for seven Advanced Addiction Fellowship sites with 19 current trainees. The SUD budget aligns support for the Coordinating Center within OMHSP to build on the foundation already established by OAA. The alignment will sustain the infrastructure necessary to increase the number of Advance Addiction Fellowship sites and to better coordinate the work between the Advanced Fellowships and the current Associated Health Education training activities. Further, Synergies gained by aligning within OMHSP and in coordination with the CESATEs is expected to enhance existing efforts to addressing training for current staff across multiple disciplines.

Metrics:

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

This effort is responsive to the following recommendations / requirements:

- The Biden-Harris Administration's Statement of Drug Policy Priorities including expanding access to evidence-based treatment, advancing the recovery-ready workplace, and expanding the addiction workforce
- NDCS – Performance Goal
- NDCS-NTP: Increase addiction and recovery workforce, including peer recovery specialists, addiction nurses, social workers, MSWs, psychologists, addiction psychiatrists and addiction medicine specialists.

**Addressing Stigma and Shifting the Culture.**

During the HSR&D SOTA Conference, *SOTA XV: Effective Management of Pain and Addiction*, policy recommendations specifically highlighted stigma, both Veteran and provider, as the most significant barrier to accessing SUD treatment and specifically to accessing guideline indicated treatment. Rates of compliance and relapse between SUD and other chronic medical conditions such as diabetes are similar. It is not uncommon for individuals to be administratively discharged from treatment due to a relapse, return to substance use, or for medications for OUD to be discontinued because of use of another substance versus modiing treatment to introduce another guideline indicated treatment. Changing the culture and ensuring that providers have the information they need to provide appropriate SUD treatment will require resources to support consultation, education, and training.

In response to COVID-19, OMHSP in collaboration with the National Tele-mental Health Center rapidly deployed a national consultation resource – AskTheExpert-SUD@va.gov. Triaging of consults for this service is currently being managed largely by the Acting National Mental Health Director, SUD with subject matter expertise provided by CESATE staff and representatives from various program offices. Since its launch at the end of March 2020, consultation requests are submitted routinely. In 2021 the AskTheExpert e-mail received incoming consultations from 140 unique clinicians. Recommendations from the OUD Workgroup from the SOTA included the establishment of a National Consultation SUD Consultation program comparable to the National Center for Posttraumatic Stress Disorder (NC-PTSD) Consultation Program as well as similar resources for Military Sexual Trauma and Suicide Risk Management. In addition, the NDCS-NTP, highlights a role for consultation in directly addressing stigma and improving access to care. The SUD budget would formally establish a National SUD Consultation resource with dedicated resources to sustain operations. The plan would leverage expertise currently available within the CESATES and align the consultation program with the CESATEs within OMHSP. The level of resources identified in the 2023 budget request are consistent with recommendations from experts at the NC-PTSD.

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

- Field-based training consistent with initiatives outlined, i.e., expansion of SUD services into BHIP and Primary Care settings, initiation of care during inpatient treatment.
- Direct to provider messaging and decision support tools designed to facilitate access to SUD treatment in Level 1 clinics.

Metrics:

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

These efforts are responsive to the following recommendations and requirements:

- The Biden-Harris Administration's Statement of Drug Policy Priorities including expanding access to evidence-based treatment, advancing the recovery-ready workplace, and expanding the addiction workforce
- HSR&D State of the Art Conference, *SOTA XV: Effective Management of Pain and Addiction*, Policy Recommendation, OUD Sub-group
- NDCS-NTP:
    - Provide training, consultation, and other support to increase the number of healthcare providers screening for and addressing all forms of SUD in general healthcare settings, including potential co-location of, consultation with, or telehealth services from addiction medicine specialists and other addiction professionals and paraprofessionals.

- Educate healthcare professionals in Primary Care, Emergency Departments, Acute Care Hospitals, Mental Health clinics and other clinical settings with an enriched SUD population on how to make a "clinical assessment" and to engage in shared decision-making on the range of appropriate SUD treatment options, similar to how they would for other chronic diseases.
- Increase addiction consultation services and integrated care

**Expansion of Supported Employment SUD Specialists**

**Purpose**: The 2022 request supported funding for an initial pilot of supported employment SUD specialists in each VISN with planned expansion beginning in 2023.

**Evidence:** During 2019, 65.8% (8,872) of Veterans newly enrolled in VHA Vocational services had a SUD diagnosis. However, research has shown that Veterans are frequently not assessed for, or if assessed, not referred to vocational services suggesting the number of Veterans in need of vocational support may be higher. The NDCS-NTP requires VA explore opportunities to support expanded access to employment for those in recovery. VA Supported employment (SE) is currently available to Veterans diagnosed with a Serious Mental Illness. Expansion would require additional staff at VA medical centers to provide the necessary vocational supports as well as support for implementation to include mechanisms for monitoring fidelity to the SE model of care. Review of the literature suggests the SE has the potential to significantly improve employment outcomes for those Veterans experiencing SUD concerns, particularly those Veterans with other co-occurring conditions (Lones et al., 2017; Rosenheck & Mares, 2007; Mueser et al., 2011). Considering the current pandemic and impact on unemployment rates nationally, the budget seeks to increase access to SE services for Veterans diagnosed with a SUD with support for one FTE per VISN during 2022 (targeted to a single VA medical center) with anticipated expansion during 2023 and 2024 to support 156 new staff. Supported employment as a treatment strategy for Veterans in recover is supported by the ONDCP.

**Implementation Plan:** In 2022, the budget projected each of the 18 VISNs to hire one SUD Supported Employment Specialist at one of their facilities. This allows for the establishment of a program framework prior to full scale implementation. It also will establish expertise in each VISN in advance of a larger deployment. The 2023 budget provides support to expand the workforce by providing one SUD Supported Employment Specialist at each facility thus increasing the total of Supported Employment SUD Specialists to 156 ensuring availability of this critical resource at each facility.

# Suicide Prevention

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Treatment Modality ($000): | | | | | | | |
| Suicide Diagnosis | $1,286,777 | $1,309,768 | $1,426,003 | $1,532,736 | $1,580,610 | $106,733 | $47,874 |
| MH care in the Emergency Room | $154,707 | $133,655 | $171,446 | $184,279 | $190,034 | $12,833 | $5,755 |
| Reach Veteran in Crisis | $1,845 | $909 | $2,044 | $2,197 | $2,266 | $153 | $69 |
| Suicide Safety Plan | $163,607 | $68,386 | $181,309 | $194,880 | $200,967 | $13,571 | $6,087 |
| High Risk of Suicide | $322,777 | $152,075 | $357,701 | $384,474 | $396,482 | $26,773 | $12,008 |
| MH Suicide Prevention PACT | $2,863 | $3,251 | $3,173 | $3,410 | $3,517 | $237 | $107 |
| COMPACT Act | $0 | $73,300 | $20,900 | $83,800 | $82,900 | $62,900 | ($900) |
| **Total Treatment** | **$1,932,576** | **$1,741,344** | **$2,162,576** | **$2,385,776** | **$2,456,776** | **$223,200** | **$71,000** |
| Suicide Prevention Outreach Program: | | | | | | | |
| Veterans Crisis Line | $119,297 | $255,968 | $255,968 | $255,968 | $278,064 | $0 | $22,096 |
| National Suicide Prevention Strategy Implementation | $48,535 | $42,131 | $42,131 | $45,606 | $45,845 | $3,475 | $239 |
| Demonstration Projects | $4,438 | $4,744 | $4,744 | $4,821 | $4,860 | $77 | $39 |
| Suicide Prevention 2.0 Initiative | $13,677 | $66,606 | $66,606 | $63,590 | $42,047 | ($3,016) | ($21,543) |
| PREVENTS | $43,434 | $104,482 | $104,482 | $0 | $0 | ($104,482) | $0 |
| Centers of Excellence (includes MIRECC and SMITREC) | $6,728 | $5,311 | $5,311 | $5,365 | $5,420 | $54 | $55 |
| Local Facility and Community Outreach Activities | $649 | $750 | $750 | $750 | $750 | $0 | $0 |
| Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program | $0 | $55,694 | $55,694 | $55,757 | $56,545 | $63 | $788 |
| Specific Purpose [Subtotal] | **$236,757** | **$535,686** | **$535,686** | **$431,857** | **$433,531** | ($103,829) | $1,674 |
| Suicide Prevention Coordinators and Teams | $60,440 | $62,311 | $62,311 | $64,741 | $67,266 | $2,430 | $2,525 |
| **Total Suicide Prevention Outreach Program** | **$297,197** | **$597,997** | **$597,997** | **$496,598** | **$500,797** | **($101,399)** | **$4,199** |

## Authority for Action

- Public Law (P.L.) 116-171, *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019*
- P.L. 114-2, *Clay Hunt Suicide Prevention for American Veterans Act*
- 38 U.S.C. §1720F authorizes the comprehensive program for suicide prevention among Veterans.
- P.L. 110-110, *Joshua Omvig Veterans Suicide Prevention Act*
- *Exec. Order No. 13822, 3 C.F.R. 1513 (2018)*
- P.L. 114-247, *No Veterans Crisis Line Call Should Go Unanswered Act*
- *Exec. Order No. 13861, 84 FR 8585 (2019)*

## Budgetary Changes

Decreases of $101.0 million in planned obligations from 2022 to 2023 are largely driven by the completion of the requirements of the 2019 EO 13861, the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS).

## Veterans Crisis Line (VCL)

**Purpose:** Serves as the operational budget for VCL, which provides 24-hours per day, 7-days per week, and 365-days per year suicide prevention and crisis intervention services. VCL connects Veterans in crisis and their families and friends with qualified, caring VA responders through a confidential toll-free hotline, online, chat, or text. VCL's 2023 budget will support operational readiness in fulfillment of the National Suicide Hotline Designation Act of 2020, which requires the Federal Communications Commission (FCC) to designate 9-8-8 as the universal telephone

number for the National Suicide Prevention Lifeline and the VCL. A volume increase of 122% to 154% is anticipated for VCL. The transition to 988 must be complete by July 16, 2022. VCL's 2023 budget request supports 2,568 full-time equivalent (FTE) employees, an increase of 1,526 FTE over 2021 levels.

**Implementation:** VCL has begun preparing for full implementation of the 988-expansion initiative. Although complete activation of 988 is not expected until July 16, 2022, some carriers have already implemented use of the 988 number. Data modeling on call volume projections show the transition to a simplified three-digit dialing code is forecasted to increase VCL call volume by 122% to 154% in total. This means that VCL could see an additional 835,690 to 1,054,888 calls, or a total of 1,520,682 to 1,739,880 calls annually by 2024. Call volume to the VCL is anticipated to increase by 44.1%-61.1% for 2023 with an 89.3%-123.6% increase through 2024. In 2021, VCL received approval and supplemental funding to increase its FTE by 460. VCL has projected it will need a total of 2,568 FTE to fulfill its mission, with recruitment efforts continuing in fiscal years 2022 through 2023. In 2024, it is anticipated that the organizational chart for 2,568 FTE will have been finalized and fully recruited resulting in the necessary increase in salary funding in 2024.

VA is proud to support the 988 expansion initiative alongside such partners as the FCC, the Substance Abuse and Mental Health Services Administration, and the National Suicide Prevention Lifeline. Once activated, the 988 expansion will directly address the need for ease of access and clarity in times of crisis, both for Veterans and non-Veterans alike. Several carriers, including T-Mobile, Verizon, and US Cellular, have already activated the 988 number. Providing a universal, unique three-digit dialing code will give VA an opportunity to work in greater collaboration with the suicide prevention community across the United States and open the door to engage new individuals in life-saving care. Additionally, on November 18, 2021, the FCC issued a press release[20] requiring covered text providers to support text messaging to 988 by routing certain text messages sent to 988 to the National Suicide Prevention Lifeline by July 16, 2022. While this is not a requirement for VCL, VA is currently ensuring operational readiness for accepting transfers of Veterans who text 988 in attempt to reach VCL. VCL's current text number, 828255, will remain active. Currently, VA and SAMHSA do not operate texting services in a coordinated effort nor share the same number.

**COVID-19:** In February 2020, VCL began implementation of processes for ensuring the well-being of staff and uninterrupted service for Veterans in crisis considering the COVID-19 pandemic. By April 24, 2020, 100% of ready and willing VCL employees were working from home. Since that time, VCL has tracked and reviewed data across the Quadruple Aim considering quality care outcomes, Veteran and Employee Experience, and cost, efficiency, and access. We have found working in a telework status to be very effective for VCL's Mission as we have maintained our performance metrics while also being able to support our team members. Transitioning to a 100% remote workforce during 2021 has provided information regarding new recruitment patterns associated with geography, internal movements, and human resource modernization activities.

[20] Federal Communications Commission (2021, November 18). FCC Approves Text-to-988 Access to Suicide Prevention Lifeline [Press release]. Retrieved from https://www.fcc.gov/document/fcc-approves-text-988-access-suicide-prevention-lifeline-0.

**National Suicide Prevention Strategy**:

**Purpose:** Serves as the core operational budget for the National Suicide Prevention Program (SPP) within the Office of Mental Health and Suicide Prevention (OMHSP). As the highest clinical priority within the 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 identiing priorities, organizing efforts, and focusing national attention and community resources to prevent suicide among Veterans while adopting a comprehensive public health approach with an emphasis on comprehensive, community-based engagement and ongoing clinical and crisis interventions.

The National Suicide Prevention Strategy core operational budget supports the Suicide Prevention Program, which expanded the program from 27 FTE to 66 FTE between 2020 and 2021. The program projects the need for further expansion to approximately 82 total FTE to support the ongoing development and roll out of our public health work, primarily under the "Suicide Prevention 2.0 Initiative." The core budget also supports contracts including those that focus on our communications and paid media efforts that aim to raise awareness about mental health and suicide prevention and educate Veterans, their families, and communities about the suicide prevention resources available to them. Contracts also support work for P. L. 114-2, *Clay Hunt Suicide Prevention for American Veterans Act*, community engagement and awareness materials that include the VCL phone number, and gun lock acquisitions – an important element of lethal means safety for suicide prevention, and part of the National Strategy.

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

**Evidence:** Building on the 2012 National Strategy for Suicide Prevention — a joint effort between the Office of the U.S. Surgeon General and the Action Alliance for Suicide Prevention — and a complement to the Department of Defense Strategy for Suicide Prevention, the National Strategy for Preventing Veteran Suicide encompasses four interconnected directional components:

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

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

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

These components are:

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

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

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

In 2021, VHA Innovation Ecosystem with SPP Innovation initiated efforts towards the development of the Suicide Prevention Grand Challenge (SPGC) to foster innovative problem solving focused on suicide prevention. Done through a partner-driven, open innovation approach using competition-style events, multiple outcomes can emerge from a structured Grand Challenge process versus a single solution derived from a pre-defined procurement mechanism. The VA Suicide Prevention Grand Challenge (SPGC) will rapidly source innovative solutions for suicide prevention from a variety of entities (academia, industry, non-profits, other government agencies, community partners, and Veteran-service organizations) with the goal of reducing Veteran suicide by 10%. On May 23, 2022, Phase 1 of VA Suicide Prevention Grand Challenge (SPGC) will launch; the challenge will call on a broad cross section of innovators to submit a wide range of solutions to address the core challenges in Veteran suicide prevention today. Solution areas will include digital life data and early warning systems, improved access to Veterans Crisis Line (VCL) services, and firearm suicide prevention and lethal means safety, in addition to other key areas of impact. Phase 2 will launch November 2022 and winners will be announce December 2022.

Beginning in 2023, this line item will also include the incorporation of any necessary sustainment efforts related to Executive Order (EO) 13861, signed on March 5, 2019, the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS). As of June 2022, PREVENTS will have completed the requirements of EO 13861. Ongoing efforts from PREVENTS will move into sustainment in alignment with the overarching National Strategy for Preventing Veteran Suicide (2018), the White House National Military, and Veteran Suicide Prevention Strategy (2021) and will include ongoing increased focus on lethal means safety effort,

public health campaigns, and community-based prevention strategies with ongoing program evaluation and research to expand implementation of practices in collaboration with other Federal agencies as part of the Administration's efforts at the national level. These areas are covered in other topics within this narrative. The PREVENTS Office staff will continue to move forward these efforts in a streamlined manner with the Suicide Prevention Program efforts underway.

SPP's Now plan, originally launched in 2020, aims to initiate quick deployment of interventions deemed to impact Veterans at high risk for suicide within one year's time. The five current areas of focus are: 1) Lethal means safety, 2) Suicide prevention in specific medical populations, 3) Outreach to and understanding of prior Veterans Health Administration (VHA) users, 4) Suicide Prevention Program enhancements, and 5) Paid media. In 2023, funding will support each year's iteration of the Now plan, which will be informed based on prior year's efforts and supporting data.

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

**Demonstration Projects**

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

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

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

1. **Clinical Practice Guidelines Implementation**: - In 2019, the updated VA/DoD Clinical Practice Guideline (CPG) for the Assessment and Management of Patients at Risk for Suicide was released, along with associated training materials (Patient and Provider Tools; Webinar; Guideline links: https://www.healthquality.va.gov/guidelines/MH/srb/) Within the CPG, 22 recommendations are provided regarding: Screening and Evaluation; Risk Management and Treatment; and Other Management Modalities. Efforts to date have focused on disseminating and implementing the CPGs across the enterprise, as well as facilitating uptake among community providers treating Veterans. As of the fourth

quarter of 2021, the live monthly CPG lecture series continues, with an average of 209 attendees per lecture. Each live lecture is recorded and turned into an enduring Talent Management System (TMS) and VHA Training Finder Real-time Affiliate-Integrated Network (TRAIN) course. In 2021, recorded CPG lectures were viewed 497 times through TMS. Continuing education credits are available to those working in VA and the community for each course. In the fourth quarter of 2021, the VA/DoD CPG "Guide to the Guide" website, a public facing website that provides information on how to implement the CPG recommendations, was finalized and launched: https://www.mirecc.va.gov/visn19/cpg/. A live webinar (which was recorded) was held regarding the website launch and presented on the Governor's and Mayor's Challenge monthly call. Further, the release of the updated CPGs was the impetus for the development of the clinical components for the "Suicide Prevention 2.0 Initiative" (see specific SP 2.0-line-item details below).

2. **Native American Veteran Suicide Prevention**: The overall goal of this project is to advance suicide prevention for Native American Veterans, a group at high-risk of suicide. In partnership with Tribal communities, this effort will develop and strategically test a model of suicide prevention that integrates VA evidence-based, system-wide approaches with culturally grounded Native American perspectives, traditions, and practices. Efforts will focus on expanding partnerships, piloting adapted tools and materials and prepare for national dissemination. In Puget Sound, 29 tribes have been contacted by local Suicide Prevention Coordinators to establish partnerships and in Iron Mountain, three tribes have been contacted. As of the fourth quarter of 2021, the project team has completed 3 pilots of the Native Veteran adapted SAVE training, and cross-trained two more VAMC suicide prevention teams on how to conduct the adapted SAVE training. Additional pilot trainings with Tribal communities will continue through 2022.
3. **Assessing Social and Community Environments with National Data (ASCEND) for Veteran Suicide Prevention:** The overarching goal of ASCEND is to design and implement a recurring national survey of Veterans that will serve as a national surveillance system to document prevalence and trends over time in non-fatal suicidal self-directed violence and provide estimates of the impact of social and community risk and protective factors in Veterans using and not using VHA care. Project development and implementation continues as a partnership between VA investigators, the vendor team, and the ASCEND Veterans Engagement Board (VEB). As of the fourth quarter of 2021, VEB continues to convene monthly or more and additional members have been recruited to increase VEB diversity. Pilot Survey data collection was completed February 2, 2021 and total surveys collected exceeded expectations, with 567 completes from 3,796 individuals contacted. The Pilot Survey sampling approach resulted in meeting or exceeding the number of targets completes for three out of four key Veteran subgroups. Pilot data analyses have been completed, including analysis of COVID-19 suicidal ideation data, and results are being used to inform the National Launch and refinements to the national survey instrument.
4. **Comparative Effectiveness of Mental Health Apps for Veterans with Anxiety and Mood Disorders:** This project will recruit Veterans to assess 9 digital interventions identified as best-practices and were created by different technology organizations or

developed by the Department of Veterans Affairs (e.g., the VA's Mood Coach, Mindfulness Coach). Over the course of the project, the three-month remission of anxiety and depressive (A/D) disorder symptoms will be assessed. The project goal is to develop an *individualized intervention rule (IIR)* using information from the baseline assessment to determine which of the best-practice interventions is likely to be optimal for each Veteran in promoting three-month remission of A/D disorder symptoms. The project is now poised to begin Veteran recruitment in December 2021 with final Veteran follow up assessments to be conducted in throughout 2022.

5. **Improving Safe Firearm Storage in Veterans**: A new project for 2022 is to conduct a feasibility and acceptability pilot of a novel firearm safety storage and mental health crisis planning intervention. Reducing access to lethal means, including firearms, is one of few universal suicide prevention strategies supported by evidence. Securing household firearms (i.e., unloaded, locked, with ammunition stored separately) is one method for reducing access and has been associated with reduced suicide rates in civilian populations (Grossman et al., 2005; Shenassa et al., 2003). Reciprocally, unsafe firearm storage practices are associated with increases in suicide death, among both active-duty military populations and civilians (Anestis et al., 2017; Dempsey et al., 2019; ; Kung et al., 2003; Miller et al., 2012; Shenassa et al., 2003). Collectively, safe storage and reducing access during at-risk periods are potential strategies to reduce suicide risk, yet there are limited broad-scale interventions to date. This pilot will aim to engage Veterans and their identified Concerned Significant Other (CSO) in conversations about safe firearm storage, how the CSO can identify warning signs for mental health symptoms or suicide risk, and how the Veteran and CSO can create a collaborative safe storage plan.
6. **Understanding Suicide Risk and Enhancing Suicide Prevention among Asian American and Pacific Islander (AAPI) Veterans:** This project, new in 2022, seeks to understand AAPI Veterans who died by suicide in terms of demographics, military service, social determinants of health, suicide methods, VA healthcare utilization, and circumstances surrounding death. The project will examine differences in these factors between AAPI and non-AAPI Veterans who died by suicide, identify suicide prevention services received, suicide prevention barriers, and opportunities for prevention among AAPI Veterans who received VHA services prior to death and explore the role of geography in suicide among AAPI Veterans. Finally, the project will identify suicide prevention needs, barriers, and facilitators, as well as critical next steps for enhancing suicide prevention care and reducing suicide among AAPI Veterans. Based on the findings obtained across these aims, the project will then seek to adapt and pilot test existing, evidence-based outpatient interventions for suicidal self-directed violence (e.g., Safety Planning, Caring Contacts) for AAPI Veterans and further develop and disseminate culturally relevant suicide prevention resources and materials to enhance suicide risk assessment and intervention for AAPI Veterans.

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

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

**COVID-19:** Some existing projects have had minor impacts due to COVID and the need for physical distancing, but the project teams are working on developing alternative approaches to out reaching Veterans.

**Suicide Prevention 2.0 Initiative (SP 2.0 Initiative)**

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

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

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

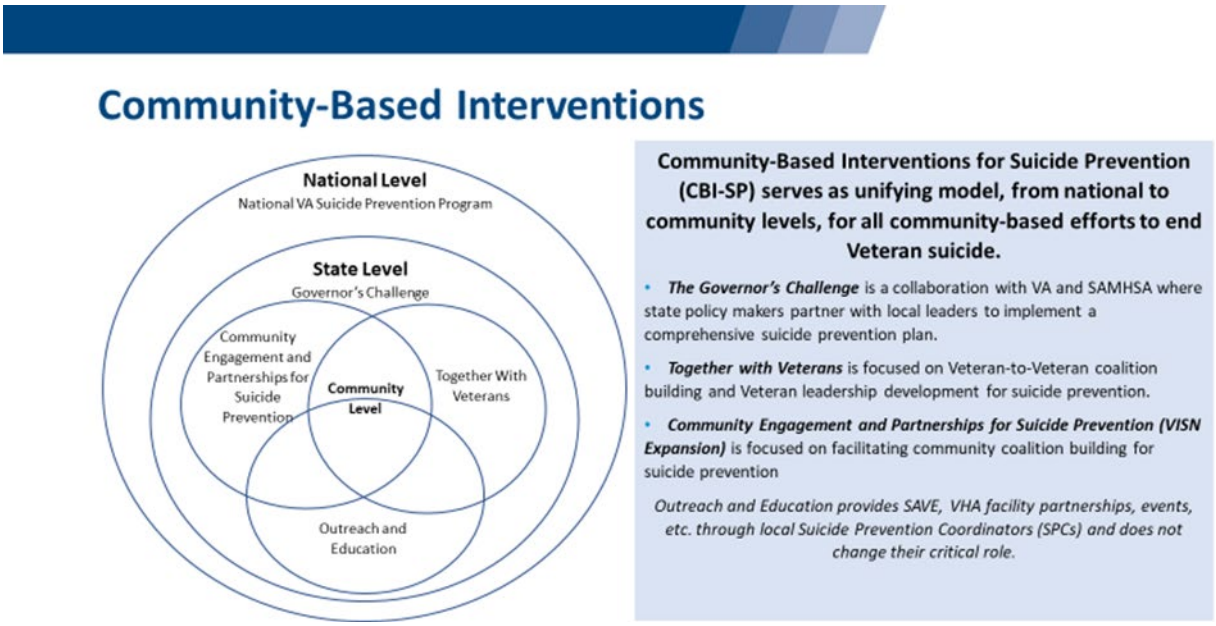


Figure 1: SP 2.0 – Community-Based Prevention

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

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

SP 2.0 Clinical Telehealth interventions target Veterans with a history of suicidal self-directed violence in the past 12 months.

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

Implementation of SP 2.0 is focused on developing both clinical and community-based approaches to reducing Veteran suicide. These strategies are evidence-based and address gaps in existing VA suicide prevention programs, which have been primarily focused on internal strategies to reach Veterans within our system.

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

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

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

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

**Implementation**: SP 2.0 started in the fourth quarter of 2020 with the phased implementation continuing through 2023 and moving to sustainment in 2023 and 2024. In the fourth quarter of 2020, for the community component of SP 2.0, four VISNs, identified as early adopters, began implementation of SP 2.0 community-based intervention strategies. In 2021, five additional VISNs were selected to start in the second quarter and the remaining nine VISNs started in the second quarter of 2022.

Additionally, the 35 states in the Governors Challenge remain engaged with technical assistance around implementation of action plans. The remaining states and territories have been invited join in 2022. By the end of the phased roll out in 2023, the CBI-SP will have expanded to all 18 VISNs and all 50 states will have been invited to participate in the Governor's Challenge.

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

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

SP 2.0 Clinical Telehealth is in its final stage of phased implementation roll out. The program has hired over 90 psychotherapists (at least 1 psychotherapist in each of the 18 VISNs), and over 90% of therapists are trained in 1, 2, 3 or 4 of the evidence-based protocols. By the end of quarter two of 2022, every VISN will have at least one therapist trained to deliver evidence-based suicide prevention treatment. SP2.0 Clinical Telehealth is currently accessible in 67% of the Health Care Systems across the country with a goal of reaching 100% of the HCS by the end of 2022.

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

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

- Increased awareness and utilization of suicide prevention resources for Veterans
- Lowered stigma and increased willingness to seek care
- Increased availability of suicide prevention-specific evidence based clinical treatments for Veterans at risk

- Increased state and community coalitions
- Increased policies and programs being implemented in the six key priority areas by local communities
- Increase collaboration between communities and VA facilities to support Veterans in need
- Decrease in Veteran suicide attempts and behaviors, and Veteran suicides

Across the spectrum of SP 2.0, the National Suicide Prevention Program anticipates supporting 424 FTE in 2023. The National Suicide Prevention Program will continue to provide minimal sustainment funding based on assessed need.

**COVID-19**: The National Suicide Prevention Program is currently working with its partners to continue to support Governor's Challenge teams and community-based coalitions during the COVID-19 pandemic. Despite limitations on travel and face-to-face engagement, Community Engagement and Partnership Coordinators have been able to establish new community coalitions. Together with Veterans continues to be implemented in existing communities and several graduated sites are operating independently. For Governor's Challenge, VA/SAMHSA technical assistance activities shifted to a virtual setting. State teams adjusted their action plans and programming to take COVID-19 considerations into account, such as an increased focus on messaging campaigns and virtual trainings. Despite COVID-19, 20 new states joined the Governor's Challenge in 2020 and completed all activities virtually and an additional eight states joined in 2021 using an all-virtual approach. CBI-SP Community Engagement and Partnership Coordinators were largely hired and trained (~100) during the pandemic and in 2021 those CEPCs added 150 coalitions working to end Veteran suicide.

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

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

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

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

**Evidence**: Many Veterans who die by suicide have not received care from VA prior to their deaths. Specifically, 11 of the 17 Veterans who die daily by suicide have not been within VHA care for two years or more (Department of Veterans Affairs, 2020). VA recognizes the critical importance

communities play in ending suicide. Community-based and public health suicide prevention have been shown to effectively reduce suicide rates in diverse communities (Hegerl et al., 2006). This grant program will strengthen local community capacity to conduct outreach to Veterans and families, provide them with suicide prevention services, and connect them to resources within the community and VA to prevent Veteran suicide. Effective community-based suicide prevention includes both health promotion and "upstream" strategies, as well as efforts to improve the delivery of clinical and crisis services throughout the community and across partners (Caine, 2013; Lai et al., 2019; Oyama et al., 2005).

**Implementation:** Congress authorized $174.0 million to be appropriated to carry out the SSG Fox SPGP, a three-year community-based grant program that will provide resources to eligible entities serving certain Veterans and their families across the country. Eligible entities can apply for grants worth up to $750,000 and may apply to renew awards from year to year throughout the length of the program. Grants will be awarded to entities that provide or coordinate the provision of suicide prevention services for eligible individuals at risk of suicide and their families that qualify, including:

- Baseline mental health screening for risk and outreach to identify those at risk of suicide
- Education on suicide risk and prevention to families and communities
- Provision of clinical services for emergency treatment
- Case management and Peer Support services
- VA benefits assistance for eligible individuals and their families
- Assistance with obtaining and coordinating other benefits provided by the federal government, a state or local government, or an eligible entity
- Assistance with emergent needs relating to health care services, daily living services, personal financial planning and counseling, transportation services, temporary income support services, fiduciary and representative payee services, legal services to assist the eligible individual with issues that may contribute to the risk of suicide, and childcare
- Nontraditional and innovative approaches and treatment practices
- Other services necessary for improving the mental health status and well-being and reducing the suicide risk of eligible individuals and their families as VA determines appropriate

In 2021, critical program infrastructure and regulation were established to ensure successful implementation of the grants program. The first grant awards are expected in the Fall of 2022 (depending on Final Rule). Additionally, VA has established a robust program evaluation design to measure short, mid, and long-term effectiveness of the program and identify best practices after the study.

**Centers of Excellence (includes MIRECC and SMITREC)**:

**Purpose:** Funds the ongoing and sustained operational support that VHA Centers of Excellence and Program Evaluation Centers provide in supporting the National Suicide Prevention Program.

VA has two nationally recognized research centers that work in collaboration with other federal, academic, and community partners and with each other to advance the science and strategy related to suicide prevention.

1. ***Center of Excellence for Suicide Prevention:*** The mission of the Center of Excellence for Suicide Prevention (CoE-SP) is to prevent morbidity and mortality from suicidal behaviors among all Veterans using a public health approach. In pursuing its mission, the CoE-SP is guided by four overarching goals that systematically drive CoE-SP activities and align with objectives outlined in the National Strategy:

   - surveillance to define the problem
   - identification of risk/protective factors
   - development/testing of novel interventions
   - implementation of evidence-informed strategies

   Consistent with these objectives, the COE-SP manages VA's Behavioral Health Autopsy Program (BHAP) on behalf of OMHSP's Suicide Prevention Program. BHAP is designed to enhance suicide prevention efforts by systematically collecting information from all Veteran suicide deaths reported to VHA clinicians and Suicide Prevention Coordinators (SPCs). Informed by psychological autopsy methodologies, BHAP is a multifaceted quality improvement program that consists of standardized chart reviews, interviews with bereaved family members, and targeted interviews with SPCs across the nation. BHAP team members combine information collected from these three sources to better understand the characteristics and contexts of Veteran suicide, and in so doing, enhance the care and services provided to Veterans.

2. ***Rocky Mountain Mental Illness Research, Education and Clinical Center (RM MIRECC):*** The mission of RM MIRECC for Suicide Prevention is to study suicide with the goal of reducing suicidal ideation and behaviors in the Veteran population. Towards this end, the work of RM RM MIRECC is focused on promising clinical interventions, as well as the cognitive and neurobiological underpinnings of suicidal thoughts and behaviors that may lead to innovative prevention strategies. In alignment with the National Strategy, members of the RM MIRECC are working to promote Veteran wellness, provide training to clinician and community providers, and promote suicide prevention activities, education, and research. This includes developing and evaluating innovative assessment strategies, as well as upstream and downstream interventions.

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

Some specific examples of ongoing operational support include:

- **Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment** (REACH VET): Officially launched in 2017, REACH VET uses a predictive model to identify Veterans who may benefit from enhanced care. The RM MIRECC Team supports implementation of this national suicide prevention program, which includes providing clinical and technical support via the REACH VET support email group or over the phone to program coordinators and providers, monthly technical assistance calls, developing and disseminating clinical tools and resources and providing ongoing education about the program to the field. The RM MIRECC team also helps expand the use of predictive analytics for suicide risk through education about the CRISTAL and SPPRITE dashboards. Additionally, RM MIRECC offers enhanced focused support to sites who are underperforming based on national performance metrics.
- **Safety Planning in the Emergency Department** (SPED): SPED is a suicide prevention intervention required for implementation in VHA. This intervention is based on a study by Stanley and colleagues (2018) that found that Veterans identified to be at risk who received the safety planning intervention plus follow-up phone calls until they were engaged in care had 45% less suicidal behaviors in the six months following the emergency department visit, as compared to a control group. The RM MIRECC team provides implementation support to SPED Champions nationwide, which includes providing technical assistance on weekly national calls and via an email support group. The RM MIRECC team also supports the development and dissemination of SPED metrics and supports underperforming sites.
- **VA Suicide Risk Management (VA SRM) Consultation Program**: Developed and led by the RM MIRECC team, the SRM Consultation Program offers consultation to any clinician (in VA or the community) working with Veterans at risk for suicide and is founded in the Therapeutic Risk Management of the Suicidal Patient model. Recommendations made are also consistent with the VA/DoD Clinical Practice Guideline (CPG), making SRM a vehicle for dissemination of the CPG.
- **Suicide Risk Identification Strategy (Risk ID)**: Required via VHA Memorandum[21] as of 2019, Risk ID is the largest population-based suicide risk screening and evaluation strategy employed by any United States healthcare system. The RM MIRECC team continues to support national implementation and evaluation of the Risk ID requirements. Support provided includes maintaining a SharePoint site, providing technical assistance via national phone calls and email, development of a community of practice among Risk ID Champions, facilitating the design of training materials, and revising and tracking performance metrics
- **VA's Behavioral Health Autopsy Program (BHAP)**: BHAP is designed to enhance suicide prevention efforts by systematically collecting information for all Veteran suicide deaths reported to VHA clinicians and Suicide Prevention Coordinators (SPCs). BHAP is a multifaceted quality improvement program that consists of standardized chart reviews, interviews with bereaved family members, and targeted interviews with

[21] Suicide Risk Identification and Management - Memo_11-13-20_Eliminating_Veterans_Suicide-Suicide_Risk_Screening_and_Evaluation-RISK_ID_Strategy.pdf - All Documents (sharepoint.com)

SPCs across the nation. BHAP combines information collected from these three sources (i.e., chart reviews, family members, and SPCs) to better understand the characteristics and contexts of Veteran suicide, and in so doing, enhance the care and services provided to Veterans.

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

*REACH VET:* By September 30, 2021, the percentage of Veterans targeted through predictive modeling algorithms (REACH VET) within the VHA system will reach 95% across the four required metrics (Coordinator Accepted; Provider Accepted; Care Evaluation; Outreach Attempted) and 80% for Successful Outreach.

In the fourth quarter of 2021, national performance exceeded the abovementioned metrics goals.

| Metric | 2021 Q4 Performance |
|---|---|
| Coordinator Accepted | 100% |
| Provider Accepted | 99% |
| Care Evaluation | 99% |
| Outreach Attempted | 99% |
| Successful Outreach | 88% |

- Findings from the McCarthy et al., (2021)[22] evaluation of the REACH VET program indicate REACH VET patients have increased outpatient appointments, decreased percentage 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*: By September 30, 2021, VA will increase implementation of SPED to ensure completion of safety planning for eligible Veterans in the ED/Urgent Care Center (UCC) from a baseline of 34 to 90%. The effectiveness of SPED as noted above was described in the Stanley and colleagues (2018) article. The original study was conducted in VHA Emergency Departments and showed a 45% reduction in suicidal behavior.

As of the fourth quarter of 2021, attempted safety plans for SPED-eligible Veterans reached 86%.

*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

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

their treatment decisions to mitigate Veterans' risk for suicide. Silva et al. (2016) conducted a survey of mental health providers (not specific to VA) regarding their training in this area. Their findings illustrate the unfortunate irony in the vital importance of suicide risk management versus the relative lack of training generally received and confidence in skills across mental health providers. "Strikingly, most behavioral healthcare staff across the overall sample reported having received no training in suicide prevention or risk assessment…This lack of training is particularly concerning among staff with greater clinical contact, especially in primary care contexts...The staff most in need of training …may not receive adequate (if any) training." [23] These issues are of vital concern to both VA and non-VA systems of care who are treating Veterans, a population that is at higher risk for suicide than non-Veteran populations. SRM addresses this need by providing resources, training and consultation to any provider serving Veterans at risk for suicide.

The need for SRM is further evidenced by the utilization and growth of the program over time. In s 2014-2017, SRM completed under 100 consults each year with VA providers. Since that time, our completed consult volume has grown each year, with over 100 consults in fourth quarter of 2021 alone (106 consults: 98 VA, 8 community). Additionally, in fourth quarter of 2021, an average of 113 individuals attended each SRM lecture (range of attendance: 36-176).

*Risk ID:* Implementation of Risk ID is currently being measured in the Emergency Department/Urgent Care (ED/UC) setting as well as ambulatory (i.e., outpatient care). As of the fourth quarter of 2021, 84% of Veterans who had a positive suicide risk screen in the ED/UC received a timely Comprehensive Suicide Risk Evaluation (CSRE).

A new annual screening requirement in ambulatory care was implemented at the beginning of the second quarter 2021. By the end of the fourth quarter of 2021, 37% of Veterans who had the screening due and attended an appointment where it could have been completed were screened. Of those who screened positive, 64% had a timely CSRE.[24]

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., 2021). These findings suggest that C-SSRS screening helps identi Veterans at high risk of suicide and connect them with appropriate services.

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

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

[24] Bahraini NH, Matarazzo BB, Hostetter T, Reis DJ, Wade C, Brenner LA. Mental health treatment engagement following suicide risk screening in the Veterans Health Administration [Lightning talk]. DoD/VA Suicide Prevention Conference 2021; 2021 May.

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

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

**Implementation:**

***REACH VET*:** Although the REACH VET national adherence metrics are quite strong, RM MIRECC aims to reduce facility- and VISN-level variation and is aiming for facilities to hit 100% outreach of their identified REACH VET Veterans. RM MIRECC provided ongoing implementation support through technical assistance, monthly coordinator calls (~100 attendees each month), dissemination and interpretation of metrics, and development of materials. REACH VET Coordinators have anecdotally shared that leadership support has been one the strongest facilitators of this program. Most common implementation barriers (e.g., provider buy-in) have been addressed in previous years. One outstanding barrier is regarding the current REACH VET note templates. Based on feedback from the field, updates have been made to both the REACH VET coordinator and REACH VET provider national note template.

Changes include, adding clickable "tips" throughout the template to assist users filling it out and overall structure of the note templates. Examples of structure changes include more options to accurately capture specific scenarios (e.g., if Veteran is in residential/inpatient care, incarcerated, etc.). Additionally, the language of the templates have been changed to make it clear each step is required of the program not an option. These changes will decrease user workload related to manual edits they previously had to make the template and improve tracking capabilities. Based on this feedback, updates to the national templates are in development. All training materials will be updated to accompany release of the updated templates. This will include an updated online training.

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

***SPED**:* RM MIRECC continues developing metrics related to SPED implementation and uses these data to engage with high performing sites to learn best practices, which are then shared on weekly technical assistance calls. These data are also used to offer tailored technical assistance to underperforming facilities to collaboratively problem-solve around barriers to implementation.

Common barriers among underperforming facilities include a lack of dedicated mental health staff in their 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 developing training resources to ensure that the SPED intervention is delivered in a high-quality manner. RM MIRECC has also updated a national template to facilitate the development of additional SPED metrics and to improve documentation of SPED efforts.

***SRM**:* RM MIRECC is working with a marketing team to improve the dissemination of SRM to both VA and community providers via the #NeverWorryAlone marketing campaign. Examples of these efforts include: the re-designed website; the monthly 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:*** During the first quarter of 2021, VHA released VHA Memorandum 2021-11-13, *Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)*. The memo related to Risk ID, changing the strategy from a three-step process to a two-step process. It also announced a new annual screening requirement for all Veterans receiving VHA care. The VA Risk ID TMS trainings have been attended by a total of 57,771 VHA staff since 2018. The RM MIRECC team provides ongoing implementation support via weekly technical assistance calls (average weekly attendance in the fourth quarter of 2021 = 149) and email support (445 emails in the fourth quarter of 2021). Guidance documents for the field have been updated per new requirements in opioid treatment programs and are located on the SharePoint site: https://dvagov.sharepoint.com/sites/ECH/srsa/. In partnership with SPP, monthly Risk ID metrics are sent to VISN CMHOs and additional support is provided to underperforming sites.

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

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

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

**Local Facility and Community Outreach Activities:**

**Purpose**: The purpose of this line item is to provide supplemental (i.e., non-salary) funding to support SPCs in the field.

**Evidence**: VA has just under 500 dedicated employees for suicide prevention efforts located at every VA Medical Center (VAMC), to connect Veterans with care and educate the community about suicide prevention programs and resources. SPCs, Case Managers, and their teams facilitate implementation of suicide prevention strategies within their respective medical centers, including gatekeeper training to clinical and non-clinical staff and providing enhanced care and outreach to Veterans identified at high risk for suicide and those who have called the Veterans Crisis Line. Further, SPCs support community outreach and education efforts.

**Implementation**: VHA's Suicide Prevention Program provides each VAMC $5,000 to be assigned to its Suicide Prevention team. Suicide Prevention Teams are directed use the provided funding in pursuit of suicide prevention activities, with a particular emphasis on Suicide Prevention Month, which occurs every September.

# Prosthetic and Sensory Aids Services

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $3,474,096 | $4,934,098 | $3,756,341 | $4,069,980 | $4,410,880 | $313,639 | $340,900 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$3,474,096** | **$4,934,098** | **$3,756,341** | **$4,069,980** | **$4,410,880** | **$313,639** | **$340,900** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Discretionary Total** | **$3,474,096** | **$4,934,098** | **$3,756,341** | **$4,069,980** | **$4,410,880** | **$313,639** | **$340,900** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $313 | $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** | **$313** | **$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** | **$313** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $3,474,096 | $4,934,411 | $3,756,341 | **$4,069,980** | **$4,410,880** | $313,639 | $340,900 |
| Medical Community Care | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Support and Compliance | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Facilities | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| **Obligations [Grand Total]** | **$3,474,096** | **$4,934,411** | **$3,756,341** | **$4,069,980** | **$4,410,880** | **$313,639** | **$340,900** |

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

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

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

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

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

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

**Populations Covered**

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

In 2021, VA obligated $3.3 billion dollars to provide nearly 22 million devices/items to more than 3.4 million Veterans, over 50% of all Veterans treated by the VHA.

**Types of Services Provided**

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

The term "prosthetic device" refers to any device that supports or replaces loss of a body part or function including a full range of equipment and services for Veterans. This includes, but is not limited to artificial limbs, orthopedic footwear, orthopedic braces and supports, eyeglasses, hearing aids, speech communication aids, cosmetic restorations, breast prostheses, wigs, home oxygen, items that improve accessibility and mobility (e.g., ramps, vehicle modifications, wheelchairs and mobility aids), and devices surgically placed in the Veteran (e.g., implants, stents, joint

replacements, and pacemakers). PSAS is responsible for provision of these items from prescription through procurement, delivery, training, replacement, and when necessary, repair.

**Recent Trends**

- Since 2013, PSAS obligations have increased by 39% from $2.1 billion dollars to $3.3 billion dollars obligated in 2021. This is largely due to increased Veteran utilization of PSAS. Additionally, VHA data analysis processes were streamlined to improve tracking and analysis of trending and emerging PSAS items and services, and better coordinate budget projection between VHA program offices for clinical policies and services, policy analysis and forecasting, and budget.
- Since 2013, the number of unique Veterans served by PSAS has increased from 2.9 to 3.4 million Veterans in 2021, and the number of devices/items provided by PSAS since has increased by approximately 80% from 12 million to 22 million.
- Since 2017, new requests for prosthetic items that were open greater than 90 days were reduced by 91% in 2021 due to streamlined policies and procedures for consult management, efficient scheduling initiatives, development of automation systems and data tools, and trainings and resources to support the PSAS workforce.
- PSAS continued supporting Community Care and implementation of the MISSION Act for Veterans receiving durable medical equipment (DME) and medical devices in the community by updating contract modification language for DME medical devices for Community Care Network (CCN) Contracts and through development of process flows, operational procedure guides, trainings, and consult templates to streamline communication between community providers and VA staff.
- PSAS supported the Improper Payment and Elimination Recovery Act, now the Payment Integrity Information Act, by reducing the improper payment error rate by 98% since 2017 by completing quarterly audit reports, determining causes of error, developing and deploying quality assurance tools, and conducting national educational trainings to promote compliance with authorizations, payments, and documentation. PSAS is no longer recognized as a high-risk program due to implementation of internal controls to sustain low improper payment error rates.
- Since 2017, PSAS has increased national acquisition strategies by utilizing historical spend data and employing clinical requirements analysis to identify vendors best positioned to meet agency needs, awarding over 118 national contracts to multiple vendors to sustain technological advances in the commercial industry and ensure a sustained quality level of service to Veterans.

**Projections for the Future**

- The PSAS budget is projected to continue to increase as more Veterans are enrolled in the VHA, the Veteran population ages and requires more prosthetic devices and services, and as advanced technology is introduced to the market.

- Timeliness to fulfill prosthetic requests will continue improving as the VHA PSAS workforce and workload is right-sized. National staffing guidance will be developed to aid personnel management.
- PSAS continues to collaborate with internal and external partners to support VA modernization efforts in the areas of the electronic health record, supply chain and finance/budget/procurement.
    - PSAS is working with clinical partners to design clinical ordering templates for the vast majority of PSAS devices and services. The ordering templates will standardize ordering workflows and provide a mechanism to ensure that prosthetic requests from clinicians include the comprehensive information for PSAS to fulfil the request and eliminate unnecessary delays.
    - PSAS continues to work within the Office of Electronic Health Record Modernization Supply Chain Council framework to process map current business processes that will inform business process reengineering initiatives that build upon critical needs and enhance workflow efficiencies. PSAS is developing business requirements to inform the next generation of PSAS operational systems that will integrate PSAS processes with the department's modernization initiatives to maximize customer satisfaction and activate internal controls for greater accountability.
    - PSAS manages a large specific purpose budget requiring a level of system integration with patient level activity to continue using data to manage and inform policy, improve Veteran services, and provide pathways to patient level accounting for costing and third-party billing. Continued collaboration with the VA Finance community helps ensure that PSAS budget requirements are met.
- PSAS has developed templates, trainings, and operational guides for prosthetic items of national implementation of CCN contracts to support provision of the increasing number of prosthetic items to Veterans receiving care in the community.
- New Automobile Adaptive Equipment regulations (proposed rule published in the Federal Register, Document Number: 2020-04564) would provide a schedule for Automobiles and Other Conveyances to calculate the amount of the monetary allowance for adaptive equipment based on industry standards and VA experience administering this program. ***Note:*** *This program is funded through VBA's appropriations.*
    - Link to proposed rulemaking- https://www.federalregister.gov/documents/2020/03/12/2020-04564/adaptive-equipment-allowance
- Procurement and issuance procedures for prosthetic items will be improved to reduce clinical administrative burden, increase Veteran access to prosthetic items, and improve the Veteran experience by:
    - Exploring more 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.
- Reducing fraud, waste, and abuse by implementing shipment tracking and delivery confirmation for prosthetic items shipped to Veterans' residence.
- Improving inventory management practices by streamlining data system reporting and responsibilities with Supply Chain Partners for increased efficiencies.
- Transforming business practices through innovation and automation strategies through supporting 4Sight project implementation and testing to Automate eye-glass ordering.

**Prosthetics Workload**

| 2021 Prosthetic and Sensory Aids Service Category | | |
|---|---|---|
| **Commodity Type** | **Unique Orders** | **Unique Veterans** |
| Artificial Limbs | 63,745 | 33,632 |
| Dialysis | 6,604 | 4,291 |
| HISA | 11,214 | 9,642 |
| Implants | 246,342 | 157,857 |
| Medical Equipment | 3,781,217 | 1,339,274 |
| Orthotic Items | 1,351,425 | 805,047 |
| Other | 1,354,280 | 938,695 |
| Respiratory Items | 2,832,847 | 812,842 |
| Restorations | 6,935 | 5,603 |
| Sensori-Neuro Aids | 4,220,321 | 1,857,957 |
| Wheeled Mobility | 294,981 | 151,487 |
| **Total** | **14,169,911** | **6,116,327** |

# Rehabilitative Care

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $770,719 | $747,304 | $894,059 | $914,733 | $877,926 | $20,674 | ($36,807) |
| Discretionary FFCRA/CARES Act Obligations | $42,536 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$813,255** | **$747,304** | **$894,059** | **$914,733** | **$877,926** | **$20,674** | **($36,807)** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $119,059 | $113,688 | $125,800 | $169,600 | $185,000 | $43,800 | $15,400 |
| Discretionary CARES Act Obligations | $1,972 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$121,031** | **$113,688** | **$125,800** | **$169,600** | **$185,000** | **$43,800** | **$15,400** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $136,018 | $129,024 | $136,200 | $174,600 | $171,200 | $38,400 | ($3,400) |
| Discretionary CARES Act Obligations | $2,948 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$138,966** | **$129,024** | **$136,200** | **$174,600** | **$171,200** | **$38,400** | **($3,400)** |
| **Discretionary Total** | **$1,073,252** | **$990,016** | **$1,156,059** | **$1,258,933** | **$1,234,126** | **$102,874** | **($24,807)** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $77,645 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 (0160) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0160) | $62 | $63 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$62** | **$77,708** | **$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 | $6,808 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0152) | $41 | $12 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$41** | **$6,820** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $22,313 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0162) | $503 | $176 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$503** | **$22,489** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Mandatory Total** | **$606** | **$107,017** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $813,317 | $825,012 | $894,059 | **$914,733** | **$877,926** | $20,674 | ($36,807) |
| Medical Community Care | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Support and Compliance | $121,072 | $120,508 | $125,800 | **$169,600** | **$185,000** | $43,800 | $15,400 |
| Medical Facilities | $139,469 | $151,513 | $136,200 | **$174,600** | **$171,200** | $38,400 | ($3,400) |
| **Obligations [Grand Total]** | **$1,073,858** | **$1,097,033** | **$1,156,059** | **$1,258,933** | **$1,234,126** | **$102,874** | **($24,807)** |

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.

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

***Blind Rehabilitation Service***

| $ in 1,000s | | Total Obligations | Total Patients |
|---|---|---|---|
| Description | 2021 Act. | $86,000 | 12,322 |
| | 2022 BE | $159,700 | 17,675 |
| | 2022 CE | $127,400 | 17,846 |
| | 2023 RR | $126,900 | 17,426 |
| | 2024 AA | $128,600 | 17,246 |
| +/- | 2022-2023 | ($500) | -420 |
| | 2023-2024 | $1,700 | -180 |
| +/- | 2022-2023 | -0.4% | -2.4% |
| | 2023-2024 | 1.3% | -1.0% |

**Authority for Action**

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

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

**Population Covered**

Blind Rehabilitation Service (BRS) Continuum of Care is a seamless service integration ensuring Veterans and Service Members with a visual impairment receive the finest medical and rehabilitative care. The mission of BRS is to assist eligible blind and visually impaired Veterans

and service members in developing the skills needed for personal independence and successful reintegration into the community and family environment. Rehabilitation in BRS is patient-centered and interdisciplinary, developing and deploying integrated plans of care that address the Veterans' needs and goals to guide service delivery. Family members, included as members of the team, are provided with education and training that allows them to understand visual impairment and provide support for goal achievement.

**Types of Services Provided**

The specialized blind rehabilitation database provides a mechanism for coordinating system-wide care, management and data analyses. BRS personnel evaluate and determine best practices for selecting, training and providing Veterans with cutting-edge technology for peak performance. BRS programs provide a model of care that extends from the Veteran's home to the local VA care site, regional low vision clinics, and lodger and inpatient training programs. Components of the model include the following:

- 13 inpatient blind rehabilitation centers;
- 9 outpatient blind rehabilitation clinics;
- 22 intermediate low vision clinics;
- 22 advance low vision clinics
- 163 Visual Impairment Services Team (VIST) Coordinators (case managers) for severely disabled blind Veterans; and
- 95 Blind Rehabilitation Outpatient Specialists (BROS) who provide care at VA medical facilities and in Veterans' homes. BROS are assigned at Polytrauma Centers and other sites of care to support the care of Servicemembers and Veterans whose injuries and disorders include vision loss.

**Recent Trends**

Recent trends in BRS Continuum of Care services include:

- ***Shift in Demographics of Population Served***. Trends in visual impairment and blindness among Veterans show a rise in the incidence of age-related macular degeneration and diabetic retinopathy among aging Veterans. This is treatable early with intravitreal anti-vascular endothelial growth factor (VEGF) injections delaying the onset of severe visual impairment. Older patients with visual impairment also experience increased co-morbidities. The combination of vision impairment and other health conditions substantially compromises their performance of activities and social participation.
- ***Workforce Management***. Development of a new monitor for workload productivity of BRS clinical disciplines permits a more detailed and current analysis of staffing distribution and workload of providers, as well the ability to pinpoint other opportunities for improvement that may exist in a local VA facility.
- ***Professional Development.*** Within the Blind Rehabilitation field, there is increased competition for certified specialists that can manage rapidly evolving technology and

address the needs of a shift in the demographic of persons served. VA is currently experiencing a shortage of providers in the continuum of care with certifications as Certified Low Vision Therapist (CLVT) and Computer Assistive Technology Instructor Specialist (CATIS). VA professional qualification standards require that BRS providers must hold an active certification or license in one of the following disciplines to practice at full performance level: CLVT, CATIS, Certified Orientation & Mobility (COMS), or Certified Vision Rehabilitation Teaching (CVRT). VA implemented the Visual Impairment Orientation and Mobility Professionals Scholarship Program (VIOMPSP) to develop young professionals entering the field. Since the implementation of VIOMPSP in 2015, BRS has provided 29 graduate training scholarships to help provide a much-needed supply of future professionals available to enter the specialty of Blind Rehabilitation.

- ***Emerging Technology***. VA BRS are more comprehensive than services provided in the civilian community. Since the release of smartphones and tablets, Computer Access Training Programs have become one of the primary referrals for blind rehabilitation. The increasing use of portable electronic hand-held magnification devices will continue to replace earlier desktop and bulky magnification systems previously used by severely visually impaired Veterans. The current renewal of a national VA contract for such devices clearly recognizes this trend and has positioned VA to effectively meet this growing trend and demand for our Veteran population. Similarly, other "smart" devices in the home environment that provide access to immediate information and communication to the outside world (e.g., Alexa, Amazon Echo, etc.) represent another growing area of assistive technology that is anticipated to become widely adopted among our patient population.
- ***Tele-Rehabilitation***. VA BRS professionals' involvement in Telerehabilitation is an emerging practice area and requires VHA practitioners to stay abreast of current technology, utilize evidence, and optimize continued education opportunities to obtain and maintain competency in using telehealth to deliver services. BRS telehealth encounters in VA increased from 1,238 in 2018 to 1,580 encounters in 2021, a 27.6% increase.

**Projections for the Future**

Projections for VA BRS Continuum of Care include:

- Addressing the shift in demographics of population served
- While still a small percentage of the overall Veteran population, female Veterans who will need to receive BRS will continue to grow as the overall number of female Veterans receiving care with VHA increases in the coming years. VA must ensure appropriate planning and programmatic posture to best meet the needs of this growing female Veteran population, particularly in our residential inpatient Blind Rehab Centers.
- Inpatient Blind Rehabilitation Center programs will continue to adapt to the changing demands and needs of our Veteran population, with growing availability of specialty and technology-focused treatment options being provided. In 2019 inpatient BRC's discharged 2,410 Veterans. Among this total, 1,348 (55.1%) received training related to technology-related devices and equipment. This changing demand for services that are more individualized and targeted will continue to shorten length of stays in some facilities and will increasingly push BRS staff to develop additional training capacity and SME-

knowledge related to training with this new and emerging technology. For a future workforce within VA to be highly effective and forward leaning to meet these future needs, BRS must adopt an ambitious goal of provider skill development with assistive technology for all staff who provide care to our Veteran population.

- ***Workload Productivity***. In the future years, BRS will continue to monitor and maximize clinician productivity and programmatic efficiency within this specialized discipline to enhance and expedite Veteran access to BRS care, services and treatment. The Productivity metric benchmarks of all BRS Providers will fall into the Inner-Quartile Range ($25^{th}$ to $75^{th}$ percentile), with an expectation of 50th percentile or higher.
- ***Workforce Development***. Over the next five years, BRS plans to partner with various universities to provide staff with the skills, tools, and resources to excel in their area of care and empower them to honor their potential. Specifically, BRS will focus on low vision therapy courses and assistive technology workshops that will result in a provider's ability to obtain professional certification. Enhancing workforce development by engaging in best practices, expanding opportunities for continuing education, will also assist with succession planning, staff retention, and overall job satisfaction for the benefit of all stakeholders.
- ***Emerging Technology***. The rapid proliferation, adoption and reliance on accessible technology among our Veteran population, particularly involving smart-phones, smart-tablets and other similar portable devices that promote independence, autonomy and mobility will continue to grow dramatically. Another burgeoning area of emerging technology that will impact this Veteran population is the growth in head-mounted electronic magnification and optical enhancement devices that will provide exciting new modalities for Veterans managing visual impairment. The implications of this emerging technological innovation include increasing need to incorporate this training utilizing these platforms across virtually facets of BRS (inpatient and outpatient), as well as across all disciplines and modalities of training areas with which BRS teams.
- ***Tele-Rehabilitation***. The expected benefits of Blind Telerehabilitation includes increased clinical capacity, resulting in improved access to BRS closer to the Veterans' home, and better continuity of care. Seamless access to care across the health care continuum has proven to decrease hospitalizations, emergency room encounters, and pharmacy costs, as well as improve access to other specialty medical services.
- ***Adoption of Alternative Modalities for Rehabilitation and Care***. An increase in the utilization tele-rehabilitation as a viable platform and alternative for face-to-face clinical care has been demonstrated in past years and represents and exciting new mechanism to improve timeliness and access to BRS programs.

*Spinal Cord Injuries and Disorders*

| $ in 1,000s | | Total Obligations | Total Patients |
|---|---|---|---|
| Description | 2021 Act. | $653,300 | 13,261 |
| | 2022 BE | $684,500 | 14,386 |
| | 2022 CE | $717,900 | 14,157 |
| | 2023 RR | $733,500 | 14,155 |
| | 2024 AA | $751,500 | 14,163 |
| +/- | 2022-2023 | $15,600 | -2 |
| | 2023-2024 | $18,000 | 8 |
| +/- | 2022-2023 | 2.2% | 0.0% |
| | 2023-2024 | 2.5% | 0.1% |

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

**Populations Covered**

The SCI/D System of Care provides lifelong care for all enrolled Veterans who have spinal cord injuries and disorders. Active Duty Service Members are also provided care as established by Memoranda of Agreement between VA and the Department of Defense, most recently under "Memorandum of Agreement between the Department of Veterans Affairs (VA) and the DoD for Medical Treatment Provided to Active Duty Service Members (ADSM) with Spinal Cord Injury, Traumatic Brain Injury, Blindness, or Polytraumatic Injuries" and "Memorandum of Understanding between Veteran Affairs (VA) and DoD For Interagency Complex Care Coordination Requirements for Service Members and Veterans of 29 July 2015."

**Types of Services Provided**

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

The SCI/D System of Care provides the full continuum of services, including acute rehabilitation, sustaining medical/surgical treatment; primary and preventive care including annual evaluations, provisions for prosthetics and durable medical equipment, and unique SCI/D care such as ventilator management, home-based care, telehealth, respite care, long term care, and end-of-life

care. Several inter-connected SCI/D programs and activities coordinate and extend care including SCI/D telehealth, SCI/D home care, and other non-institutional care programs. There are also dedicated institutional SCI/D long-term care units at six (6) SCI/D Centers.

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

**Recent Trends**

- ***COVID-19***

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

- ***Bowel & Bladder Program***

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

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

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

there is an existing SCI/D uSPEQ Patient Experience PowerBI data product and a forthcoming SCI/D Registry and Critical Population Information PowerBI data product.

**Projections for the Future**

- ***SCI/D Telehealth***

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

- ***SCI/D Data and Outcomes***

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

- ***Transition to New Cerner Electronic Health Record***

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

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

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

- Obligations by Program and overall Average Daily Census and Per Diem
- Institutional Programs:
  - Average Daily Census by Long & Short Stay
  - Patients Treated by Long & Short Stay
  - Obligations by Long & Short Stay
  - Per Diem by Long & Short Stay
- Non-Institutional Obligations & Clinic Stops/Procedures
- Obligations by Appropriation for the following VA System Provided
  - VA Community Living Centers
  - Community Residential Care
  - Home Telehealth
  - Home-Based Primary Care
  - Spinal Cord Injury & Disability Home Care
  - VA Adult Day Health Care
- Obligations by Appropriation for the following Non-VA Providers
  - Community Nursing Home
  - State Home Nursing
  - State Home Domiciliary
  - State Home Adult Day Health Care
  - Community Adult Day Health Care
  - Home Hospice Care
  - Home Respite Care
  - Homemaker/Home Health Aide Programs
  - Purchased Skilled Care
- 2021 Unique Patients using Non-Institutional Long-Term Supportive Services by Fund

# Obligations by Program and Overall Average Daily Census and Per Diem

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Obligations ($000)** | | | | | | | |
| Institutional | | | | | | | |
| Community Nursing Home | $1,257,935 | $1,907,731 | $1,402,472 | $1,550,526 | $1,668,076 | $148,054 | $117,550 |
| State Home Domiciliary | $44,096 | $56,357 | $51,632 | $49,095 | $48,729 | ($2,537) | ($366) |
| State Home Nursing | $1,503,738 | $1,707,451 | $1,403,639 | $1,490,482 | $1,496,039 | $86,843 | $5,557 |
| VA Community Living Centers | $4,514,583 | $4,423,856 | $4,650,213 | $4,942,654 | $5,093,007 | $292,441 | $150,353 |
| Institutional Obligations [Total] | **$7,320,352** | **$8,095,395** | **$7,507,956** | **$8,032,757** | **$8,305,851** | $524,801 | $273,094 |
| Non-Institutional | | | | | | | |
| Community Adult Day Health Care | $157,323 | $236,193 | $196,757 | $220,338 | $233,372 | $23,581 | $13,034 |
| Community Residential Care | $85,285 | $100,822 | $83,049 | $86,238 | $85,941 | $3,189 | ($297) |
| Home Hospice Care | $30,944 | $105,292 | $32,802 | $35,158 | $36,810 | $2,356 | $1,652 |
| Home Respite Care | $77,513 | $56,167 | $86,922 | $96,900 | $105,260 | $9,978 | $8,360 |
| Home Telehealth | $315,834 | $276,726 | $328,481 | $345,103 | $357,174 | $16,622 | $12,071 |
| Home-Based Primary Care | $1,046,097 | $1,092,667 | $1,115,662 | $1,221,183 | $1,300,463 | $105,521 | $79,280 |
| Homemaker/Home Health Aide Prgs. | $1,160,708 | $1,141,134 | $1,316,192 | $1,432,533 | $1,518,921 | $116,341 | $86,388 |
| Purchased Skilled Home Care | $518,665 | $635,182 | $553,823 | $599,848 | $632,270 | $46,025 | $32,422 |
| Spinal Cord Injury & Disability Home Care | $11,387 | $12,778 | $11,465 | $12,184 | $12,594 | $719 | $410 |
| State Home Adult Day Health Care | $1,780 | $4,734 | $1,034 | $1,286 | $1,086 | $252 | ($200) |
| VA Adult Day Health Care | $1,594 | $14,987 | $1,628 | $1,825 | $1,943 | $197 | $118 |
| Non-Institutional Obligations [Total] | $3,407,130 | $3,676,682 | $3,727,815 | $4,052,596 | $4,285,834 | $324,781 | $233,238 |
| Long-Term Services & Supports Obligations [Total] | $10,727,482 | $11,772,077 | $11,235,771 | $12,085,353 | $12,591,685 | $849,582 | $506,332 |
| **Institutional Average Daily Census** | | | | | | | |
| Community Nursing Home | 9,928 | 11,566 | 11,612 | 12,205 | 12,797 | 593 | 593 |
| State Home Domiciliary | 2,342 | 2,717 | 2,512 | 2,691 | 2,706 | 179 | 15 |
| State Home Nursing | 14,449 | 19,587 | 19,526 | 19,235 | 18,944 | (291) | (291) |
| VA Community Living Centers | 6,684 | 8,374 | 8,302 | 7,902 | 7,502 | (400) | (400) |
| Institutional Average Daily Census [Total] | 33,403 | 42,244 | 41,952 | 42,033 | 41,949 | 80 | (84) |
| **Institutional Per Diem** | | | | | | | |
| Community Nursing Home | $347.12 | $451.90 | $330.90 | $348.07 | $356.14 | $17.17 | $8.07 |
| State Home Domiciliary | $51.60 | $56.83 | $56.31 | $49.98 | $49.20 | ($6.33) | ($0.78) |
| State Home Nursing | $285.13 | $238.83 | $196.94 | $212.29 | $215.77 | $15.35 | $3.48 |
| VA Community Living Centers | $1,850.39 | $1,447.30 | $1,534.60 | $1,713.70 | $1,854.93 | $179.10 | $141.23 |
| Institutional Per Diem [Total] | $600.42 | $525.02 | $490.31 | $523.58 | $540.98 | $33.27 | $17.40 |

# Average Daily Census

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Nursing Home Average Daily Census, Long & Short Stay** | | | | | | | |
| Community Nursing Home | | | | | | | |
| Long Stay | 8,039 | 9,312 | 9,402 | 9,882 | 10,362 | 480 | 480 |
| Short Stay | 1,889 | 2,254 | 2,210 | 2,322 | 2,435 | 113 | 113 |
| Community Nursing Home Stays [Total] | 9,928 | 11,566 | 11,612 | 12,205 | 12,797 | 593 | 593 |
| State Home Nursing | | | | | | | |
| Long Stay | 13,860 | 18,834 | 18,730 | 18,451 | 18,172 | (279) | (279) |
| Short Stay | 589 | 753 | 796 | 784 | 772 | (12) | (12) |
| State Nursing Home Stays [Total] | 14,449 | 19,587 | 19,526 | 19,235 | 18,944 | (291) | (291) |
| VA Community Living Centers | | | | | | | |
| Long Stay | 5,357 | 6,345 | 6,653 | 6,332 | 6,012 | (321) | (321) |
| Short Stay | 1,328 | 2,029 | 1,649 | 1,569 | 1,490 | (79) | (79) |
| VA Community Living Centers Stays [Total] | 6,684 | 8,374 | 8,302 | 7,902 | 7,502 | (400) | (400) |
| All Nursing Home Average Daily Census, Long & Short Stay [Grand Total] | 31,062 | 39,527 | 39,440 | 39,342 | 39,243 | (99) | (99) |
| **Nursing Home Average Daily Census by Age** | | | | | | | |
| Community Nursing Home | | | | | | | |
| < 65 | 1,041 | 1,236 | 1,217 | 1,279 | 1,342 | 62 | 62 |
| 65 to 84 | 6,917 | 7,589 | 8,090 | 8,503 | 8,915 | 413 | 413 |
| > 84 | 1,971 | 2,741 | 2,305 | 2,423 | 2,540 | 118 | 118 |
| Community Nursing Home Stays [Total] | 9,928 | 11,566 | 11,612 | 12,205 | 12,797 | 593 | 593 |
| State Home Nursing | | | | | | | |
| <65 | 695 | 865 | 939 | 925 | 911 | (14) | (14) |
| 65 to 84 | 8,215 | 9,969 | 11,102 | 10,937 | 10,771 | (166) | (166) |
| > 84 | 5,538 | 8,754 | 7,485 | 7,373 | 7,262 | (112) | (112) |
| State Home Nursing Stays [Total] | 14,449 | 19,587 | 19,526 | 19,235 | 18,944 | (291) | (291) |
| VA Community Living Centers | | | | | | | |
| < 65 | 883 | 1,274 | 1,096 | 1,043 | 991 | (53) | (53) |
| 65 to 84 | 4,621 | 5,445 | 5,739 | 5,463 | 5,186 | (277) | (277) |
| > 84 | 1,181 | 1,655 | 1,467 | 1,396 | 1,325 | (71) | (71) |
| VA Community Living Centers Stays [Total] | 6,684 | 8,374 | 8,302 | 7,902 | 7,502 | (400) | (400) |
| All Nursing Home Average Daily Census by Age [Grand Total] | 31,062 | 39,527 | 39,440 | 39,342 | 39,243 | (99) | (99) |
| **Nursing Home Average Daily Census by Priority 1A, SC & Non-SC** | | | | | | | |
| Community Nursing Home | | | | | | | |
| Priority 1A | 8,211 | 9,421 | 9,604 | 10,094 | 10,584 | 490 | 490 |
| Non-Service Connected | 1,029 | 1,299 | 1,204 | 1,265 | 1,327 | 61 | 61 |
| Service-Connected | 688 | 847 | 804 | 845 | 887 | 41 | 41 |
| Community Nursing Home Stays [Total] | 9,928 | 11,566 | 11,612 | 12,205 | 12,797 | 593 | 593 |
| State Home Nursing | | | | | | | |
| Priority 1A | 4,162 | 5,089 | 5,625 | 5,541 | 5,457 | (84) | (84) |
| Non-Service Connected | 7,812 | 11,173 | 10,557 | 10,399 | 10,242 | (157) | (157) |
| Service-Connected | 2,475 | 3,325 | 3,344 | 3,295 | 3,245 | (50) | (50) |
| State Home Nursing Stays [Total] | 14,449 | 19,587 | 19,526 | 19,235 | 18,944 | (291) | (291) |
| VA Community Living Centers | | | | | | | |
| Priority 1A | 4,006 | 4,918 | 4,976 | 4,736 | 4,496 | (240) | (240) |
| Non-Service Connected | 1,779 | 2,355 | 2,210 | 2,104 | 1,997 | (107) | (107) |
| Service-Connected | 899 | 2,273 | 1,116 | 1,062 | 1,009 | (54) | (54) |
| VA Community Living Centers Stays [Total] | 6,684 | 8,374 | 8,302 | 7,902 | 7,502 | (400) | (400) |
| All Nursing Home Stays by Priority 1A, SC & Non-SC [Total] | 31,062 | 39,527 | 39,440 | 39,342 | 39,243 | (99) | (99) |

# Patients Treated

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Patients Treated by Long & Short Stay** | | | | | | | |
| Community Nursing Home | | | | | | | |
| Long Stay | 11,574 | 13,825 | 12,359 | 13,145 | 13,930 | 785 | 785 |
| Short Stay | 24,099 | 32,394 | 25,734 | 27,369 | 29,004 | 1,635 | 1,635 |
| Community Nursing Home Patients Trtd., [Total] | 35,673 | 46,219 | 38,093 | 40,514 | 42,934 | 2,420 | 2,420 |
| State Home Nursing | | | | | | | |
| Long Stay | 17,853 | 22,959 | 20,564 | 21,477 | 21,807 | 913 | 329 |
| Short Stay | 4,632 | 6,185 | 5,554 | 6,004 | 6,331 | 451 | 327 |
| State Home Nursing Patients Trtd., [Total] | 22,484 | 29,144 | 26,118 | 27,482 | 28,138 | 1,364 | 656 |
| VA Community Living Centers | | | | | | | |
| Long Stay | 7,326 | 8,938 | 12,234 | 12,068 | 12,068 | (166) | 0 |
| Short Stay | 18,998 | 32,162 | 31,725 | 31,296 | 31,296 | (429) | 0 |
| VA Community Living Centers Patients Trtd., [Total] | 26,324 | 41,100 | 43,959 | 43,364 | 43,364 | (595) | 0 |
| Grand Total Patients Treated by Long & Short Stay | 84,481 | 116,463 | 108,171 | 111,360 | 114,436 | 3,189 | 3,077 |
| **Patients Treated by Age** | | | | | | | |
| Community Nursing Home | | | | | | | |
| < 65 | 4,035 | 5,530 | 4,309 | 4,583 | 4,856 | 274 | 274 |
| 65 to 84 | 23,590 | 28,893 | 25,191 | 26,791 | 28,392 | 1,601 | 1,601 |
| > 84 | 8,048 | 11,796 | 8,594 | 9,140 | 9,686 | 546 | 546 |
| Community Nursing Home Stays [Total] | 35,673 | 46,219 | 38,093 | 40,514 | 42,934 | 2,420 | 2,420 |
| State Home Nursing | | | | | | | |
| < 65 | 971 | 1,087 | 1,128 | 1,187 | 1,381 | 59 | 194 |
| 65 to 84 | 12,580 | 14,151 | 14,613 | 15,376 | 15,296 | 763 | (80) |
| > 84 | 8,933 | 13,906 | 10,377 | 10,919 | 11,462 | 542 | 543 |
| State Home Nursing Stays [Total] | 22,484 | 29,144 | 26,118 | 27,482 | 28,138 | 1,364 | 656 |
| VA Community Living Centers | | | | | | | |
| < 65 | 4,032 | 6,877 | 6,733 | 6,642 | 6,642 | (91) | 0 |
| 65 to 84 | 17,610 | 25,729 | 29,407 | 29,009 | 29,009 | (398) | 0 |
| > 84 | 4,682 | 8,494 | 7,819 | 7,713 | 7,713 | (106) | 0 |
| VA Community Living Centers Stays [Total] | 26,324 | 41,100 | 43,959 | 43,364 | 43,364 | (595) | 0 |
| All Patients Treated by Age [Grand Total] | 84,481 | 116,463 | 108,171 | 111,360 | 114,436 | 3,189 | 3,077 |
| **Patients Treated by Priority 1A, SC & Non-SC** | | | | | | | |
| Community Nursing Home | | | | | | | |
| Priority 1A | 23,108 | 28,022 | 24,676 | 26,244 | 27,812 | 1,568 | 1,568 |
| Non-Service Connected | 8,239 | 5,863 | 8,798 | 9,357 | 9,916 | 559 | 559 |
| Service-Connected | 4,326 | 12,334 | 4,620 | 4,913 | 5,207 | 294 | 294 |
| Community Nursing Home Stays [Total] | 35,673 | 46,219 | 38,093 | 40,514 | 42,934 | 2,420 | 2,420 |
| State Home Nursing | | | | | | | |
| Priority 1A | 6,373 | 6,067 | 7,403 | 7,790 | 7,976 | 387 | 186 |
| Non-Service Connected | 12,193 | 17,939 | 14,164 | 14,903 | 15,259 | 739 | 356 |
| Service-Connected | 3,918 | 5,138 | 4,551 | 4,789 | 4,903 | 238 | 114 |
| State Home Nursing Stays [Total] | 22,484 | 29,144 | 26,118 | 27,482 | 28,138 | 1,364 | 656 |
| VA Community Living Centers | | | | | | | |
| Priority 1A | 10,706 | 15,301 | 17,878 | 17,636 | 17,636 | (242) | 0 |
| Non-Service Connected | 10,613 | 17,698 | 17,723 | 17,483 | 17,483 | (240) | 0 |
| Service-Connected | 5,005 | 8,101 | 8,358 | 8,245 | 8,245 | (113) | 0 |
| VA Community Living Centers Stays [Total] | 26,324 | 41,100 | 43,959 | 43,364 | 43,364 | (595) | 0 |
| All Patients Treated by Priority 1A, SC & Non-SC [Total] | 84,481 | 116,463 | 108,171 | 111,360 | 114,436 | 3,189 | 3,077 |

# Obligations

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Obligations by Long & Short Stay** | | | | | | | |
| Community Nursing Home | | | | | | | |
| Long Stay | $1,009,061 | $1,513,062 | $1,127,564 | $1,246,767 | $1,339,435 | $119,203 | $92,668 |
| Short Stay | $248,874 | $394,669 | $274,908 | $303,759 | $328,641 | $28,851 | $24,882 |
| Community Nursing Home Patients Trtd., [Total] | $1,257,935 | $1,907,731 | $1,402,472 | $1,550,526 | $1,668,076 | $148,054 | $117,550 |
| State Home Nursing | | | | | | | |
| Long Stay | $1,442,939 | $1,640,900 | $1,350,668 | $1,436,568 | $1,443,443 | $85,900 | $6,875 |
| Short Stay | $60,799 | $66,551 | $52,971 | $53,914 | $52,596 | $943 | ($1,318) |
| State Home Nursing Patients Trtd., [Total] | $1,503,738 | $1,707,451 | $1,403,639 | $1,490,482 | $1,496,039 | $86,843 | $5,557 |
| VA Community Living Centers | | | | | | | |
| Long Stay | $3,408,034 | $3,074,484 | $3,560,194 | $3,830,475 | $3,985,641 | $270,281 | $155,166 |
| Short Stay | $1,106,549 | $1,349,372 | $1,090,019 | $1,112,179 | $1,107,366 | $22,160 | ($4,813) |
| VA Community Living Centers Patients Trtd., [Total] | $4,514,583 | $4,423,856 | $4,650,213 | $4,942,654 | $5,093,007 | $292,441 | $150,353 |
| Grand Total Obligations by Long & Short Stay [Total] | $7,276,256 | $8,039,038 | $7,456,324 | $7,983,662 | $8,257,122 | $527,338 | $273,460 |
| **Obligations by Age** | | | | | | | |
| Community Nursing Home | | | | | | | |
| < 65 | $145,447 | $226,732 | $162,158 | $179,277 | $192,869 | $17,119 | $13,592 |
| 65 to 84 | $877,487 | $1,255,646 | $978,311 | $1,081,587 | $1,163,585 | $103,276 | $81,998 |
| > 84 | $235,001 | $425,353 | $262,003 | $289,662 | $311,622 | $27,659 | $21,960 |
| Community Nursing Home Obligations [Total] | $1,257,935 | $1,907,731 | $1,402,472 | $1,550,526 | $1,668,076 | $148,054 | $117,550 |
| State Home Nursing | | | | | | | |
| < 65 | $73,568 | $76,317 | $68,670 | $72,919 | $73,191 | $4,249 | $272 |
| 65 to 84 | $862,682 | $880,526 | $805,257 | $855,078 | $858,266 | $49,821 | $3,188 |
| > 84 | $567,488 | $750,608 | $529,712 | $562,485 | $564,582 | $32,773 | $2,097 |
| State Home Nursing Obligations [Total] | $1,503,738 | $1,707,451 | $1,403,639 | $1,490,482 | $1,496,039 | $86,843 | $5,557 |
| VA Community Living Centers | | | | | | | |
| < 65 | $623,760 | $670,503 | $642,499 | $670,503 | $694,596 | $28,004 | $24,093 |
| 65 to 84 | $3,101,104 | $2,985,039 | $3,194,270 | $3,503,837 | $3,604,591 | $309,567 | $100,754 |
| > 84 | $789,719 | $768,314 | $813,444 | $768,314 | $793,820 | ($45,130) | $25,506 |
| VA Community Living Centers Obligations [Total] | $4,514,583 | $4,423,856 | $4,650,213 | $4,942,654 | $5,093,007 | $292,441 | $150,353 |
| Grand Total Obligations by Age | $7,276,256 | $8,039,038 | $7,456,324 | $7,983,662 | $8,257,122 | $527,338 | $273,460 |
| **Obligations by Priority 1A, SC & Non-SC** | | | | | | | |
| Community Nursing Home | | | | | | | |
| Priority 1A | $1,047,426 | $1,562,525 | $1,167,775 | $1,291,053 | $1,388,931 | $123,278 | $97,879 |
| Non-Service Connected* | $125,855 | $209,354 | $140,316 | $155,129 | $166,889 | $14,813 | $11,761 |
| Service-Connected* | $84,654 | $135,852 | $94,381 | $104,344 | $112,255 | $9,963 | $7,911 |
| Community Nursing Home Obligations [Total] | $1,257,935 | $1,907,731 | $1,402,472 | $1,550,526 | $1,668,076 | $148,054 | $117,550 |
| State Home Nursing | | | | | | | |
| Priority 1A | $463,652 | $486,460 | $432,788 | $459,565 | $461,278 | $26,777 | $1,713 |
| Non-Service Connected* | $785,954 | $935,281 | $733,636 | $779,026 | $781,930 | $45,390 | $2,904 |
| Service-Connected* | $254,132 | $285,710 | $237,215 | $251,891 | $252,831 | $14,676 | $940 |
| State Home Nursing Obligations [Total] | $1,503,738 | $1,707,451 | $1,403,639 | $1,490,482 | $1,496,039 | $86,843 | $5,557 |
| VA Community Living Centers | | | | | | | |
| Priority 1A | $2,595,885 | $2,442,924 | $2,673,872 | $2,842,026 | $2,928,479 | $168,154 | $86,453 |
| Non-Service Connected* | $1,282,142 | $1,313,831 | $1,320,660 | $1,403,714 | $1,446,414 | $83,053 | $42,700 |
| Service-Connected* | $636,556 | $667,101 | $655,680 | $696,914 | $718,114 | $41,234 | $21,200 |
| VA Community Living Centers Obligations [Total] | $4,514,583 | $4,423,856 | $4,650,213 | $4,942,654 | $5,093,007 | $292,441 | $150,353 |
| Obligations by Priority 1A, SC & Non-SC [Total] | $7,276,256 | $8,039,038 | $7,456,324 | $7,983,662 | $8,257,122 | $527,338 | $273,460 |

# Per Diems

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Per Diems by Long & Short Stay** | | | | | | | |
| Community Nursing Home | | | | | | | |
| Long Stay | $343.89 | $445.17 | $328.56 | $345.65 | $353.18 | $17.09 | $7.53 |
| Short Stay | $360.90 | $479.72 | $340.85 | $358.33 | $368.72 | $17.48 | $10.39 |
| Community Nursing Home Patients Trtd., [Total] | $347.12 | $451.90 | $330.90 | $348.07 | $356.14 | $17.17 | $8.07 |
| State Home Nursing | | | | | | | |
| Long Stay | $285.23 | $238.70 | $197.56 | $213.31 | $217.03 | $15.75 | $3.72 |
| Short Stay | $282.89 | $242.17 | $182.37 | $188.43 | $186.14 | $6.06 | ($2.29) |
| State Home Nursing Patients Trtd., [Total] | $285.13 | $238.83 | $196.94 | $212.29 | $215.77 | $15.35 | $3.48 |
| VA Community Living Centers | | | | | | | |
| Long Stay | $1,743.05 | $1,327.54 | $1,466.07 | $1,657.25 | $1,811.39 | $191.18 | $154.14 |
| Short Stay | $2,283.48 | $1,821.71 | $1,811.08 | $1,941.47 | $2,030.61 | $130.39 | $89.14 |
| VA Community Living Centers Patients Trtd., [Total] | $1,850.39 | $1,447.30 | $1,534.60 | $1,713.70 | $1,854.93 | $179.10 | $141.23 |
| Overall Per Diem by Long & Short Stay | $641.79 | $557.20 | $517.95 | $555.98 | $574.89 | $38.03 | $18.91 |
| **Per Diem by Age** | | | | | | | |
| Community Nursing Home | | | | | | | |
| < 65 | $382.86 | $502.60 | $364.96 | $383.90 | $392.80 | $18.94 | $8.90 |
| 65 to 84 | $347.57 | $453.29 | $331.32 | $348.51 | $356.60 | $17.19 | $8.09 |
| > 84 | $326.69 | $425.20 | $311.41 | $327.57 | $335.17 | $16.16 | $7.60 |
| Community Nursing Home Overall Per Diem | $347.12 | $451.90 | $330.90 | $348.07 | $356.14 | $17.17 | $8.07 |
| State Home Nursing | | | | | | | |
| < 65 | $289.94 | $241.85 | $200.26 | $215.87 | $219.40 | $15.61 | $3.53 |
| 65 to 84 | $287.70 | $241.99 | $198.72 | $214.21 | $217.71 | $15.49 | $3.50 |
| > 84 | $280.72 | $234.93 | $193.90 | $209.01 | $212.43 | $15.11 | $3.42 |
| State Home Nursing Overall Per Diem | $285.13 | $238.83 | $196.94 | $212.29 | $215.77 | $15.35 | $3.48 |
| VA Community Living Centers | | | | | | | |
| < 65 | $1,936.26 | $1,441.64 | $1,605.82 | $1,760.67 | $1,915.97 | $154.85 | $155.30 |
| 65 to 84 | $1,838.62 | $1,501.99 | $1,524.84 | $1,757.31 | $1,899.07 | $232.47 | $141.76 |
| > 84 | $1,832.24 | $1,271.74 | $1,519.55 | $1,507.92 | $1,636.60 | ($11.63) | $128.68 |
| VA Community Living Centers Overall Per Diem | $1,850.39 | $1,447.30 | $1,534.60 | $1,713.70 | $1,854.93 | $179.10 | $141.23 |
| Overall Per Diem by Age | $641.79 | $557.20 | $517.95 | $555.98 | $574.89 | $38.03 | $18.91 |
| **Per Diem by Priority 1A, SC & Non-SC** | | | | | | | |
| Community Nursing Home | | | | | | | |
| Priority 1A | $349.48 | $454.42 | $333.14 | $350.43 | $358.56 | $17.29 | $8.13 |
| Non-Service Connected* | $334.98 | $441.66 | $319.32 | $335.88 | $343.68 | $16.56 | $7.80 |
| Service-Connected* | $337.20 | $439.62 | $321.43 | $338.11 | $345.96 | $16.68 | $7.85 |
| Community Nursing Home Overall Per Diem | $347.12 | $451.90 | $330.90 | $348.07 | $356.14 | $17.17 | $8.07 |
| State Home Nursing | | | | | | | |
| Priority 1A | $305.18 | $261.87 | $210.79 | $227.22 | $230.94 | $16.43 | $3.72 |
| Non-Service Connected* | $275.66 | $229.34 | $190.40 | $205.24 | $208.60 | $14.84 | $3.36 |
| Service-Connected* | $281.34 | $235.44 | $194.32 | $209.47 | $212.90 | $15.15 | $3.43 |
| State Home Nursing Overall Per Diem | $285.13 | $238.83 | $196.94 | $212.29 | $215.77 | $15.35 | $3.48 |
| VA Community Living Centers | | | | | | | |
| Priority 1A | $1,775.25 | $1,360.89 | $1,472.28 | $1,644.11 | $1,779.61 | $171.83 | $135.50 |
| Non-Service Connected* | $1,974.06 | $1,528.47 | $1,637.17 | $1,828.24 | $1,978.91 | $191.07 | $150.67 |
| Service-Connected* | $1,940.45 | $804.05 | $1,609.29 | $1,797.11 | $1,945.21 | $187.82 | $148.10 |
| VA Community Living Centers Overall Per Diem | $1,850.39 | $1,447.30 | $1,534.60 | $1,713.70 | $1,854.93 | $179.10 | $141.23 |
| Overall Per Diem for Priority 1A, SC & Non-SC | $641.79 | $557.20 | $517.95 | $555.98 | $574.89 | $38.03 | $18.91 |

## Non-Institutional Obligations & Clinic Stops/Procedures

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Non-Institutional Obligations ($000)** | | | | | | | |
| Community Adult Day Health Care | $157,323 | $236,193 | $196,757 | $220,338 | $233,372 | $23,581 | $13,034 |
| Community Residential Care | $85,285 | $100,822 | $83,049 | $86,238 | $85,941 | $3,189 | ($297) |
| Home Hospice Care | $30,944 | $105,292 | $32,802 | $35,158 | $36,810 | $2,356 | $1,652 |
| Home Respite Care | $77,513 | $56,167 | $86,922 | $96,900 | $105,260 | $9,978 | $8,360 |
| Home Telehealth | $315,834 | $276,726 | $328,481 | $345,103 | $357,174 | $16,622 | $12,071 |
| Home-Based Primary Care | $1,046,097 | $1,092,667 | $1,115,662 | $1,221,183 | $1,300,463 | $105,521 | $79,280 |
| Homemaker/Home Health Aide Prgs. | $1,160,708 | $1,141,134 | $1,316,192 | $1,432,533 | $1,518,921 | $116,341 | $86,388 |
| Purchased Skilled Home Care | $518,665 | $635,182 | $553,823 | $599,848 | $632,270 | $46,025 | $32,422 |
| Spinal Cord Injury & Disability Home Care | $11,387 | $12,778 | $11,465 | $12,184 | $12,594 | $719 | $410 |
| State Home Adult Day Health Care | $1,780 | $4,734 | $1,034 | $1,286 | $1,086 | $252 | ($200) |
| VA Adult Day Health Care | $1,594 | $14,987 | $1,628 | $1,825 | $1,943 | $197 | $118 |
| **Non-Institutional Obligations [Total]** | **$3,407,130** | **$3,676,682** | **$3,727,815** | **$4,052,596** | **$4,285,834** | **$324,781** | **$233,238** |
| **Non-Institutional Clinic Stops/Procedures** | | | | | | | |
| Community Adult Day Health Care | 290,468 | 588,072 | 252,688 | 222,463 | 192,239 | (30,225) | (30,224) |
| Community Residential Care | 36,719 | 76,413 | 51,722 | 60,724 | 69,726 | 9,002 | 9,002 |
| Home Hospice Care | 577,064 | 526,361 | 603,858 | 616,786 | 629,714 | 12,928 | 12,928 |
| Home Respite Care | 21,803 | 21,574 | 23,482 | 24,751 | 26,021 | 1,269 | 1,270 |
| Home Telehealth 1/ | 766,817 | 773,112 | 742,355 | 730,124 | 717,893 | (12,231) | (12,231) |
| Home-Based Primary Care | 1,222,310 | 1,760,997 | 1,471,052 | 1,719,793 | 1,968,535 | 248,742 | 248,742 |
| Homemaker/Home Health Aide Prgs. | 10,456,956 | 14,535,236 | 11,464,836 | 12,472,715 | 13,279,019 | 1,007,880 | 806,304 |
| Purchased Skilled Home Care | 99,904 | 162,427 | 105,958 | 109,590 | 113,222 | 3,632 | 3,632 |
| Spinal Cord Injury Home Care | 15,105 | 23,248 | 17,163 | 18,246 | 19,329 | 1,083 | 1,083 |
| State Adult Day Health Care | 8,613 | 8,737 | 8,815 | 9,010 | 9,237 | 195 | 227 |
| VA Adult Day Health Care | 3,272 | 80,331 | 3,000 | 3,000 | 3,000 | 0 | 0 |
| **Non-Institutional Clinic Stops/Procedures [Total]** | **13,499,031** | **18,556,508** | **14,744,927** | **15,987,202** | **17,027,935** | **1,242,275** | **1,040,733** |
| **Non-Institutional Cost Per Clinic Stops/Procedures** | | | | | | | |
| Community Adult Day Health Care | $541.62 | $401.64 | $778.66 | $990.45 | $1,213.97 | $211.79 | $223.52 |
| Community Residential Care | $2,322.64 | $1,319.44 | $1,605.68 | $1,420.16 | $1,232.55 | ($185.52) | ($187.61) |
| Home Hospice Care | $53.62 | $200.04 | $54.32 | $57.00 | $58.46 | $2.68 | $1.46 |
| Home Respite Care | $3,555.16 | $2,603.46 | $3,701.69 | $3,914.99 | $4,045.19 | $213.30 | $130.20 |
| Home Telehealth | $411.88 | $357.94 | $442.49 | $472.66 | $497.53 | $30.17 | $24.87 |
| Home-Based Primary Care | $855.84 | $620.48 | $758.41 | $710.08 | $660.62 | ($48.33) | ($49.46) |
| Homemaker/Home Health Aide Prgs. | $111.00 | $78.51 | $114.80 | $114.85 | $114.39 | $0.05 | ($0.46) |
| Purchased Skilled Home Care | $5,191.63 | $3,910.57 | $5,226.82 | $5,473.57 | $5,584.34 | $246.75 | $110.77 |
| Spinal Cord Injury Home Care | $753.86 | $549.64 | $668.02 | $667.76 | $651.56 | ($0.26) | ($16.20) |
| State Adult Day Health Care | $0.82 | $2.16 | $0.47 | $0.57 | $0.47 | $0.10 | ($0.10) |
| VA Adult Day Health Care | $487.02 | $186.57 | $542.67 | $608.33 | $647.67 | $65.66 | $39.34 |
| **Non-Institutional Cost Per Clinic Stops/Procedures** | **$252.40** | **$198.13** | **$252.82** | **$253.49** | **$251.69** | **$0.67** | **($1.80)** |

# VA Community Living Centers Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $2,920,406 | $2,621,543 | $3,361,213 | $3,250,754 | $3,345,807 | ($110,459) | $95,053 |
| Discretionary FFCRA/CARES Act Obligations | $243,733 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$3,164,139** | **$2,621,543** | **$3,361,213** | **$3,250,754** | **$3,345,807** | **($110,459)** | **$95,053** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $561,081 | $524,412 | $593,000 | $799,500 | $872,100 | $206,500 | $72,600 |
| Discretionary CARES Act Obligations | $28,831 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$589,912** | **$524,412** | **$593,000** | **$799,500** | **$872,100** | **$206,500** | **$72,600** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $695,253 | $586,300 | $696,000 | $892,400 | $875,100 | $196,400 | ($17,300) |
| Discretionary CARES Act Obligations | $62,098 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$757,351** | **$586,300** | **$696,000** | **$892,400** | **$875,100** | **$196,400** | **($17,300)** |
| **Discretionary Total** | **$4,511,402** | **$3,732,255** | **$4,650,213** | **$4,942,654** | **$5,093,007** | **$292,441** | **$150,353** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $448,023 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 (0160) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0160) | $242 | $171 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$242** | **$448,194** | **$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 | $43,369 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0152) | $200 | $88 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$200** | **$43,457** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $199,950 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0162) | $2,739 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$2,739** | **$199,950** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Mandatory Total** | **$3,181** | **$691,601** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $3,164,381 | $3,069,737 | $3,361,213 | **$3,250,754** | **$3,345,807** | ($110,459) | $95,053 |
| Medical Community Care | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Support and Compliance | $590,111 | $567,869 | $593,000 | **$799,500** | **$872,100** | $206,500 | $72,600 |
| Medical Facilities | $760,091 | $786,250 | $696,000 | **$892,400** | **$875,100** | $196,400 | ($17,300) |
| **Obligations [Grand Total]** | **$4,514,583** | **$4,423,856** | **$4,650,213** | **$4,942,654** | **$5,093,007** | **$292,441** | **$150,353** |

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

# Community Residential Care Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $65,037 | $80,534 | $63,349 | $60,438 | $59,341 | ($2,911) | ($1,097) |
| Discretionary FFCRA/CARES Act Obligations | $529 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$65,566** | **$80,534** | **$63,349** | **$60,438** | **$59,341** | **($2,911)** | **($1,097)** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $263 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$263** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $8,835 | $8,900 | $9,300 | $12,500 | $13,600 | $3,200 | $1,100 |
| Discretionary CARES Act Obligations | $148 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$8,983** | **$8,900** | **$9,300** | **$12,500** | **$13,600** | **$3,200** | **$1,100** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $10,427 | $9,500 | $10,400 | $13,300 | $13,000 | $2,900 | ($300) |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$10,427** | **$9,500** | **$10,400** | **$13,300** | **$13,000** | **$2,900** | **($300)** |
| **Discretionary Total** | **$85,239** | **$98,934** | **$83,049** | **$86,238** | **$85,941** | **$3,189** | **($297)** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $1,879 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 (0160) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0160) | $5 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$5** | **$1,879** | **$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 | $9 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0152) | $3 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$3** | **$9** | **$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) | $38 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$38** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Mandatory Total** | **$46** | **$1,888** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $65,571 | $82,413 | $63,349 | **$60,438** | **$59,341** | ($2,911) | ($1,097) |
| Medical Community Care | $263 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Support and Compliance | $8,986 | $8,909 | $9,300 | **$12,500** | **$13,600** | $3,200 | $1,100 |
| Medical Facilities | $10,465 | $9,500 | $10,400 | **$13,300** | **$13,000** | $2,900 | ($300) |
| **Obligations [Grand Total]** | **$85,285** | **$100,822** | **$83,049** | **$86,238** | **$85,941** | **$3,189** | **($297)** |

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

## Home Telehealth Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $216,974 | $182,113 | $232,481 | $219,003 | $226,574 | ($13,478) | $7,571 |
| Discretionary FFCRA/CARES Act Obligations | $5,103 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$222,077** | **$182,113** | **$232,481** | **$219,003** | **$226,574** | **($13,478)** | **$7,571** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $43,806 | $42,200 | $46,300 | $62,400 | $68,100 | $16,100 | $5,700 |
| Discretionary CARES Act Obligations | $74 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$43,880** | **$42,200** | **$46,300** | **$62,400** | **$68,100** | **$16,100** | **$5,700** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $49,658 | $46,300 | $49,700 | $63,700 | $62,500 | $14,000 | ($1,200) |
| Discretionary CARES Act Obligations | $6 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$49,665** | **$46,300** | **$49,700** | **$63,700** | **$62,500** | **$14,000** | **($1,200)** |
| **Discretionary Total** | **$315,622** | **$270,613** | **$328,481** | **$345,103** | **$357,174** | **$16,622** | **$12,071** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $6,105 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 (0160) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0160) | $18 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$18** | **$6,105** | **$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 | $8 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0152) | $15 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$15** | **$8** | **$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) | $180 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$180** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Mandatory Total** | **$212** | **$6,113** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $222,094 | $188,218 | $232,481 | **$219,003** | **$226,574** | ($13,478) | $7,571 |
| Medical Community Care | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Support and Compliance | $43,895 | $42,208 | $46,300 | **$62,400** | **$68,100** | $16,100 | $5,700 |
| Medical Facilities | $49,844 | $46,300 | $49,700 | **$63,700** | **$62,500** | $14,000 | ($1,200) |
| **Obligations [Grand Total]** | **$315,834** | **$276,726** | **$328,481** | **$345,103** | **$357,174** | **$16,622** | **$12,071** |

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

# Home Based Primary Care Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $779,536 | $856,508 | $860,362 | $885,583 | $952,663 | $25,221 | $67,080 |
| Discretionary FFCRA/CARES Act Obligations | $16,285 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$795,821** | **$856,508** | **$860,362** | **$885,583** | **$952,663** | **$25,221** | **$67,080** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $2 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$2** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $119,019 | $99,436 | $125,800 | $169,600 | $185,000 | $43,800 | $15,400 |
| Discretionary CARES Act Obligations | $673 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$119,692** | **$99,436** | **$125,800** | **$169,600** | **$185,000** | **$43,800** | **$15,400** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $129,364 | $103,500 | $129,500 | $166,000 | $162,800 | $36,500 | ($3,200) |
| Discretionary CARES Act Obligations | $647 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$130,011** | **$103,500** | **$129,500** | **$166,000** | **$162,800** | **$36,500** | **($3,200)** |
| **Discretionary Total** | **$1,045,526** | **$1,059,444** | **$1,115,662** | **$1,221,183** | **$1,300,463** | **$105,521** | **$79,280** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $29,586 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 (0160) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0160) | $60 | $73 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$60** | **$29,659** | **$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 | $473 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0152) | $40 | $964 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$40** | **$1,437** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $2,127 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0162) | $470 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$470** | **$2,127** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Mandatory Total** | **$571** | **$33,223** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $795,882 | $886,167 | $860,362 | **$885,583** | **$952,663** | $25,221 | $67,080 |
| Medical Community Care | $2 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Support and Compliance | $119,732 | $100,873 | $125,800 | **$169,600** | **$185,000** | $43,800 | $15,400 |
| Medical Facilities | $130,482 | $105,627 | $129,500 | **$166,000** | **$162,800** | $36,500 | ($3,200) |
| **Obligations [Grand Total]** | **$1,046,097** | **$1,092,667** | **$1,115,662** | **$1,221,183** | **$1,300,463** | **$105,521** | **$79,280** |

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

# Spinal Cord Injury & Disability Home Care Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $9,255 | $10,421 | $9,365 | $9,384 | $9,694 | $19 | $310 |
| Discretionary FFCRA/CARES Act Obligations | $81 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$9,336** | **$10,421** | **$9,365** | **$9,384** | **$9,694** | **$19** | **$310** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $1,084 | $1,100 | $1,100 | $1,500 | $1,600 | $400 | $100 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,084** | **$1,100** | **$1,100** | **$1,500** | **$1,600** | **$400** | **$100** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $962 | $1,100 | $1,000 | $1,300 | $1,300 | $300 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$962** | **$1,100** | **$1,000** | **$1,300** | **$1,300** | **$300** | **$0** |
| **Discretionary Total** | **$11,382** | **$12,621** | **$11,465** | **$12,184** | **$12,594** | **$719** | **$410** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $157 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 (0160) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0160) | $1 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$1** | **$157** | **$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) | $3 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$3** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Mandatory Total** | **$5** | **$157** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $9,337 | $10,578 | $9,365 | **$9,384** | **$9,694** | $19 | $310 |
| Medical Community Care | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Support and Compliance | $1,085 | $1,100 | $1,100 | **$1,500** | **$1,600** | $400 | $100 |
| Medical Facilities | $966 | $1,100 | $1,000 | **$1,300** | **$1,300** | $300 | $0 |
| **Obligations [Grand Total]** | **$11,387** | **$12,778** | **$11,465** | **$12,184** | **$12,594** | **$719** | **$410** |

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

# VA Adult Day Home Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $1,161 | $12,030 | $1,228 | $1,225 | $1,343 | ($3) | $118 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,161** | **$12,030** | **$1,228** | **$1,225** | **$1,343** | **($3)** | **$118** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $215 | $1,500 | $200 | $300 | $300 | $100 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$215** | **$1,500** | **$200** | **$300** | **$300** | **$100** | **$0** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $217 | $1,300 | $200 | $300 | $300 | $100 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$217** | **$1,300** | **$200** | **$300** | **$300** | **$100** | **$0** |
| **Discretionary Total** | **$1,593** | **$14,830** | **$1,628** | **$1,825** | **$1,943** | **$197** | **$118** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $157 | $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** | **$157** | **$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) | $1 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$1** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Mandatory Total** | **$1** | **$157** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $1,161 | $12,187 | $1,228 | **$1,225** | **$1,343** | ($3) | $118 |
| Medical Community Care | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Support and Compliance | $215 | $1,500 | $200 | **$300** | **$300** | $100 | $0 |
| Medical Facilities | $217 | $1,300 | $200 | **$300** | **$300** | $100 | $0 |
| **Obligations [Grand Total]** | **$1,594** | **$14,987** | **$1,628** | **$1,825** | **$1,943** | **$197** | **$118** |

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.

# Community Nursing Home Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $68,530 | $118,825 | $37,805 | $27,556 | $28,895 | ($10,249) | $1,339 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$68,530** | **$118,825** | **$37,805** | **$27,556** | **$28,895** | **($10,249)** | **$1,339** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $1,133,113 | $1,670,206 | $1,305,367 | $1,443,170 | $1,552,581 | $137,803 | $109,411 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,133,113** | **$1,670,206** | **$1,305,367** | **$1,443,170** | **$1,552,581** | **$137,803** | **$109,411** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $53,557 | $115,500 | $56,600 | $76,300 | $83,200 | $19,700 | $6,900 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$53,557** | **$115,500** | **$56,600** | **$76,300** | **$83,200** | **$19,700** | **$6,900** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $2,735 | $3,200 | $2,700 | $3,500 | $3,400 | $800 | ($100) |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$2,735** | **$3,200** | **$2,700** | **$3,500** | **$3,400** | **$800** | **($100)** |
| **Discretionary Total** | **$1,257,935** | **$1,907,731** | **$1,402,472** | **$1,550,526** | **$1,668,076** | **$148,054** | **$117,550** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 (0160) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0160) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Community Care Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8004 (0140) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 (0140) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Veterans Choice Fund (0172) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0152) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0162) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Mandatory Total** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $68,530 | $118,825 | $37,805 | **$27,556** | **$28,895** | ($10,249) | $1,339 |
| Medical Community Care | $1,133,113 | $1,670,206 | $1,305,367 | **$1,443,170** | **$1,552,581** | $137,803 | $109,411 |
| Medical Support and Compliance | $53,557 | $115,500 | $56,600 | **$76,300** | **$83,200** | $19,700 | $6,900 |
| Medical Facilities | $2,735 | $3,200 | $2,700 | **$3,500** | **$3,400** | $800 | ($100) |
| **Obligations [Grand Total]** | **$1,257,935** | **$1,907,731** | **$1,402,472** | **$1,550,526** | **$1,668,076** | **$148,054** | **$117,550** |

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 in response to workload demand requirements throughout 2022 and 2023.

# State Nursing Home Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $1,524 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,524** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $1,156,216 | $1,705,051 | $1,403,639 | $1,490,482 | $1,496,039 | $86,843 | $5,557 |
| Discretionary FFCRA/CARES Act Obligations | $98,078 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,254,294** | **$1,705,051** | **$1,403,639** | **$1,490,482** | **$1,496,039** | **$86,843** | **$5,557** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $2,400 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$2,400** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Discretionary Total** | **$1,255,818** | **$1,707,451** | **$1,403,639** | **$1,490,482** | **$1,496,039** | **$86,843** | **$5,557** |
| **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) | $247,920 | $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]** | **$247,920** | **$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** | **$247,920** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $1,524 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Community Care | $1,502,214 | $1,705,051 | $1,403,639 | **$1,490,482** | **$1,496,039** | $86,843 | $5,557 |
| Medical Support and Compliance | $0 | $2,400 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Facilities | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| **Obligations [Grand Total]** | **$1,503,738** | **$1,707,451** | **$1,403,639** | **$1,490,482** | **$1,496,039** | **$86,843** | **$5,557** |

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.

## State Home Domiciliary

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $41,237 | $56,357 | $51,632 | $49,095 | $48,729 | ($2,537) | ($366) |
| Discretionary FFCRA/CARES Act Obligations | $779 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$42,016** | **$56,357** | **$51,632** | **$49,095** | **$48,729** | **($2,537)** | **($366)** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Discretionary Total** | **$42,016** | **$56,357** | **$51,632** | **$49,095** | **$48,729** | **($2,537)** | **($366)** |
| **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) | $2,080 | $0 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 (0140) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Veterans Choice Fund (0172) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$2,080** | **$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** | **$2,080** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Community Care | $44,096 | $56,357 | $51,632 | **$49,095** | **$48,729** | ($2,537) | ($366) |
| Medical Support and Compliance | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Facilities | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| **Obligations [Grand Total]** | **$44,096** | **$56,357** | **$51,632** | **$49,095** | **$48,729** | **($2,537)** | **($366)** |

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.

# State Home Adult Day Health Care Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $1,383 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,383** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $397 | $4,734 | $1,034 | $1,286 | $1,086 | $252 | ($200) |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$397** | **$4,734** | **$1,034** | **$1,286** | **$1,086** | **$252** | **($200)** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Discretionary Total** | **$1,780** | **$4,734** | **$1,034** | **$1,286** | **$1,086** | **$252** | **($200)** |
| **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 | $1,383 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Community Care | $397 | $4,734 | $1,034 | **$1,286** | **$1,086** | $252 | ($200) |
| Medical Support and Compliance | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Facilities | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| **Obligations [Grand Total]** | **$1,780** | **$4,734** | **$1,034** | **$1,286** | **$1,086** | **$252** | **($200)** |

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.

# Community Adult Day Health Care Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $9,219 | $17,897 | $7,307 | $6,430 | $6,537 | ($877) | $107 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$9,219** | **$17,897** | **$7,307** | **$6,430** | **$6,537** | **($877)** | **$107** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $138,537 | $211,495 | $181,550 | $203,308 | $215,335 | $21,758 | $12,027 |
| Discretionary FFCRA/CARES Act Obligations | $1,823 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$140,360** | **$211,495** | **$181,550** | **$203,308** | **$215,335** | **$21,758** | **$12,027** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $7,219 | $6,500 | $7,600 | $10,200 | $11,100 | $2,600 | $900 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$7,219** | **$6,500** | **$7,600** | **$10,200** | **$11,100** | **$2,600** | **$900** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $349 | $300 | $300 | $400 | $400 | $100 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$349** | **$300** | **$300** | **$400** | **$400** | **$100** | **$0** |
| **Discretionary Total** | **$157,147** | **$236,192** | **$196,757** | **$220,338** | **$233,372** | **$23,581** | **$13,034** |
| **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 | $1 | $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) | $176 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$176** | **$1** | **$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** | **$176** | **$1** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $9,219 | $17,897 | $7,307 | **$6,430** | **$6,537** | ($877) | $107 |
| Medical Community Care | $140,536 | $211,496 | $181,550 | **$203,308** | **$215,335** | $21,758 | $12,027 |
| Medical Support and Compliance | $7,219 | $6,500 | $7,600 | **$10,200** | **$11,100** | $2,600 | $900 |
| Medical Facilities | $349 | $300 | $300 | **$400** | **$400** | $100 | $0 |
| **Obligations [Grand Total]** | **$157,323** | **$236,193** | **$196,757** | **$220,338** | **$233,372** | **$23,581** | **$13,034** |

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

# Home Hospice Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $5,832 | $8,975 | $5,357 | $5,343 | $5,483 | ($14) | $140 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$5,832** | **$8,975** | **$5,357** | **$5,343** | **$5,483** | **($14)** | **$140** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $23,345 | $92,017 | $26,045 | $27,915 | $29,227 | $1,870 | $1,312 |
| Discretionary FFCRA/CARES Act Obligations | $442 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$23,787** | **$92,017** | **$26,045** | **$27,915** | **$29,227** | **$1,870** | **$1,312** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $1,256 | $4,100 | $1,300 | $1,800 | $2,000 | $500 | $200 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,256** | **$4,100** | **$1,300** | **$1,800** | **$2,000** | **$500** | **$200** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $69 | $200 | $100 | $100 | $100 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$69** | **$200** | **$100** | **$100** | **$100** | **$0** | **$0** |
| **Discretionary Total** | **$30,944** | **$105,292** | **$32,802** | **$35,158** | **$36,810** | **$2,356** | **$1,652** |
| **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 | $5,832 | $8,975 | $5,357 | **$5,343** | **$5,483** | ($14) | $140 |
| Medical Community Care | $23,787 | $92,017 | $26,045 | **$27,915** | **$29,227** | $1,870 | $1,312 |
| Medical Support and Compliance | $1,256 | $4,100 | $1,300 | **$1,800** | **$2,000** | $500 | $200 |
| Medical Facilities | $69 | $200 | $100 | **$100** | **$100** | $0 | $0 |
| **Obligations [Grand Total]** | **$30,944** | **$105,292** | **$32,802** | **$35,158** | **$36,810** | **$2,356** | **$1,652** |

[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.

## Home Respite Care Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $0 | $805 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$805** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $76,350 | $52,562 | $86,922 | $96,900 | $105,260 | $9,978 | $8,360 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$76,350** | **$52,562** | **$86,922** | **$96,900** | **$105,260** | **$9,978** | **$8,360** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $1,062 | $2,800 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,062** | **$2,800** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Discretionary Total** | **$77,413** | **$56,167** | **$86,922** | **$96,900** | **$105,260** | **$9,978** | **$8,360** |
| **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) | $100 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$100** | **$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** | **$100** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $0 | $805 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Community Care | $76,451 | $52,562 | $86,922 | **$96,900** | **$105,260** | $9,978 | $8,360 |
| Medical Support and Compliance | $1,062 | $2,800 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Facilities | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| **Obligations [Grand Total]** | **$77,513** | **$56,167** | **$86,922** | **$96,900** | **$105,260** | **$9,978** | **$8,360** |

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.

# Homemaker/Home Health Aide Programs Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $65,067 | $73,718 | $38,951 | $28,641 | $28,522 | ($10,310) | ($119) |
| Discretionary FFCRA/CARES Act Obligations | $27 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$65,094** | **$73,718** | **$38,951** | **$28,641** | **$28,522** | **($10,310)** | **($119)** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $1,042,852 | $1,008,773 | $1,223,541 | $1,331,692 | $1,411,999 | $108,151 | $80,307 |
| Discretionary FFCRA/CARES Act Obligations | $840 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,043,691** | **$1,008,773** | **$1,223,541** | **$1,331,692** | **$1,411,999** | **$108,151** | **$80,307** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $48,457 | $54,100 | $51,200 | $69,000 | $75,300 | $17,800 | $6,300 |
| Discretionary CARES Act Obligations | $3 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$48,460** | **$54,100** | **$51,200** | **$69,000** | **$75,300** | **$17,800** | **$6,300** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $2,543 | $1,900 | $2,500 | $3,200 | $3,100 | $700 | ($100) |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$2,543** | **$1,900** | **$2,500** | **$3,200** | **$3,100** | **$700** | **($100)** |
| **Discretionary Total** | **$1,159,788** | **$1,138,491** | **$1,316,192** | **$1,432,533** | **$1,518,921** | **$116,341** | **$86,388** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $626 | $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** | **$626** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Community Care Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $1,933 | $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) | $919 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$919** | **$1,933** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $84 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0152) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$84** | **$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** | **$919** | **$2,643** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $65,094 | $74,344 | $38,951 | **$28,641** | **$28,522** | ($10,310) | ($119) |
| Medical Community Care | $1,044,610 | $1,010,706 | $1,223,541 | **$1,331,692** | **$1,411,999** | $108,151 | $80,307 |
| Medical Support and Compliance | $48,460 | $54,184 | $51,200 | **$69,000** | **$75,300** | $17,800 | $6,300 |
| Medical Facilities | $2,543 | $1,900 | $2,500 | **$3,200** | **$3,100** | $700 | ($100) |
| **Obligations [Grand Total]** | **$1,160,708** | **$1,141,134** | **$1,316,192** | **$1,432,533** | **$1,518,921** | **$116,341** | **$86,388** |

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.

## Purchased Skilled Home Care Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $36,238 | $46,198 | $23,854 | $19,163 | $19,058 | ($4,691) | ($105) |
| Discretionary FFCRA/CARES Act Obligations | $641 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$36,879** | **$46,198** | **$23,854** | **$19,163** | **$19,058** | **($4,691)** | **($105)** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $447,849 | $536,445 | $504,369 | $546,285 | $575,812 | $41,916 | $29,527 |
| Discretionary FFCRA/CARES Act Obligations | $6,304 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$454,153** | **$536,445** | **$504,369** | **$546,285** | **$575,812** | **$41,916** | **$29,527** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $23,193 | $50,800 | $24,500 | $33,000 | $36,000 | $8,500 | $3,000 |
| Discretionary CARES Act Obligations | $153 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$23,347** | **$50,800** | **$24,500** | **$33,000** | **$36,000** | **$8,500** | **$3,000** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $1,144 | $1,100 | $1,100 | $1,400 | $1,400 | $300 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,144** | **$1,100** | **$1,100** | **$1,400** | **$1,400** | **$300** | **$0** |
| **Discretionary Total** | **$515,523** | **$634,543** | **$553,823** | **$599,848** | **$632,270** | **$46,025** | **$32,422** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $157 | $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** | **$157** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Community Care Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $473 | $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) | $3,142 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$3,142** | **$473** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $9 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0152) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$9** | **$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** | **$3,142** | **$639** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $36,879 | $46,355 | $23,854 | **$19,163** | **$19,058** | ($4,691) | ($105) |
| Medical Community Care | $457,295 | $536,918 | $504,369 | **$546,285** | **$575,812** | $41,916 | $29,527 |
| Medical Support and Compliance | $23,347 | $50,809 | $24,500 | **$33,000** | **$36,000** | $8,500 | $3,000 |
| Medical Facilities | $1,144 | $1,100 | $1,100 | **$1,400** | **$1,400** | $300 | $0 |
| **Obligations [Grand Total]** | **$518,665** | **$635,182** | **$553,823** | **$599,848** | **$632,270** | **$46,025** | **$32,422** |

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 based in response to workload demand requirements throughout 2022 and 2023.

## 2021 Unique Patients using Non-Institutional Long-Term Supportive Services by Fund

| FY 2021 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 | 144 | 144 | 144 | 0 | 0 | 0 |
| Community Adult Day | 5,141 | 5,141 | 5,141 | 29 | 5,112 | 0 |
| Home-Based Primary | 83,986 | 83,986 | 83,986 | 286 | 0 | 0 |
| Home Respite Care | 21,857 | 21,857 | 21,857 | 54 | 21,803 | 0 |
| Purchased Skilled Care | 98,509 | 99,081 | 99,081 | 449 | 99,080 | 824 |
| Hospice Care | 88,639 | 88,639 | 88,639 | 427 | 60,131 | 0 |
| Homemaker/Home Health Aide | 143,674 | 143,675 | 143,675 | 652 | 143,030 | 2 |
| SCI Home Care | 1,748 | 1,748 | 1,748 | 0 | 0 | 0 |
| Community Residential | 4,022 | 4,022 | 4,022 | 0 | 0 | 0 |
| Home Telehealth | 183,337 | 183,337 | 183,337 | 771 | 0 | 0 |
| State Adult Day Health Care | 0 | 112 | 0 | 0 | 112 | 0 |

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

## LTSS Programs

### Authority for Action

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

### Population Covered

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

## Types of Services Provided

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

## Recent Trends

GEC honored Veterans' preferences to receive care at home by providing access to home and community-based services throughout the COVID-19 Pandemic, serving 344,973 Veterans in 2021 – a 7.8% decrease over 2020. The decrease reflected changes in care patterns, particularly in Skilled Home Health Care. Before COVID, GeriPACT saw an increase in unique veterans of 12.65% between 2018 and 2019 (69,851 in 2019, 61,021 in 2018). In QRT 1 of 2020, before COVID measures which negatively impacted the number of unique veterans in GeriPACT, the number of unique patients had increased by 11.46% over 2019 QRT 1. As the number of unique veterans in GeriPACT continues to rise toward pre-COVID levels, there remains a decrease of 6.76% between 2020 and 2021.

There were 149,032 Veterans who received personal care services in 2021, 1.9% fewer than in 2020. Homemaker/Home Health Aide services continued to represent the main offering for Veterans, growing 0.5% to 139,355. Veteran Directed Care, an innovative personal care program allowing Veterans more flexibility, grew to 5,055 Veterans in 2021, a 15% increase over 2020.

As community adult day health care (CADHC) centers remained closed, GEC continued to support Veteran access to personal care services through the amended service plan to give these centers state-based flexibility to provide home care to Veterans. GEC also took action to support community nursing homes and the Veterans they serve by responding to reimbursement increases in line with state increases and reimbursing the greater costs of Veterans requiring isolation. GEC provided additional support to Veterans in Veteran Directed Care by implementing provisions of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020.

HBPC increased overall contacts and interventions from the previous fiscal year, despite the ongoing pandemic. HBPC programs implemented use of GIS software to improve organizational efficiencies within programs. This program allows programs to map and group Veterans geographic location to allow for driving efficiencies. During COVID, this software was advanced to track vaccine administration to allow for tracking of vaccines, allowing programs to track vaccinated/unvaccinated Veterans and maximize the number of vaccines given in the community

per day without waste. HBPC now has an 82% vaccination rate among this frail population that has access limitations. Despite overwhelming data supporting the need for VHA HBPC growth and population data indicating growing Veteran population demand for HBPC level of care, growth has been slow over the past five years, likely related to the start-up cost burden of the program and delayed 2–3-year return on investment.

Home Based Primary Care is an extensively researched evidenced based program of comprehensive home care with demonstrated outcomes to cost effectively support the goal of Veterans aging in place. 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).[25]

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

VA continues to update information on quality in the CLC program, using the same metrics as the Centers for Medicare and Medicaid Services use for Care Compare. Between 3rd quarter 2019 and 3rd quarter 2020, VA CLCs improved in quality ratings from 10.4% being rated as one-star (lowest rating) to 0.7% being rated as one-star. The number of overall one star rated CLCs also remained at 0 during the same timeframe. Results on the homes that VA contracts with are also posted on VA's public facing website.

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

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

- Screening residents and staff for symptoms consistent with COVID-19,
- Limiting admissions
- Implementing a 14-day observation for Veterans returning to the CLC for continued care
- Restricting non-essential personnel
- Promoting consistent staffing
- Promoting use of telehealth modalities for consults and clinic visits outside of the CLC
- Establishing virtual communication between the CLC residents and families
- 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 Office of GEC is committed to ensure the CLC programs and services assist Veterans to achieve the highest practicable level of well-being and function. In recognition of the elevated risks and impact that COVID-19 poses on the highly vulnerable CLC residents, VA Office of GEC will continue to actively monitor COVID-19 activity and adjust guidance with the evolving COVID-19 information.

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

**Projections for the Future**

The Department of Veterans Affairs (VA) operates the Veterans Health Administration (VHA), the largest integrated healthcare system in America. Our mission is to provide the highest quality of care to our nation's Veterans and their families. VHA must meet many challenges to fulfill this mission, including meeting the demands of a rapidly-aging patient population regardless of the Veteran's capacity – whether healthy and stable, in decline, or at the end of life.

Roughly 90% of aging adults would prefer to remain at home for care versus admission to a care facility. However, VA allocated nearly 70% of its Geriatrics and Extended Care (GEC) program spending on institutional care in 2021, with overall spending totaling 10% of VHA's overall

budget.[26,27] VA projects demand for long-term care will continue to increase, creating an enterprise-wide need to expand home and community-based services, which will honor Veterans' preferences and allow Veterans to age successfully at home and in their communities.

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

## State Home Programs

The State Home Per Diem (SHPD) Program is a grant program providing federal assistance to VA recognized State Veteran Home (SVH) facilities through the provision of a percentage of the cost of construction and paying a per diem payment for care provided to eligible veterans in SVH. Admissions to SVHs are limited to eligible veterans and certain categories of veteran-related family members to include spouses and Gold Star Parents. Almost all obligations related to State Home Programs are funded through the Medical Community Care account. Please refer to this chapter for a more detailed discussion.

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

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

# Camp Lejeune Family Member Program (CLFMP)

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $262 | $29 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$262** | **$29** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $2,996 | $2,780 | $3,319 | $3,808 | $3,957 | $489 | $149 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$2,996** | **$2,780** | **$3,319** | **$3,808** | **$3,957** | **$489** | **$149** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $2,853 | $100 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$2,853** | **$100** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Discretionary Total** | **$6,111** | **$2,909** | **$3,319** | **$3,808** | **$3,957** | **$489** | **$149** |
| **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 | $262 | $29 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Community Care | $2,996 | $2,780 | $3,319 | **$3,808** | **$3,957** | $489 | $149 |
| Medical Support and Compliance | $2,853 | $100 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Facilities | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| **Obligations [Grand Total]** | **$6,111** | **$2,909** | **$3,319** | **$3,808** | **$3,957** | **$489** | **$149** |

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.

The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154) extended eligibility for VA hospital care and medical services to certain Veterans who were stationed at Camp Lejeune, North Carolina, for at least 30 days between 1957 and 1987. Additional details can be found in the Medical Community Care chapter.

# CHAMPVA (Excluding Caregivers) Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $395,412 | $489,308 | $426,434 | $365,844 | $522,816 | ($60,590) | $156,972 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$395,412** | **$489,308** | **$426,434** | **$365,844** | **$522,816** | **($60,590)** | **$156,972** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $1,482,871 | $1,605,523 | $1,355,733 | $1,527,504 | $1,527,504 | $171,771 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,482,871** | **$1,605,523** | **$1,355,733** | **$1,527,504** | **$1,527,504** | **$171,771** | **$0** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $19,275 | $157,303 | $152,500 | $157,303 | $161,662 | $4,803 | $4,359 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$19,275** | **$157,303** | **$152,500** | **$157,303** | **$161,662** | **$4,803** | **$4,359** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $8,700 | $0 | $8,700 | $8,700 | $8,700 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$8,700** | **$0** | **$8,700** | **$8,700** | **$8,700** | **$0** |
| **Discretionary Total** | **$1,897,558** | **$2,260,834** | **$1,934,667** | **$2,059,351** | **$2,220,682** | **$124,684** | **$161,331** |
| **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 | $5,700 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$5,700** | **$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** | **$5,700** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $395,412 | $489,308 | $426,434 | **$365,844** | **$522,816** | ($60,590) | $156,972 |
| Medical Community Care | $1,482,871 | $1,611,223 | $1,355,733 | **$1,527,504** | **$1,527,504** | $171,771 | $0 |
| Medical Support and Compliance | $19,275 | $157,303 | $152,500 | **$157,303** | **$161,662** | $4,803 | $4,359 |
| Medical Facilities | $0 | $8,700 | $0 | **$8,700** | **$8,700** | $8,700 | $0 |
| **Obligations [Grand Total]** | **$1,897,558** | **$2,266,534** | **$1,934,667** | **$2,059,351** | **$2,220,682** | **$124,684** | **$161,331** |

[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.

## Foreign Medical Programs Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $2 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$2** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $65,826 | $55,861 | $47,978 | $50,026 | $51,977 | $2,048 | $1,951 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$65,826** | **$55,861** | **$47,978** | **$50,026** | **$51,977** | **$2,048** | **$1,951** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Discretionary Total** | **$65,829** | **$55,861** | **$47,978** | **$50,026** | **$51,977** | **$2,048** | **$1,951** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 (0160) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0160) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Community Care Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8004 (0140) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 (0140) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Veterans Choice Fund (0172) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0152) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0162) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Mandatory Total** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $2 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Community Care | $65,826 | $55,861 | $47,978 | **$50,026** | **$51,977** | $2,048 | $1,951 |
| Medical Support and Compliance | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Facilities | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| **Obligations [Grand Total]** | **$65,829** | **$55,861** | **$47,978** | **$50,026** | **$51,977** | **$2,048** | **$1,951** |

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.

## Spina Bifida Program Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $108 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$108** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $53,374 | $55,575 | $52,440 | $54,486 | $56,610 | $2,046 | $2,124 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$53,374** | **$55,575** | **$52,440** | **$54,486** | **$56,610** | **$2,046** | **$2,124** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Discretionary Total** | **$53,482** | **$55,575** | **$52,440** | **$54,486** | **$56,610** | **$2,046** | **$2,124** |
| **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 | $108 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Community Care | $53,374 | $55,575 | $52,440 | **$54,486** | **$56,610** | $2,046 | $2,124 |
| Medical Support and Compliance | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Facilities | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| **Obligations [Grand Total]** | **$53,482** | **$55,575** | **$52,440** | **$54,486** | **$56,610** | **$2,046** | **$2,124** |

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.

## Children of Women Vietnam Vets Obligations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $2 | $200 | $200 | $208 | $216 | $8 | $8 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$2** | **$200** | **$200** | **$208** | **$216** | **$8** | **$8** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Discretionary Total** | **$2** | **$200** | **$200** | **$208** | **$216** | **$8** | **$8** |
| **MANDATORY** | | | | | | | |
| Medical Services Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 (0160) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0160) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Community Care Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8004 (0140) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 (0140) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Veterans Choice Fund (0172) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0152) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Facilities Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0162) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Mandatory Total** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Community Care | $2 | $200 | $200 | **$208** | **$216** | $8 | $8 |
| Medical Support and Compliance | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Facilities | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| **Obligations [Grand Total]** | **$2** | **$200** | **$200** | **$208** | **$216** | **$8** | **$8** |

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.

VA is currently providing healthcare benefit administration for the beneficiaries of the following programs: CHAMPVA, Foreign Medical Programs, Spina Bifida Program, and Children of Women Vietnam Veterans. This includes reimbursement for Inpatient, Outpatient, Durable

Medical, Pharmacy, travel and limited dental. Covered medical claims are reimbursed to the provider or the beneficiary directly. Additional details can be found in the Medical Community Care chapter.

## Caregiver Support Program

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $856,519 | $1,347,933 | $1,398,765 | $1,811,210 | $2,222,940 | $412,445 | $411,730 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$856,519** | **$1,347,933** | **$1,398,765** | **$1,811,210** | **$2,222,940** | **$412,445** | **$411,730** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $16,658 | $5,200 | $14,368 | $35,000 | $36,365 | $20,632 | $1,365 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$16,658** | **$5,200** | **$14,368** | **$35,000** | **$36,365** | **$20,632** | **$1,365** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Discretionary Total** | **$873,177** | **$1,353,133** | **$1,413,133** | **$1,846,210** | **$2,259,305** | **$433,077** | **$413,095** |
| **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 | $856,519 | $1,347,933 | $1,398,765 | **$1,811,210** | **$2,222,940** | $412,445 | $411,730 |
| Medical Community Care | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Support and Compliance | $16,658 | $5,200 | $14,368 | **$35,000** | **$36,365** | $20,632 | $1,365 |
| Medical Facilities | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| **Obligations [Grand Total]** | **$873,177** | **$1,353,133** | **$1,413,133** | **$1,846,210** | **$2,259,305** | **$433,077** | **$413,095** |

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

**Authority for Action**

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

**Increasing Support to Families and Caregivers**

VA's Caregiver Support Program (CSP) empowers family caregivers to provide care and support to Veterans with a wide range of resources through the Program of General Caregiver Support Services (PGCSS) and the Program of Comprehensive Assistance for Family Caregivers (PCAFC). VA began a major expansion of PCAFC on October 1, 2020.

The PCAFC expansion is implemented in two phases. The first phase, which commenced on October 1, 2020, includes eligible Veterans who incurred or aggravated a serious injury in the line of duty on or before May 7, 1975. As of March 8, 2022, VA has received more than 139,000 unique applications for the PCAFC since October 1, 2020 and added 18,600 additional Veterans and their Family Caregivers in the program. Approximately 10,500 applications remain in process and are pending a determination of eligibility. The program office is preparing for Phase II of PCAFC expansion that is scheduled to begin on October 1, 2022. This phase of expansion will include eligible Veterans who incurred or aggravated a serious injury in the line of duty between May 7, 1975 and September 11, 2001.

In parallel to expanding the program, VA is re-examining its approach to evaluating applications. Feedback from numerous stakeholders and results of recent reassessments of legacy program (post-9/11) participants led to concerns that implementing the regulations as written was preventing some Veterans with moderate to severe caregiving needs from participating in the

program. VA is currently reviewing potential modifications to achieve intended outcomes in all new and legacy cases.

In addition, CSP is responding to a recent court ruling which is expected to have notable impact to the program. On April 19, 2021, the U.S. Court of Appeals for Veterans Claims (Court), in the case of *Jeremy Beaudette & Maya Beaudette v. Denis McDonough*, Secretary of Veterans Affairs, ruled in favor of petitioners seeking review by the Board of Veterans' Appeals (Board) of decisions under VA's PCAFC. As a result of this ruling, Veterans and caregivers who disagree, in whole or in part, with a VA decision under the PCAFC now have expanded appeal options outside the VHA Clinical Appeals process. For cases that have already been adjudicated, Veterans and caregivers who disagree with a PCAFC decision have an opportunity to appeal using the following methods: Higher Level Review, Supplemental Claim or the Board of Veteran Appeals (Board).

# Readjustment Counseling

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $233,010 | $263,383 | $276,663 | $279,635 | $291,612 | $2,972 | $11,977 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$233,010** | **$263,383** | **$276,663** | **$279,635** | **$291,612** | **$2,972** | **$11,977** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $5,295 | $11,951 | $10,136 | $11,951 | $12,345 | $1,815 | $394 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$5,295** | **$11,951** | **$10,136** | **$11,951** | **$12,345** | **$1,815** | **$394** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $43,679 | $48,455 | $39,490 | $48,455 | $49,686 | $8,965 | $1,231 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$43,679** | **$48,455** | **$39,490** | **$48,455** | **$49,686** | **$8,965** | **$1,231** |
| **Discretionary Total** | **$281,984** | **$323,789** | **$326,289** | **$340,041** | **$353,643** | **$13,752** | **$13,602** |
| **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 | $233,010 | $263,383 | $276,663 | **$279,635** | **$291,612** | $2,972 | $11,977 |
| Medical Community Care | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Support and Compliance | $5,295 | $11,951 | $10,136 | **$11,951** | **$12,345** | $1,815 | $394 |
| Medical Facilities | $43,679 | $48,455 | $39,490 | **$48,455** | **$49,686** | $8,965 | $1,231 |
| **Obligations [Grand Total]** | **$281,984** | **$323,789** | **$326,289** | **$340,041** | **$353,643** | **$13,752** | **$13,602** |

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**

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

**Recent Legislation**

***Public Law 116-159, "Continuing Appropriations Act, 2021 and Other Extensions Act." Division E, Section 5106*****,** "Extension of Authority for Pilot Program on Counseling in Retreat Settings for Women Veterans Newly Separated from Service," extends the directive for RCS to provide retreats for women veterans newly separated from service to September 30, 2022. The original allocation for this program was $2.0 million for no less than three retreats per year.

***Public Law 116-315 (The Johnny Isakson and David P. Roe, M.D. Veterans' Health Care and Benefits Improvement Act of 2020), Section 5104*** includes legislation to expand and make 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 (*Public Law 116-315 (Megabus) 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.

***Public Law 116-171, Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019.*** **Section 502**, "Establishment of Department of Veterans Affairs Readjustment Counseling Service Scholarship Program," requires VA to set up a scholarship program for RCS along with the Specialty Education Loan Repayment Program, and to begin awarding scholarships within one year of enactment. The law did not come with funding, and it is estimated that the cost will be approximately $301,200 the first year, assuming five new scholarships will be awarded each year until the first-year cohort graduates and stasis is achieved. Second-year costs would be approximately $590,000, third year approximately $897,600, and fourth approximately $1.3 million, etc., until first cohort graduates and a standing number of scholarships are achieved.

***Public Law 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.

***Public Law 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 will become effective January 1, 2022. VA is in the process of assessing impact and determining resources required for implementation of this legislation.

**Population Covered**

RCS clients include Veterans (95%) and active-duty service members (3%), along with their families, who experience challenges from deployment, combat, or other military-related trauma. Approximately 84% of clients are male and 16% female. The average age of RCS clients is 53 and 61% are currently younger than 60 years.

Over 31% of clients have served or are serving in recent combat theaters or areas of hostility such as Iraq or Afghanistan, with an additional 8% having served in Desert Storm/ Desert Shield. The second largest group of clients served are Vietnam Veterans, representing 29% of those receiving Vet Center Services. Another 15% have served in other areas of Combat or Hostility (not otherwise specified), 10% of those who come to RCS for services have experienced military sexual trauma, and approximately 1% of clients are provided services for bereavement care.

RCS client population is diverse. By self-report, 59% of clients are Caucasian, 20% African American and 13% Hispanic. Approximately 2% are Asian Americans, 2% Pacific Islander/Hawaiian and 1.3% Alaskan Native or Native American. RCS provides services to individuals who have both honorable (90%) and problematic (4%) discharges, as well as those currently engaged in discharge upgrade activities (6%).

**Types of Services Provided**

RCS consists of 300 Vet Centers, 83 Mobile Vet Centers, 1,026 Community Access Points (CAPS) and 22 Vet Center Outstations. Vet Centers across the country provide a broad range of counseling, outreach, and referral services to eligible Veterans, active-duty service members, and their families, to include individuals with problematic discharges. Vet Centers provide guidance to Veterans, service members, and their families through various challenges that often occur after individuals return from deployment or exposure to other traumatic situations. Services for eligible individuals include individual, group, marriage and family counseling for challenges such as the symptoms associated with Post-traumatic stress disorder (PTSD), substance-abuse, suicidal or homicidal ideations and socio-economic issues. Vet Centers also provide connection to other services and benefits available through VA. Vet Center services are provided to family members of Veterans and service members for military-related issues when it is found to aid in the readjustment of those that have served. This includes bereavement counseling for families who experience an active-duty death. All services are at no cost and are strictly confidential.

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

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

**Recent Trends**

Outreach has increased 3% from 2020 to 2021. From 2020 to 2021, RCS has seen a 3% decrease in the total number of unique clients seen either through outreach or providing counseling services. During the same period of 2020 to 2021, crisis interventions continue within RCS with a 9% decrease in acute counseling interventions suggesting that the acuity of those seen in Vet Centers has decreased slightly.

From 2020 to 2021, RCS demonstrated growth in the percentage of clients who identify as female. In 2020, less than 14% of all RCS visits were provided for female clients. In 2021 this number increased to 16% of the overall client visits.

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

Bereavement services were delivered to 5% more clients in 2021 compared to 2020. Consequently, in response to this growing demand, RCS has increased the number of Outstations (satellites of Vet Centers) as well as Community Access Points (CAPs), where counselors are regularly available, albeit not every day, where clients can access services. While Vet Centers are the main service delivery sites, nearly 23% of visits are provided outside of these settings. To meet the needs of Veterans and to provide greater access to services, RCS has CAPs. In addition, hours of operation are adjusted to meet the needs of Veterans and to make access to RCS services convenient.

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

In 2021:

- RCS has provided 1,490,261 visits and 168,586 outreach services for a total of 1,658,847 for 216,809 unique Veterans, Service members and families through visits and outreach.
- Among the 1,490,261 visits, there were 49,395 family visits, 75,386 couple visits, 432,580 group visits and 932,900 individual visits.
- The modalities of the 1,490,261 visits include 720,566 phone visits, 392,986 telehealth visits and 376,709 in-person visits.
- Visits during Non-Traditional Hours totaled 210,201. (Defined as before 8:00 a.m., after 4:30 p.m., and weekends.)

- Vet Center staff provided services in over 1,026 CAPs and 22 Outstations. Four percent of all visits were provided in these distant locations.
- RCS has hosted and/or participated in 32,415 Outreach Events.
- RCS has processed 120,945 live telephone calls from Veterans, Service Members, families and community stakeholders through the Vet Center Call Center.
- RCS continues to be an integral part of the VA 4th Mission (Emergency Response) such as the response to COVID-19, hurricanes, flooding, tornados, shootings and wildfires, providing services to 12,331 Veterans, 1,764 Service members, 1,315 families and 4,263 citizens.
- RCS supported 87 deployment efforts, including 11 Emergency Responses, 75 COVID Vaccination efforts and 1 VAMC support mission.
- RCS awarded 33 leases totaling 7.8 million for Tenant Improvements/Buildouts. The buildout for 13 Vet Center relocations were completed and the space activated, completing 4 expansions and 16 lease renewals.

**Projections for the Future**

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

In 2023 and beyond RCS will:

- Implement the RCS scholarship program (P.L. 116-171, *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019*);
- Increase capacity to expand eligibility for Vet Center services (P.L. 116-176, *Vet Center Eligibility Expansion Act)*;
- Continue the Outdoor Experiences for Veterans Program into 2023 and beyond with the addition of necessary precautions to mitigate COVID-19 related risk and implement 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 (*Public Law 116-315 (Megabus), Section 5104 & 5107 (b);*
- In consultation with the Secretary of Defense, extend 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 will become effective January 1, 2022 (*Public Law 116-283, The William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (NDAA)*;
- Continue to assess infrastructure needs to increase capacity and access;

- Continue efforts to expand and relocate Vet Centers that are inadequate for current staffing needs, authorized staff growth, and optimal service delivery to eligible individuals and their families as well as address infrastructure deficiencies;
- Seek the approval for the movement of CAPs to Outstations;
- Expand Tele-Mental Health Services (Vet Center to eligible individual's home; Vet Center to VA Medical Center when higher level care is required);
- Provide employees with training opportunities to ensure successful knowledge transfer and leadership development;
- Replace aging Mobile Vet Centers;
- Continue to modernize the Mobile Vet Center Fleet; improve infrastructure by adding to the number of Vet Centers and/or relocations in 2023 to include, but not limited to, 2 additional Vet Centers, the relocation of 27 Vet Centers, 3 expansions, and 20 contracted lease renewals.

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

To mitigate this barrier and forecast initial demand, RCS applied planning factors based upon average percentage of service members who seek behavioral health services and applied this to a phased increase of individuals seen as the new eligibilities become more well known. Additionally, to ensure proper resource allocation, RCS will collect specific Vet Center service utilization data on these new eligibility demographics and continually evaluate respective capacity to meet demand. Furthermore, RCS plans to utilize new service projection model data that is currently under development to help improve forecasting of demand, and subsequent resources required to meet that demand, in future budget cycles. RCS will also utilize direct customer feedback data from the newly implemented RCS Vet Centers V-Signals surveys 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 begin providing services for newly eligible reserve component individuals related to recent eligibility expansions in Public Laws. 116-176 and 116-283; however, additional budgetary allocations are required to fully support the anticipated program growth. As these new eligibilities are further socialized and become more widely recognized by DoD and

community partners, RCS anticipates the need for subsequent growth in staffing and physical infrastructure to provide adequate service levels in direct correlation to the increase in eligible individuals referred for services.

With the newly enacted Legislation, RCS expects continued growth and expansion of services. To meet this demand, RCS will hire approximately 118 Counseling, 32 outreach staff, and 25 support staff to increase Vet Center services and support the multi-year planned expansions and/or relocations of Vet Centers nationwide in high-demand and rural areas.

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

In consideration of 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 Servicemembers 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, with relocations/build-outs averaging $600,000. A competitive marketplace coupled with the increase in cost and materials are just a few challenges RCS has encountered during the solicitation process for new space.

The RCS budget request for fiscal years 2023 through 2024 allows for the sustainment and strengthening of services to Veterans, Service members and their families due to projected growth, infrastructure requirements and the recently enacted legislation. With the requested budget, RCS can deliver quality services to Veterans today, address a previous backlog and future RCS capital improvements and more capably address the growing future demand combat Veterans have for RCS services.

### RCS Workload

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **203 Revised Request** | **2024 Advance Approp.** | +/- 2021-2022 | +/- 2022-2023 |
|---|---|---|---|---|---|---|---|
| Visits (000) | 1,490 | 2,275 | 1,522 | 1,553 | 1,583 | 31 | 30 |
| Unique Patients (000) | 217 | 359 | 235 | 244 | 258 | 9 | 14 |

## Activations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Obligations** | | | | | | | |
| Medical Services (0160): | $322,422 | $609,608 | $609,608 | $591,526 | $360,651 | ($18,082) | ($230,875) |
| Medical Community Care (0140): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance (0152): | $32,001 | $112,060 | $112,060 | $132,193 | $103,733 | $20,133 | ($28,460) |
| Medical Facilities (0162): | $37,521 | $174,814 | $174,814 | $46,185 | $35,616 | ($128,629) | ($10,569) |
| **Obligations [Grand Total]** | **$391,944** | **$896,482** | **$896,482** | **$769,904** | **$500,000** | **($126,578)** | **($269,904)** |

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

## Epilepsy Centers of Excellence: Telehealth & Tele EEG Expansion

| Description (dollars in thousands) | 2021 Actual 1/ | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary Obligations** | | | | | | | |
| Medical Services (0160): | $7,764 | $10,000 | $10,000 | $19,086 | $18,751 | $9,086 | ($335) |
| Medical Community Care (0140): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance (0152): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Facilities (0162): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Grand Total]** | **$7,764** | **$10,000** | **$10,000** | **$19,086** | **$18,751** | **$9,086** | **($335)** |

The Epilepsy Centers of Excellence (ECoE) were established to improve the health and well-being of Veterans with epilepsy and other seizure disorders through integration of clinical care, outreach, research and education. The ECoE network comprises four regional centers and 17 VA Hospitals and associated consortium sites that provide comprehensive epilepsy care for Veterans with seizure disorders, including those with post traumatic epilepsy due to traumatic brain injury (TBI). In addition to TBI, stroke and dementia increase risk of developing epilepsy—diseases that are increasing as the population ages (Forsgren et al., 1996; Feigin et al., 2019). The number of Veterans with definite or probable epilepsy/seizures receiving care in VA has increased from 327,758 in 2014 to 404,579 in 2020, a 23% increase over the past six years. To reach these Veterans, there is an acute need to expand access to specialized epilepsy care: approximately 25% of Veterans with seizures are seen by neurologists, and less than 5% are seen by epilepsy subspecialists (epileptologists). Access to electroencephalograms (EEGs), the gold standard test for diagnosing and treating epilepsy, is insufficient at many VA Hospitals and medical centers resulting in expensive community transfers. EEG studies sent to the community are often interpreted by general neurologists who lack the subspecialty expertise that VA has amassed within

ECoE. Further expanding the current ECoE TeleHealth and Tele-EEG programs will extend the expertise of VA epileptologists to ensure that Veterans nationwide receive equitable care.

**Evidence**

Thirty-four percent of Veterans with seizures live in rural areas, far from VA Hospitals that provide specialized epilepsy care. Community neurology care is limited in these areas, and subspecialty epilepsy care is virtually non-existent. As a result, numerous Veterans with epileptic and non-epileptic seizures remain undiagnosed or misdiagnosed (Salinsky et al., 2012). Lack of timely correct diagnosis leads to treatment delays, unnecessary morbidity and increased costs due to frequent emergency department visits and hospital admissions (Lewis et al., 2021). The mean added cost of poorly controlled epilepsy versus well controlled epilepsy in the U.S. has been calculated to be $9,399 per individual (Cramer et al., 2014). Seizures dramatically impair Veteran quality of life. Those with inadequately treated seizures often cannot drive or work. Consequently, the suicide rate in Veterans with seizures is double that of other Veterans—an already high-risk population (Bornovski et al., 2021).

ECoE can deploy epilepsy care to remote areas via TeleHealth. Tele-EEG networks allow EEGs to be performed in remote VA hospitals or clinics and interpreted by a remote epilepsy subspecialist. Despite the dramatic increase in TeleHealth visits for Veterans with epilepsy during the COVID-19 pandemic, access and connectivity to epilepsy specialists remains insufficient to meet needs of Veterans with seizures. Fewer than 5% of Veterans with epilepsy/seizures are evaluated by an epileptologist, whereas an estimated 30% of epilepsy/seizure patients have intractable epilepsy requiring subspecialty care (Schuele & Lüders, 2008). The expansion and optimization of TeleHealth and Tele-EEG networks proposed here will expedite diagnosis, reduce Veteran wait times & travel distances, and decrease reliance on community care referrals. Thus, this proposal will reduce inequities in epilepsy care across VA. The alternative to this expansion is the status quo, a situation in which Veterans who live in urban areas with epilepsy expertise have access to state-of-the-art diagnosis and treatment whereas rural Veterans may not be diagnosed correctly if at all.

**Implementation Plan**

The expanded epilepsy TeleHealth and Tele-EEG program proposed here will include:

- Development of a Tele-epilepsy team to complete virtual seizure evaluations nationwide. This team comprises 16 physicians at 0.25 FTE each, 2 RNs at 0.5 FTE each.
- Development of a pool of epileptologists to interpret outpatient EEGs, as well as continuous EEGs to support critical care provided in VA intensive care units and EDs. A portion of this pool will come from existing ECoE staff epileptologists. To provide 24/7/365 continuous EEG services, a minimum of 8.4 additional epileptologist FTEs are required.
- Both physician teams above will report to a Tele-Epilepsy physician lead (0.51 FTE).
- EEG administrative and technical infrastructure to support the above 2 initiatives includes a project manager (GS-14), a national lead EEG technician (GS-12), 4 regional EEG

technologists at 0.25 FTE each (GS-11), and regional biomed support (GS-12 at 0.25 FTE times four) and a national biomed lead (GS-15 at 1 FTE). Project manager will coordinate with biomed and OI&T to ensure adequate connectivity.

- Development of four regional Tele-EEG servers and provision of EEG equipment for new connections.
- Site visits to bring up new sites (one traveler to eight sites per year).
- Two planning meetings per year with VA stakeholders including the VA Office of Connected Care, Tele-Critical Care Program Office and Tele-Neurology Program. Outside consultants with network management and TeleHealth expertise will be included as needed.
- Creation of national contracts with three home-based EEG vendors to complement VA Tele-EEG. These vendors provide service in areas remote from all Tele-EEG connections or in sites lacking EEG technologists. Contracts will speci EEG interpretation by VA epileptologists.

Program implementation is feasible: a pilot program involving several ECoE sites supports four Tele-EEG hubs (Boston, Portland, Madison, and Durham) and 22 remote connections. This current network supports only store-and-forward EEG used for outpatient evaluations. The continuous (real-time synchronous) Tele-EEG monitoring proposed here to support VA critical care is also feasible, requiring only additional staffing and connections. One barrier is the paucity of EEG technologists, particularly in rural areas, which will be addressed by contracting with EEG vendors for the technologist service component while retaining the professional component (EEG interpretation by VA epileptologists) within VA.

Effectiveness of the program expansion will be evaluated by the following metrics:

- Increase the proportion of Veterans with seizure disorder/epilepsy receiving care from an epileptologist by 50% within 4 years.
- Increase EEG access at VAMCs:
    - Increase the number of VAMCs offering routine EEGs by 50% of VAMC over 4 years.
    - Increase the number of VAMCs offering stat EEGs by 50% over 4 years.
    - Increase the number of VAMCs offering continuous EEG monitoring by 50% over four years.
- Decrease the proportion of community care ED or hospital transfers for EEG by 25% within four years.

The above metrics will be determined by review of 20,000 Veteran charts annually (~5% sampling) by the External Peer Review Program (EPRP) to assess these and other quality indicators. This is feasible as VA has contracted with EPRP over more than a decade to assess care quality provided within VHA, and ECoE staff have effectively partnered with EPRP previously.

References:

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# Education & Training

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | $2,237,422 | $2,400,650 | $2,400,650 | $2,511,533 | $2,650,338 | $110,883 | $138,805 |
| Medical Community Care (0140): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance (0152): | $71,304 | $76,128 | $76,128 | $79,626 | $83,998 | $3,498 | $4,373 |
| Medical Facilities (0162): | $99,366 | $106,091 | $106,091 | $110,971 | $117,075 | $4,880 | $6,103 |
| **Discretionary Total** | **$2,408,092** | **$2,582,869** | **$2,582,869** | **$2,702,130** | **$2,851,411** | **$119,261** | **$149,281** |
| **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) | $3,533 | $2,365 | $2,365 | $2,448 | $2,533 | $83 | $85 |
| **Mandatory Obligations [Subtotal]** | **$3,533** | **$2,365** | **$2,365** | **$2,448** | **$2,533** | **$83** | **$85** |
| 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) | $2,717 | $1,453 | $1,453 | $1,504 | $1,556 | $51 | $52 |
| **Mandatory Obligations [Subtotal]** | **$2,717** | **$1,453** | **$1,453** | **$1,504** | **$1,556** | **$51** | **$52** |
| Medical Facilities Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0162) | $2,011 | $269 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$2,011** | **$269** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Mandatory Total** | **$8,261** | **$4,087** | **$3,818** | **$3,952** | **$4,089** | **$134** | **$137** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $2,240,955 | $2,403,015 | $2,403,015 | $2,513,981 | $2,652,871 | $110,966 | $138,890 |
| Medical Community Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance | $74,021 | $77,581 | $77,581 | $81,130 | $85,554 | $3,549 | $4,425 |
| Medical Facilities | $101,377 | $106,360 | $106,091 | $110,971 | $117,075 | $4,880 | $6,103 |
| **Obligations [Grand Total]** | **$2,416,353** | **$2,586,956** | **$2,586,687** | **$2,706,082** | **$2,855,500** | **$119,395** | **$149,418** |

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.

## Graduate Medical Education (GME) Trainees

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | $744,310 | $832,212 | $832,212 | $862,532 | $892,721 | $30,320 | $30,189 |
| 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** | **$744,310** | **$832,212** | **$832,212** | **$862,532** | **$892,721** | **$30,320** | **$30,189** |
| **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) | $3,533 | $2,365 | $2,365 | $2,448 | $2,533 | $83 | $85 |
| **Mandatory Obligations [Subtotal]** | **$3,533** | **$2,365** | **$2,365** | **$2,448** | **$2,533** | **$83** | **$85** |
| 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) | $2,717 | $1,453 | $1,453 | $1,504 | $1,556 | $51 | $52 |
| **Mandatory Obligations [Subtotal]** | **$2,717** | **$1,453** | **$1,453** | **$1,504** | **$1,556** | **$51** | **$52** |
| Medical Facilities Category | | | | | | | |
| Veterans Medical Care and Health Fund (0173) 1/ | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0162) | $2,011 | $269 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$2,011** | **$269** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Mandatory Total** | **$8,261** | **$4,087** | **$3,818** | **$3,952** | **$4,089** | **$134** | **$137** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $747,843 | $834,577 | $834,577 | $864,980 | $895,254 | $30,403 | $30,274 |
| Medical Community Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance | $2,717 | $1,453 | $1,453 | $1,504 | $1,556 | $51 | $52 |
| Medical Facilities | $2,011 | $269 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Grand Total]** | **$752,571** | **$836,299** | **$836,030** | **$866,484** | **$896,810** | **$30,454** | **$30,326** |

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.

## Education and Training Non-GME Trainees

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | $243,937 | $234,727 | $234,727 | $253,939 | $285,827 | $19,212 | $31,888 |
| Medical Community Care (0140): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance (0152): | $328 | $349 | $349 | $361 | $374 | $12 | $13 |
| Medical Facilities (0162): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Total** | **$244,265** | **$235,076** | **$235,076** | **$254,300** | **$286,201** | **$19,224** | **$31,901** |
| | | | | | | | |
| **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 | $243,937 | $234,727 | $234,727 | $253,939 | $285,827 | $19,212 | $31,888 |
| Medical Community Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance | $328 | $349 | $349 | $361 | $374 | $12 | $13 |
| Medical Facilities | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Grand Total]** | **$244,265** | **$235,076** | **$235,076** | **$254,300** | **$286,201** | **$19,224** | **$31,901** |

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.

# Education and Training Support

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | $1,249,175 | $1,333,711 | $1,333,711 | $1,395,062 | $1,471,790 | $61,351 | $76,728 |
| Medical Community Care (0140): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance (0152): | $70,976 | $75,779 | $75,779 | $79,265 | $83,624 | $3,486 | $4,360 |
| Medical Facilities (0162): | $99,366 | $106,091 | $106,091 | $110,971 | $117,075 | $4,880 | $6,103 |
| **Discretionary Total** | **$1,419,517** | **$1,515,581** | **$1,515,581** | **$1,585,298** | **$1,672,489** | **$69,717** | **$87,191** |
| **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 | $1,249,175 | $1,333,711 | $1,333,711 | $1,395,062 | $1,471,790 | $61,351 | $76,728 |
| Medical Community Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance | $70,976 | $75,779 | $75,779 | $79,265 | $83,624 | $3,486 | $4,360 |
| Medical Facilities | $99,366 | $106,091 | $106,091 | $110,971 | $117,075 | $4,880 | $6,103 |
| **Obligations [Grand Total]** | **$1,419,517** | **$1,515,581** | **$1,515,581** | **$1,585,298** | **$1,672,489** | **$69,717** | **$87,191** |

[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

As one of four statutory missions, VA, through the VHA Office of Academic Affiliations (OAA) conducts the largest education and training platform for Health Professions Trainees (HPTs) in the Nation "to assist in providing an adequate supply of health personnel to the Nation" (38 United States Code [U.S.C.], section 7302). In accordance with this mission "to educate for VA and for the Nation," clinical education and training efforts are accomplished through coordinated programs and activities in partnership with affiliated U.S. academic institutions.

In addition, Public Law 113-146, *Veterans Access, Choice, and Accountability Act of 2014* (VACAA), Section 301(b)(2) of the Act, charges VA to "increase the number of Graduate Medical Education (GME) residency positions at medical facilities of the Department by up to 1,500 positions," over a five-year period beginning one year after the enactment of the VACAA. Subsequently, P.L. 114-315, *Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016*, extended the period for the increase in GME residency positions at medical facilities of the Department of Veterans Affairs from five to ten years (expiring August 7, 2024). Additionally, Public Law 115-182, *VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018* (VA MISSION), Section 403 of the Act, charges the VA to develop and implement a pilot program to establish Graduate Medical Education (GME) physician residency programs at covered facilities in underserved areas. P.L. 116-159 extended the authority of Section 403 from August 7, 2024, to August 7, 2031.

**VA Staff Impacted**

Over 113,000 trainees participated in over 7,000 training programs offered through partnerships between 150 VA health care facilities and over 1,400 academic institutions during the 2020-2021 academic year. Ninety-seven percent of all U.S.-based medical schools are affiliated with VA, including 153 of the nation's 155 Liaison Committee on Medical Education (LCME)-accredited MD-granting schools and all 37 Commission on Osteopathic College Accreditation (COCA)-accredited DO-granting medical schools in the United States. In addition to physicians, over 50 other clinical disciplines are represented in VA's training programs. Nearly 20,000 trainees in VA come from Minority Serving Institutions, such as Hispanic Serving Institutions (HSIs) and Historically Black Colleges and Universities (HBCUs). GME Physician Residents, primarily paid indirectly through disbursement agreements, account for approximately 78% of the clinical trainee budget; non-GME trainees account for the remainder. Non-GME trainees include all other health professions such as nursing, podiatry, optometry, psychology and pharmacy. OAA creates and maintains policy oversight of the health professions education mission in VA, and offers guidance and consultation to field facilities, Veterans Integrated Service Networks, and other VA constituencies. OAA is the primary source for health professions trainee data in VA and acts as the main liaison to external stakeholders such as professional and member organizations, specialty societies and accrediting bodies for health professions education.

**Type of Services Provided**

Health professional trainees contribute substantially to VA's mission to deliver cost-effective, high-quality patient care for Veterans. VA Health Professions Education (HPE) programs play a leading role in creating the health care workforce for VA and the Nation. For example, over 70% of VA podiatrists and psychologists, over 80% of VA optometrists and over 60% of VA physicians participated in VA training programs prior to employment. When HPTs are queried about the impact of their recent training experiences in VA, their willingness to work for VA increases by 20% as compared to before participating in VA training. VA's involvement in health professions education has thus been shown to be an effective mechanism to support VA's patient care mission.

Data shows that registered nurses and nurse practitioners continue to be ranked as Mission-Critical Occupations. In response, OAA has implemented multiple innovative nursing education training programs aimed to address VHA and national Registered Nurse (RN) and Nurse Practitioner (NP)

workforce shortages, such as a robust expansion of RN and NP residency programs.

**Recent Trends**

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

The VACAA allowed VA to increase the number of GME physician residency positions by up to 1,500 over a ten-year period, with an emphasis on primary care, mental health and other specialties that the Secretary deemed appropriate. Thus far, over 1,425 positions have been awarded through this initiative, with two thirds of awarded positions in primary care (internal medicine, family medicine and geriatrics) and mental health (addiction medicine, general psychiatry and psychiatric sub-specialties). VA plans to implement the remaining 75 VACAA positions in 2023.

The VA MISSION Act contained numerous provisions to augment recruitment of trainees into the VA workforce. Section 304 requires VA to conduct a pilot program to provide funding for the medical education of a single cohort of eligible Veterans. In 2020, VA awarded 12 Veterans with scholarships at eight of the nine eligible medical schools.[28] Each of the 12 recipients have completed their first year of medical school. The single cohort is funded for four years. WMC manages the scholarship program and funding. VA does not anticipate that the program will continue past the pilot. With the understanding that physicians tend to stay and practice in the area they last trained, Section 403 aims to increase GME programs in high priority rural locations named in the legislation (Indian and tribal lands, facilities managed by IHS and underserved VHA facilities). This would provide a workforce pipeline for these rural locations. Section 403 provides new authorities for the payment of resident stipends and benefits and reimburses startup costs for new residency programs. The MISSION Act recognizes that in rural areas, the density of Veteran

[28] Eligible Medical Schools:

- Charles R. Drew University School of Medicine
- Howard University
- Meharry Medical College
- Morehouse School of Medicine
- East Tennessee State University
- Marshall University
- Texas A&M University
- University of South Carolina
- Wright State University

patients alone may not be enough to establish new residency programs; therefore, this section also authorizes VA to expand its ability to pay for resident time beyond delivering Veteran care.

**Projections for the Future**

VA continues to be a sought-after partner for health professions training programs, due to its size, national scope and breadth of training opportunities. Veterans are a unique patient population and trainees value their experiences working with Veterans. VA is the second-largest federal payor of GME (second to the Center for Medicare and Medicaid Services) and is a major funder of residency programs across a variety of health professions.

VA expects continued growth in health professions education, due to accreditation of new professions as well as the continued addition of new levels of training (e.g., new residency programs for both nurse practitioners and physician assistants). Furthermore, OAA has conducted extensive outreach to minority serving institutions and expects continued growth in the number of partnerships with these institutions.

VA is the largest employer of nursing personnel in the country, with more than 112,000 registered nurses. The VHA Office of Workforce Management and Consulting (WMC) projection models indicate that VA will need to annually hire approximately 14,260 additional nursing personnel across all education levels for a total of roughly 71,300 new hires over the next five years to fulfill a critical mission of caring for our Nation's Veterans. OAA nurse residency programs serve as critical components of the VA nursing workforce supply chain, facilitating VA's recruitment and retention goals. OAA, in collaboration with WMC and the Office of Nursing Services, devised a VHA Nurse Residency Expansion plan with the goal of increasing 2023 Nurse Residency allocations by an additional 110 RN residency and 30 NP residency positions, with the goal of continuing expansion into the future.

VA expects that solicitation for pilot sites for the MISSION Act Section 403 would begin in calendar year 2022, and residency programs would be established in 2023-2024. Because of the multi-year accreditation processes for GME that require curriculum development and faculty recruitment, VA estimates that it will be 2024 before residents are able to begin the pilot at these new residency sites.

**Approved Graduate Medical Education (GME) Positions:**

| Academic Year | Fiscal Year | Category | Filled GME Positions |
|---|---|---|---|
| 2020 – 2021 | 2021 | Actual | 11,546 |
| 2021 – 2022 | 2022 | Estimate | 11,770 |
| 2022 – 2023 | 2023 | Estimate | 11,844 |
| 2023 - 2024 | 2024 | Estimate | 11,938 |

The 2023 request also includes a legislative proposal to implement a joint VA-United States Public Health Service (PHS) Health Professions Scholarship Program (HPSP) for students enrolled in the Hébert School of Medicine at the Uniformed Services University of the Health Sciences (USU).

This new program and legislative authority would enable VA to expand its own HPSP program and fund the education of medical students enrolled in USU as commissioned junior PHS officers and serve as VA physicians to fulfill their 10-year PHS service obligation. This program will provide VA with a committed cadre of Veteran-oriented, mission-focused physicians.

# Health Care Professionals Educational Assistance Program

| Description (Dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Obligations [Total]** | **$140,822** | **$205,785** | **$205,785** | **$248,033** | **$318,758** | **$42,248** | **$70,725** |
| Education Debt Reduction Program (EDRP) | $92,156 | $145,000 | $145,000 | $160,000 | $210,000 | $15,000 | $50,000 |
| Specialty Education Debt Reduction Program (SELRP) | $380 | $8,000 | $8,000 | $12,000 | $12,000 | $4,000 | $0 |
| Employee Incentive Scholarship Program (EISP) | $3,237 | $2,900 | $2,900 | $3,600 | $7,470 | $700 | $3,870 |
| VA National Education for Employees Program (VANEEP) | $13,892 | $12,287 | $12,287 | $13,900 | $19,478 | $1,613 | $5,578 |
| Nat'l Nursing Education Initiative (NNEI) | $14,031 | $17,049 | $17,049 | $18,460 | $19,871 | $1,411 | $1,411 |
| Health Professional Scholarship Program (HPSP) | $16,800 | $20,324 | $20,324 | $39,848 | $49,714 | $19,524 | $9,866 |
| Visual Impairment Education Assistance Program (VIOMPSP) | $326 | $225 | $225 | $225 | $225 | $0 | $0 |

## Education Debt Reduction Program

### Purpose

The Education Debt Reduction Program (EDRP) serves as a critical recruitment and retention tool used by the Department of Veterans Affairs (VA), Veterans Health Administration (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 healthcare providers.

### Evidence

Since program inception, EDRP has been used to recruit and retain over 20,000 individuals providing direct patient care to Veterans. During the 2021 application cycle, VHA awarded 2,091 new EDRP awards. Physicians historically receive the most EDRP awards followed by Registered Nurses (including Advanced Practice Nurses) and Psychologists. The EDRP remains a strong recruiting tool for VHA used to help meet the immediate need to fill hard-to-recruit patient care providers in nationally scarce specialties.

### Implementation Plan

EDRP will be used by medical centers to recruit and retain 3,000 additional healthcare professionals annually in hard-to-fill patient care positions, while continuing to retain current program participants for the remainder of their service periods, which typically lasts five years.

### Costs

EDRP participants can receive up to $200,000 over five years at $40,000 annually. Average award amounts have increased along with program demand to meet VHA recruitment and retention healthcare provider needs. Demand in recent years represents a 295% increase in active participants in 2021, compared to 2015 program participation.

New EDRP awards averaged $77,000 in 2018 and increased to $112,000 in 2019 with the implementation of Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act. Average EDRP award amounts reached $114,000 in 2020 and in 2021, the average EDRP award for new participants was near $111,000–a 44% increase to the award average when compared to pre-MISSION awards.

EDRP will reimburse 6,000 participants in 2022. In 2023, EDRP participants are projected to reach 9,000 and will require $160.0 million in EDRP loan reimbursement payments. Program projections for 2024 includes approximately 12,000 participants and will require $210.0 million in reimbursement payments and additional operational staff to execute the program. Nine additional operational staff for the national program office are required to support the exponential program growth, centralized reimbursement payment, and standardization for a more strategic implementation of the program and significant reduction of collateral duties burdening over-extended field staff, at a cost of $1.2 million in 2023 and $1.2 million in 2024. Centralization will result in more efficient application processing as well as fewer errors and delays that require corrective action.

## Specialty Education Loan Repayment Program

### Purpose

The Specialty Education Loan Repayment Program (SELRP) was authorized by Section 303 of the MISSION Act of 2018 as a loan repayment program specifically targeted to attract recent medical school graduates for VA service in exchange for a total of $160,000 (at $40,000 per year) in education loan repayment. The program will establish a pipeline of specialized providers to meet VHA's future staffing needs by offering loan repayment to medical school graduates with at least two years remaining in their residency programs, thereby allowing VHA to compete with the private sector for new graduates.

### Evidence

SELRP is a new program mandated by the MISSION Act 2018 and was deployed in April 2021. According to the Association of American Medical Colleges (AAMC), the United States faces a shortage of up to 122,000 physicians by 2032, including a critical need for specialists to treat an aging population that will increasingly live with chronic disease. The VHA currently competes against lucrative privatesector offers to physicians during their residency training. It is imperative that VHA use financial incentive programs like the SELRP to secure early employment commitments from physicians completing training programs. The VHA currently anticipates system wide recruitment challenges for physicians with specialized training in Primary Care, Geriatrics, Emergency Medicine, Gastroenterology and Psychiatry, all of which are among the nation's most scarce specialties. The SELRP will target medical students and residents training in these specialties to establish a pipeline of specialists to address the projected needs.

### Implementation Plan

SELRP was deployed in April 2021 with an initial cohort of ten participants. Full implementation is expected in 2022. SELRP will offer loan payment up to $40,000 annually in return for twelve months of service for every $40,000 received. SELRP participants may receive up to $160,000 maximum for four years of service.

### Costs

The 2022 estimate of $8.0 million will cover the reimbursement costs for 200 SELRP participants at a rate of $40,000 each. The program will continue to expand each year, offering loan repayment for 100 new participants annually for a cost of $12.0 million in 2023 and 2024.

**Employee Incentive Scholarship Program (EISP) /VA National Education for Employees Program (VANEEP)/ National Nursing Education Initiative (NNEI):**

**Purpose**

Title 38 United States Code, Chapter 76, established the Employee Incentive Scholarship Program (EISP). EISP authorizes VA to award scholarships to employees pursuing academic degrees in clinical occupations where recruitment and retention of qualified personnel may be challenging. The academic curricula covered under this program includes education and training programs in fields leading to appointments or retention in clinical occupations. EISP awards cover tuition and related expenses such as registration, fees, and books in return for a one to three-year service obligation following graduation and licensure or certification. The VA National Education for Employees Program (VANEEP) and the National Nursing Education Initiative (NNEI) are initiatives within EISP. Under VANEEP, VA facilities allow certain scholarship participants to accelerate their degree completion by attending school full time. VANEEP provides educational funding and replacement salary to the facility to cover critical staffing needs during the participant's absence. The NNEI program is limited to funding Registered Nurses (RN) pursuing associate, baccalaureate, and other advanced degrees.

**Evidence**

As the Nation's largest integrated health care delivery system, VA nursing workforce challenges mirror those of the health care industry. The EISP, NNEI, and VANEEP help alleviate the healthcare workforce shortages in VA by requiring scholarship recipients to complete a one to three-year service obligation at a VA medical facility. As of September 30, 2021, VA has awarded 22,970 scholarships to EISP, NNEI, and VANEEP participants since the program started in 2000. During 2021, VA administered scholarships for 2,332, including 633 new awards, to EISP, NNEI and VANEEP participants.

The NNEI program is a key source for retention of employees in the registered nursing occupation. Rugs, et al., (2021)[29], conducted an evaluation of NNEI and identified predictors of degree completion for 10,043 participants in 162 VHA facilities from 2000 to 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 VHA two years later. Consistent with the statutory intent, NNEI helps alleviate the health care workforce shortages as well as helps VA build a highly qualified nursing workforce capable of supplying the best care to Veterans.

**Implementation Plan**

Current scholarship program funding limits the number of new and continuing participant awardees thereby inhibiting program expansion. The increased funding for the NNEI program would provide increased opportunities for registered nurses to remain in current clinical occupations with a service obligation commitment at a VA facility. The NNEI expansion would also result in increased demands, workload, and support required by the national program office. Workforce Management and Consulting (WMC) is requesting an increase in NNEI funding ($18.4

[29] Rugs D, Nedd N, Quast T, Wang X, Hyacinthe M, Hall KS, Powell-Cope G. An evaluation of the Veterans Health Administration National Nursing Education Initiative. *Nurse Outlook. 2021 Mar-Apr;69*(2):193-201

million) for 2023 and ($19.8 million) for 2024 to sustain and grow the NNEI scholarship program and to prepare and retain VA registered nurses to meet patient demand.

Based on the five-year average, VHA will continue to award at least 801 new scholarships annually in 2023 and 2024, with an added 160 NNEI awards. This is in addition to managing and funding the EISP, VANEEP, and NNEI awards for continuing participants. Priority consideration is given to applicants whose completion occupations align with those entering the mental health field, and those agreeing to fulfill their service obligations at a rural health facility. Failure to secure funding to continue the work of the EISP, VANEEP, and NNEI programs would have an adverse impact on the ability to sustain the increased new and continuing awards supported by the national program office. This would also limit future expansion of critical nursing workforce initiatives. If the 2023 or 2024 budgets are not adjusted, NNEI would continue to provide employees educational assistance at current levels.

**Costs**

EISP, VANEEP and NNEI awards are based on the average total of educational assistance awarded to all occupations. The current average annual cost per participant for EISP of $9,171, VANEEP of $43,947 and NNEI of $8,819 is based on historical disbursements to employees. The increase in medical compliance and support would sustain the infrastructure necessary to increase the number of new awards, continuing awards, developing and deploying training and education to over 336 field-based coordinators, enhancing academic partnerships and expanding new partnerships, and conducting daily management and operations of the Scholarship Clinical Education Program (SCEP) Application and database. For 2023 and 2024, WMC included a request for the addition of one support staff to support NNEI program growth. The added FTE is calculated for one GS-09 Training Technician (2021 Rest of US Salary Pay Scale). Salary increases use 3.4% OMB economic assumption and benefits at 34%.

## Health Professional Scholarship Program

**Purpose**

The Health Professional Scholarship Program (HPSP) allows VA to award scholarships to applicants pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel are difficult. The HPSP prioritizes applicants training in a clinical occupation commensurate with the largest staffing shortages in the VA. The increased funding for the HPSP would expand the pipeline of qualified candidates to fill critical healthcare workforce shortage areas since the applicants awarded the scholarship must fulfill a service obligation at a VA medical facility.

**Evidence**

From the inception of the HPSP in 2016, VA has awarded scholarships to participants in the following occupational disciplines: Physician Assistants, Nurses, Nurse Practitioners, Pharmacists, Physical Therapists, and Medical Technologists. In 2018, Title III of the MISSION Act was passed with the intent to create a pipeline of medical doctors to fill vacancies and increase access to care for Veterans.

Section 301 of the VA MISSION Act requires that not less than 50 scholarships be awarded each year to individuals who are accepted for enrollment or are enrolled in a program of education or

training leading to employment as a physician or dentist until such date as the Secretary determines that the staffing shortage of physicians and dentists in the Department is less than 500.

In 2021, the HPSP expanded to include medical students as directed by Section 301 of the VA MISSION Act of 2018. As of September 30, 2021, 178 medical students have been awarded scholarships. From the inception of the HPSP in 2016 through September 30, 2021, VA has awarded 763 total scholarships to HPSP participants. Each HPSP recipient agrees to a service obligation period at a VA medical facility which helps alleviate health care workforce shortages. Upon award of the scholarship, recipients sign a minimum two-year service obligation as well as a mobility agreement. Since the inception of HPSP in 2016, VA placed over 291 clinicians, in multiple disciplines, across the Nation. Additionally, HPSP enables students to gain academic credentials without additional burden of student loan debt. Future benefits are gained in reduced recruitment costs as scholarship recipients will have obligated service agreements to fulfill.

**Implementation Plan**

In 2023 and 2024, HPSP will award a minimum of 75 new awards annually while managing and funding the continuing HPSP awards for active participants. This program will provide a pipeline of providers once medical school and the required residency training are completed.

In 2023, HPSP will expand Nurse selection to a minimum of 300 from its current rate of 50 per year. In 2024, the minimum nursing selection rate will increase to 400 annually.

**Costs**

HPSP costs are based on the average annual individual award amount of $67,000, which includes tuition charges, miscellaneous expenses and a monthly stipend. The average annual awards are based on historical payments to schools and students. Scholarship amounts include a 3.3% annual average increase for each out-year of the program. These percentage increases are based on average rate of growth of percentage increase published by The College Board.

A cost analysis was completed. The $39.8 million request for 2023 and the $49.7 million request for 2024 (Mission Act HPSP) would sustain the medical student portion of HPSP as required by the VA MISSION Act of 2018 and allow for the nursing selection expansion. This amount allows for 75 new awards annually as well as funding for continuing awards from previous years for medical students, the selection of an additional 300 nurses annually and supports awards for other critical specialties.

Cost includes scholarships and an increase in staff to support by four employees (three GS-12s and one GS-9) totaling, as well as automating services.

Increase FTE: Current HPSP staff includes the Program Manager and two GS-12s. In addition, we currently rely on staff from other program offices and contracting representatives to manage the workload. The additional four FTE will enable the program to increase awards from 170 per year to 600 per year to medical students and nursing students while continuing to offer awards in other critical specialties. The increased staff will ensure candidates have an overall positive customer experience and will eventually increase providers at the bed side of VHA facilities increasing access to care for our Veterans.

**Visual Impairment Education Assistance Program (VIOMPSP)**

**Purpose**

VHA's Program Guide provides specific direction and guidance related to the application, selection, and award procedures of the Visual Impairment and Orientation and Mobility Professionals Scholarship Program (VIOMPSP). It provides a summary of the rights and liabilities of an individual whose VIOMPSP application is approved, and acceptance agreement is consummated by VA. AUTHORITY: 38 United States Code 7501 through 7505.

**Evidence**

From the inception of the VIOMPSP in 2015 through September 30, 2021, VA has awarded 30 scholarships to VIOMPSP focusing on orientation and mobility, living skills and low vision. In 2022 the budget was reduced from $900,000 to $225,000 to match the demand and participant awards.

**Implementation Plan**

The VIOMPSP provides financial assistance to individuals pursuing a program of study leading to a degree or certificate in visual impairment or orientation and mobility. For VIOMPSP, each scholarship recipient receives tuition (up to $15,000) for each year of a degree program (not to exceed a total of $45,000). As of September 30, 2021, VA has awarded 30 scholarships to VIOMPSP participants since the program started in 2015. Plans are to award five per year annually.

**Costs**

VIOMPSP costs are based on the average annual individual award amount of $15,000, which includes tuition charges and miscellaneous expenses. The average annual awards are based on historical payments to schools. VIOMPSP awards are made on a competitive basis to eligible students who meet certain selection criteria. During the selection process, students are ranked with their peers for each health care profession. Scholarship amounts include a 3.3% annual average increase for each out year of the program. The percentage increases are based on average rate of growth published by the College Board. Cost includes scholarships totaling $225,000 in 2023 and $225,000 in 2024.

## Indian Health Service (IHS)/Tribal Health Programs (THP) / Urban Indian Organizations (ITU) Reimbursement Agreements Program

| | | 2022 | | **2023** | **2024** | | |
|---|---|---|---|---|---|---|---|
| Description (dollars in thousands) | 2021 Actual | Budget Estimate | Current Estimate | **Revised Request** | **Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
| **Discretionary Obligations** | | | | | | | |
| Medical Services (0160): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Community Care (0140): | $28,010 | $30,000 | $31,196 | $32,345 | $33,606 | $1,149 | $1,261 |
| 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]** | **$28,010** | **$30,000** | **$31,196** | **$32,345** | **$33,606** | **$1,149** | **$1,261** |

Under the authority of 25 U.S.C. §1645(c) and 38 U.S.C §8153, the Department of Veterans Affairs (VA) established a national interagency sharing/ reimbursement agreement with the Department of Health and Human Services/Indian Health Service (HHS/IHS) in 2012 to reimburse

IHS for the provision of Direct Care Services to eligible American Indian (AI)/Alaska Native (AN) Veterans. The National Reimbursement Agreement paved the way for VA to enter into individual agreements with Tribal Health Programs (THPs) to reimburse THPs for Direct Care Services provided to eligible AI/AN Veterans. Additional details can be found in the Medical Community Care chapter.

## Intensive Evaluation and Treatment Program (IETP) for Veterans and Service Members with Traumatic Brain Injury (TBI) and Polytrauma

| | | 2022 | | 2023 | 2024 | | |
|---|---|---|---|---|---|---|---|
| Description (dollars in thousands) | 2021 Actual | Budget Estimate | Current Estimate | **Revised Request** | **Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
| **Discretionary Obligations** | | | | | | | |
| Medical Services (0160): | $0 | $11,584 | $11,584 | $11,776 | $12,439 | $192 | $663 |
| Medical Community Care (0140): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance (0152): | $0 | $149 | $149 | $149 | $149 | $0 | $0 |
| Medical Facilities (0162): | $0 | $3,550 | $3,550 | $14,045 | $0 | $10,495 | ($14,045) |
| **Obligations [Grand Total]** | **$0** | **$15,283** | **$15,283** | **$25,970** | **$12,588** | **$10,687** | **($13,382)** |

### Purpose

The IETP for TBI and polytrauma is a highly successful rehabilitation program initially developed at the Tampa Polytrauma Rehabilitation Center (PRC) as the Post-Deployment Rehabilitation and Evaluation Program (PREP) initiative. The expansion of this program from one to five PRC locations approved by VHA will address increasing demand for IETP services in maintaining the military readiness of Service members, treating Veterans with chronic TBI-related symptoms, fulfilling requirements for TBI-related research mandated by Congress, and advancing the overall support for Veterans and Service members.

The IETP provides specialized integrated rehabilitation care for Veterans and Service members with a complex history of multiple TBIs, numerous body injuries, post-traumatic stress disorder, and emotional dysregulation. This population has been historically underserved due to bias towards diagnosis-based medical care. Service members are eligible for VA care as per the "Memorandum of Agreement between VA and DoD for Medical Treatment Provided to Active Duty Service Members with Spinal Cord Injury, TBI, Blindness, or Polytraumatic Injuries (TRICARE Operations Manual 6010.56-M).

The IETP is the only program of this kind in the country, integrating medical, rehabilitation, mental health, and whole health resources to develop an intensive and comprehensive recovery plan tailored to the needs of the individuals served. Care is provided in an inpatient bed unit environment. The IETP employs teams of licensed, credentialed rehabilitation professionals including physiatry, nursing, physical therapy, occupational therapy, speech-language pathology, social work, neuropsychology, psychology and recreation therapy. The IETP has access to a broad range of specialists who participate in interdisciplinary assessment and treatment planning to address disorders of sleep, vision, pain, vestibular system, musculoskeletal problems system, cognitive difficulties, and other problems, as indicated.

**Evidence**

The expansion of IETP as a critical step to modernize VA care and support DoD to maintain force readiness was determined by a strategic review of the PRCs by the Deloitte Consulting LLP team, with oversight from the VHA Office of Healthcare Transformation. The reviewers conducted over 35 interviews with more than 100 stakeholders across both VA and DoD to gather information, conduct analysis of data, and develop a set of recommendations for the VHA Executive in Charge.

The success of Tampa's IETP delivering rehabilitation care to Special Operation Forces personnel led to a growing demand for these services and a wait list of pending admissions. Based on input from the U.S. Special Operations Command, the experience of the Tampa IETP, and the TBI prevalence among Service members and Veterans, the review team determined that demand for IETP services exceeds existing capacity and recommended expanding IETP capacity at four additional PRCs by a total of 24 additional inpatient beds. Initial implementation of the IETP at the Tampa site in 2020 focused on program development and obtaining participant feedback on the clinical experience to assist in developing a core data set. Data shows that 89% of participants in the Tampa IETP rate their cognitive abilities as improved at the completion of the program and 92% of participants report similar improvements in their physical skills. In 2020, 80% of participants rated their physical, cognitive, and emotional functioning as improved and ranked their overall satisfaction with services received at 9.5 on a 10-point scale. Tampa IETP is accredited by the Commission on Accreditation of Rehabilitation Facilities for brain injury specialty programming under the medical rehabilitation standards.

Funding reductions from the Defense and Veterans Brain Injury Center in 2020 have hampered the translation of IETP and PRC outcomes and research contributions into improved clinical care for Veterans and Service members with TBI. To mitigate this reduction in resources, the strategic review team recommended the addition of a Knowledge Translation (KT) specialist at each of the PRCs. These KT staff will collaborate with the Physical Medicine and Rehabilitation (PMR) Program Office to form a virtual KT Center focused on enhancing outcome data collection and analysis and translating the findings into actionable clinical enhancements. KT positions will be clinical positions focused on quality improvement efforts and standardizing TBI clinical care delivery.

**Recent Trends**

The IETP expansion started in 2021 with increased volume of services at the Palo Alto, Richmond, San Antonio and Tampa locations. Programs focused on meeting the demand for care by offering flexible outpatient and virtual admissions. The volume of admissions to IETP grew to 170 patients in 2021 compared to 52 patients in 2020. Participant feedback on the clinical experience at all locations showed outstanding satisfaction with services.

**Future Trends:**

IETP expansion plans for 2022 include:

- A standardized and objective core data set has been developed with data collection to begin in 2022. The data set includes standardized tools to measure changes in physical and mental health function, societal participation, satisfaction with life, and satisfaction with services.
- Increase bed capacity by eight beds overall.
- Hiring additional clinical staff to support increased bed capacity.
- Begin buildout operations at Minneapolis and San Antonio.
- Collaborate with the *Partnered Evaluation Initiative* group under VHA QUERI program to determine parameters for the evaluation the IETP model of care.

**Implementation Plan**

The 2023 budget request is to supplement clinical positions and augment facility renovation needed to support expanded IETP clinical programming. In 2023, 46% of the budget request is for medical services. In 2024, 100% of the budget is allocated to medical services. The proposed staffing model is based on the proven success of the Tampa IETP model. Of the 47.3 number of proposed total staff, 41.3 (87.3%) are clinical and 6 (12.7%) are administrative support. FTE necessary to meet the expansion include physicians, nurses, psychologists, neuropsychologists, physical therapists, occupational therapists, speech-language pathologists, social workers, recreation therapists, and creative art and music therapists.

2023

- Expand IETP to a total of 36 bed capacity at Tampa, Palo Alto, San Antonio, and Richmond. The 2023 budget: $11.9 million for medical services and $14.0 million for facility buildout/renovation.
- Complete facility buildout/renovation at Minneapolis and San Antonio to allow bed unit expansions at these sites.
- Finalize treatment protocols for Mental Health, Vestibular Rehab, and Sleep Assessment/Treatment.
- Analyze outcome data collected and initiate performance improvement measures, as appropriate.
- Train new staff in protocol implementation and data collection via virtual and F2F events.

2024

- Expand IETP by additional six beds to a total of 42 beds at the five PRCs. 2024 budget: $12.5 million for medical services.
- Analyze outcome data of IETP to refine treatment protocols and revise clinical programming to maximize impact and duration of intervention.
- Travel and training for the development of a fidelity of practice monitoring method.

# Intimate Partner Violence Assistance Program (IPVAP)

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary Obligations** | | | | | | | |
| Medical Services (0160): | $18,309 | $25,756 | $25,756 | $23,837 | $24,070 | ($1,919) | $233 |
| Medical Community Care (0140): | $0 | $4,000 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance (0152): | $0 | $846 | $846 | $510 | $515 | ($336) | $5 |
| Medical Facilities (0162): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Grand Total]** | **$18,309** | **$30,602** | **$26,602** | **$24,347** | **$24,585** | **($2,255)** | **$238** |

## Authority for Action

VHA's Intimate Partner Violence Assistance Program (IPVAP) was launched in January 2014, in response to recommendations provided in the *VHA Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program* (2013). Congress included an initial $17.0 million for VA's Intimate Partner Violence (IPV) Program in both P.L. 115-141, *Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2018*, and P.L. 115-244, *Energy and Water, Legislative Branch, and Military Construction and Veterans Affairs Appropriation Act, 2019*. VHA Directive 1198, Intimate Partner Violence Assistance Program was published in January 2019, requiring every VA medical facility to implement and maintain an Intimate Partner Violence Assistance Program to ensure that Veterans, their intimate partners, and employees impacted by IPV (experiencing or using) have access to services including education, resources, assessment, intervention and/or referrals to VA or community agencies as deemed appropriate and clinically indicated. As the largest healthcare system in the nation, VA is committed to developing and delivering quality programming and services to address this national health epidemic.

Intimate Partner Violence (defined as physical, verbal, emotional, psychological, stalking, and sexual abuse) is a national health epidemic with far-reaching bio-psycho-social consequences. IPV impacts individuals from all racial, ethnic, religious, and socioeconomic backgrounds and is a significant health concern among Veteran populations - including their partners and caregivers. It is significantly correlated with increased risks for other public health issues including suicide and homicide, homelessness, and substance abuse.

VA's IPVAP has made tremendous strides toward national program implementation including the expansion of vital services for Veterans, their partners, caregivers, and VA staff impacted by IPV. This expansion includes implementation of screening, assessment and various modalities of safety planning and intervention to promote safety and healthy relationships. To date, the program achieved national IPVAP coverage, with an identified IPVAP Coordinator covering all VA medical facilities. IPVAP funding is distributed from the National IPVAP to VA medical facilities in support of IPVAP staffing and program implementation.

**Purpose**

The purpose IPVAP budget request is two-fold:

1) Existing IPVAP Coordinator positions at each VA Medical Facility: IPVAP request supports at least one Full-Time Employee Equivalent (FTE) IPVAP Coordinator at every VA medical facility, allowing for attrition and turnover of existing staff, and to support a cost-of-living adjustment for the salaries of existing staff.

2) National Program staffing: Currently, the IPVAP national program office is staffed by a one FTE, the National Program Manager located in VA central office. This is insufficient to effectively manage the expanding scope of the program and national implementation efforts. IPVAP national program 2022 budget request supported the addition of three FTE to national program staff. The additional staff will provide direct support for facility IPVAP Program Coordinators and stakeholders to ensure compliance, accountability, and data collection and analysis related to program operations. Coordinating these tasks at the national level are essential to the successful provision of IPVAP services for Veterans, their intimate partners and VA staff. IPVAP 2023 budget request includes resources for continued support of the national program office.

**Evidence**

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

The IPVAP Coordinators in the field implement a complex, high visibility, comprehensive program for Veterans, their partners and caregivers and VA staff. Many of the established IPVAP Programs are beginning to request additional staff to support expansion of services and manage the complex array of programming. The IVAP national program anticipates that existing and sustained funding will be utilized by sites to expand program operations (integrating screening, assessment, and intervention) and enhance staffing as needed. IPVAP national office support in the form of guidance, training, resources and data analysis is required for successful program implementation at the facility level. Essential staffing (four FTE total) in the National program is required to support additional program expansion, and guide field-based endeavors, enhance accountability and provide ongoing quality evaluation of IPVAP services.

**Implementation Plan**

The IPVAP has national coverage with an identified IPVAP Coordinator covering all VA medical facilities. The IPVAP national program office will continue to work with VA facilities to support hiring and program expansion.

**Costs**

- **Field-Based Staff:** Each of the VA 'parent' facilities will have at least one designated IPVAP Coordinator who administrates the operations of the IPVAP at that site and throughout the catchment area. The field-based staff must be a licensed independent practitioner (LIP) in their discipline and possess knowledge and experience in IPV programming.
- **National Program:** The program has grown to require four Full-Time Equivalent Employees (FTE) – which includes the National Program Manager (existing), to provide national program oversight, evaluation, consultative site visit, support to the field, and participate in outreach and training.

## National Center for Posttraumatic Stress Disorder (NCPTSD)

| | | 2022 | | 2023 | 2024 | | |
|---|---|---|---|---|---|---|---|
| Description (dollars in thousands) | 2021 Actual 1/ | Budget Estimate | Current Estimate | Revised Request | Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
| **Discretionary Obligations** | | | | | | | |
| Medical Services (0160): | $29,764 | $13,001 | $13,001 | $13,001 | $13,001 | $0 | $0 |
| Medical Community Care (0140): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance (0152): | $9,564 | $26,999 | $26,999 | $26,999 | $26,999 | $0 | $0 |
| Medical Facilities (0162): | $158 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Grand Total]** | **$39,486** | **$40,000** | **$40,000** | **$40,000** | **$40,000** | **$0** | **$0** |

### Authority for Action

NCPTSD, a multisite Center of Excellence in the Office of Mental Health and Suicide Prevention (OMHSP), was created in 1989 in response to a Congressional mandate (P.L. 98-528, 98 Stat. 2686, 1984) to address the needs of Veterans with PTSD. In 2014, National Center for PTSD (NCPTSD) received funding that had two goals: to establish a PTSD brain bank to facilitate PTSD research, and to enhance access for rural Veterans by providing PTSD treatment consultation to community providers.

### Population Covered

The NCPTSD mission is to advance the clinical care and social welfare of America's Veterans through research, education, and training, but without direct responsibility for patient care. NCPTSD also was mandated to serve as a resource center for information about PTSD research and education for VA and other Federal and non-Federal organizations. NCPTSD currently consists of seven divisions located at VA facilities, with headquarters in White River Junction, VT. Other division locations include Boston, MA; West Haven, CT; Palo Alto, CA; and Honolulu, HI. NCPTSD is an integral component of the Office of Mental Health and Suicide Prevention.

### Type of Services Provided

NCPTSD aims to translate basic research findings into clinically relevant techniques and to study how best to implement evidence-based practices into care. Each of NCPTSD's divisions has an area of specialization towards this aim, with the PTSD Consultation and Mentoring programs providing pathways for dissemination. Besides its own staff, NCPTSD has built strong collaborative relationships with institutions and agencies from VA, other branches of government,

the health care community, and academia. NCPTSD brings current research and clinical knowledge from the field to Veterans, their families, the public, clinicians, military leaders, and others via an award-winning website (https://www.ptsd.va.gov ), publications, online resources, as well as nationwide trainings.

**Recent Trends**

***Research Support:***

- Maintained a robust program of research on PTSD and traumatic stress. Research productivity data for 2021 have not been finalized. According to current information, NCPTSD had 133 grants (total funding $244.0 million); 33 additional grant proposals were submitted. Center staff had 266 published and 276 in-press publications. Even with COVID-19 travel restrictions, staff made 218 presentations (mostly virtual) at national professional meetings. Center investigators continued to conduct innovative studies through the Consortium to Alleviate PTSD (CAP), a seven-year $42.0 million award to fund research in PTSD diagnosis, prevention and treatment for Service members and Veterans. The consortium is led by the National Center and University of Texas Health Science Center at San Antonio. As of 2021, all 11 CAP projects are completed; two of these have published their findings, and the remainder are finishing data analyses.
- Maintained a repository of COVID-19 resources for researchers. As of the end of 2021, the Center had published 45 COVID-19 papers, created 7 measures of COVID-19 related risk, exposure, mental health responses, and distress, and maintained a broad research portfolio on the mental health impact of COVID-19.
- Established VA's National Posttraumatic Stress Disorder Brain Bank (PTSD Brain Bank) in 2014 as the first and only brain bank devoted exclusively to PTSD. The PTSD Brain Bank is a consortium of five VA Medical Centers and the Uniformed Services University of Health Sciences. The Brain Bank studies postmortem brain tissue to characterize gene expression associated with stress, PTSD, and suicide, which may lead to biological markers that could be used to diagnose and monitor treatment response. At the end of 2021, the Brain Bank had acquired 305 frozen hemispheres (roughly divided in thirds from donors with PTSD, donors with major depression, and controls without depression or PTSD); 190 individuals have enrolled in our antemortem donor program. NCPTSD's partnership with PinkConcussions to encourage donations from women with traumatic brain injury has yielded 30 living female donors. This year, we also recruited 23 living donors from the Vietnam Era Twin Registry. The Bank's research program has 14 peer-reviewed publications to date on genetic, transcriptomic, synaptic, and neuroinflammatory alterations in key brain regions associated with 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 and analysis for a study that will be helpful for determining which psychotherapy is optimal for which patients and launched another large study that will identi optimal medications for sleep problems in Veterans with PTSD.

- Developed and validated PTSD questionnaires and interviews for assessing PTSD according to the revised diagnostic criteria for PTSD in the 5th edition of the American Psychological Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, including publication of a validated scoring cutoff for the Primary Care PTSD screen for DSM-5 for use in VA primary care settings. Continued research on effective screening for military sexual trauma and intimate partner violence.
- Participated in large-scale studies of the implementation of evidence-based treatments for PTSD. Investigated barriers to implementation in outpatient and residential PTSD treatment programs. Continued a large multi-site study aimed at increasing the use of Prolonged Exposure for PTSD, one of the most effective treatments for PTSD within the military health system.
- Continued data collection for LIGHT, the Longitudinal Investigation of Gender, Health, and Trauma study, which focuses on the impact of community violence on Veteran mental, physical, and reproductive health. COVID-19 exposure related assessment continued in 2021 in order to understand the impact of COVID-19 on male and female Veterans from different ethnic and racial groups.
- Expanded the Center's portfolio focused on PTSD and suicide, including continued work investigating whether PTSD treatment during inpatient hospitalization reduces risk of suicide, predictors of suicidal ideation among Veterans during the post-deployment transition period, and understanding suicide related endophenotypes.
- Produced the PTSD Trials Standardized Data Repository (PTSD-Repository) in 2020, a database that contains information extracted from 389 randomized controlled clinical trials for PTSD. In 2021, the database expanded the number of PTSD RCTs included and also began including data from studies that intentionally target both PTSD and substance use, conditions that often co-occur. Outcome measures were expanded to include information on suicide and risk of bias ratings were added for all RCTs. New data stories and visualizations were created, along with a treatment coding guide to help users understand the data that the site makes available.

***Provider Support:***

- Responded to over 2,100 requests in the PTSD Consultation Program. The program offers a monthly continuing education webinar on the topics that providers often ask about in consultation. Each webinar is then made available as an online course with free continuing education units. With a continued focus on supporting providers in rural areas, the program collaborated with VA's Suicide Risk Management Consultation Program and the Center for Deployment Psychology to provide training for community mental health providers who treat Veterans. Expert clinicians from all three programs offered three 2-day trainings that covered military culture and the assessment of PTSD and suicide risk. Over 100 providers participated in the trainings and received free continuing education credits. Plans are underway to increase the capacity of these trainings next year.
- Promoted best practices for PTSD Specialty Care within VHA through the PTSD Mentoring Program. Initiated in 2008, the program provides administrative guidance to ensure best management and clinical practices. Working with investigators at the Center for Delivery and Outcomes Research, the program piloted implementation facilitation at

seven sites. The Mentoring Program also partnered with the mental health metrics groups to pilot new Strategic Analytics for Improvement and Learning Value Model metrics for PTSD. Rounding out its collaborative work, they continued to work closely with the Northeast Program Evaluation Center to track outpatient specialty care, including identification of PTSD specialists, and with OMHSP leadership to ensure alignment with priorities. The program also made further enhancements to its PTSD Clinic Dashboard and launched a new extensive online toolkit for program managers.

- Expanded academic detailing and facilitation to improve the PTSD treatment of rural Veterans at six VA medical centers across the county. By looking at contextual factors present in each site, it helps sites expand the use of PTSD care that aligns with the VA/DoD Clinical Practice Guideline for PTSD. Sites appreciate and benefit from the technical support they receive. One of the sites, originally a low adopter of evidence-based treatment (EBT), emerged as a national leader in EBT reach by the end of the year.
- Utilized the Practice-Based Implementation Network, a robust program that unites clinicians, researchers, and other practitioners from inside and outside of VA to leverage technology and improve uptake of innovative best practices and evidence-based interventions for Veterans. Under the auspices of its Tech into Care initiative, the Network launched a section of the website that streamlines access to project resources, including videos, courses, patient handouts, and provider guides. Specific to VA, a Joint Incentive Fund-supported quality improvement project has established mHealth Specialists—an internal champion—in each VISN. In concert with mHealth Ambassadors across VA, they focus on the use of technology tools to reduce Veteran suicide risk and improve coping. The Network continued to offer two lecture series, one that is open to everyone and another that is available only to VA providers. Attendance at both increased this fiscal year.
- Supported VA's efforts to respond to COVID-19 by curating key OMHSP operational information and ensuring rapid dissemination to the field. The Mentoring Program also provided consultation as usual to sites within the broader PTSD specialty network (N=424). These consultations significantly increased from last fiscal year, in part due to additional consultation regarding the PTSD Dashboard data and data reports generated for the field to track access to evidence-based psychotherapy for PTSD across the mental health continuum of care. Staff also worked closely with the Northeast Program Evaluation Center for tracking outpatient specialty care, including identification of PTSD specialists and OMSHP leadership to ensure alignment with priorities. Continued support of the OMHSP Measurement Base Care (MBC) initiative this year by working with the PTSD Mentoring Program's data analytic team to enhance our PTSD Dashboard and provide aggregate MBC data and quarterly VISN MBC reports disseminated to VISN Chief Mental Health Officers and VISN PTSD workgroups. We continue to work closely with OMHSP and MBC in MH Initiative to gather implementation feedback from the field to inform future best practices in MBC.
- Continued to develop and disseminate free online trainings to VA and community providers with continuing education credits, including a three-course curriculum that uses state-of-the-art responsive virtual patient technology to teach the administration of the Clinician-Administered PTSD Scale for *DSM-5*.

- Finalized redesign of the Community Provider Toolkit, a site that offers information and tools relevant to Veterans' mental health and well-being curated especially for community providers. The revamped site was developed using a human-centered design approach that integrates the perspectives of key stakeholder groups. Addressing many of the issues covered in the Community Provider Toolkit, but also intended for VA providers, the podcast Caring for Those Who Have Served was released this year. In six episodes, experts from across VA offer key insights into providing behavioral health care in a Veteran-centric way.

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

- Launched a new website design (www.ptsd.va.gov); the site had 8 million views in 2021.
- Maintained a suite of 19 mobile apps, including self-help apps like COVID Coach and apps to support Cognitive Behavioral Therapy for Insomnia and Cognitive Processing Therapy. The newest app, Beyond MST, offers information and resources to help survivors cope with challenges related to military sexual trauma (MST) and improve their health, relationships and quality of life.
- Developed and updated the first online PTSD Treatment Decision Aid to correspond to the 2017 VA/DoD Clinical Practice Guideline for PTSD. This interactive tool assists patients in learning about treatments for PTSD and can play a key role in shared decision-making.
- Produced AboutFace, a public awareness campaign to motivate Veterans to seek treatment. Includes videos of Veterans, family members, and expert clinicians. In 2021 we completed development of a new feature focused on MST and began an extensive overhaul of the site to streamline access to its resources.
- Created new educational products for family members including infographics, animated whiteboard videos, and traditional brochures. Spanish translations of these materials increase their reach.
- Developed online self-help programs such as PTSD Coach Online to help Veterans cope with symptoms like anger, sadness, anxiety, and trouble sleeping, webSTAIR to help with problems with mood and relationships, and VetChange to help Veterans cut down on their drinking and manage their PTSD symptoms.

**Projections for the Future**

- Continue to investigate the neurobiology of PTSD to better address its identification, prevention, and treatment. An example of this work includes expanding the VA's National PTSD Brain Bank through strategic partnerships with groups that include potential donors, such as Veteran registries, Service member registries, and medical examiners' offices.
- Continue to develop and test novel treatments for PTSD. Examples of this work include the continued development of psychotherapeutic interventions associated with increased patient engagement, studies of psychological and pharmacological enhancers of psychotherapy effectiveness, and ongoing collaboration with VA's Office of Research and Development to develop more effective medications for PTSD.

- Continue to expand our research portfolio to better understand the neurobiology, epidemiology, prevention, and treatment of suicide risk in individuals with PTSD.
- Continue to study the implementation of evidence-based treatments for PTSD. Continue to increase awareness, recognition, and understanding of PTSD and decrease barriers to seeking help.
- Continue to promote the dissemination of evidence-based care for Veterans and other trauma survivors through the PTSD Consultation and Mentoring Programs, in-person trainings, and educational products.
- Expand reach by more effectively targeting Veterans with PTSD who need care during the post-deployment transition period and Veterans who are not engaged in care at VA.
- Continue a newly established Center-wide Diversity in Research workgroup to explore how we may expand our work studying the intersection of race and trauma, racial disparities in access to care, and differential outcomes in PTSD treatment.

## National Veterans Sports Program

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Direct Programs (Medical Services): | | | | | | | |
| VA National Rehabilitation Adaptive Sports and Therapeutic Arts Events | $4,270 | $3,600 | $3,600 | $2,750 | $2,805 | ($850) | $55 |
| Veteran Monthly Assistance Allowance for Disabled Veterans Training Paralympic & Olympic Sports Program | $0 | $2,000 | $2,000 | $2,000 | $2,000 | $0 | $0 |
| Grants for Adaptive Sports Programs for Disabled Veterans & Disabled Members of the Armed Forces Program | $15,850 | $14,500 | $14,500 | $14,500 | $14,500 | $0 | $0 |
| Equine Therapy Grants for Adaptive Sports Programs | $0 | $1,500 | $1,500 | $1,500 | $1,500 | $0 | $0 |
| Program Administration (Medical Support & Compliance) | $3,256 | $5,448 | $5,448 | $6,479 | $6,609 | $1,031 | $130 |
| **Grand Total** | **$23,376** | **$27,048** | **$27,048** | **$27,229** | **$27,414** | **$181** | **$185** |

### Authority for Action

- 38 U.S. Code §322 establishes the Office of National Veterans Sports Programs and Special Events
    - 38 U.S. Code 322 (d) authorizes a monthly assistance allowance for Veterans with a disability training or competing in Paralympic or Olympic sports
    - Regulation for the monthly assistance allowance 38 CFR Part 76
- 38 U.S. Code 521A authorizes the adaptive sports programs for disabled veterans and members of the Armed Forces
    - Regulation for the Adaptive Sports Grant Program is listed in 38 CFR Part 77

### Populations Covered

The Veteran population impacted will primarily include Veterans with spinal cord injuries, amputations, traumatic brain injuries, visual impairments, multiple sclerosis, stroke, post-traumatic stress disorder, and other neurological and mental health conditions. In addition, VA

staff are offered training in adaptive sports and therapeutic arts through hands-on experience as well as (in-person training and online modules) offering continuing education credits.

## Type of Services Provided

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

Provides a monthly stipend to Veterans with disabilities who are actively training in a Paralympic or Olympic sport. Eligibility includes meeting the standard established by the sport governing body or being selected as a member of the National Team in a qualiing sport.

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

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

### *VA National Rehabilitation Adaptive Sports and Therapeutic Arts Events*

Provides opportunities for Veterans to improve their independence, well-being, and quality of life through adaptive sports and therapeutic arts programs in accordance with 38 U.S.C. §§ 322 and 521A. Complementing the VA's rehabilitation system of care, the program encourages 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. These programs embrace formalized adaptive sports medicine as a practice specialty. Additionally, VA provides the largest coordinated therapeutic arts program for Veterans. Built on VA clinical expertise and operations, with essential support from Veteran Service Organizations, corporate sponsors, individual donors, and community partners, the program allows VA to provide lifelong rehabilitation care to Veterans. The rehabilitation events, held in cities across the nation, serve thousands of Veterans and train hundreds of VA rehabilitation providers across more than 135 VA medical centers annually.

- ***National Veterans Wheelchair Games (NVWG)***
  The National Veterans Wheelchair Games, co-presented by VA and Paralyzed Veterans of America, serves Veterans with spinal cord injuries, multiple sclerosis, amputations, stroke, and other neurological disorders. Since 1981, National Veterans Wheelchair Games have been inspiring Veterans to live healthier and more active lives through adaptive sports. It is the largest wheelchair sports rehabilitation event for Veterans with disabilities in the United States.
- ***National Veterans Golden Age Games (NVGAG)***
  Founded in 1985, this program serves Veterans ages 55 years and older who are eligible for VA health care. Through its "Fitness for Life" motto, the Golden Age Games offers sports competitions and health education sessions to demonstrate the value that sports,

wellness, and fitness provide to assist senior Veterans live an active and healthy lifestyle. National Veterans Golden Age Games is a qualiing event for the National Senior Games.

- ***National Disabled Veterans Winter Sports Clinic (NDVWSC)***

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

- ***National Veterans Creative Arts Festival (NVCAF)***

  The National Veterans Creative Arts Competition and Festival recognizes the role creative arts therapy plays in the rehabilitation of Veterans. Veterans who showcase their achievements in the festival are selected gold medal winners of national art, music, dance, drama, and writing competitions in which thousands of Veterans enter from VA facilities across the nation. Established in 1989, the festival is presented by VA and the American Legion Auxiliary and culminates with a stage performance, writing exhibition, and gallery-style showcase of artwork.

- ***National Disabled Veterans Golf Clinic Tournament***

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

- ***National Veterans Summer Sports Clinic (NVSSC)***

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

**Recent Trends**

During the past few years, several important trends have been identified. All six national rehabilitation events have noted an increase in women Veterans. Women Veterans comprised over 20% of the participants at the national rehabilitation events in 2020 and 2021. Increased outreach efforts to women Veterans accounted for this trend. Outreach efforts to women Veterans included focus groups, forums and other engagements tailored to women Veterans to gain feedback on program improvement and then implementing recommendations into the Veteran experience that is offered. Outreach efforts also included round tables and one-to-one meetings with Veteran

Service Organizations to elevate awareness of the programs and garner feedback from women Veterans.

Interest in non-traditional sports continues to grow, and the National Veterans Sports Programs and Special Events has added adaptive esports and adaptive fitness (CrossFit) to its portfolio. These growth areas are well suited for national efforts that leverage virtual platforms and regional VA support along with collaborations with industry partners.

During the pandemic, the national rehab events pivoted to at home or hybrid versions as did many of the VA adaptive sports grant recipients. Veteran's satisfaction with remote programming was demonstrated through a 50% increased participation in 2021 events versus 2020 events. To reach more Veterans, VA enhanced services by utilizing multiple delivery models. Small group instruction and large-scale competitions were achieved through both true at home and programing in collaboration with support from VA medical center rehabilitation providers nationally. VA's modernization efforts and ability to leverage technology continues to show success in new methods of care delivery for VA adaptive sports and therapeutic arts.

The adaptive sports grant program awarded a record $16.0 million though a total of 119 grants to community based adaptive sports providers in 2021. These record totals reflect a year after year trend which has allowed more Veterans to participate in adaptive sports activities. In addition, adaptive sports grantees have offered programming to Veterans in all 50 states, the District of Columbia and Puerto Rico.

**Projections for the Future**

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

**Program Budget Justification:**

**Purpose**

The NVSPSE's mission is to incorporate adaptive sports and creative arts in the lifelong rehabilitation plan of Veterans with disabilities. This service leads the nation in formalized adaptive sports medicine as a practice specialty and coordinates the growing therapeutic arts programs for Veterans. These programs encourage Veterans to lead and improve their independence, quality of life and wellbeing.

**Evidence**

The NVSPSE program serves thousands of Veterans and trains hundreds of VA rehabilitation providers across more than 135 VA medical centers annually. Veterans' satisfaction with remote

options has increased in the past year by 50%. VA's modernization efforts and ability to leverage technology have shown success in this new method of care delivery and outcomes for VA adaptive sports and therapeutic arts.

### Implementation Plan

The NVSPSE will be furthering outreach opportunities to meet the challenge by Veterans to provide them with virtual opportunities to engage in familiar and new avocations and lifestyle changes. In person events have resumed in redesigned models due to the global pandemic to keep all participants safe. NVSPSE shall provide further opportunities for Veterans' experiential learning and life enhancement.

## Non-Recurring Maintenance (NRM)

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations - All Other | $1,495,055 | $430,072 | $430,072 | $2,443,698 | $995,000 | $2,013,626 | ($1,448,698) |
| Discretionary P.L. 115-141 sec 255 | $184,251 | $0 | $115,406 | $0 | $0 | ($115,406) | $0 |
| Discretionary P.L. 115-244 sec 248 | $176,112 | $61,302 | $336,087 | $61,302 | $0 | ($274,785) | ($61,302) |
| Discretionary CARES Act Obligations | $187,250 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$2,042,668** | **$491,374** | **$881,565** | **$2,505,000** | **$995,000** | **$1,623,435** | **-$1,510,000** |
| Veterans Medical Care and Health Fund 1/ | $0 | $1,772,522 | $1,772,552 | $0 | $0 | ($1,772,552) | $0 |
| VACAA, Section 801 | ($10,347) | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **($10,347)** | **$1,772,522** | **$1,772,552** | **$0** | **$0** | **($1,772,552)** | **$0** |
| **Obligations [Total]** | **$2,032,321** | **$2,263,896** | **$2,654,117** | **$2,505,000** | **$995,000** | **($149,117)** | **($1,510,000)** |

Note: The 2020 NRM actual in the above table includes additional object classes than what is displayed in the Budget Overview chapter's Obligations by Object table, such as Personnel Compensation and benefits, Other Contractual Services, Supplies & Materials, and Equipment.

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

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 and Cancer Research

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** |
|---|---|---|---|---|---|
| **Discretionary Obligations** | | | | | |
| Medical Services (0160): | $59,399 | $95,337 | $95,337 | $145,109 | $217,747 |
| Medical Support and Compliance (0152): | $3,097 | $4,281 | $4,281 | $13,519 | $15,087 |
| Medical Facilities (0162): | $199 | $399 | $399 | $8,599 | $20,599 |
| *Pharmacogenomics (Non-add; included in above)* | | | | $15,610 | $35,616 |
| **Medical Care, Obligations [SubTotal]** | **$62,695** | **$100,017** | **$100,017** | **$167,227** | **$253,433** |
| Medical and Prosthetic Research - Precision Oncology Only | $11,025 | $17,058 | $17,058 | $22,550 | |
| Information Technology - Precision Oncology Only | | | | $5,000 | |
| **Precision Oncology, Obligations [Total]** | | | | **$194,777** | |

**Precision Oncology and Cancer Research**
*(dollars in thousands)*

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** |
|---|---|---|---|---|
| **Appropriation** | | | | |
| Medical Care - Precision Oncology Only | $62,695 | $100,017 | $100,017 | $167,227 |
| Medical and Prosthetic Research - All Cancers | $71,512 | $69,285 | $69,285 | $81,295 |
| Information Technology - Precision Oncology Only | $0 | $0 | $0 | $5,000 |
| **Obligations [Total]** | **$134,207** | **$169,302** | **$169,302** | **$253,522** |

## Purpose

As the largest integrated provider of cancer care in the United States, VA is committed to providing access to the best possible cancer care. The vision of the Precision Oncology Initiative is that Veterans will have access to care as close to their homes as possible that is comparable to that available at the nation's leading cancer centers. VA's implementation of this vision is based on three clinical pillars: oncology clinical pathways that define preferred practice, molecular diagnostic services that facilitate access to testing and the requisite expertise to use the results, and TeleOncology that delivers clinic care led by expert oncologists affiliated with National Cancer Institute-designated Cancer Centers to underserved areas. The ongoing rapid evolution of oncology clinical practice driven by continuing scientific and medical advances necessitates the close integration of research structures and clinical services to form an oncology learning healthcare system, the dual goals are to facilitate agile implementation of new clinical practices in response to new scientific discovers and to develop new knowledge from clinical practice. Clinical trials are often part of standard clinical care for patients with cancer and are a second area of clinical-research integration in Precision Oncology. Together, these elements form a System of Excellence for the full spectrum of care for a particular cancer type. Systems of Excellence are established for Prostate/Genitourinary Cancers and Lung. In 2023, VA will specifically address molecular diagnostics (tumor testing, germline testing and required enhancement of genetic counseling, and pharmacogenomics), complete the establishment of the Breast and Gynecologic Cancers System of Excellence, launch the Rare Cancers System of Excellence, and enhance Radiation Oncology services.

In 2017 there were approximately 43,000 new cancer cases reported in VA (VA National Oncology Program, unpublished report). Of those cases, 96.5% were men and 3.5% were women, similar to 2010. [xxvii] In 2010, the three most frequently occurring cancers within VA were prostate

(29%), lung/bronchus (18%), and colon/rectum (8%), with lung cancer being the deadliest. [xxvii] In 2017, prostate and lung/bronchus remained the top two most frequent, same as in the general US population, but bladder cancer became the 3rd most common cancer (7%) replacing colon/rectum (VA National Oncology Program, unpublished report). In the US, bladder cancer is the fourth most common cancer following colon/rectum. Other cancer types such as liver (8th most common in VA but 11th in the US overall) and kidney (5th most common in VA but 6th in the US overall) were found to be more common in VA than reported in the general US population. In 2017, female Veterans represented 3.5% of the total cancer diagnoses in VA, with breast cancer being the most frequently diagnosed, accounting for 30% of their diagnoses.

VA continues to expand molecular diagnostics in Precision Oncology through the National Precision Oncology Program (NPOP), addressing all three of its strategic goals. In addition to providing cutting-edge clinical tumor DNA sequencing, the program also provides germline testing for patients with cancer to guide treatment decisions and address the in-depth knowledge gained regarding patient risks of developing cancer. NPOP, targeting the most frequently diagnosed and deadly cancers within the VA, provides access to standardized tumor testing for both metastatic lung and prostate cancers for nearly every VA oncology practice site. The program also provides an expert consultation service to assist with interpretation of complex test results and a system-wide Molecular Oncology Tumor Board. Germline testing for metastatic prostate cancer is currently offered at over half of VA's oncology practice sites and will be expanded to all sites by the end of 2022.

In 2023, NPOP will expand to include testing for a broader range of cancer types, including rare cancers. Systematic implementation of molecular testing via clinical pathways within the electronic health record system is planned to ensure broad adoption. To enable a true learning healthcare system, gathering data from VA's precision oncology efforts and the use of this data for clinical decision support will also be a part of NPOP's 2023 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 the National Cancer Institute under an existing collaboration named APOLLO (Applied Proteogenomics Organizational Learning and Outcomes) with a planned expansion of VA sites that can submit biospecimens to APOLLO biorepositories.

VA is expanding the use of TeleOncology, which facilitates cutting-edge cancer care to Veterans anywhere, reducing geographical disparities. The United States, and by default the VA, are facing a shortage in oncologists, geneticists, and genetic counselors.[ii] The American Society of Clinical Oncology (ASCO) anticipates a shortage of approximately 2,250 oncologists by 2025.[i] Attracting top oncologists and research talent remains a priority for VA. Again, VA is uniquely positioned to achieve this goal through its ability to offer incentives such as: partnerships with National Cancer Institute (NCI) designated cancer centers, partnerships with academic affiliates, research opportunities, and working within the largest Telehealth program in the country. Oncologists working with the TeleOncology service participate in research and innovation through these partnerships, bringing state of the art care opportunities within the VA veterans.

The TeleOncology service provides expertise across the spectrum of oncology care in addition to those areas already covered by Precision Oncology such as use of immunotherapy, chemotherapy,

genetic counseling, virtual tumor boards, decentralized clinical trials, survivorship and palliative care. Through participation in the National TeleOncology service, veterans receive sub-specialized oncology care. Care is provided in disease site specific teamlets that consist of a sub-specialized oncologist and an oncology certified team consisting of an advanced practice provider, registered nurse, and clinical pharmacy practitioner. In 2023 the team will expand to include a social worker and dietitian, additional tumor boards will be developed, decentralized clinical trial access will expand, and breast and gynecologic care will be enhanced and its care coordination will be standardized.

**Evidence**

**TeleOncology**

According to ASCO's 2020 State of the Oncology Workforce in America, only 11.6% of oncologists practice in a rural area and 4 in 10 Americans living in rural areas with cancer report there are no cancer specialists near their home. [i] With 2.7 million rural veterans enrolled in VA and an additional 2.0 million rural veterans not currently enrolled, VA must position itself to address the potential access needs for rural cancer care, ensuring that rural veterans receive the same state of the art care as their urban counterparts. [xxviiii] VA is addressing this through expansion of its TeleOncology services. In 2020, VA paid more than $1.2 billion in Community Care services for oncology care and is projected to meet or exceed this amount in 2021.[iii] 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. [xxviii] VA believes the quality of care is better in the VA because of the sub-specialized care utilizing TeleOncology and the standardized care coordination of oncology care with other VA-provided and community provided care.

**Molecular Diagnostics and Rare Cancers**

Rare cancers have been defined by the Rare Tumor Initiative at the National Institute of Health's National Cancer Institute as those affecting fewer than 200,000 total people in the US or less than 40,000 annually. There are hundreds of different types of rare and less common cancers and when combined, they have a devastating impact. In 2017, there were approximately 8,000 new cases of rare cancers in VA which account for 16% of all VA cancers (VA National Oncology Program, unpublished report). This number is expected to grow as precision oncology is fundamentally changing how cancers have conventionally been defined. Cancers considered common are emerging as a collection of multiple rare subtypes that share the same tissue of origin but distinct pathophysiology that can directly impact prognosis and treatment efficacy.[iv]

Every day Veterans are prescribed medications that could be made safer through the use of genetic testing for medications (pharmacogenomics or PGx). 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, in

order to better categorize cancer types for treatment decisions and to determine patient eligibility for clinical trials, molecular diagnostics will continue to play an increasingly important role in oncology clinical practice.

**Breast and Gynecologic Cancers**

In 2017, female Veterans represented 3.5% of the total cancer diagnoses in VA, with breast cancer being the most frequently diagnosed, accounting for 30% of their diagnoses (VA National Oncology Program, unpublished report). Consistent with both overall VA and the frequency seen in the overall U.S. population, the second and third most frequently occurring cancer for women veterans are cancers of the lung/bronchus (15%) and colon/rectum (7%). [xxvii] The Breast and Gynecologic System of Excellence will develop a framework for Veterans with breast and gynecologic cancers to receive state of the art, guideline-adherent care, whether in the VA system or at outside institutions. This will include development of a dashboard that will track veterans with these cancers across their care journey, regardless of where they receive care. It will also include defining guideline-adherent quality care and care coordination between VA and community care, identifying necessary system components for care coordination. Finally, it will build infrastructure to support oversight of end-to-end care in the system, linkages to research and clinical trials, and national tumor boards.

**Implementation Plan**

**TeleOncology & Breast and Gynecologic Cancer System of Excellence**

The VA was awarded a grant for $4.5 million in 2020 by the Bristol Meyer Squibb Foundation to develop infrastructure for a TeleOncology program to reduce rural disparities in cancer treatment. VA implemented TeleOncology in 12 new locations across the country by the end of 2021. VA also provided interim coverage to support four additional sites and plans to expand to 22 sites by the end of 22. In October 2021, VA hired the Director for the Breast and Gynecology System of Excellence and is currently designing the system structure and framework. Through the TeleOncology service, the VA will build clinical and research teams in partnership with NCI designated cancer centers and nation-leading academic affiliates to address breast, gynecologic and rare cancers in 2023. These multidisciplinary teams will provide expert sub-specialized oncology services as well as care coordination across the cancer care continuum, from diagnosis to survivorship or palliative care. They will focus on ensuring quality evidence-based care is received regardless of location. This innovative cancer care coordination model will be the first of its kind for these subsets of cancer within the VA. VA will also expand national expert consultation services through e-consultation with TeleOncology sub-specialists and virtual tumor boards.

Germline genetic testing is becoming increasingly important for patients with cancer not only to assess whether they and their families have increased risk for developing cancer but also for informing how best to treat patients. TeleOncology will increase the availability of genetic testing along with educating the oncology provider workforce in this practice. The VA clinical genetics workforce needs to expand to keep pace with increasing demand, which will be accelerated by the precision oncology programs for prostate and lung cancers and the VA TeleOncology initiative. In the US there are 10 to 15 genetics professionals per 1,000,000 residents. [vii] TeleOncology will create the infrastructure and communications plan to support oncology related genetic testing in 2022. In 2023, TeleOncology will expand the genetic testing service to include training for field oncologists.

**Clinical Pathways**

VA will expand upon current clinical pathways to provide the best-in-class and system-wide standardized Oncology care. Clinical pathways formally standardize oncology practice in a multi-disciplinary fashion. The clinical pathways provide decision-support to the clinical care team through technology embedded within both electronic health records systems (CPRS and Cerner). This technology also allows precision monitoring of care to facilitate systematic, real-time assessment of care in coordination with national experts. Clinical pathways customized for VA were developed and deployed for lung and prostate cancer in 2021. In 2022, VA completed initial development of a Renal cancer pathway and is in final stages of developing a Head & Neck, Salivary Gland cancer pathway. Clinical pathway implementation will continue to expand to additional cancer types such as bladder cancer and Hematological Malignancies in 2022 and breast cancer and some rare cancers in 2023 as a tool to support the adoption of molecular testing for rare cancers and other cancer types that can benefit from precision oncology approaches.

**Molecular Diagnostics and Rare Cancers**

Since 2016, NPOP has established national level contracts for molecular testing with commercial reference laboratories to provide system wide access to cutting edge technologies for the testing of advanced cancers. To expand molecular diagnostics under NPOP, the VA will pursue additional national level acquisitions to cover testing for a broad range of cancer types including rare cancers in 2023. This would occur through a systematic expansion, cancer type by cancer type. For monitoring of drug response and resistance, emerging liquid biopsy methods that require repeat testing of patients during the course of their treatment will be required. This will lead to the need for acquisitions with new testing partners offering best in class molecular tests to cover additional sample types, cancer types, different stages of the disease and diverse molecular testing applications including diagnosis, risk prediction, prognosis, and treatment monitoring.

**Funding**

In 2023, VA is requesting an additional $67.2 million above the 2022 request. The base funding from 2022 will sustain new health care programs for example TeleOncology, Women's Oncology, and Rare Cancers care teams and the 2023 additional funding will support the implementation of new or expanded care programs such as pharmacogenomics, additional molecular testing for rare cancers, and two new radiotherapy sites of care. The additional funding in 2023 is primarily Medical Services with $8.0 million in Medical Facilities supporting two new sites for radiation oncology care in sites where VA radiotherapy doesn't exist today. In addition to increased molecular testing for rare cancers, the 2023 funding will provide for an increase in 67 new pharmacogenomics trained pharmacists; support for clinical pathways; data aggregation and analysis; and a national pharmacogenomics testing contract.

The 2023 request supports an additional 67 pharmacists at VA facilities nationwide specializing in pharmacogenomics. TeleOncology will partner with VA's National Teleradiology Program for central collection and review of VA and non-VA imaging by the oncology care teams and expert radiologists in 2023.

Finally, the complex data generated by Precision Oncology requires advanced informatics systems both to maximize the clinical utility of the data and to facilitate knowledge generation that can improve future care of Veterans. It is critical to ensure the learnings from a molecular test do not end with the single patient and can be used to inform the care of the next patient particularly for

rare cancers where the number of patients may be small. In September 2020, the VA awarded a contract to assess the informatics needs to support precision oncology. This work highlighted the complexity of this data and the need for a larger effort around defining informatics requirements with more specialized partners than originally anticipated.

The use of technologies such as machine learning, natural language processing and advanced analytics will be needed within a precision oncology data platform to unveil unprecedented insights for clinical care and research. In addition to its complexity, much of the data generated requires significant storage space and analysis for example Binary Alignment Map (BAM) files. These files represent unique needs due to its size and multidimensionality. Therefore, the VA will use a portion of these funds to fulfill these data needs either through partnership(s) or by building the capability within the VA system. A significant portion of the funding required for developing the data systems will have to come from the OIT appropriation. The current estimates range between $5.0 million annually for two years for development.

**COVID-19 Impact**

A study conducted May 29, 2020, found a high rate of mortality in patients who have both COVID-19 and cancer. A second similar study also found high COVID-19 mortality rates among cancer patients. "The two studies are the largest to date to examine how cancer patients, who are often older, immunocompromised, and have high levels of contact with the healthcare system, are affected by SARS-CoV-2, the virus that causes COVID-19. Initial reports have suggested cancer patients, especially those receiving treatment, are at increased risk from the disease."[viii]

TeleOncology utilizes several virtual modalities which endeavor to ensure both high quality care and the safest delivery method for the patient's individual treatment plan. Telehealth can be used to avoid dangerous exposure to healthcare systems where COVID-19 may be more prevalent.

**Pharmacogenomics**

**Purpose**

Pharmacogenomics (PGx) is a proactive, medication optimization strategy that can reduce adverse drug events (ADEs), treatment outcomes, and/or reduce costs. Every Veteran prescribed selected, high-risk medications should have PGx used to inform their prescription therapy. Similarly, selected patients at high-risk for ADEs or who would be at risk for poor outcomes due to therapeutic failure should also undergo PGx to inform their prescriptions. A National Pharmacogenomics Program (NPP) would provide a coordinated approach to pharmacogenomics services for all Veterans across the VA. In addition to providing clinical leadership, a NPP would establish evidence-based criteria for appropriate PGx testing within the VA, create the data infrastructure needed to identify the Veterans eligible for such testing; build the capability to provide PGx testing to the up to 50,000 patients annually in whom PGx is considered a high-impact and high-value intervention for the following conditions: mental health, chronic pain, cancer, cardiovascular, infectious disease, auto-immune, and neurological disorders; educate and train the workforce of providers, including pharmacists, on the appropriate ordering, interpretation, and application of PGx in clinical practice; monitor Veterans' prescriptions, medication outcomes, and health care utilization over time; establish metrics to ensure that high-quality pharmacogenomics care is being delivered; ensure that all VA facilities have the capability for providers to order clinically appropriate pharmacogenomics tests for their patients; and incorporate

software to provide clinical decision support systems into the VistA and Cerner electronic health records.

**Evidence**

Nearly 1 out of 2 Veterans is currently prescribed a medication that is potentially impacted by their genetics.[ix] The Food and Drug Administration (FDA) has evaluated the evidence supporting dozens of medications impacted by PGx and concluded that there are many where there is "sufficient scientific evidence to suggest that subgroups of patients with certain genetic variants…are likely to have altered drug metabolism, and in certain cases, differential therapeutic effects, including differences in risks of adverse events."[x] The Clinical Pharmacogenomics Implementation Consortium (CPIC) is a National Institutes of Health 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 therapeutic outcomes.[xi]

To date there are 26 medication classes where CPIC and/or FDA has concluded that there is moderate to strong evidence that modifying prescription therapy based on a patients PGx test results is likely to improve medication outcomes. CPIC guidelines are used by many US medical centers implementing PGx including VA (see below) and many are also endorsed by the American Society of Health System Pharmacists.[xii] A comprehensive review of the evidence used to support PGx testing is provided by CPIC and varies depending on the medication of interest. For some medications there are randomized controlled trials[xiii-xx], for example, while others are supported by non-randomized trials[xxi], retrospective studies[xxii-xxiii], or extrapolation from the known pharmacology and drug mechanisms of action.[xxiv] In summary, pharmacogenomic testing is an evidenced-based practice that can prevent adverse drug effects and improve therapeutic outcomes to some of the most prescribed medications to Veterans.

**Implementation Plan**

In 2019, the VA launched the Pharmacogenomics testing for Veterans (PHASER) program, a partnership between VHA and Sanford Health (Sioux Falls, SD), which is bringing panel-based PGx testing for up to 250,000 Veterans at approximately 40 VA facilities nationwide through a $50.0 million donation provided to VA by Sanford Health. Through the PHASER program, Veterans have access to PGx testing as part of their regular health care for the duration of this 5-year program which is slated to end in 2023. The PHASER program provides education and training for health care providers, including pharmacists to learn how to integrate PGx into their practice.

In addition, PHASER is implementing a series of clinical decision support systems (CDSS) in the VistA electronic health record. These CDSS assist providers so that they are aware of the availability of PGx test results, their interpretation, and action to mitigate the impact of gene-drug interactions through dose modification or an alternative medication. The PHASER program has gained significant experience and knowledge regarding the barriers to effective implementation of pharmacogenomics with the VA. While a significant advance, the PHASER program is time-limited (as it is externally funded, it is a temporary program) and of limited scope in terms of the number of medications impacted and the number of facilities where it is offered. As a consequence, this request for funding for 2023 aims to sustain the implementation efforts of the PHASER program beyond its original funding, expand implementation nationwide so that all eligible Veterans have access to appropriate, evidenced-based PGx testing, continue to educate clinicians

and pharmacists on the use of PGx, hire new, local, clinical pharmacists with expertise in pharmacogenomics that are expected to be needed to help interpret and manage Veterans who have undergone PGx testing, and begin to transition PGx testing currently offered through PHASER to a vendor selected by VA. In 2023, we expect to provide PGx testing to approximately 5,000 Veterans with this funding that fall outside of the scope of the PHASER program. In subsequent years VA will expand testing to additional, eligible Veterans who will be identified through the growing network of providers.

**Radiation Oncology**

VA has 130 sites that provide medical oncology but only 41 have radiation oncology facilities available. Upon last review 45,000 dually enrolled Veterans receive radiotherapy annually and 15,000 Veterans receive radiotherapy in-house at 40 sites in the VA. The 2023 Budget would increase the number of sites available to provide radiation oncology services to Veterans.

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.[xxvi] Also, on-site VA Radiation Oncology ensures an expert opinion and referral for proton therapy when in the best medical interests of the patient. VA believes the following six sites of care would be optimal for Veteran care: Salisbury, North Carolina, Las Vegas, Nevada, Phoenix, Arizona, San Diego, California, West Haven, Connecticut, and Portland, Oregon. VA is considering other sites and additional models to include a hub and spoke model.

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[xxviiii] RURAL VETERANS - Office of Rural Health (va.gov)

# Rural Health

| Description (dollars in thousands) | 2021 Actual 1/ | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary Obligations** | | | | | | | |
| Medical Services (0160): | $240,805 | $275,688 | $275,688 | $275,688 | $275,688 | $0 | $0 |
| Medical Community Care (0140): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance (0152): | $15,709 | $19,459 | $19,459 | $19,459 | $19,459 | $0 | $0 |
| Medical Facilities (0162): | $10,828 | $12,308 | $12,308 | $12,308 | $12,308 | $0 | $0 |
| **Obligations [Grand Total]** | **$267,342** | **$307,455** | **$307,455** | **$307,455** | **$307,455** | **$0** | **$0** |

## Purpose

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

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

In addition to these programs, ORH's five Veterans Rural Health Resource Centers, in Portland, Oregon; Salt Lake City, Utah; Iowa City, Iowa; Gainesville, Florida; and White River Junction, Vermont are assigned (38 U.S.C. §7308) the following purposes:

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

## Evidence

In 2021, the Office increased Rural Health Initiative contributions to the programs named above as well as to funding far reaching new programs in rural workforce training and education, MISSION Act Emergency Room Medical Scribe Program, and continuing mental/behavioral health programs focused on rural Veterans. In all, ORH has worked with VHA clinical and non-clinical offices to create more than 50 mature Enterprise-Wide Initiatives (EWIs) that reach Veterans at more than 99% of all VHA sites that serve rural Veterans. The development of new programs will continue through 2022 and beyond. Historically, ORH receives approximately $50.0 million annually in requests for funding new EWIs that go unfulfilled due to lack of available funding.

The Rural Health Initiative 2022 budget supports innovative programs in the rural space across these clinical and vital non-clinical access program areas:

- Primary Care
- Specialty Care
- Mental Health
- Clinical Resource Hubs
- Workforce Training and Education
- Care Coordination and
- Transportation

Overall, in 2021 to date, these programs touched the lives of more than 3 million Veterans at 700 rural serving sites across VHA. VA will see a significant expansion of many of these programs in 2022 and 2023 as new sites are added and new rural access innovations are created

**Implementation Plan**

ORH has already worked with partners across VHA program offices to project 2023 programming. Implementation and expansion plans for rural projects are being formulated now, with a significant portion of the 2023 budget going to third-year sustainment and expansion of thriving innovations, and the creation of long-term funding streams for the rural portion of vital initiatives such as Tele-Critical Care, Clinical Resource Hubs, and the Rural Veteran Tablet program. In addition, ORH has nearly $40.0 million in projected new Enterprise-Wide Initiatives queued up for 2022 and 2023. ORH and its partners continue to purposefully manage program execution. Each ORH-funded initiative is required to have a strong implementation plan and quantitative implementation evaluation that is overseen by VHACO program offices, ORH, and ORH's new Center for the Evaluation of Enterprise-Wide Initiatives (CEEWI).

In 2021, ORH and Specialty Care Services (SCS) developed a five-year funding agreement to support rural Tele-Critical Care expansion, that served 44 Tele-Critical Care sites and 13,000 Veterans.

CRHs are rural-serving telehealth hubs in every VISN across the country for primary care and mental health services. In 2022 and 2023, ORH is continuing support for a significant expansion in tele-specialty care services at the hubs, broadening access to specialty care in cardiology, pulmonology, urology, dermatology, sleep medicine, endocrinology, and other specialty care services that are increasingly more difficult to access in rural areas of the United States, even from community partners. As the COVID-19 pandemic has demonstrated, these hubs supply the flexibility necessary to rapidly respond to changing health care demands and to satis rural access requirements outlined in the MISSION Act.

All 18 VISNs now have an operational CRH to meet the needs of underserved facilities across the VA. Specialty care service expansion is underway, funded in 2021 and 2022 and ready for sustainment and further expansion in 2023 and 2024.

- CRHs assisted Clinical Contact Centers and covered inpatient services and emergency departments throughout the enterprise during the COVID-19 pandemic.
- As of July 15, 2021, CRHs provided coverage to 570 spoke sites with 825,475 active patients and 334,433 total encounters.

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

- As of August 1, 2021, 55,711 patients have received tablets in 2021, generating 245,599 VVC encounters in 2021.
- Six months after receiving a tablet, there was an increase in Veterans reporting more convenient care (from 67% to 80%), 28% fewer missed appointments or no shows in mental health, and an increase in VA's mental health continuity of care measure (from 31.6% to 40.2%).

ORH expects this trend to continue and is creating a long-term funding stream to acquire tablets for rural Veterans over the next several years to ensure that every rural Veteran that needs a tablet will have one.

In the area of rural workforce training and compensation, ORH collaborated with the VA Office of Academic Affiliations (OAA) to develop the Rural Interprofessional Faculty Development Initiative designed to attract providers and improve retention by developing teaching and training skills for rural clinician/educators. The program has trained over 500 clinicians including 60+ community-based clinicians at 54 sites.

The congressionally mandated pilot Veterans Affairs Farming and Recovery Mental Health Services (VA FARMS) continues to enjoy success in the face of the pandemic. VA FARMS is at eight sites with 550+ Veterans enrolled. Veterans report the VA FARMS helped them with their socialization and life skills, reduced their anxiety, helped them relax, and increased their vocational skills. This program will be expanded to at least two more sites in 2022, with plans for sustainment into 2023 and beyond.

ORH's five Veterans Rural Health Resource Centers (VRHRCs) continue to fulfill their congressionally mandated mission to conduct research, innovate new rural access programs, and disseminate them system wide. In 2022, these resource centers will establish additional new Rural Promising Practices, bringing the total number of Rural Promising Practices in system-wide mentored implementation to at least 9. The VRHRC promising practices range from training programs like Rural Clergy Training and Geriatric Scholars, to clinical programs such as In-home Cardiac Rehabilitation, HIV virtual teams, and Rural Implementation of Comprehensive Telehealth-Based Diabetes Care. These rural promising practices are up and running more than 100 sites across VHA, and each of them expands to new sites every fiscal year. In 2023, ORH will see significant expansion of our Rural Promising Practices program in the areas of rural diabetes care and pulmonary rehabilitation.

The ORH VRHRCs strong innovation programs focus on addressing gaps in rural Veterans' access to care and services and reach into program areas such as women's health with specific programs focused on the challenges our rural women Veterans face in accessing the health care they have earned. These programs include Post Natal, Web Based Care (Mom Mood Booster) that reached out to 8,500 Veteran mothers and ultimately provided care to strategies to 335 participants. This important rural-focused effort complements the ORH-funded Enterprise-Wide Initiative that conducts clinical skills training focused on women Veterans' care. In 2020, this program trained over 100 clinicians at 19 sites across the country in 12 courses of instruction for providers who care for our rural women Veterans.

In addition, some VRHRC programs focus on American Indian/Alaska Native rural Veterans, including ORH's latest: Rural Native Veteran Health Care Navigation. Still developing, , the goal of this innovative new program is to reach all rural AI/AN Veterans to ensure their access to VHA health care. ORH anticipates first pilots in fiscal year 2022 and expansion of the program through 2023. 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 2023 and beyond.

**COVID-19 Impact**

COVID-19 showed the value of the establishment of far-reaching telehealth programs. ORH devoted $180.0 million in 2021 to telehealth programs and has allocated nearly $200.0 million for telehealth programs in 2022, with anticipation of a similar commitment for 2023.

# Supply Chain Management

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **DISCRETIONARY** | | | | | | | |
| Medical Services (0160): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Community Care (0140): | | | | | | | |
| Discretionary Non-FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary FFCRA/CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Medical Support and Compliance (0152): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $113,753 | $0 | $129,514 | $142,404 | $139,838 | $12,890 | ($2,566) |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$113,753** | **$0** | **$129,514** | **$142,404** | **$139,838** | **$12,890** | **($2,566)** |
| Medical Facilities (0162): | | | | | | | |
| Discretionary Non-CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Discretionary Total** | **$113,753** | **$0** | **$129,514** | **$142,404** | **$139,838** | **$12,890** | **($2,566)** |
| **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 | $129,514 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 (0152) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$129,514** | **$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** | **$129,514** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Combined Discretionary and Mandatory by Category** | | | | | | | |
| Medical Services | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Community Care | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| Medical Support and Compliance | $113,753 | $129,514 | $129,514 | **$142,404** | **$139,838** | $12,890 | ($2,566) |
| Medical Facilities | $0 | $0 | $0 | **$0** | **$0** | $0 | $0 |
| **Obligations [Grand Total]** | **$113,753** | **$129,514** | **$129,514** | **$142,404** | **$139,838** | **$12,890** | **($2,566)** |

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.

| Medical Care Appropriation<br>Description (dollars in thousands) | 2021<br>Actual | 2022<br>Budget<br>Estimate | 2022<br>Current<br>Estimate | **2023<br>Revised<br>Request** | **2024<br>Advance<br>Approp.** | +/-<br>2022-2023 | +/-<br>2023-2024 |
|---|---|---|---|---|---|---|---|
| Inventory Management and Access | $64,311 | $91,259 | $91,259 | $101,938 | $99,235 | $10,679 | -$2,703 |
| Medical Surgical Prime Vendor (MSPV) 2.0 | $7,959 | $13,756 | $13,756 | $13,756 | $13,756 | $0 | $0 |
| Defense Logistics Agency (DLA) Source Support for MSPV | $31,730 | $13,756 | $13,756 | $13,756 | $13,756 | $0 | $0 |
| Supply Chain Master Catalog | $5,138 | $5,175 | $5,175 | $5,175 | $5,175 | $0 | $0 |
| Point of Use | $2,395 | $2,973 | $2,973 | $5,184 | $5,321 | $2,211 | $137 |
| Clinical Decision Strategic Sourcing | $2,220 | $2,595 | $2,595 | $2,595 | $2,595 | $0 | $0 |
| **Grand Total** | $113,753 | $129,514 | $129,514 | $142,404 | $139,838 | $12,890 | -$2,566 |

**Inventory Management and Access**

*(dollars in thousands)*

| | 2021<br>Actual | 2022<br>Budget<br>Estimate | 2022<br>Current<br>Estimate 2/ | **2023<br>Revised<br>Request** | **2024<br>Advance<br>Approp.** | +/-<br>2022-2023 | +/-<br>2023-2024 |
|---|---|---|---|---|---|---|---|
| Medical Support and Compliance Category | | | | | | | |
| Discretionary Medical Support and Compliance (0152): | $64,311 | $0 | $91,259 | $101,938 | $99,235 | $10,679 | -$2,703 |
| Mandatory Veterans Medical Care and Health Fund (0173) 1/ | $0 | $91,259 | $0 | $0 | $0 | $0 | $0 |
| **MSC subtotal** | $64,311 | $91,259 | $91,259 | $101,938 | $99,235 | $10,679 | -$2,703 |
| OIT Category | | | | | | | |
| Discretionary OI&T | $78,474 | $107,263 | $107,263 | $141,412 | $144,230 | $34,149 | $2,818 |
| Mandatory ARP Act, Section 8003 | $0 | $100,000 | $100,000 | $0 | $0 | -$100,000 | $0 |
| **OIT subtotal** | $78,474 | $207,263 | $207,263 | $141,412 | $144,230 | -$65,851 | $2,818 |
| **Grand Total** | $142,785 | $298,522 | $298,522 | $243,350 | $243,465 | -$55,172 | $115 |

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

2/ The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, together with updated for etimated transfers, reimbursements, and medical care collections.

The Department of Veterans Affairs' (VA) 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 / equipment

accountability management; facility and environmental management for building service equipment and work orders; assemblage management; business analytics; and total asset visibility.

VA's COVID-19 response efforts highlighted the deficiencies with the existing, 50-year-old legacy inventory system, especially the lack of enterprise visibility of personal protective equipment. Standardization of VHA business practices across the enterprise consistent with federal and commercial best business practices will enable VA to build a lean supply chain that provides timely access to meaningful data focused on improved patient and financial outcomes.

Currently VA is assessing potential to systems for feasibility and compatibility with the other system transformations underway.

**Medical/Surgical Prime Vendor (MSPV)**

MSPV-Next Generation (NG) is a collection of contract vehicles that enable the VA to streamline supply chain management for an array of Medical, Surgical, Dental, Lab, and Environmental Medical Supplies (EMS). The program achieves long term savings for VA Medical Centers by combining a "just in time" logistics approach with strategic sourcing and volume buying for Med-Surg supply needs. Item prices, prior to the application of the distribution fee, are published on the MSPV website.

VHA facilities transitioned to MSPV-NG Bridge contracts on April 1, 2020, to prevent a gap in MSPV program coverage between expiration of the MSPV-NG contracts and implementation of the next MSPV contract vehicle. The Strategic Acquisition Center (SAC) worked in collaboration with VHA Logistics to extend the MSPV-NG Bridge contracts for eight months -- from April 1, 2021 to December 1, 2021 -- ensuring continuity of care as the next PV contract vehicle is developed and solicited.

**Defense Logistics Agency Electronic Catalog (DLA e-Cat)**

VA is seeking to access to DLA contracts and suppliers to ensure VA facilities have continuous, efficient, and cost-effective access to quality medical supplies. VA and DLA signed an Interagency Agreement (IAA) for VAMCs to leverage DLA's best-in-class medical logistics capabilities. The intent is for VAMCs to receive DLA-sourced materiel through the Electronic Catalog (ECAT) Prime Vendor Web Ordering (PVWO) until the supply chain is modernized throughout VA.

Expanding this partnership has several benefits. VA will: be able to deliver products faster and more consistently; expand the breadth and depth of medical materiel available to better support Veterans; increase opportunities for small businesses with the Federal Government; reduce operating costs; address documented challenges the VA program has encountered. Achieving these goals will continuously improve upon VA's medical services and support 9.3 million+ Veteran beneficiaries.

## Clinically Driven Strategic Sourcing (CDSS)

CDSS is a commercial healthcare 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 & Time Resource Survey -- highlighted procedural and structural challenges in VA's supply chain processes that increased patient care risks and clinician dissatisfaction, while decreasing cost avoidance opportunities.

Using CDSS helps reduce clinically equivalent medical supply variation used across VHA. Reducing variation decreases the time required to train clinicians on proper product use and promotes product knowledge continuity. VA clinicians benefit by having more time for patient care, which improves patient outcomes.

VA continues its strategic partnership with DoD supporting VA's obligation to ensure we provide optimum care and benefits to Veterans. VA is engaging with the clinically driven Medical Materiel Enterprise Standardization Office to understand their collaborative clinical process for medical materiel standardization, determine applicability to VA processes, and develop a strategy for integration and enterprise implementation to further strengthen the CDSS program.

## Supply Chain Master Catalog (SCMC)

VA's SCMC will provide VA users with visibility of all VA medical commodities, prosthetic devices (to include durable medical equipment), expendable and non-expendable equipment and non-clinical products. The SCMC is a fully searchable, online catalog available via a web interface offered to VA as a Software Service solution through the Microsoft Azure Government cloud host.

The VA SCMC harmonizes contract information from VA and other approved Federal contract offices. It is a critical element in improving product oversight, visibility and establishing enterprise best practices. Further, the SCMC is essential to providing the standard product information necessary for electronic health record (Cerner) and financial (Momentum) systems.

VA lacks standardized enterprise business rules for its cataloging efforts, which results in inconsistencies including incomplete records, duplicate records, stock-level discrepancies, incorrect dollar values, conversion factor errors and missing mandatory sources. Multiple contract systems operate across the VA and VHA that do not share product or sourcing data. These multiple siloed systems contribute to the lack of data standardization, inconsistent ordering practices and redundant contracts for identical products. For these reasons the SCMC is a critical element in product oversight, visibility and establishing enterprise best practices.

**Point of Use (POU)**

The POU program seeks to standardize the supply POU system at the enterprise level across medical centers while maintaining local efficiencies already realized. POUs automatically inventory, manage, and store expendable medical supplies in the vicinity of patient care. POUs ensure proper supplies are available at the proper time for patient procedures. POUs optimize inventory with usage data trend analysis, on-hand inventory cost reduction, and increased clinical staff focus on patient care and patient safety. The program aims to centrally standardize POU procurement, sustainment, vendor support, cybersecurity support, training, and the POU implementation efforts with supply chain modernization and EHRM at the enterprise level.

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

# Telehealth

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Treatment Modality ($000): | | | | | | | |
| Telehealth Treatment | $3,891,077 | $2,135,182 | $4,222,841 | $4,844,912 | $5,056,418 | 622,071 | 211,506 |
| **Total Treatment** | **$3,891,077** | **$2,135,182** | **$4,222,841** | **$4,844,912** | **$5,056,418** | **622,071** | **211,506** |
| Connected Care Program Funding: Sustainment and Expansion | | | | | | | |
| Office of Connected Care program and medical center support | $318,079 | $300,000 | $300,000 | $329,906 | $329,906 | 29,906 | 0 |
| CARES Act | $47,534 | $0 | $0 | $0 | $0 | 0 | 0 |
| Veterans Medicl Care and Health Fund (0173) 1/ | $0 | $150,000 | $150,000 | $0 | $0 | (150,000) | 0 |
| **Sustainment and Expansion Total** | **$365,613** | **$450,000** | **$450,000** | **$329,906** | **$329,906** | **(120,094)** | **0** |

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the column displays estimated allocations by category. Final 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

Recent legislation, such as the *VA MISSION Act of 2018* and the *National Defense Authorization Act for Fiscal Year 2021*, authorize the practice of telehealth by VA healthcare professionals across the country, irrespective of the location of the provider or the Veteran. This allows for the expansion of the Telehealth/Connected Care Services program with the goal to increase Veteran access to healthcare.

### The Office of Connected Care – Telehealth/Connected Care Services

The Office of Connected Care, and its' Telehealth/Connected Care Services, has the mission to deliver high-quality, Veteran-centered care, optimize individual and population health, advance health care that is personalized and proactive, and enhance the health care experience through virtual modalities of care.

**Home and Community Based Services**

Purpose - Supports sustainment and expansion of synchronous, asynchronous, and remote patient monitoring services in the home or home communities inclusive of VA Video Connect, the

Veteran tablet initiative, Remote Patient Monitoring/Home Telehealth Program's equipment and services, and ATLAS (Advancing Telehealth Through Local Access Stations) pilot.

**Clinic Based Services**

Purpose - Supports expansion of clinical resource hubs for primary care, mental health, and specialty care; expansion of targeted initiatives such at TeleDermatology, TeleEye Care, and TeleSleep medicine; and expansion of the national expert consultation services.

**Hospital and Emergency Services**

Purpose - Supports expansion of inpatient and emergency room telehealth programs including TeleStroke Care and TeleCritical Care. It also includes the telehealth emergency management initiative.

**Program Foundations**

Purpose - Supports the staffing, training, application development and remediation, national equipment maintenance and refresh, provider and Veteran facing help desk support, communications, and research needed to support and expand Connected Care services.

**COVID-19 Impact**

VA has leveraged telehealth to maintain the safe delivery of high-quality outpatient VA services in the context of pandemic-related social distancing guidelines. As a result, Telehealth has experienced a surge in adoption since early in 2020 which continued into 2021.

In 2021, VA provided Veterans more than 9.5 million video telehealth visits to their home or other offsite location, representing an increase of greater than 146% compared to 2020 and over 3,100% compared to 2019. Overall, when considering all its telehealth modalities, VA provided more than 2.3 million Veterans with over 11.2 million telehealth episodes of care in 2021. The number of Veterans utilizing telehealth in 2021 grew by greater than 43% when compared with 2020 and by greater than 158% when compared with 2019.

VA's connected care capabilities have become a vital part of VA's health care system. VA will continue to build on its success and leadership as a provider of digitally enabled care. By continuing its connected care innovation, VA will further enhance the human connections that are at the heart of health care and help more Veterans turn to VA as their health care system of choice. VA is also accelerating a transformation of health care that will provide Veterans more quality options going into the future.

**Program Budget Justification**:

## Purpose

The Office of Connected Care budget request increases in 2023 over 2022 to account for the sustainment of services expanded during the pandemic and the lack of CARES Act and ARP funding available to Connected Care starting in 2023. The increase is noted in the Home and Community Based Services Category of the budget request for Connected Care.

## Evidence

Video-to-home telehealth utilization increased over tenfold in 2020 due to the pandemic and resulting need to deliver safe, quality, engaging care while adhering to social distancing. The VA's pivot to virtual care drove growth of the connected tablets program to support Veterans impacted by the digital divide. Further, the VA continues to provide telehealth technology (i.e., Web cameras) to health care professionals to ensure they are capable of delivering services through telehealth. In addition, VA is expanding its capabilities to deliver comprehensive service to Veterans by increasing availability of peripheral technologies (i.e., digital stethoscopes) that can be provided to Veterans for use as part of their video visits from home.

In 2021, CARES ACT funding supported sustainment and expansion of the connected tablet program, health care professional telehealth equipment, and Veterans peripheral technology costs. These costs will be addressed using ARP funding in 2022. However, ARP funding has not been allocated to cover these costs in 2023. To enable growth in 2022 in this category and sustain this growth in 2023, additional funding is needed in the Connected Care budget.

In addition, the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019* authorizes VA to establish a grant program to develop telehealth access points (ATLAS) in the community; however, it does not appropriate additional funding for this effort. Connected Care's 2023 budget for Home and Community Based Services also includes the funding needed to support the law's intended purpose.

## Implementation Plan

The combination of ongoing expansion of video-to-home services, enhanced video-to-home telehealth capabilities, and the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019* are the basis for the budget increase.

# Veterans Homelessness Programs

| Description (Dollars in thousands) | 2021 Actual | 2022 Budget Estimate 2/ | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Appropriation | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Homeless Veterans Treatment Costs** | **$8,444,900** | **$8,247,124** | **$8,851,500** | **$9,145,900** | **$9,342,800** | $294,400 | $196,900 |
| **Programs to Assist Homeless Veterans** | | | | | | | |
| **Permanent Housing Supportive Services** | | | | | | | |
| HUD-VASH Case Management: | | | | | | | |
| HUD-VASH Case Management Base (I) 1/ | *$445,165* | *$516,860* | *$516,860* | *$557,921* | *$617,618* | $41,061 | $59,697 |
| HUD-VASH Case Management CARES Act (I) | *$1,262* | *$0* | *$0* | *$0* | *$0* | $0 | $0 |
| HUD-VASH Case Management ARP Act (I) 3/ | *$0* | *$0* | *$61,800* | *$0* | *$0* | ($61,800) | $0 |
| **HUD-VASH Case Management [Subtotal]:** | **$446,427** | **$516,860** | **$578,660** | **$557,921** | **$617,618** | ($20,739) | $59,697 |
| HUD-VASH (S) | $351,568 | $250,637 | $366,334 | $381,354 | $396,226 | $15,020 | $14,873 |
| **Perm. Housing Supp. Services [Subtotal]** | **$797,995** | **$767,497** | **$944,994** | **$939,275** | **$1,013,844** | ($5,719) | $74,570 |
| **Transitional Housing** | | | | | | | |
| Grant & Per Diem: | | | | | | | |
| Grant & Per Diem Base (I) 1/ | *$218,698* | *$285,665* | *$285,665* | *$240,423* | *$250,074* | ($45,242) | $9,651 |
| Grant & Per Diem CARES Act (I) | *$122,000* | *$0* | *$0* | *$0* | *$0* | $0 | $0 |
| Grant & Per Diem ARP Act 3/ (I) | *$0* | *$50,000* | *$75,000* | *$0* | *$0* | ($75,000) | $0 |
| **Grant & Per Diem [Subtotal]:** | **$340,698** | **$335,665** | **$360,665** | **$240,423** | **$250,074** | ($120,242) | $9,651 |
| Grant & Per Diem Liaisons (I) | $35,997 | $35,241 | $35,241 | $35,945 | $37,383 | $704 | $1,438 |
| Other (S) | $8,041 | $12,764 | $8,379 | $8,722 | $9,062 | $344 | $340 |
| Health Care for Homeless Vets: | | | | | | | |
| Health Care for Homeless Base (I) | *$174,671* | *$202,464* | *$202,464* | *$229,484* | *$236,368* | $27,020 | $6,884 |
| Health Care for Homeless CARES Act (I) | *$13,230* | *$0* | *$0* | *$0* | *$0* | $0 | $0 |
| Health Care for Homeless ARP Act 3/ (I) | *$0* | *$0* | *$45,000* | *$0* | *$0* | ($45,000) | $0 |
| **Health Care for Homeless Vets [Subtotal]:** | **$187,901** | **$202,464** | **$247,464** | **$229,484** | **$236,368** | ($17,980) | $6,884 |
| **Transitional Housing [Subtotal]** | **$572,637** | **$586,134** | **$651,749** | **$514,574** | **$532,887** | ($137,174) | $18,313 |
| **Prevention Services** | | | | | | | |
| Supportive Svcs Low Income Vets & Families: | | | | | | | |
| Supportive Svcs Low Income Vets & Families Base (I) | *$570,000* | *$395,352* | *$395,352* | *$730,436* | *$774,744* | $335,084 | $44,308 |
| Supportive Svcs Low Income Vets & Families CARES Act (I) | *$173,749* | *$0* | *$0* | *$0* | *$0* | $0 | $0 |
| Supportive Svcs Low Income Vets & Families ARP Act 3/ (I) | *$0* | *$436,000* | *$294,500* | *$0* | *$0* | ($294,500) | $0 |
| **Supportive Svcs Low Income Vets & Families [Subtotal]:** | **$743,749** | **$831,352** | **$689,852** | **$730,436** | **$774,744** | $40,584 | $44,308 |
| National Call Center for Homeless Veterans (I) | $6,258 | $7,947 | $7,947 | $8,044 | $8,142 | $97 | $98 |
| Justice Outreach Homeless Prevention Base (I) | $49,462 | $55,866 | $55,866 | $56,983 | $64,723 | $1,117 | $7,740 |
| Legal Services for Veterans (I) 1/ | $0 | $1,585 | $1,585 | $12,992 | $28,056 | $11,407 | $15,064 |
| Justice Outreach Homeless Prevention CARES Act (I) | $192 | $0 | $0 | $0 | $0 | $0 | $0 |
| Justice Outreach Homeless Prevention ARP Act (I) 3/ | $0 | $0 | $1,000 | $0 | $0 | ($1,000) | $0 |
| Justice Outreach Homeless Prevention (S) | $10,527 | $14,237 | $10,969 | $11,419 | $11,864 | $450 | $445 |
| **Prevention Services [Subtotal]** | **$810,188** | **$910,987** | **$767,219** | **$819,874** | **$887,529** | $52,655 | $67,655 |
| **Treatment** | | | | | | | |
| Domiciliary Care for Homeless Vets (S) | $190,384 | $211,976 | $198,380 | $206,514 | $214,568 | $8,134 | $8,054 |
| Homeless Patient Aligned Care Teams (I) | $0 | $10,000 | $10,000 | $12,000 | $12,468 | $2,000 | $468 |
| Homeless Patient Aligned Care Teams ARP(I) 3/ | $0 | $0 | $5,000 | $0 | $0 | ($5,000) | $0 |
| Telephone Homeless Chronically Mental Ill (S) | $87,860 | $56,454 | $91,550 | $95,304 | $99,021 | $3,754 | $3,717 |
| **Treatment [Subtotal]** | **$278,244** | **$278,430** | **$304,930** | **$313,817** | **$326,056** | $8,887 | $12,239 |
| **Employment/Job Training** | | | | | | | |
| Homeless Veterans Community Employment Prg (I) | $14,790 | $15,182 | $15,182 | $19,800 | $19,968 | $4,618 | $168 |
| Homeless Veterans Community Employment ARP (I) | $0 | $0 | $1,000 | $0 | $0 | ($1,000) | $0 |
| Homeless. Ther. Empl., CWT & CWT/TR (S) | $59,466 | $66,402 | $61,964 | $64,504 | $67,020 | $2,541 | $2,516 |
| **Employment/Job Training [Subtotal]** | **$74,256** | **$81,584** | **$78,146** | **$84,304** | **$86,988** | $6,159 | $2,684 |
| **Administrative** | | | | | | | |
| Supportive Svces Low Income Vets & Families Adm | $8,648 | $9,060 | $9,060 | $9,731 | $10,223 | $671 | $492 |
| National Homeless Registry | $2,295 | $2,762 | $2,762 | $3,817 | $3,969 | $1,055 | $152 |
| National Homeless Registry ARP 3/ | $0 | $0 | $2,700 | $0 | $0 | ($2,700) | $0 |
| **Administrative [Subtotal]** | **$10,943** | **$11,822** | **$14,522** | **$13,548** | **$14,192** | ($974) | $644 |
| **Obligations [Total]** | **$2,544,263** | **$2,636,454** | **$2,761,560** | **$2,685,392** | **$2,861,497** | ($76,167) | $176,105 |
| *CARES Act [Total included above]* | *$310,433* | *$0* | *$0* | *$0* | *$0* | $0 | $0 |
| *ARP Act 1/ [Total included above]* | *$0* | *$486,000* | *$486,000* | *$0* | *$0* | ($486,000) | $0 |
| **Breakout by Specific & General Purpose** | | | | | | | |
| (I) Initiative Specific Purpose | $1,836,417 | $2,023,984 | $2,023,984 | $1,917,576 | $2,063,736 | ($106,408) | $146,160 |
| (S) Sustainment General Purpose | $707,846 | $612,470 | $737,576 | $767,816 | $797,761 | $30,241 | $29,945 |
| **Obligations [Total]** | **$2,544,263** | **$2,636,454** | **$2,761,560** | **$2,685,392** | **$2,861,497** | ($76,167) | $176,105 |

[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.

[2/] This program has been previously displayed within the HUD-VASH case management row.

VA's goal is a systematic end to Veteran homelessness, which means ensuring communities across the country:

- Have identified all Veterans experiencing homelessness;
- Can provide shelter immediately to any Veteran experiencing unsheltered homelessness who wants shelter;
- Provide service-intensive transitional housing in limited instances;
- Have capacity to assist Veterans to swiftly move into permanent housing;
- Have resources, plans, and system capacity in place should any Veteran become homeless or be at risk of homelessness in the future.

**Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH):**

**Purpose**

HUD-VASH is a collaborative program between the U.S. Department of Housing and Urban Development (HUD) and VA which provides eligible homeless Veterans a Housing Choice Voucher (HCV) from HUD paired with case management and supportive services from VA. These services are targeted to assist HUD-VASH Veterans in obtaining and sustaining permanent housing while recovering from physical and mental health problems, substance use disorders, and functional concerns contributing to or resulting from homelessness. HUD-VASH is authorized by 38 U.S.C § 2003(b) which requires VA to ensure that sufficient case management is provided to HUD-VASH participants.

**Evidence**

HUD-VASH subscribes to the principles of the "Housing First" model of care. Housing First is an evidence-based practice model which has demonstrated that rapidly moving individuals into housing, and wrapping supportive services around them as needed, assists homeless individuals in exiting from homelessness and maintaining housing stability. HUD-VASH program goals include assisting homeless Veterans and their families in achieving housing stability while promoting maximum recovery and independence in the community. HUD-VASH targets Veterans with the greatest needs, ensuring that the most vulnerable Veterans are moved into housing as quickly as possible.

HUD-VASH Voucher Utilization as of September 30, 2021:

- Vouchers Allocated: 105,411
- Vouchers Under Lease: 81,132
- Vouchers Issued to Veterans Seeking Housing: 5,343
- Vouchers Reserved for Veterans: 1,272

HUD-VASH Measures of Success:

- Voucher Utilization Rate: Target 92% (Utilization as of September 30, 2021: 83%)
- HUD-VASH Case Manager Positions Filled: Target 90% (Positions filled as of September 30, 2021: 86%)

**Implementation Plan**

HUD awards HUD-VASH vouchers based on geographic need to public housing authorities (PHAs) who self-identify to HUD their interest in receiving an allocation. HUD announced its 2020 allocation of 4,875 new vouchers in December 2020 and anticipates an additional voucher award of approximately 2,000 vouchers will be made prior to the end of 2021. Additionally, in September 2021 HUD's Office of Native American Programs (ONAP) announced an award of $4.4 million in Tribal HUD-VASH Demonstration Program grants to 28 Tribes and Tribally Designated Housing Entities (TDHEs). This included $1.0 million in expansion grants designed to help house 95 additional Veterans and Veteran families. On October 29, 2021 HUD updated their prior Notice of Funding Availability (NOFA), making available another $2.2 million in grant funding to further expand Tribal HUD-VASH. It is expected these funds will be awarded in 2022.

Upon HUD's publication of new HUD-VASH voucher awards and Tribal HUD-VASH grants, VA funds will be distributed to the VAMCs partnering with local PHAs or Tribally Designated Housing Authorities (TDHEs). These funds will be used to provide VA or VA-contracted case management services to HUD-VASH Veterans. The 2022 total funding level of $945 million is projected to support the 108,000 vouchers anticipated to be available in 2022. These costs will be increased in 2023 and 2024 to support expanded case management, in the form of staff and contracts, congruent with HUD's expected annual allocation of 5,000 vouchers. Fiscal year 2023 funds will also be used to assist with the design and development of project-based housing partnerships for aging Veterans, a growing need and area of focus for the HUD-VASH Program. These efforts will be carried over into 2024, with additional appropriations needed to sustain staffing and service enhancements for aging HUD-VASH Veterans and contract case management services which will be supported in 2022 and 2023 with funds provided under P.L. 117-2, the *American Rescue Plan Act of 2021* (ARP), funds.

**COVID-19 Impact**

HUD-VASH Veterans are uniquely vulnerable to COVID-19 due to their living conditions, age, and high rate of chronic health problems. HUD-VASH plays a critical role in VA's overall COVID-19 response by assisting these Veterans in obtaining and sustaining permanent housing. HUD-VASH programs have been encouraged to consider every Veteran placed in a temporary accommodation (e.g., hotel, congregate shelter, isolation/quarantine facility) in response to the COVID-19 emergency for HUD-VASH, as admitting these Veterans to HUD-VASH ensures they have a safe and stable living environment while simultaneously freeing up capacity in temporary quarantine settings. In 2021, $4.0 million in CARES Act funding was provided to expand case management services to support these efforts. ARP funds will be utilized in 2023 and 2024 to continue and expand these efforts.

**Grant & Per Diem (GPD):**

**Purpose**

P.L. 109-461, *Veterans Benefits, Health Care, and Information Technology Act of 2006,* permanently authorized VA's GPD Program 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 12,800 transitional housing beds nationwide. Grantee awards entitled them to receive per diem payments from VA to offset the operational costs associated with serving these Veterans. Per diem rates are statutorily tied to the State Home for Domiciliary Care and increase annually with inflation. VA assumes a two % inflation factor in future years to support anticipated increases in the State Home per diem rate. The most recent State Home per diem rate came into effect October 2021.

**Evidence**

The GPD Program has effectively served as a resource for communities to assist homeless Veterans with transitioning out of homelessness since it was first authorized in 1994. GPD fosters a partnership between VA and community-based agencies to create transitional housing resources for homeless Veterans nationwide. GPD-funded projects offer communities a way to help homeless Veterans with housing and services while assisting VA medical centers by augmenting or supplementing care. Although the GPD funding request is not to support a new initiative, these funds will allow VA to continue to support this much-needed housing resource. The increase in funding will support costs associated with projected inflation of per diem and new provisions for minor dependents associated with the implementation of P.L. 116-315, which the Department is statutorily required to provide.

*GPD evidence continues:*

- VA's largest transitional housing program with approximately 12,800 beds nationwide.
- 15,447 Veterans entered GPD transitional housing in 2021 through August 31, 2021.
- In 2021 through August 31, 2021, 21,348 homeless Veterans were served by GPD transitional housing grants.
- In 2021 through August 31, 2021, 7,461 homeless Veterans exited GPD transitional housing to permanent housing.
    - **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. October 1, 2020, a total of 369 grants to organizations were awarded to provide 12,138 beds and 18 service centers totaling approximately $216.0 million. These awards are for one year with up to two option years. VA exercised the first option year on over 350 grants which started October 1, 2021.
    - **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. October 1, 2020, a total of 46 grants to organizations were awarded to provide 723 beds totaling $55.3 million. These awards are for three years.

- **Special Need grants** provide funding to organizations that incur additional operational costs to help Veterans with special needs who are experiencing homelessness, including women, individuals with chronic mental illnesses and Veterans who care for minor dependents. October 1, 2020, a total of 11 grants to organizations were awarded totaling approximately $2.4 million. These awards were for one year.

- In 2021, VA announced three Notices of Funding Opportunity. These grants were awarded beginning October 1, 2021.
  - Case Management grant- VA awarded approximately $28.4 million for two-year renewal funding of 121 grants and 155 case manager positions. This is an opportunity for existing grantees providing housing retention services to formerly homeless Veterans and Veterans at risk for homelessness.
  - Special Need- VA awarded approximately $23.7 million for 26 three-year grants to provide funding for 217 transitional housing beds to organizations to help Veterans with special needs who are experiencing homelessness, including women, individuals with chronic mental illnesses and elderly Veterans.
  - Capital grant- VA awarded approximately $64.2 million of CARES Act for 60 grants to current Per Diem Only transitional housing grant recipients to improve approximately 1,400 beds over 18-24 months. The grant would be used to reduce shared living spaces within transitional housing by creating private bedrooms and private bathrooms for homeless Veterans. VA is awarding 36 capital grants totaling approximately $64.7 million to community organizations using ARP Act resources.

**Implementation Plan**

With the grant award announcement, GPD had approximately 12,800 transitional housing beds in 2021, which sustained existing capacity. Performance standards are established and tracked for all GPD grants. GPD liaisons review progress toward meeting these targets with all grantees at least quarterly. The 2022 total funding level of $270.0 million is projected to support approximately 12,800 transitional housing beds and 18 independent services centers. Additionally, in 2022 the GPD Program will use $75.0 million in ARP funds to offer a capital grant to create new individualized living spaces which will continue to transform the programs' housing resources to more safely serve Veterans experiencing homelessness. In 2023, the GPD Program expects to announce Notice of Funding Opportunities (NOFOs) for Per Diem Only, Transition in Place, and Special Need grants, and in 2024 a Case Management NOFO is planned.

**COVID-19 Impact**

The GPD Program received approximately $159.9 million in CARES Act funding, the majority of which supported increased per diem rates in 2020 and 2021. The Secretary waived the current cap on per diem on April 28, 2020. This funding has allowed grantees to support the additional costs of providing services to homeless Veterans during COVID-19, including the cost to provide personal protective equipment, secure quarantine spaces, deep cleaning of facilities, etc. On

February 1, 2021, the per diem waiver for all GPD grantees was capped at three times the rate for State Homes for Domiciliary Care, per the modified statutory authority under P.L. 116-315. From this point forward and, considering the State Home rate increase for 2022, per diem rates cannot exceed $152.73 for transitional housing and $19.09 for service centers. Note, per diem rate waivers will stop at the end of the current public health emergency and rates will revert to the new statutory maximum articulated in P.L. 116-315. In 2021, $64.2 million in CARES Act funding was awarded to support the Capital grant to create individual living spaces in transitional housing. VA will continue to monitor any ongoing impacts of COVID-19 on program requirements and incorporate them in future budget requests.

**Health Care for Homeless Veterans (HCHV):**

**Purpose**

The HCHV program has effectively provided outreach services to the nation's most vulnerable Veterans and has served as a resource for communities to assist homeless Veterans with transitioning out of homelessness since it was first authorized in 1987. The central goal of all HCHV programs is to reduce homelessness among Veterans by engaging and connecting homeless Veterans with health care and other needed services. HCHV programs provide outreach, case management and HCHV Contract Residential Services (CRS) programs ensuring that homeless Veterans, especially those who are chronically homeless (many with serious mental health diagnoses and/or substance use disorders) can engage with VA and community partners that provide quality housing and services that meet the needs of these special populations. The HCHV Program is authorized by 38 U.S.C. §2031 and 38 CFR Part 63.

**Evidence**

Through August 31, 2021 HCHV program staff provided outreach services to 107,556 Veterans, case management to over 10,610 Veterans, and served more than 19,400 through Stand Downs. The HCHV Program also supports 3,900 operational CRS emergency transitional housing beds with 3,427 Veterans exiting the CRS programs into permanent housing this fiscal year (October 2021 through August 2022). The percentage of homeless Veterans exiting the CRS transitional housing into permanent housing was 56% for 2020, surpassing the measure's goal of 55%. This percentage of Veterans exiting into permanent housing has increased each consecutive year from 48% in 2017, to 51% in 2018, and then 54% in 2019. It is expected that 140,000 Veterans will need outreach services in 2022 and 142,000 Veterans in 2023. The alternative would be to decrease staffing levels across all aspects of HCHV services, as well as decrease contracted bed capacity which would then leave more vulnerable homeless Veterans on the streets. Successful implementation of these funds will be evaluated through HCHV performance measures and the maintenance of current positions filled.

**Implementation Plan**

Each VA medical center across the country implements the HCHV program at the field level and ensures continuity of services each year. Performance standards are established and tracked for all HCHV CRS Programs. CRS liaisons review progress toward meeting these targets with all grantees at least quarterly. The 2022 funding level of $270.5 million is projected to support more than 3,900 HCHV CRS beds, which offer residential treatment for Veterans experiencing homelessness; 86 Coordinated Entry Specialists who work with local Continuums of Care to

identify and coordinate services for homeless Veterans in their communities; and 32 Community Resource and Referral Centers (CRRC) which are a collaborative effort of VA, the community, service providers, and agency partners which provide an open door, one-stop hub for homeless Veterans, providing a central location to engage homeless Veterans in VA and community services.

The HCHV CRS programs provide temporary, emergency housing for Veterans who are experiencing literal street homelessness, serving as a gateway or bridge to permanent housing options for that Veteran. As the homeless Veteran population ages, there is a need nationally for contracted programs that can meet the needs of the geriatric population. This is a highly specialized type of service, requiring a program that is equipped to serve this specific population. Developing this resource via a 10-site pilot program beginning in 2023 is the best way to ensure future success in meeting this gap in VHA homeless services. This pilot is contingent on the approval of additional funds.

Over the past several years, VA and its federal partners have made a concerted effort to collaborate at the federal level to ensure strategic use of resources to end Veteran homelessness and coordinate services for each individual Veteran experiencing homelessness in a community. A systematic approach to this effort is needed at the community level to ensure that resources are being utilized in the most effective way possible and that every Veteran in that community is offered the resources he or she needs to end their homelessness. To accomplish this high level of coordination amongst community partners, as well as assist homeless Veterans in navigating these complex health and social service systems, additional HCHV staff are needed. The HCHV program is requesting additional funding in 2023 to hire 140 additional HCHV social workers (one per VAMC), whose primary role will be to support homeless Veterans in enrolling in VA healthcare or community healthcare services and coordinate with community partners through their local coordinated entry systems to effectively serve each individual Veteran in the ways they require to end their homelessness.

**COVID-19 Impact**

The HCHV program received $20.0 million in CARES Act funding in 2020 and 2021. These funds provided support during the national emergency by providing funds to HCHV CRS providers to cover the additional costs of providing services to homeless Veterans during COVID-19. This includes the cost to provide personal protective equipment, deep cleaning of facilities, isolation, and quarantine spaces. These funds also allowed sites to add additional bed capacity in HCHV CRS programs as a temporary remedy to assist more Veterans who entered homelessness during the pandemic a placement. VA will continue to monitor any ongoing impacts of COVID-19 on program requirements and incorporate them in future budget requests.

**<u>Supportive Services for Low Income Veterans & Families (SSVF)</u>:**

**Purpose**

SSVF is a critical initiative designed to help reach the Administration's goal of ending homelessness among Veterans. The SSVF program was authorized by P.L. 110-387, *Veterans' Mental Health and Other Care Improvements Act of* 2008, and provides supportive services to very low-income Veteran families that are currently in or transitioning to permanent housing. SSVF is designed to rapidly re-house homeless Veteran families and prevent homelessness for

those at imminent risk due to a housing crisis. Funds are granted to private non-profit organizations and consumer cooperatives that will assist very low-income Veteran families by providing a range of supportive services designed to promote housing stability.

**Evidence**
Annual reports published since the inception of the SSVF program continue to demonstrate the efficiency and effectiveness of the SSVF program (reports are available at VA SSVF Research Library webpage). SSVF interventions help keep families together. Research conducted by the National Center on Homelessness Among Veterans found that of those placed in permanent housing, only 12% of families and 15% of individuals re-enter the homeless system one year after discharge from SSVF. By comparison, estimates from the 2010 Annual Homelessness Assessment Report, the last year that the association between poverty and homelessness was assessed, indicate that 13% of all Veterans in poverty will become homeless at some point during the year. This means that those placed by SSVF are at no greater risk of returning to homelessness than any Veteran living in poverty. In ten years of operation, SSVF has exited more than 80% of Veterans and their families to permanent housing. SSVF's success has significantly contributed to halving the numbers of homeless Veterans since 2010.

*SSVF evidence continues:*

- Base grant awards of $418.0 million in support for 2022 grantees (through a combination of the 2022 annual appropriation and supplemental ARP funding) were provided to non-profit organizations in all 50 states, Puerto Rico, the District of Columbia, Guam, and the Virgin Islands.
    - In addition to base awards, 2022 funding includes $150.0 million in 2021 special purpose funding and $200.0 million in ARP funding ($350.0 million in total) to support as the national expansion of Shallow Subsidies. Shallow Subsidies provide two-years of continuous rental assistance (traditional SSVF rental assistance provides only 10 to 12 months of rental assistance in a two-year period) for Veteran families who do not need intensive clinical supports and reside in areas with high housing costs, and very low vacancy rates for affordable housing.
- SSVF will re-commence training on its Rapid Resolution initiative in 2022. This initiative was introduced nationally in 2020 when SSVF, in partnership with HUD and United States Interagency Council on Homelessness (USICH), implemented the Initiative. This Initiative reunifies imminently at-risk or homeless Veterans with family or friends as an alternative to entering the homeless system. This initiative seeks to reduce overall demand for traditional affordable housing resources while simultaneously reducing trauma for Veterans and their families who would otherwise become or remain homeless.
- Between October 2020 and September 2021, SSVF assisted 114,175 individuals; with 80,049 Veterans assisted; and 19,266 dependent children assisted, 17% of all those enrolled.
    - Of the Veterans assisted, 10,416, or 13% were female (compared to eight to nine %of the homeless Veteran population).
    - 77% of those discharged from the SSVF program obtained permanent housing.

**Implementation Plan**

VA publishes the SSVF NOFO in the Federal Register, typically at the end of the calendar year. Awards are made to community-based, non-profit organizations who are responsible for delivering SSVF services. Currently, Veteran families throughout the country can access SSVF services as grantees are in all 50 states, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. The 2022 total funding level of $812.0 million includes resources drawn from both ARP and special purpose funding as well as regular appropriation. These funds will support the following initiatives.

- $418.0 million to sustain existing grant awards.
- $350.0 million to expand the current Shallow Subsidy initiative into a national effort.
- $24.0 million to expand access to legal services.
- $20.0 million to sustain the Health Care Navigator initiative.

ARP funding will be used as a supplement to sustain support for SSVF grants at the $420.0 million level in 2022 and 2023; however, additional regular appropriations will be required for 2024, as requested. Included in the 2023 and 2024 requests are additional appropriations to sustain the Shallow Subsidy and Health Care Navigator initiatives supported by ARP funding in 2022.

**COVID-19 Impact**

SSVF has played a leading role in VA's response to mitigating COVID-19 risks to vulnerable homeless Veterans. Between March 2020 and September 2021, SSVF placed nearly 32,000 Veterans in hotels/motels. These Veterans were previously unsheltered or in congregate environments that put them at increased risk of contagion. Operational slowdowns among HUD supported Public Housing Authorities (PHAs) have meant that voucher issuance and completion of required inspections have delayed in HUD-VASH placements. SSVF supported those waiting for HUD-VASH placement, assuring that permanent housing is secured despite these PHA delays. Between May 2020 and August 2021, SSVF assisted 11,044 Veterans, acting as a bridge to support moves into permanent housing while awaiting PHA voucher processing. Additional, SSVF has provided critical needed prevention services for Veterans facing eviction. The *CARES Act* provided $774.0 million in additional support to SSVF grantees for additional COVID-19 specific enhancements in 2020 and 2021.

- As the COVID-19 health emergency has significantly increased the population of Veteran families at-risk of homelessness, VA is expanding SSVF's Shallow Subsidy initiative. The Shallow Subsidy provides two-years of rental assistance to very low-income Veteran households. This rental support remains the same throughout the entire two-year period regardless of changes in household income, incentivizing income growth. SSVF is partnering with Department of Labor's Homeless Veterans Reintegration Program, a Veteran specific employment and training program, co-enrolling and coordinating care to participants so that they may reach economic self-sufficiency by the end of the two-year rental subsidy. Currently Shallow Subsidies are only available through 13 grantees in selected metropolitan areas. This national expansion will now allow an additional 237 grantees serving homeless and at-risk Veteran families in all 50 states, the District of

Columbia, Puerto Rico, Guam, and the Virgin Islands to offer this new level of support. The expansion is being funded through the American Rescue Plan.

- As all Veterans placed in hotels and motels had come from homelessness, and many had come directly from encampments, they had significant health needs. It quickly became apparent that SSVF grantees needed to place a greater emphasis on supporting access to health and mental health care. Access to care had become particularly challenging as lockdowns and travel restrictions introduced new barriers that disproportionately impacted those in poverty. SSVF responded by requiring all grantees hire health care navigators.
- HPO has learned from this crisis the value of a hotel/motel emergency housing option for those unsheltered homeless unwilling to go into traditional shelter or emergency housing options available through the community or VA. SSVF's hotel/motel option will continue to be utilized post-COVID as a critical engagement option for this population. A current example of this reliance on hotel/motel emergency housing is the recent effort announced by Secretary McDonough to help Veterans get out of encampments near the Greater Los Angeles VAMC and into permanent housing.

**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,"[30] Member Services NCCHV program plans to improve homeless support services by improving quality, expanding communication modalities and closing the gap from Active Duty to post-service life as a Veteran.

Our quality improvement effort will provide NCCHV leadership the ability to quickly identi, understand, and resolve problems within the contact and proactively implement changes for future interactions with Veterans. This will help NCCHV become a more Highly Reliable Organization (HRO) by not only rectiing intermittent and systemic problems but also objectively identiing improvement opportunities for Veteran Access.

Adding text capability to the current phone and chat modalities will enhance the Veteran experience and allow NCCHV to be more responsive to younger and more tech savvy Veterans who are more willing to correspond via text, while saving money for those with limited cell plan minutes or calling card resources.

Currently, there is no coordination between the Transition Assistance Program (TAP), which provides information, resources, and tools to Service Members and their families to help prepare for the move from military to civilian life, and NCCHV to assist Service Members at risk for homelessness upon separation from the military. Creating a mechanism for a warm handoff with NVVHC contact prior to leaving active service will ensure at-risk Members are actively managed and connected with the appropriate VA Homeless Veteran's representative. Follow-up reviews will ensure each Veteran has adequate housing prior to their first night on the street.

**Evidence**

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

Commission on Accreditation of Rehabilitation Facilities **(**CARF) and International Customer Management Institute (ICMI) Accreditation depends on the establishment and utilization of a quality monitoring program. A Quality Monitoring Pilot conducted in 2019 showed an eight %increase in productivity for NCCHV due to coaching and monitoring to ensure Social Service Representatives were using the correct processes. Text messaging is currently used by the Veterans Crisis Line (VCL) as one of three effective modalities high-risk Veterans use to contact a VA representative to assist them with their needs. Currently NCCHV takes over 50,000 chats per year, text messaging will provide another avenue like chat. Approximately 18,000 separating Service Members per year without Post Transition Housing Plans are projected to receive an inbound phone call. Each new Veteran served would receive at a minimum one (1) referral and one (1) follow-up review.

**Implementation Plan**

NCCHV would rely on Health Resource Center's current Quality Monitoring Team to implement a plan specific to NCCHV. NCCHV can piggyback off/duplicate an already established text messaging process utilized by the Veterans Crisis Line. NCCHV would work with VBA, Homeless Program Office, and DoD to establish a pilot and determine appropriate roles. The 2022 funding level of $7.9 million will support NCCHV's Quality Monitoring Pilot for VCL's already-established text messaging process and its coordination efforts with the Transition Assistance Program to better assist Service Members who are at risk for homelessness upon separation from the military. NCCHV has no new initiatives planned for 2023 but will continue to improve the quality monitoring program and expand communication modalities. Additional funds are requested to support projected inflation/cost of living increases of two % annually.

**Veterans Justice Outreach Homeless Prevention (VJO):**

**Purpose**

The VJO program facilitates access to VA health care and other services for Veterans who are involved with the criminal justice system, and therefore face heightened risks of homelessness, suicide, opioid-related overdose, and other negative outcomes. Congress has recognized the value of this program by mandating the expansion of VJO field staff by 50 Fulltime Equivalent (FTE) in 2019, through P.L. 115-240, *Veterans Treatment Court Improvement Act of 2018*. This request provides for the continued growth and sustainment of the program, in keeping with Congress's demonstrated intent.

**Evidence**

The demand for VJO services is expected to continue growing through 2023. As communities become increasingly aware of the presence of Veterans in their criminal justice system, and of resources available for addressing their needs, more and more of these communities adopt and develop program models such as Veterans Treatment Courts, and/or Veteran-specific housing units in local jails. The number of VTCs and other Veteran-focused courts is now more than 600, and the number of Veteran-specific housing units in local jails is now over 100 and rising. To facilitate Veterans' access to VA services at the earliest possible point after contact with the criminal justice system, these programs require assistance from VJO Specialists, whose time and capacity are finite.

As noted above, communities across the country continue to launch new Veteran-specific criminal justice programs – such as Veterans Treatment Courts and Veteran-specific jail housing units – and in some cases to expand the capacity of such programs that already exist. The sustained growth in demand for VJO services is evidenced by VAMCs' continued requests for additional VJO FTE to serve justice-involved Veterans in the communities they serve. The 2022 increase in the VJO budget will allow VAMCs to add approximately 25 new FTE, which should satis a significant amount of the demand for new VJO capacity. This will allow for a more modest increase in 2023 to address VAMCs' needs for additional VJO positions.

VJO Specialists serve a Veteran population with significant and often complex clinical needs, and recent evidence demonstrates a high level of effectiveness at linking these Veterans to responsive services. In 2020, 94% of Veterans served by VJO Specialists went on to access face-to-face VHA services. Of these Veterans:

- 73% were diagnosed with one or more mental health disorders, and 93% of those with such diagnoses entered VHA mental health treatment.
- 56% were diagnosed with one or more substance use disorders, and 68% of those with such diagnoses entered VHA substance use disorder treatment.

**Implementation Plan**

The requested additional funds would support VAMCs' hiring of additional VJO Specialists (approximately eight FTE) to develop and/or expand partnerships with local criminal justice agencies to facilitate justice-involved Veterans' access to needed VA treatment at the earliest possible point. The award and hiring processes would follow a model that has been in place for ten years. These positions are awarded on a needs-driven basis, in response to VA facilities' demonstrations to the VJO program office of current and projected demand for VJO services in the communities they serve. After receiving notification of a new award, each receiving VAMC fills its allocated position and reports on its status to VHACO via the Homeless Staffing Database operated by the Veterans Support Service Center. Facilities are given 90 days to fill newly awarded positions, after which the award is subject to withdrawal.

The use of specific-purpose funding from VHACO has been critical to the growth of the VJO program to date and will remain so. Because VJO Specialists must spend significant time in collaborative planning with criminal justice partners, as well as traveling to distant outreach locations, their clinical workload is often lower than that of staff in VAMC-based programs. VAMC's have generally requested additional funding from VHACO to sustain locally funded positions over time.

The 2023 funding level of $71.5 million is projected to support outreach and linkage to VA services for justice-involved Veterans by approximately 415 VJO staff in 2023. This expanded VJO workforce will be able to respond to the continued growth of Veteran-focused interventions in local criminal justice systems, including by providing direct support to more than the 601 VTCs and 100 Veteran-specific prison and jail housing units in which they currently serve Veterans. Further expansion of the VJO workforce, by an estimated 50 additional FTE, for a total of approximately 465 is projected for 2024 in response to a continued increase in demand for VJO services.

**Legal Services for Veterans (LSV):**

**Purpose**

This is a new program within the Homeless Programs Office, focused on facilitating Veterans' access to legal services, including for civil legal matters such as landlord/tenant disputes and child support arrears that can present barriers to housing stability. In addition to providing training, technical assistance, and partnership-development support with legal service providers for VHA, the LSV program will administer two streams of grant funding to support the provision of legal services to Veterans by eligible non-VA entities.

**Evidence**

These new grant programs are mandated by P.L. 116-315 § 4202, *The Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020*, and P.L. 116-283 § 548, *The William M. (Mac) Thornberry National Defense Authorization Act (NDAA) for Fiscal Year 2021*.

**Implementation Plan**

P.L. 116-283 § 548 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.

VA plans to establish the pilot grant program required by section 548(b) by first consulting with external groups that currently provide legal assistance to Veterans and former Service members for issues identified in the statute: discharge upgrades, benefits assistance, and others. This consultation process was completed in October 2021. The results of this consultation process will inform the development and publication of regulations under which VA will be able to award grants to eligible entities. As required by section 548(b), these grants will be awarded through a competitive process that ensures consideration of applicants' experience, financial capacity, and other specified qualifications.

The $15.0 million requested for 2024 will support the award of an estimated 100 grants to legal service providers, in amounts up to $150,000 each. Each grant would cover the annual salary and benefit costs for approximately one attorney position, depending on experience and locality (National Association for Law Placement, 2018), as well as data collection, reporting, and other administrative costs associated with the grant. The grant program mandated by P.L. 116-315 § 4202 will be supported by funds provided under the budget line item for the NAVY SEAL Bill Mulder Act of 2020 (P.L. 116-315, Title IV).

**Homeless Patient Aligned Care Team (HPACT)**

**Purpose**

The HPACT program is a multi-disciplinary, population-tailored medical home designed around the unique needs and distinct challenges homeless Veterans face both accessing and engaging in health care. Interdisciplinary teams of doctors, nurses, case managers, and other health professionals respond to the ongoing and evolving medical, social, mental health, and substance abuse needs of homeless Veterans entering the VA system. The program serves as a conduit for treatment engagement and involvement in VA Homeless Programs and clinical services and support through a "no wrong door" policy. The HPACT program provides and coordinates health care that Veterans may need to help accelerate placement into permanent housing and prevent a return to homelessness. HPACT is authorized to provide health care to eligible Veterans under Title 38 U.S.C. §7302(b), Title 38 CFR Section 17.38.

**Evidence**

In 2012, the HPACT program began with a total of 32 pilot sites. To date there are 87 HPACT teams and providers operating at 57 VAMCs, Community Based Outpatient Clinics (CBOCs), and Community Resource and Referral Centers (CRRCs) across the country. HPACTs are located in every VISN with over 188 full time equivalent staff serving over 22,000 Veterans annually. Collectively, Veterans enrolled in HPACT show a 19% reduction in emergency department visits and a 35% reduction in inpatient hospitalizations. Veterans in HPACTs were housed in permanent housing 81 days faster than those not enrolled in a HPACT. In addition, HPACT Veterans are more likely to report positive patient care experiences related to 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 Veteran in one setting. This is 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 also provide food and clothing assistance, hygiene items, showers, and laundry facilities and other services on-site to meet the full spectrum of Veteran needs.
- 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 last issued funding for the start-up of new teams or expansion of existing teams in 2017. Additional specific purpose funds would support growth of the HPACT program to additional field

sites serving homeless Veterans and expansion of effective services such as outreach, mobile health units, and telehealth for existing teams. Priority would be given to teams that had a strong core team identified and infrastructure to begin seeing patients immediately, strong local leadership buy-in, in-kind staff support, and clinical space that could accommodate multi-disciplinary team co-location. Specific purpose funding is an integral part of the growth, expansion, and sustainment of HPACT programs. The 2022 funding level of $10.0 million is projected to support active HPACT teams. A $2.0 million increase is requested for 2023 to cover the expansion of HPACT services (i.e., FTE to support outreach services and rural health needs, telehealth, expansion of clinic hours, etc.) among current programs and support the launch of new teams at additional VA medical centers. These requested funds will support HPACT FTE (e.g., MD/NP, RN, SW, MSA, peer support specialist, etc.) for up to eight new or expanded HPACT programs (max $250,000 per site) or potentially more sites if max funding per site is not requested. With over 22,000 Veterans served by HPACT in 2021, this additional funding will create an opportunity for more Veterans experiencing homelessness to have access to HPACT programs and further engage those Veterans disconnected from services all in one setting. Administrative cost is also included in this request.

**COVID-19 Impact**

The HPACT program continues to focus on the ongoing COVID-19 pandemic and supporting Veterans experiencing homelessness. VA will continue to monitor any ongoing impacts of COVID-19 on program requirements and incorporate them in future budget requests.

**Homeless Veterans Community Employment Services (HVCES):**

**Purpose**

HVCES provides employment services and resources to Veterans participating in Veterans Health Administration (VHA) homeless programs in order to increase access to permanent housing and improve housing stability. This is accomplished both through the provision of direct services and by providing a bridge to employment opportunities and resources in the local community. To help improve employment outcomes for homeless Veterans, VA continues to support the Vocational Development Specialists who are embedded in homeless program teams and serve as Employment Specialists and Community Employment Coordinators (CEC). HVCES staff ensure that a range of employment services are accessible to Veterans who have experienced homelessness, including chronically homeless Veterans and complement existing medical center-based employment services. Homeless Veteran Community Employment Services (HVCES) is authorized by 38 U.S. Code § 2031 and 2033.

**Evidence**

In 2021, employment outcomes for homeless Veterans remained stable despite the impact of the COVID-19 pandemic. During that time 5,063 Veterans exited homeless residential programs with competitive employment (i.e., Grant & Per Diem (GPD), Low-Demand Supportive Housing (LDSH), and Healthcare for Homeless Veterans – Contract Residential Services (HCHV-CERS). Employment rates for Veterans housed through HUD-VASH exceeded the national target by over three %. Between October 1, 2021 and August 31, 2021, there were 12,497 newly documented, unique instances of employment for Veterans engaged in or who exited from VA Homeless Programs or Services. In response to COVID-19, HVCES staff increased the use of telehealth and

telephone visits and developed strategies for providing employment services and supports through virtual platforms by more than 50%.

**Implementation Plan**

HVCES has not received increased funding since its inception in 2014. However, the numbers of Veterans served in HUD-VASH case management (the largest VHA homeless program) has risen from 66,287 in 2014 to 89,472 in 2021. While not all Veterans served by VHA Homeless Programs may be interested in employment, it is critical to provide employment assistance to all Veterans who are able to return to work. The requested funds support the Vocational Development Specialists who provide direct employment services to homeless Veterans and develop employment opportunities and community partnerships to broaden available resources. In 2023, the collaboration between VHA homeless programs and Department of Labor (DOL) programs such as, but not limited to, Veterans' Employment and Training Services (VETS), Homeless Veterans Reintegration Program (HVRP), and Senior Community Services Employment Program (SCSEP) will continue to be a focus on both national and local levels including joint trainings for staff and highlighting the impact of this partnership on employment for Veterans who have experienced homelessness. The 2023 funding level of $19.8 million is projected to support 200 FTE in 2023. Increased FTE will also mitigate higher rates of unemployment following the COVID-19 pandemic. The 46 additional FTE will be distributed across the nation based on needs identified by local homeless programs to include rural areas and Community Based Outpatient Clinics (CBOCs) which have previously been unable to provide employment services to homeless Veterans and may have fewer community resources available.

**COVID-19 Impact**

Given the increased unemployment rate among both the general and Veteran populations, as well as changes in the job market in response to COVID-19, VA requests additional funding for staff to provide employment services to mitigate these impacts.

**National Homeless Registry:**

**Purpose**

The National Homeless Registry is a comprehensive repository of Veterans who have been identified as homeless or at risk for homelessness any time since October 1, 2005, and their associated housing, employment, clinical, administrative, and benefit information. It is designed as both a robust repository and data management tool that provides longitudinal information designed to monitor VA's progress in achieving the goal of ending Veteran homelessness. The Homeless Registry incorporates information from Homeless Operations, Management and Evaluation (HOMES), a data collection tool used by front-line homeless coordinators to manage their outreach, assessment, referral, and case management work, as well as VHA healthcare records, VBA benefits and claims, homeless program specific evaluation data, and community partner data related to services provided to homeless Veterans and those at risk for homelessness. The Homeless Registry also contains geographic, programmatic, and Veteran-specific information related to housing stability, treatment engagement, and VA benefit enrollment.

**Evidence**

To actualize the goal to advance the VA's mission to end Veterans' homelessness, a consolidated repository of Veteran data was created. In 2010, funding for the Registry Budget was secured to

address this gap. The creation of this registry of Veteran data has become the foundation for guiding program development and formatting research to enhance services for Veterans. Knowledge gained from these efforts augment the original registry content and adds to its ongoing development.

Maintenance and addition to the Registry is an ongoing process. The Registry Budget supports the development and maintenance of a comprehensive repository of Veterans who have been identified as homeless or at risk for homelessness any time since October 1, 2005, and their associated housing status, employment, clinical, administrative, and benefit information. It is designed as both a robust repository and data management tool that provides longitudinal information intended to monitor VA's progress in achieving the goal of ending Veteran homelessness.

**Implementation Plan**

Plans are on the way to expand the development and evaluation of new interventions (targeting housing instability, health needs, and social determinants of health) in partnership with other VA program offices and universities with an estimated cost of $400,000. Additional opportunities include exploring additional expansion of deployment of evidence-based practice training. Currently, the National Center on Homelessness among Veterans (the Center) is working with a university affiliate and engaging non-VA subject matter experts along with operational partners to create practice informed outreach models based on Critical Time Intervention Models for CRRC and HCHV outreach staff. Implementation of the program design is expected in at least two sites. Follow up for 2023 will be enhancing this model and replicating at four additional sites. Contracting costs will increase for 2023. Initial costs are expected at $30,000; additional costs expected to increase to $60,000 for additional sites. Also, the Center is currently working with a VA medical center and HCHV operational partners to implement a program for highly vulnerable Veterans experiencing housing instability. Implementation of two pilot sites in first quarter of 2023 is expected. Additional sites will be added to further sample size and test the pilot implementation and adoption to four additional sites in 2024. Costs for 2022 are expected to be $30,000. Costs for 2023 and 2024 are expected to be $240,000 and $720,000 respectively.

**Navy Seal Bill Mulder Act of 2020**

The 2023 budget request for the Veterans Homelessness Program includes resources necessary to implement provisions in the NAVY SEAL Bill Mulder Act of 2020, included in P.L. 116-315, *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020,* Title IV, Subtitle B, signed into law to January 5, 2021. The 2022 and 2023 budget request will support implementation of a new $12.0 million grant program to provide legal services for homeless and at risk, improve VA's Grant and Per Diem program by making an additional $50.0 million available to grantees, and improve HUD-VASH voucher utilization by providing $32.0 million for contract case management services.

## Whole Health

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary Obligations** | | | | | | | |
| Medical Services (0160): | $56,615 | $64,627 | $64,627 | $66,508 | $66,527 | $1,881 | $19 |
| Medical Community Care (0140): | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical Support and Compliance (0152): | $7,836 | $8,973 | $8,973 | $9,343 | $9,347 | $370 | $4 |
| Medical Facilities (0162): | $50 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Grand Total]** | **$64,501** | **$73,600** | **$73,600** | **$75,851** | **$75,874** | **$2,251** | **$23** |

[1/]Whole Health budget includes the entire $33.0 million in obligations requested for Patient Centered Care Services and Administration supporting P.L. 114-198 §933 (part of *Jason's Law*). This amount is also included in the Opioid Prevention, Treatment, and Program budget shown earlier in the chapter.

**Authority for Action:** The activities of the office are governed by the following public laws, Executive Orders, and VA/VHA initiatives:

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

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

- Executive Order 13822, *Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life*, issued January 2018. It requires the Departments of Defense, VA, and Homeland Security, through the Assistant to the President for Domestic Policy, to develop "a joint plan that describes concrete actions to provide, to the extent consistent with the law, seamless access to mental health treatment and suicide prevention resources for transitioned uniformed services members in the year following discharge, separation, or retirement." A VA-specific component of the joint plan subsequently developed by the Departments includes VA's obligation to "[Expand] peer community outreach and group sessions in the VA Whole Health initiative from 18 Whole Health Flagship facilities to all facilities. Whole Health includes wellness and establishing individual health goals." Hence, the scope of services to be provided under the Whole Health Initiative (pilot program) was expanded to 1) include expanded peer community outreach and group sessions and 2) include new transitioning Veterans during their first year after their discharge, separation, or retirement. There have been over 50,000 participants in Introduction to Whole Health group sessions offered at 96% of VHA Health Care Systems and over 3,000 Transitioning Service members participating in these sessions through quarter two of 2021. In addition, 14% of these have resulted in request for referrals to Mental Health.

- VA's 2018 – 2024 Strategic Plan includes strategy 2.1.4: "Emphasizing Veterans' and their Families' Whole Health and Wellness." The strategic plan highlights VA's focus on personalized, proactive, patient driven health care to empower, equip, and encourage Veterans to take charge of their well-being and adopt healthy living practices that deter or defer preventable health conditions. Programs like MyHealtheVet engage the Veteran in managing their own health and provide virtual access to their providers without the burden of traveling to a facility. Support and consideration of the needs of Veterans' families, caregivers, and supporters is included in this approach to Veteran wellness.
- Within the VHA Plan for Modernization, the integration of Whole Health approaches into Mental Health and Primary Care clinics is mandated in the Executive Decision Memo (EDM) on Engaging Veterans in Lifelong Health, Well-being, and Resilience. The "2021 Transform Healthcare Deliver: Whole health" Lane of Effort focuses on Veterans at increased risk for suicide in Mental Health and Primary Care clinics by helping Veterans reconnect with their mission and purpose in life as part of the comprehensive approach to reducing risk.
- The first stage of an evaluation of the outcomes of the Whole Health Flagship effort was completed by a team from VHA's Health Services Research and Development Service's (HSR&D) Quality Enhancement Research Initiative (QUERI) in January 2020. The report was the basis of the Congressional progress report mandated in *Jason's Law*, which was submitted to congress March 31, 2020. Even relatively early in the course of the Whole Health deployment at the flagships, the evaluation indicated positive results, including:
    - 31% of Veterans with chronic pain at the flagships engaged in some Whole Health services.
    - There was a threefold reduction in opioid use among Veterans with chronic pain who used Whole Health services compared to those who did not. Opioid use among comprehensive Whole Health users decreased 38% compared with only an 11% decrease among those with no Whole Health use.
    - Compared to Veterans who did not use Whole Health services, Veterans who used Whole Health services reported:
        - Greater improvements in perceptions of the care received as being more patient centered.
        - Greater improvements in engagement in healthcare and self-care.
        - Greater improvements in engagement in life indicating improvements in mission, aspiration, and purpose.
        - Greater improvements in perceived stress indicating improvements in overall well-being.

In March 2020, the VHA Governance Board approved the increased emphasis on Whole Health Clinical Care to reach more high-risk Veterans proactively in Mental Health, Primary Care/Mental Health Integration, and Primary Care by building upon the previously approved adoption of the Whole Health System of approach. The goals include training of all team primary care and mental health team members in basic whole health principles; establishment of local facility protocol for offering engagement in Whole Health, completion of a Personal

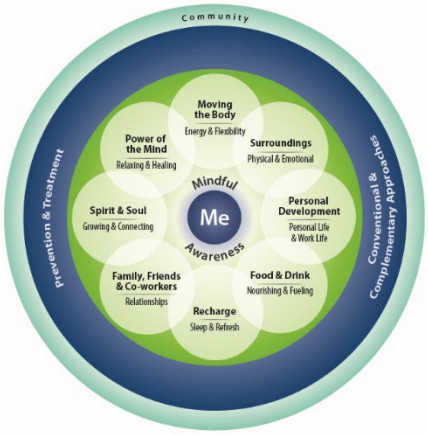
Health Inventory, beginning with those identified at high risk of suicide; and identiing a whole health champion on each clinic team. Launch of this initiative was delayed by the COVID-19 pandemic but, remains a priority for VA, and resumed at full speed in March 2021.

**Populations Covered:** All Veterans regardless of eligibility status are encouraged to participate in the Whole Health approach to care. Whole Health concepts are introduced in the Military Health System via in person contact through the Transition Assistance Program (TAP). The materials include an overview of Whole Health and steps for engaging in the approach at local VA facilities or through on-line resources. All Veterans and the public have access to Whole Health web-based tools and resources: https://www.va.gov/wholehealth/ and VA medical sites are encouraged to develop outreach mechanisms for both enrolled and unenrolled Veterans to encourage participation. The Whole Health system is also designed to be used by employees, both to engage employees in the system of care for Veterans as well as to positively impact the lives of the VA workforce. Research shows that personal experience with health interventions makes it more likely that a provider will share those interventions with their patients and increases the likelihood that the interventions will be effective.[31] [32] Employee Whole Health will create an environment that encourages VA staff to adopt healthy behaviors that promote well-being, reduce the incidence of preventable illness and injury, staff turnover, and burnout. Likewise, Employee Whole Health fosters a culture of engagement, which increases productivity and job satisfaction that results in the best care for Veterans. VA has created support tools for employees, especially during and following the coronavirus pandemic, to support wellbeing and resiliency, both of which are critical for a high-reliability organization (resources available at VA Employee Whole Health webpage). Employees who reported involvement with Whole Health also reported their facility as a "best place to work," lower voluntary turnover, lower burnout, and greater motivation.

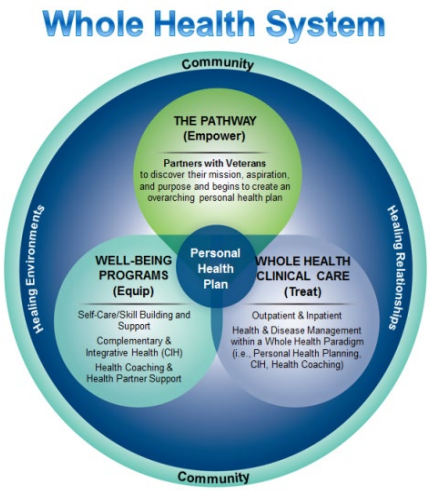
[31] Witt, Martins, Willich, Schützler. 2012. "Can I help you? Physicians' Expectations as Predictor for Treatment outcome". *European Journal of Pain.*

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

**Types of Services Provided:** The Whole Health System centers around supporting the Veteran to improve their overall health and well-being. It integrates peer-led personalized health planning, use of Whole Health Coaches and well-being classes, with both allopathic (conventional medicine) and complementary and health approaches (e.g., stress reduction, yoga, tai chi, mindfulness, nutrition, acupuncture, and health coaching) that focus on Veterans' goals and priorities. The Whole Health approach partners with Veterans to improve their whole health and is especially important for Veterans with complex conditions, such as chronic pain and mental health issues. The Whole Health approach also improves access by using trained Whole Health coaches and trained peer facilitators, which reduces the burden on primary care. The goals of the Whole Health approach focus on understanding the patient's life mission, aspiration or purpose (i.e., what matters most to the Veteran versus what is the matter with the Veteran). Completion of the Personal Health Inventory that addresses the Whole Health Components of proactive health and well-being (first graphic), results in a Personalized Health Plan. The Personal Health Plan is owned by the Veteran and serves as an integrator among the components of the Whole Health System, keeping all members of the Veteran's team informed (second graphic).




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




**Recent Trends:** Nationally, there is a growing trend toward more patient-centered, value-based healthcare, with a focus on well-being as opposed to purely disease-management. Though leaders in healthcare including the Institute for Healthcare Improvement and the National Academy of Medicine are spearheading this trend, the Whole Health approach in VA is seen nationally as a cutting-edge example of how to implement this new focus.[33] The Whole Health System is the cornerstone of the VA strategy to implement this shift.

[33] Jonas, Schoomaker, Marzolf. 2019. "Finding the Cause of the Crises: Opioids, Pain, Suicide, Obesity, and Other "Epidemics". *NEJM Catalyst.*

Introduction to Whole Health sessions offer Veterans and family members an overview of the Whole Health approach and the opportunity to begin a Personal Health Inventory. Next, Veterans can choose to participate in the full program, *Taking Charge of My Life and Health*, which leads to development of a Personal Health Plan. With implementation of Executive Order 13822, 96% of VA medical centers now offer *Introduction to Whole Health* sessions in person or through telehealth modalities with over 50,000 participants through quarter two of 2021. In addition, 14% of these have resulted in request for referrals to Mental Health.

As Veterans, family members, and caregivers begin to engage in the Whole Health approach at VA facilities, interest in accessing aspects of the Whole Health approach in the community has also grown. VA facilities, through a national memorandum of understanding with the YMCA, have partnered to offer Introduction to Whole Health, Taking Charge of My Life and Health and some complementary and integrative health modalities (e.g., yoga, tai chi) at local YMCA facilities. The VA Caregiver Support Program is also exploring opportunities for caregivers to participate in Whole Health coaching.

A detailed evaluation plan was developed for the flagship sites by the Office of Patient Centered Care and Cultural Transformation (OPCC&CT) in collaboration with VHA's HSR&D QUERI to achieve the objective of the *Jason's Law*/Whole Health System evaluation effort. The results of the current pilot justi making this program permanent and available across the entire VA health care system. At the 18 pilot sites, Veteran-participants dealing with chronic pain or mental health issues are experiencing a reduction in symptoms and a reduced need for long-term opioid therapy. Early data on the impact of Whole Health suggests that it can lead to a decrease in overall outpatient costs as well as to a more rapid decrease in opioid utilization than is being seen in the overall VHA patient population. Veterans at the 18 Flagship facilities are also experiencing an improvement in their sense of well-being. Based on the outcomes we are seeing in the *Jason's* Law-mandated pilot sites, we conclude that system-wide expansion of the Whole Health initiative can help to avoid or mitigate the recognized dangers of opioid overuse, while still clinically managing the chronic pain of our patients, improve overall well-being and other clinical outcomes. In addition, the VA can provide a model of healthcare delivery that will transform American healthcare.

During the first two quarters of 2021, there have been 529,495 Whole Health encounters in VHA bringing the total number of Veterans reached by Whole Health to 346,629 (7.4% of active Veterans). To reach an annual goal of 10% of Veterans receiving Whole Health at the intensive level (five Whole Health encounters) the projected cost is an average of $1.9 million per facility. This includes the provision of Whole Health services to Veterans as well as support for Employee Whole Health Coordinator positions, and Whole Health Program Manager and Clinical Director positions.

**Projections for the Future**

VHA is leading the nation in transforming healthcare from a disease-based system of care to one that is centered on health and well-being by focusing on what matters to the patient.

VA continues expansion of Whole Health in the telehealth environment at individual (e.g., development of a Personal Health Plan, coaching) and group levels (e.g., yoga, mindfulness training, healthy eating instruction). Telehealth technology has enabled VA to expand complementary and integrative health services to Veterans when in-person care is not available, or when geographic/accessibility/transportation or other barriers exist. Since the beginning of the pandemic and with the temporary closure of non-urgent in-person services, more VAMCs are offering complementary and integrative health and Whole Health approaches via telehealth. Tele-Whole Health has grown to include 28,793 unique Veterans participating in 72,659 encounters through the month of March 2021. This growth highlights continued Veteran demand for Whole Health and complementary and integrative health services and emphasizes the feasibility for both providers delivering and Veterans receiving telehealth services. Continued growth in the delivery of Whole Health and complementary and integrative health services via telehealth is expected as health care continues to be shaped by the pandemic.

OPCC&CT continued collaboration with VHA program offices to offer virtual well-being resources to VA staff to support them through the pandemic. Through April 30, 2021 there have been over 60,000 page views. In response to COVID-19, VHA launched the *#LiveWholeHealth* self-care blog series for Veterans, offering self-care experiential videos include meditation, yoga, breathwork, movement, healthy cooking and more are posted weekly to VA social media that Veterans, family, caregivers, and staff can access on demand. The *#LiveWholeHealth* self-care blog series includes 66 *VAntage Point* blog posts with embedded self-care videos and over 4.9 million reaches over the past year. VA has also continued the expansion of Employee Whole Health Coordinators and programs to additional sites.

OPCC&CT is partnering with the Homeless Veterans Program Office, as well as other initiatives aimed at addressing how the Whole Health approach can help identi and address systemic racism and the social determinants of health (education, employment, food security, housing, spiritual support, and transportation), all of which that can have significant negative impacts on Veterans physical and mental health.

VA continues the integration of Whole Health principles with the Military Health System. Specifically, the documentation of a Personal Health Plan for every transitioning service member in Cerner's One Plan platform in the new electronic health record will facilitate self-empowerment, self-healing, and self-care as well as continuity during this critical transition. VA is also expanding its partnerships with Veterans Service Organizations to assist in spreading the word about VA's Whole Health services.

VA is also actively assessing the effectiveness of the Whole Health Self-Assessment Tool and the Whole Health System Designation Framework to further evaluate the system-wide transformation to a Whole Health System of Care. The Whole Health System Designation Framework outlines milestone accomplishments sites can achieve toward Whole Health transformation as they progress through four phases of implementation: Preparation, Foundational, Developmental, and Full. The Designation Framework describes key accomplishments across each phase and is organized around seven domains of focus: Governance, Operations, Pathway, Well-Being, Clinical Care, Employee Whole Health, and Community Partnerships.

## Programs for Select Veteran Populations

This section provides narrative descriptions of selected programs that serve certain Veteran populations.[34] The obligations shown in each table below reflect the cost of total health care services provided to each designated Veteran population.[35] 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*) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary & Mandatory Obligations by Category:** | | | | | | | |
| Medical Services | $1,208,300 | $1,239,000 | $1,219,900 | $1,260,100 | $1,303,000 | $40,200 | $42,900 |
| Medical Community Care | $135,700 | $123,400 | $137,200 | $142,000 | $147,200 | $4,800 | $5,200 |
| Medical Support and Compliance | $115,400 | $127,600 | $116,600 | $120,500 | $124,600 | $3,900 | $4,100 |
| Medical Facilities | $92,900 | $109,500 | $94,000 | $97,100 | $100,400 | $3,100 | $3,300 |
| **Obligations [Total]** | $1,552,300 | $1,599,500 | $1,567,700 | $1,619,700 | $1,675,200 | $52,000 | $55,500 |

### Authority for Action

The Veterans Health Administration's (VHA) National Human Immunodeficiency Virus (HIV) Program is governed by Title 38 United States Code (U.S.C.) 7301(b), 7332, and 1703; Title 38 Code of Federal Regulations (C.F.R.) 17.38; and VHA Directive 1304. The Program falls under the jurisdiction of VHA's HIV, Hepatitis and Related Conditions Programs Office (HHRC), within the Specialty Care Program Office (SCPO). HHRC is responsible for providing primary guidance and advice to the Under Secretary for Health on policy and services related to HIV infection. Using population-based approaches, HHRC leads the coordination of activities within VHA for HIV prevention, and for diagnosis, care, and treatment of Veterans living with HIV (VLHIV).

VLHIV suffer from high rates of medical and psychiatric co-morbidities, including mental health and substance use disorders, cardiovascular disease, renal dysfunction, and metabolic disorders. VHA's National HIV Program ensures that these Veterans receive the highest quality comprehensive clinical care: testing, diagnosis, timely linkage to care, and treatment of co-morbidities, Additionally, the office strives to reduce health disparities, and promote evidence-based HIV preventive services.

VHA's HIV prevention efforts are based on recommendations by the U.S. Centers for Disease Control and Prevention, and approval by the U.S. Food and Drug Administration (FDA) of drugs found to be safe and effective for HIV Pre-exposure Prophylaxis (PrEP). In 2014, VHA's

[34] The sources of the clinical and utilization data used to identi the sub-populations are the Inpatient discharge file, the Outpatient encounter file and Purchased Care payment file. The cost of the relevant patients and the services associated with each of the sub-populations is based on the Managerial Cost Accounting (MCA) system. The MCA system assigns costs to all VHA inpatient and outpatient encounters. In the budget submission, the MCA costs are augmented with the payments for community care services and adjusted to reflect obligations.

[35] Obligations exclude the Captain James A. Lovell Federal Health Care Center (JALFHCC) fund (0169).

Pharmacy Benefits Management Service (PBM) added PrEP to its Criteria for Use for a fixed-dose combination of emtricitabine/tenofovir that was already on the VA National Formulary (VANF) for treatment of HIV. VA continues to promote the broader use of PrEP across the VHA system by addressing local and systemic barriers to increased uptake, as well as working to make condoms universally available to all Veterans in VA care.

**Population Covered**

VHA policy requires that all Veterans be offered HIV testing at least once in their lifetime as part of routine health care, with testing offered at least annually to those who have on-going risk of exposure. Multiple published studies have shown that individuals who are aware of their infection are less likely to transmit HIV to others and are more likely to modi behaviors likely to transmit HIV, decreasing the number of new HIV infections in the community.

In calendar year (CY) 2021, the number of Veterans in VHA care who were candidates for HIV screening, i.e., all Veterans in VA care who had not received an HIV testing and did not have a diagnosis of HIV, was 3,699,806.[36] VA continues to increase HIV testing each year, with a cumulative %age of 47.5% of all Veterans in VA care having been tested for HIV as of December 31, 2021. Of those who tested positive and were alive for at least 90 days after their HIV diagnosis, 74.8% were linked to care within 30 days of their diagnosis. Since 2016, rates of linkage to care within 30 days have ranged from 74% - 87%, while rates of linkage to care within 90 days have consistently been close to or at 100%.

VA is the single largest provider of HIV care in the U.S., with 31,680 VLHIV in VA care in 2021. VLHIV receiving care in VA in 2021 had a median age of 60 years (range, 20 y – 98 y); 96.2% were men. With regard to race, 48.8% were reported as Black or African American and 42.8% as White. With regard to ethnicity, 7.9% were reported as Hispanic or Latino. With regard to rurality, 15.8% lived in rural, highly rural, or insular island areas. With regard to period of service, 40.8% were classified as serving in the Persian Gulf War era, 29.1% in the Vietnam War era, and 28.9% in the post-Vietnam War era.

Of all VLHIV in VA care in 2021, 84.8% had a prescription filled for an antiretroviral drug filled during that fiscal year. Of all VLHIV in VA care in 2021, 71.8% were virally suppressed, while of those who had a viral load test in that year, 92.9% were virally suppressed.

As of December 31, 2021, 4,889 HIV – negative Veterans in VA care were receiving PrEP, an increase of 699 (16.7%) compared to December 31, 2020. Because of the transition to the Cerner EHR at the Mann-Grandstaff VA Medical Center in Spokane, WA, this number does not include HIV-negative Veterans in care at that facility who received PrEP.

**Services Provided**

VA has aligned its HIV care and prevention services with the White House's National HIV/Acquired Immunodeficiency Syndrome (AIDS) Strategy (NHAS). The first NHAS was released in July 2010, with four major goals: Reducing New HIV Infections; Increasing Access to Care and Improving Health Outcomes for People Living with HIV; Reducing HIV-Related Disparities and Health Inequities; and Achieving a More Coordinated National Response to the

[36] These data do not include testing at the Mann-Grandstaff VA Medical Center in Spokane, WA, because of the transition at the Cerner HER at that facility.

HIV Epidemic. The NHAS was revised and updated in December 2015, with addition of measurable indicators reflecting all steps in the HIV Care Continuum: diagnosis; active linkage to, and retention in care; initiation of antiretroviral therapy (ART); and viral suppression, meaning that no detectable virus is present in the blood. The third iteration of the NHAS is currently undergoing final review and clearance by participating Federal agencies.

As one of the Federal agencies participating in formulating and implementing the NHAS, the VA utilizes the HIV Care Continuum model to assess gaps in care and for population health-based management of HIV services at the individual facility level. VA provides comprehensive HIV prevention and clinical care across the healthcare system from prevention of HIV to diagnosis, linkage to care, management, and treatment. All medications approved by FDA for ART are available on the VANF, as is comprehensive care management for co-morbid mental health and medical comorbidities. All VA medical centers and outpatient clinics offer HIV testing, with timely linkage to HIV-specific care for patients with newly diagnosed infection.

All VHA facilities have access to benchmark data across the VHA system at the national, VISN, and facility levels on annual HIV testing rates and performance on the HIV Care Continuum. Other clinical and population health decision support resources include dashboards for population health management of VLHIV in VA care to monitor linkage to and retention in care, utilization of antiviral therapy, and rates of viral suppression; point-of-care electronic clinical reminders for HIV testing and for PrEP and dashboards designed to increase PrEP uptake, particularly among Veterans identified as being at increased risk from STI screening results.

HHRC offers training and educational programs throughout the year to VHA HIV providers and holds monthly teleconferences for all HIV providers in the VHA system to discuss current issues. Under VHA policy, all VHA facilities have an HIV Lead Clinician, who acts as both a point of contact with HHRC and as a local champion for initiatives to improve access to and quality of HIV care and prevention services.

**Recent Trends**

Table 1 shows recent trends in HIV diagnosis and care metrics within VHA.

**Table 1. HIV diagnosis and care metrics, 2018 - 2021**

| | 2018 | 2019 | 2020[4] | | 2021 |
|---|---|---|---|---|---|
| % of Veterans in VA care ever tested for HIV[1] | 43.1% | 43.5%[3] | 46.8%[3] | | 47.5% |
| Number of previously untested Veterans in VA care tested for HIV in calendar year[1] | 239,977 | 154,289 | 145,313 | | 185,382[5] |
| % of Veterans with new HIV diagnosis linked to care within 30 days[1] | 84.6% | 83.1% | 77.9% | | 74.8% |
| % of VLHIV in VA care on ART[2] | 85.5% | 85.8% | 86.2% | | 84.9% |
| % viral suppression among VLHIV in VA care[2] | | | | | |
| All VLHIV | 73.3% | 73.5% | 75.5% | 72.7% | 71.8% |
| All VLHIV with VL obtained in | 88.5% | 90.6% | 92.5% | 92.7% | 92.9% |

[1] Data source: HHRC Data and Analysis Group

[2] Data source: VSSC HIV Clinical Data Cube

[3] Data measured over calendar year

[4] The lack of 2020 data is related to EHRM at the Mann-Grandstaff facility. Also, further investigation revealed a revised number of 215 HIV tests for 2020, rather than 1. However, it is not possible to validate this result at this time.

[5] Includes data from Mann-Grandstaff VAMC; however, only one Veteran reported as having HIV test at Mann-Grandstaff in 2021, compared to 482 in 2018 and 598 in 2019.

## Projections for the Future

Based on the trends over the last four years, VA projects the following:

- HIV testing rates in VHA have increased over the last few years but have plateaued when compared to the rate of increase a decade ago. The proportion of Veterans in care who have ever been tested actually decreased in CY 2020, although the absolute number increased; this may reflect the effects of COVID-19 on VHA operations. VA is working to increase HIV testing rates in 2022 through targeted outreach to sites with low testing rates; implementing strategies to increase rates of screening for sexually transmitted infections; and promotion of testing among Veterans in care at increased risk for HIV infection. VA projects a 1% to 3% annual increase in cumulative HIV testing rates over the next 3 to 5 years.
- Despite year-to-year variability in rates of linkage to care within 30 days, linkage to care within 90 days has consistently reached levels of 95% to 100%. Most HIV care in VHA occurs in infectious disease clinics. During 2020, VHA ambulatory care shifted to virtual encounters for routine outpatient care because of the COVID-19 pandemic, with face-to-face encounters limited to high priority clinical situations. Although such situations included linkage to care of patients newly diagnosed with HIV, the pandemic likely led to a decrease in linkage to care rates. VA expects to reverse this trend and increase linkage to care rates for newly diagnosed Veterans over the next two to three years.
- Since 2017, the proportion of Veterans with HIV in VA care receiving ART has remained stable or increased; the small decrease in 2021 is likely due to the effects of the COVID-19 pandemic on VHA operations. VA's internal goal is to have ART prescribed to 90% of VLHIV in care by 2030; strategies to accomplish this include broadening deployment of HIV telehealth clinics in VHA, as well as improving rates of linkage to and retention in care.
- HIV prevention continues to be a major focus for VHA. Although barriers to PrEP uptake have slowed the increase in the number of HIV-negative Veterans receiving preventive medication, VA is moving aggressively to implement and execute an integrated set of strategies aimed at dramatically reducing new HIV infections among Veterans in care. In addition to PrEP, these include standing up syringe service programs at individual VA Medical Centers and increasing access to STI screening. Both of these will enhance VA's ability to offer PrEP and other preventive measures to Veterans at increased risk of HIV infection, particularly harm reduction interventions benefiting injecting drug users.

## AIDS / HIV Workload

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Advance Approp. | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|---|
| **Unique Patients** | | | | | | | | |
| AIDS/HIV | 32,267 | 32,356 | 32,589 | 32,649 | **32,928** | **33,271** | 339 | 343 |

## Health Outcomes Military Exposures (HOME) formerly Post Deployment Health Services (PDHS)

*HOME: Gulf War Program*

| Description (*dollars in thousands*) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary & Mandatory Obligations by Category:** | | | | | | | |
| Medical Services | $3,451,700 | $3,665,300 | $3,840,100 | $4,271,100 | $4,654,900 | $431,000 | $383,800 |
| Medical Community Care | $694,000 | $579,200 | $773,400 | $861,400 | $939,800 | $88,000 | $78,400 |
| Medical Support and Compliance | $512,900 | $518,700 | $570,900 | $635,300 | $692,600 | $64,400 | $57,300 |
| Medical Facilities | $574,600 | $545,500 | $639,900 | $712,400 | $777,100 | $72,500 | $64,700 |
| **Obligations [Total]** | $5,233,200 | $5,308,700 | $5,824,300 | $6,480,200 | $7,064,400 | $655,900 | $584,200 |

*HOME: Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND)/Operation Inherent Resolve (OIR) Program*

| Description (*dollars in thousands*) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary & Mandatory Obligations by Category:** | | | | | | | |
| Medical Services | $6,824,200 | $7,092,500 | $7,393,800 | $7,977,500 | $8,591,900 | $583,700 | $614,400 |
| Medical Community Care | $1,619,600 | $1,525,800 | $1,757,900 | $1,900,400 | $2,049,700 | $142,500 | $149,300 |
| Medical Support and Compliance | $919,600 | $946,600 | $996,200 | $1,074,600 | $1,157,300 | $78,400 | $82,700 |
| Medical Facilities | $868,800 | $893,600 | $940,500 | $1,013,700 | $1,091,000 | $73,200 | $77,300 |
| **Obligations [Total]** | $10,232,200 | $10,458,500 | $11,088,400 | $11,966,200 | $12,889,900 | $877,800 | $923,700 |

| Description (dollars in thousands) | 2021 Actual 1/ | 2022 Budget Estimate 1/ | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary Obligations** | | | | | | | |
| Medical Care | | | $30,738 | $63,000 | $65,457 | $32,262 | $2,457 |

1/ Information is unavailable and has not been previously displayed.

## Authority for Action

The activities of the office are governed by the following public laws, Federal Registry, and Presidential, VA/VHA initiatives. Environmental exposures are of great interest to Congress.

### *Public Laws*

- P.L. 91-441: directed the Department of Defense to contract with the National Academy of Sciences to conduct a comprehensive study of dangers of herbicides and the defoliation program in Vietnam. In 1978, VA began the Agent Orange Registry.

- P.L. 99-576, *Veterans' Benefits Improvement and Health Care Authorization Act of 1986*: Established the Ionizing Radiation Registry (IRR), including physical examination, medical history and baseline laboratory tests.
- P.L. 100-321, *Radiation-Exposed Veterans Compensation Act of 1988*: Authorized a list of "presumptive" diseases that qualify Veterans involved in "radiation risk activities" for compensation.
- P.L. 100-322, *Veterans Benefits and Services Act of 1988*: Specifies requirements to provide medical services, domiciliary care, and nursing home care to Veterans. Provides for the confidentiality of medical records that identify persons with acquired immune deficiency syndrome (AIDS), except in specifically described circumstances and prohibits discrimination in admission to VA facilities for treatment of Veterans infected with AIDS. Also includes a number of administrative, personnel, and reporting requirements.
- P.L. 102-4, *Agent Orange Act of 1991*: Requires VA to obtain independent scientific review of the available scientific evidence regarding associations between diseases and exposure to dioxin and other chemical compounds in herbicides.
- P.L. 105-277, *Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999*: Requires VA to determine, based on IOM reports, whether particular illnesses warrant a presumption of service connection and to set compensation regulations establishing such a connection for each illness.
- P.L. 105-368, *Veterans Programs Enhancement Act of 1998*: Directed VA to establish an advisory committee to help review research on the medical problems of Gulf War Veterans and submit an annual report to Congress on the results of research on the health consequences of military service in the Gulf War.
- P.L. 107-103, *Veterans Education and Benefits Expansion Act of 2001:* Expanded the definition of service-connected "qualifying chronic disability" to include "a medically unexplained chronic multi-symptom illness."
- P.L. 108-170, *Veterans Health Care, Capital Asset, and Business Improvement Act of 2003*: Provided priority enrollment (Category 6) for Veterans who participated in Project 112/SHAD, allowing them to be eligible for VA health care at no cost for any illness possibly related chemical warfare agent testing.
- P.L. 108-183, *Veterans Benefits Act of o 2003*: Required VA and DoD to establish The Veterans' Advisory Board on Dose Reconstruction to audit dose reconstructions and VA claims decisions for service connection of radiogenic diseases.
- P.L. 109-417, *Pandemic and All-Hazards Preparedness Act of 2006*: requires VA to work in coordination with HHS, DHS, and DoD on a national response plan for influenza.

***Presidential directive***

- Homeland Security Presidential Directive 10 (HSPD-10) Biodefense for the 21st Century: provides a comprehensive framework for the nation's biodefense.

***Registries***

- **Agent Orange Registry:** P.L. 102-4, 38 U.S.C. §527, 38 U.S.C. §1116, P.L. 102-585 §703, and P.L. 100-687
- **Ionizing Radiation Registry:** 38 U.S.C. 527, 38 U.S.C. §1116, P.L. 102-585 §703, and P. L. 100-687
- **Depleted Uranium Registry:** 38 U.S.C. §7301(b), P.L. 102-585 §703(b) (2)
- **Gulf War Registry:** P.L. 102-585, P.L. 103-446, 38 U.S.C. §1117
- **Airborne Hazards and Open Burn Pits Registry:** 38 U.S.C. §527, P.L. 112-260 §201; and P.L 102-585 (1992), Step 3: Clari Organizational Mission and Vision

**Types of Services Provided**

Health Outcomes Military Exposures assesses the impact of deployment/military environmental exposures on Veterans and develops related policy, research, education, and health care strategies. The Epidemiology Service manages several surveillance programs on specific military/combat exposures and conducts original research to understand the effects of military service and deployment on Veterans' health. The affected Veteran populations include:

- Agent Orange (AO) Veterans: Vietnam, Korean 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 exposure.
- 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 Depleted Uranium and possible toxins in embedded fragments.
- Airborne Hazard Open Burn Pit Veterans: served in Afghanistan, Djibouti, Syria, and Uzbekistan during the Persian Gulf War, from September 19, 2001, to the present, **or** The Southwest Asia theater of operations from August 2, 1990, to the present
- Garrison-related environmental health concerns, such as Camp Lejeune and aqueous fire-fighting foam (AFFF) exposures in garrison water supplies (PFAS).
- Karshi-Khanabad (K2) Veterans– possibly exposed to various hazards; fuels, DU, asbestos, lead, etc. at a former Soviet airbase in Uzbekistan from 2001-2005.
- Reviews of other emerging issues such as exposures to anomalous health events, directed energy, prophylactic medications, rare cancers, respiratory illness, fuels, fire-fighting foams (PFAS - Perfluoroalkyl and polyfluoroalkyl substances), directed energy (anomalous health incidents) and vaccines and concerns for intergenerational and gender issues.

***Vietnam War*:** HOME continues to review the health of Veterans who may have been exposed to Agent Orange. This now includes the health of Blue Water Navy Veterans, not in Vietnam, but within 12 miles of the coast. Additional presumptions added in 2021 were: bladder cancer, hypothyroidism and Parkinson's-like conditions.

***Gulf War*:** The Gulf War Veteran program provides special clinical and diagnostic evaluations for combat Veterans with difficult-to-diagnose illnesses and research on these health issues. VA works to meet the special medical needs of Gulf War Veterans. VA conducts surveys of Gulf War Veterans to determine if they have any adverse health effects related to their deployment and develops effective outreach and educational tools for Gulf War Veterans. Research includes collaborations with DoD and uses Millennium Cohort Study , and the use of DoD-VA longitudinal data to create a longitudinal exposure and health record and examine temporal changes in the burden of disease among Gulf War and Gulf Era Veterans.

***OEF/OIF/OND/OIR**:* VA provides medical care to military personnel who served in OEF/OIF/OND/OIR. Veterans deployed to combat zones are entitled to five years of eligibility for VA health care services following separation, even if they are not otherwise eligible to enroll in VA. VA's outreach ensures that returning Service members receive full information about VA benefits and services. Each medical center and benefits office has a point of contact assigned to work with returning OEF/OIF/OND/OIR Veterans who represent 18% of the overall VA patients served. Care includes Airborne Hazards Open Burn Pit Registry exams and Karshi-Khanabad (K2), where Service members were possibly exposed to various hazards: fuels, DU, asbestos, lead, etc. at a former Soviet airbase in Uzbekistan from 2001-2005.

***War Related Illness and Injury Study Center (WRIISC)*** *(New Jersey, District of Columbia, California)*: The WRIISC is a Congressionally mandated VA program devoted to the post-deployment health concerns of Veterans. Overseen by the Post-Deployment Health Service, the three WRIISC sites are located within VA medical centers in Washington, DC; East Orange, NJ; and, Palo Alto, CA. These centers serve as a resource providing clinical evaluation, research, education, and risk communication for Veterans, their families, health care providers, and others. In addition, the WRIISC provides specialized evaluations for Veterans with difficult to diagnose deployment-related health concerns utilizing a multidisciplinary team with an evidence-based approach.

**Recent Trends**

- Social media and Veterans special interest groups have had a great influence on highlighting emerging concerns related to environmental exposures among Veterans. HOME monitors, conducts, and interprets these positions and the scientific research. Select areas of emphasis among these sources include:
    - Karshi-Khanabad (K2)
    - Intergenerational effects, such as VA care of Camp Lejeune family member health concerns.
    - Burn pit and airborne hazard exposures
    - PFAS - Perfluoroalkyl and polyfluoroalkyl substances such fire-fighting foams and Teflon found at many military bases.

    - Anomalous Health Incidents/Directed Energy
    - Fuels exposures
- Continued interest in registry development
- Approval for funding for Veterans Exposure Team-Health Outcomes Military Exposures (VET-HOME): the VET HOME call center will connect Veterans with a cadre of 40 dedicated Environmental Health (EH) Subject Matter Experts geographically distributed across the country, thereby increasing access, improving quality of care, and yielding a better return on investment when compared to the current suboptimal model for evaluating military environmental exposures.
- Increased interest in Garrison exposures, such as exposures seen at Camp Lejeune (water), Ft. Benning (lead paint in housing), and Ft. McClellan (industrial off post contamination).
- Increased interest in the creation of self-reported registries for purposes of documenting what Veterans experienced and when the experienced it. This would be used in combination with objective medical data and authoritative sources of deployment information to help VA medical, benefits, and research teams triangulate insights into environmental exposures and potential health outcomes.
- VA and DoD are currently working on the Individual Longitudinal Exposure Record (ILER), which will compliment registries by providing a validated exposure record for each Service member with location, time/date and exposure monitoring noted where the military captured that information. This record will not be able to provide information on historic events if the data does not currently exist within DOD systems.

**Projections for the Future**

- Steady growth in concern surrounding military environmental exposures and garrison exposures due to continued military conflicts.
- Continued development of the Individual Longitudinal Exposure Record (ILER) with DoD and adding ILER as a key and essential component to the Electronic Health Record. ILER would match individual Service Members and Veterans with a time, place and exposure based on authoritative records. This would minimize the need for creation and maintenance of multiple self-reported registries for identifying those exposed and improve care and benefits determinations for Veterans.
- Creation of VET-HOME and expansion of HOME to accommodate increased work demands and to better serve Veterans, as noted above.
    - Increase staffing from 27 to 42 FTE within HOME to support new and emerging requirements due to the impact of deployment and military environmental exposures on Veteran's health.
    - The creation and staffing of a HOME cell to support scientific literature reviews for determination of presumptions as directed by the Military Environmental Exposure Sub-Committee (MEESC), subordinate to the VA Operations Board (VAOB) and the VE Executive Board (VAEB).

## HOME Workload

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Advance Approp. | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|---|
| **Unique Patients** | | | | | | | | |
| Gulf War | 451,636 | 446,118 | 468,271 | 458,816 | **485,742** | **503,496** | 17,471 | 17,754 |
| OEF/OIF/OND/OIR | 1,193,651 | 1,236,559 | 1,270,975 | 1,303,055 | **1,345,706** | **1,421,800** | 74,731 | 76,094 |

## Traumatic Brain Injury (TBI) and Polytrauma System of Care (PSC)

### *TBI: OEF/OIF/OND/OIR**

| Description (*dollars in thousands*) | 2021 Actual | 2022 Budget Estimate 1/ | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary & Mandatory Obligations by Category:** | | | | | | | |
| Medical Services | $175,900 | $25,000 | $184,700 | $191,000 | $197,300 | $6,300 | $6,300 |
| Medical Community Care | $20,100 | $10,300 | $21,000 | $21,700 | $22,400 | $700 | $700 |
| Medical Support and Compliance | $26,400 | $180,900 | $27,700 | $28,600 | $29,600 | $900 | $1,000 |
| Medical Facilities | $30,600 | $28,900 | $32,200 | $33,300 | $34,400 | $1,100 | $1,100 |
| **Obligations [Total]** | $253,000 | $245,100 | $265,600 | $274,600 | $283,700 | $9,000 | $9,100 |

### *TBI: All Veteran Care***

| Description (*dollars in thousands*) | 2021 Actual | 2022 Budget Estimate 1/ | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary & Mandatory Obligations by Category:** | | | | | | | |
| Medical Services | $590,600 | $87,300 | $619,700 | $645,600 | $666,500 | $25,900 | $20,900 |
| Medical Community Care | $152,200 | $95,200 | $159,400 | $165,900 | $171,100 | $6,500 | $5,200 |
| Medical Support and Compliance | $94,700 | $590,800 | $99,400 | $103,500 | $106,900 | $4,100 | $3,400 |
| Medical Facilities | $109,000 | $97,300 | $114,400 | $119,200 | $123,100 | $4,800 | $3,900 |
| **Obligations [Total]** | $946,500 | $870,600 | $992,900 | $1,034,200 | $1,067,600 | $41,300 | $33,400 |

1/ The 2022 Budget Estimate had the respective costs swapped between the Medical Services and Medical Support and Compliance categories.

*Included in TBI-All Veteran Care. VA estimates the 10-year cost (2022-2031) to be $2.8 billion for TBI-OEF/OIF/OND/OIR Veteran Care.

**VA estimates the 10-year cost (2022-2031) to be $9.9 billion for TBI-All Veteran Care.

As required by P.L. 110-161, *Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2008,* the 10-year cost is reported in compliance with Senate Report 110-85, page 7: "The Committee therefore directs the VA to include in its budget calculations not only the current health care needs of all Veterans but also the long-range projected health care needs of OEF/OIF Veterans, particularly those suffering from Post-Traumatic Stress Disorder and Traumatic Brain Injury."

### Authority for Action

Public laws and the United States Code governing rehabilitation provided by the Polytrauma System of Care include:

- P.L. 104-262, *Veterans' Health Care Eligibility Reform Act of 1996,* Section 104: Requires the Department of Veterans Affairs (VA) to maintain its capacity to provide for the specialized treatment and rehabilitative needs of disabled Veterans, including those with spinal cord dysfunction, amputations, blindness, and mental illness, within distinct programs dedicated to the specialized treatment of those Veterans.
- P.L. 108-447, *Consolidated Appropriations Act, 2005*: Directs VA to ensure that Veterans with loss of limb and other very severe and lasting injuries have access to the best of both modern medicine and integrative holistic therapies for rehabilitation.
- P.L. 110-181, *National Defense Authorization Act for Fiscal Year 2008*, Section 1704(d): Directs VA to collaborate with the TBI rehabilitation research community, grantees of the National Institute of Disability and Rehabilitation Research of the Department of Education, the Defense and Veterans Brain Injury Center and other Governmental entities engaged in TBI rehabilitation.

*Title 38 United States Code:*

- *§1710C* – TBI: plans for rehabilitation and reintegration into the community
- *§1710D* – TBI: Comprehensive program for long-term rehabilitation
- *§1710E* – TBI: use of non-Department facilities for rehabilitation
- *§7327* – Centers for research, education, and clinical activities on complex multi-trauma
- *§8111* – Sharing of DVA and DoD health care resources
- *§8153* – Sharing of health-care resources

**Type of Services Provided**

VHA's PSC provides a full range of rehabilitation services for eligible Veterans and Active Duty Servicemembers covered by Defense Health Agency Great Lakes or TRICARE authorization, who sustained polytrauma and TBI. This includes persons with:

- TBI (whether military-related deployment related or not);
- Blast and non-blast related traumatic injuries including but not limited to amputations, musculoskeletal injuries and open wounds;
- Other acquired brain injuries including, but not limited to, stroke, brain tumors, infection, poisoning, hypoxia, ischemia, encephalopathy, or substance abuse, as appropriate for specific cases;
- Physical, cognitive, emotional, and behavioral impairments related to the brain injury;
- Impairments that are clinically and functionally significant and lead to activity and participation restrictions.

PSC programs are organized into a four-tier system that ensures access to the appropriate level of specialized rehabilitation care at 110 medical centers across VA. Medical rehabilitation services in PSC address the goals of recovery and community re-integration of Veterans with TBI and polytrauma including:

- Mandatory TBI Screening of all Veterans of post 9/11 combat operations. Veterans with positive screens are referred for comprehensive evaluations by specialty providers.
- Veterans with TBI requiring rehabilitation receive an Individualized Rehabilitation and Community Reintegration (IRCR) Plan of Care documenting the physical, cognitive, mental health and vocational problems that affect the Veteran's successful community re-integration, and the plan for addressing those problems. The functional status of Veterans with an IRCR Plan of Care is measured using a validated tool that allows VA providers to track changes and to provide appropriate interventions at the right time.
- The interdisciplinary teams providing services in PSC comprise specialists from physiatrists, nursing, psychology, social work, physical therapy, occupational therapy, speech-language pathology, recreational therapy, and other disciplines, as appropriate for the individual needs of the patient.
- Since 2010, the five Polytrauma Rehabilitation Centers (PRCs) have collaborated with Department of Health and Human Services' (HHS) TBI Model System Program sponsored by the National Institute on Disability, Independent Living, and Rehabilitation Research. This enables VA to benchmark outcomes against those facilities that are the gold standard for private sector rehabilitation, for which VA has demonstrated outcomes that are similar or better than the community standard.
- VA continues to demonstrate patient outcomes that are similar or better than the community standard as measured by functional improvement, discharge rates, and length of stay in inpatient care. These outcomes reflect the outstanding rehabilitative care, prosthetic services, benefits, and adaptive modifications to the home and automobile that help Veterans with severe disabilities overcome obstacles to achieving personal independence, positive life adjustment, and opportunities in meaningful areas of life.
- PSC collaborates with specialists in the DoD, HHS, academia, and private sector to develop and deploy consensus positions and guidance on best practices such as the *VA/DoD Clinical Practice Guidelines for the Management of Mild TBI.* The Guidelines have been widely disseminated to VA rehabilitation providers through educational and training opportunities and reinforced through information technology solutions in the computerized medical record.

**Recent Trends**

VHA has seen a steady increase in demand for TBI related services since 2009, the year when this data became available. The area of specific growth has been services for management of long-term effects of TBI. The Polytrauma Specific Purpose Funding provides supplementary support for the interdisciplinary teams that ensure access to TBI expertise throughout the health care system and maintain readiness for potential surge in demand.

VHA is at the forefront of trends in rehabilitation care with the development of clinical services including:

- Assistive Technology Labs now in operation at 27 PSC locations to provide assessment, training, prescriptions and consultations for devices and equipment that optimize Veteran's independence and support their community participation goals.

- The Emerging Consciousness Programs at the five PRCs are unique in their dedication to improving the lives of Veterans and Service members with severe injuries and their caregivers.
- 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 2021, the growth was accelerated by the conditions created by COVID-19, 55.3% of patients treated in polytrauma clinic stop codes had telehealth encounters compared to 32.2% in 2020 .
- PSC developed a framework for managing the long-term effects of TBI in response to recent research findings about the potential devastating consequences of such events. Collaboration with the Chronic Effects of Neurotrauma Consortium enabled VA to perform multi-center research protocols in collaboration with DoD, academic centers and non-profit organizations.

**Projections for the Future**

VHA's focus for the future is to maintain capacity for specialized TBI rehabilitation while allowing sufficient flexibility in the system to respond to potential uptakes in demand for services. Among the trends for the future:

- Expanding access to TBI expertise through telehealth with the goal that all Veterans receiving care in PSC are offered the option of utilizing telehealth services;
- Strengthening collaboration with community partners to provide effective and efficient options for services for Veterans;
- Enhancing long term rehabilitation surveillance and services for Veterans with TBI related chronic disabilities;
- Collaborating with the Long-Term Impact of Military-related Brain Injury Consortium, a government, academic and non-profit consortium, conducting research in the long-term impact of military related brain injury, in order to advance identification treatment and prevention of brain injuries.

**Headache Centers of Excellence (HCOE)**

**Authority for Action**

*Public Law 115-141*: Directs VA to create Headache Centers of Excellence

**Type of Services Provided**

The covered populations include Veterans with a history of polytrauma, TBI, migraines and multiple co-morbidities who present with refractory headaches. The services include:

- Appropriate pharmacologic management of headaches;

- Non-pharmacologic options including cognitive behavioral therapy, physical modalities, and devices;
- Interdisciplinary team interventions.

**Recent Trends**

In 2021:

- Funding was distributed to seven VA medical centers for continued development of HCOE programs and serve as Hub referral centers.
- Funding was also provided to six VA medical centers to serve as HCOE Consortium sites to expand the network of headache specialists and improve access to interdisciplinary headache management for Veterans.
- Funding was also distributed to the Pain Research, Informatics, Multi-morbidities, and Education Center at the West Haven VA Medical Center to establish a centralized process to compile and aggregate data and provide analysis to improve understanding of current practice, and guide enhancements to care and education of Veterans, caregivers and clinicians, and understand how to implement care programs by learning from Veterans with headaches.
- A Request for Program announcement for additional HCOE Consortium sites was put out into the field. Six additional VA medical centers were awarded HCOE Consortium status to begin in 2022. With this expansion of the program, every Veterans Integrated Service Network (VISN) now has either an HCOE Hub or Consortium site.
- In collaboration with DoD, Clinical Practice Guidelines for the Management of Headaches was published and disseminated to ensure evidence-based management of headaches. Patient and provider educational materials have been developed by the VA/DoD Headache CPG, and includes a coding manual for headache, patient handouts, and headache diaries (https://www.healthquality.va.gov/guidelines/Pain/headache/).
- A monthly HCOE lecture series targeted to Primary Care Providers regarding the evaluation and treatment of headache disorders has expanded. The monthly lecture has more than 120 attendees every month attending the lecture in real-time. Materials are also available on the Talent Management System and VA TRAIN. Learners can obtain continuing education credit for participation in the lecture series.
- Additional educational materials have been developed by the HCOE Education Workgroup which include Quick-Draw Videos where providers and patients can learn more about post-TBI headache, the role of health psychologists in the management of headache, and exercise and nutrition for headache.
- The HCOE has developed, implemented, and widely disseminated telehealth protocols for headache management, which have included guidance on conducting headache evaluations over VA Video Connect, teaching Veterans how to use neuromodulatory devices for headache, and using monthly, Veteran self-administered injectable medications.
- Telehealth continues to be a widely used means of providing headache care. In 2021 approximately 10% of all VHA clinical visits for headache were conducted via telehealth.

## Projections for the Future

In 2022 and beyond:

- Expand the network of VA Medical Center sites with Headache expertise through the addition of Consortium network sites;
- Provide innovative-interdisciplinary clinical care;
- Update protocols for appropriate use of devices marketed for headache management, given that two new devices have been Food and Drug Administration (FDA)-approved in the last year;
- Drive advances in clinical research and promote opportunities for Veterans to participate in clinical research trials;
- Develop guidance regarding the use of intravenous ketamine as a bridge therapy for Veterans with the most severe, refractory headache;
- Expand and strengthen relationships with the VA Airborne Hazards and Open Burn Pit Registry to gain a more thorough understanding of the association between headache and burn pit exposure;
- Updated the VA/DoD Headache CPG to reflect the more than 10 new treatments approved by the FDA in the last year and a half;
- Further incorporate Whole Health modalities and increase training of HCOE providers as Whole Health coaches, and;
- Disseminate best practices in headache management to all health care providers.

## TBI Workload

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Advance Approp. | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|---|
| **Unique Patients** | | | | | | | | |
| TBI-OEF/OIF/OND/OIR 1/ | 58,221 | 56,690 | 59,878 | 57,026 | **60,722** | **61,365** | 844 | 643 |
| TBI-All Veteran Care | 113,826 | 108,872 | 117,337 | 109,703 | **119,928** | **121,330** | 2,591 | 1,402 |

*1/ Included in TBI-All Veteran Care.*

## Women Veterans Health Care

### *Women Veterans Health: Gender-Specific Care 1/*

**Gender-Specific Care**
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary & Mandatory Obligations by Category:** | | | | | | | |
| Medical Services | $355,500 | $423,400 | $396,000 | **$433,600** | **$472,500** | $37,600 | $38,900 |
| Medical Community Care | $169,400 | $160,100 | $188,800 | **$206,700** | **$225,300** | $17,900 | $18,600 |
| Medical Support and Compliance | $56,000 | $63,100 | $62,300 | **$68,200** | **$74,300** | $5,900 | $6,100 |
| Medical Facilities | $47,900 | $58,900 | $53,400 | **$58,400** | **$63,700** | $5,000 | $5,300 |
| **Obligations [Total]** | $628,800 | $705,500 | $700,500 | **$766,900** | **$835,800** | $66,400 | $68,900 |

[1/] Included in Women Veterans Health-All Care.

### *Women Veterans Health: All Care*

**All Women Veterans Care**
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary & Mandatory Obligations by Category:** | | | | | | | |
| Medical Services | $5,451,300 | $5,517,500 | $5,911,400 | **$6,409,000** | **$6,936,000** | $497,600 | $527,000 |
| Medical Community Care | $1,477,200 | $1,487,900 | $1,599,900 | **$1,732,400** | **$1,872,600** | $132,500 | $140,200 |
| Medical Support and Compliance | $728,200 | $746,200 | $789,500 | **$855,900** | **$926,200** | $66,400 | $70,300 |
| Medical Facilities | $661,300 | $670,500 | $717,200 | **$777,600** | **$841,500** | $60,400 | $63,900 |
| **Obligations [Total]** | $8,318,000 | $8,422,100 | $9,018,000 | **$9,774,900** | **$10,576,300** | $756,900 | $801,400 |

**Program Office & Initiative Budget**
*(dollars in thousands)*

| Description (*dollars in thousands*) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary & Mandatory Obligations:** | | | | | | | |
| Obligations | $57,816 | $104,946 | $106,489 | $134,219 | $138,852 | $27,730 | $4,633 |

## Authority for Action

VA Public Law 102-585, Veterans Health Care Act of 1992, enacted November 4, 1992, authorized the Department of Veterans Affairs (VA) to provide gender-specific services, such as Pap tests, breast examinations, mammography, and general reproductive health care to eligible women Veterans. Public Law 103-452 provided authority and priority for counseling and treatment for sexual trauma incurred while on duty in the military.

Public Law 114-223, Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, authorized VA to offer in-vitro fertilization (IVF) and Public Law 115-141, Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017, removed the expiration date for IVF services and the time limits on cryopreservation of embryos and gametes.

Public Law 116-315, *Johnny Isakson and David P. Roe M.D., Veterans Health Care and Benefits Improvement Act of 2020*, establishes an Office of Women's Health and provides greater opportunities for women Veterans to enhance their overall well-being by getting direct care and services related to fertility, expansion of newborn care, childcare, sexual assault and trauma, and homelessness.

- §3005 - Continuation of Women's Health Transition Training program of Department of Veterans Affairs.
- §3006 - Authority for Secretary of Veterans Affairs to furnish medically necessary transportation for newborn children of certain women veterans.
- §4203 - Gap analysis of Department of Veterans Affairs programs that provide assistance to women veterans who are homeless.
- Title V, *Deborah Sampson Act of 2020,* §5101 - §5402 - This comprehensive legislation will help enhance and improve VA program and health services for women Veterans, as well as address issues such as health care access, harassment and sexual assault, MST, and gender-specific prosthetics.

P.L. 116-171, *Hannon Mental Health Improvement Act,* Title VI – This legislation will help improve care and services for Women Veterans.

- §601 - Expansion of capabilities of Women Veterans Call Center to include text messaging.
- §602 - Requirement for Department of Veterans Affairs internet website to provide information on services available to women Veterans.

P.L. 116-214, *COMPACT Act,* Title III – This legislation will help improve care and services for Women Veterans.

- §301- Gap analysis of Department of Veterans Affairs programs that provide assistance to women veterans who are homeless.
- §302- Report on locations where women veterans are using health care from Department of Veterans Affairs.

P.L. 116-283 §764, *National Defense Authorization Act for Fiscal Year 2021:* Inclusion Of Members of Reserve Components in Mental Health Programs of Department Of Veterans Affairs.

**Population Covered**

In 2021, approximately 39% of women Veteran VHA patients were 18-44 years old, 44% were 45-64 years old, and 18% were 65+ years old. Within these age groups, gender-specific care was provided to 38%, 46%, and 16% of patients respectively. As of 2021, 84% of women overall were assigned to specially trained, and/or experienced designated women's health primary care providers (WH-PCP), which has been shown to enhance satisfaction and quality of care.

## Type of Services Provided

VA provides high-quality comprehensive care that includes basic preventive care, acute care, and chronic disease management, reproductive health care (such as maternity and gynecology care) and treatment for all gender-specific conditions and disorders, as well as mental health care.

VA provides comprehensive specialty medical and surgical services for women Veterans either on site or through referrals to the community. In addition, VA is providing infertility counseling and treatment and assistive reproductive technology/ in vitro fertilization services through Integrated Veteran Care/Office of Community Care.

## Recent Trends

The number of women Veterans enrolling in VA health care is increasing, placing new demands on VA's health care system. Women make up 16.9% of today's active-duty military forces and 19% of National Guard and Reserves. Based on the upward trend of women in all service branches, the expected number of women Veterans using VA health care is and will continue to rise. More women are choosing VA for their health care than ever before, with women accounting for over 30% of the increase in Veterans enrolled over the past 5 years. The number of women Veterans using VHA services has nearly tripled since 2001, growing from 159,810 to over 550,000 today. This increase may reflect, in part, successful efforts to enroll women Veterans in VHA at military discharge, through the Women's Health Transition Training Program, as well as increasing awareness of and availability of specific services for women throughout VHA. The rapid demographic shift highlights the need to ensure ample capacity for clinical services for women in their childbearing years, including reproductive health services.

VA has enhanced provision of care to women Veterans by focusing on the goal of developing designated Women's Health Primary Care Providers (WH-PCP) at every site where women access VA. To ensure we meet the needs for the increasing numbers of women Veterans, the VHA is rapidly increasing access to trained designated Women's Health Providers through large scale educational initiatives and has now trained over 5,561 primary care providers since 2008. Educational efforts include hosting national mini-residency programs at training conferences each year; local mini-residency programs and the newest training at rural sites. In 2017, the Office of Women's Health engaged in a partnership with the Office of Rural Health to adapt the mini-residency into a mobile training program targeted for rural providers and nurses. As a result of this effort the VA has trained over 900 rural clinicians to enhance rural women Veterans' VA experience. VA has at least two WH-PCPs at all of VA's health care systems and 90% of CBOCs have a WH-PCP in place. VA is in the process of training additional providers to ensure that every woman Veteran has the opportunity to receive her primary care from a WH-PCP. Despite all of these initiatives, VA continues to have an ongoing need to train approximately 800 primary care providers per year to become WH-PCPs. In addition, VA has focused training with primary care providers to target musculoskeletal conditions in women, one of the top conditions affecting women Veterans.

In addition to expanding the primary care workforce, VA has recognized the importance of developing the gynecology workforce. Academic affiliations with Departments of Obstetrics and Gynecology have increased. Additionally, VA is developing training for VA gynecologists and

building a community of practice to enhance their ability to provide services. VA has also developed training for Emergency Medicine providers to ensure up-to-date skills in caring for women Veterans. For services not provided in the VA, such as maternity care, VA has hired maternity care coordinators to facilitate transition between VA and the Community during pregnancy.

VA is proud of high-quality health care for women Veterans. VA is on the forefront of information technology for women's health and has redesigned its electronic medical record to track breast and reproductive health care. Quality measures show that women Veterans are more likely to receive breast cancer and cervical cancer screening than women in private sector health care. VA also tracks quality by gender and, unlike other health care systems, has been able to reduce and eliminate gender disparities in important aspects of health screening, prevention, and chronic disease management.

In 2014, VA established a hotline specific for women Veterans. The Women Veteran Call Center (WVCC) makes outgoing calls to women Veterans to provide information about VA services and resources and responds to incoming calls from women Veterans their families and caregivers. The call center implemented a chat feature in May 2016 and in 2019 a text option to increase access for women Veterans. During 2021, the WVCC received 15,829 inbound calls, 965 inbound chats, and made 96,250 successful outbound calls (spoke with Veteran or left a voice message) and mailed 6,787 informational packets.

**Projections for the Future**

Women comprise 16.9% of today's active-duty military forces and 19% of National Guard and Reserves. Women are now the fastest growing cohort within the Veteran community. The %of women Veterans is projected to increase to about 18% of the total Veteran population by 2040 from 6% in 2000. The overall Veteran population is decreasing at a rate of about 1.5% per year, while the women Veteran population is increasing at a rate of 1% per year.

Based on the upward trend of women in all service branches, the decision to allow women in combat roles, and the increased number of women choosing VA for health care, the expected number of women Veterans using VA health care will continue to rise rapidly, the complexity of injuries of returning troops is likely to increase, and the cost associated with their care will grow accordingly.

**Relevant Proposed Legislation:**

**Treatment Authority for Infertility Counseling and Infertility Treatment using Assisted Reproductive Technology, Including In Vitro Fertilization, for Certain Veterans and their Partners, and Authority to Provide Reimbursement for Adoption-Related Expenses for Certain Veterans**

This legislative proposal would enhance equity by expanding access to Assisted Reproductive Technology (ART), including in vitro fertilization (IVF) and adoption reimbursement to single Veterans, those in same-sex relationships, and those who need donor gametes and/or embryos to

build their families. This legislative proposal is necessary to fill the gap created by the legal requirements, exclusions, and limitations in VA's current program. It would also help VA comply with its statutory mission to provide a complete set of hospital and medical services for Veterans.

**Eliminating Veteran Cost-Sharing for Contraception**

VA proposes to eliminate copays for contraception. Contraception ensures that individuals capable of pregnancy are able to decide whether and when to become pregnant. However, many people face barriers to accessing contraception, which can result in unintended pregnancy and adverse physical and mental health outcomes. Reducing unintended pregnancy in women is an important element of reducing maternal mortality by reducing the number of high-risk and high-parity births. Contrary to the situation of the general United States population under certain other Federal or private insurance plans, however, VA still requires some Veterans to pay a copay for contraception. VA proposes to eliminate cost-sharing for contraception medications, and to eliminate cost-sharing for contraception-related health care and services when contraception-related services are the only care provided within the visit, to improve access to contraception and improve health outcomes.

**Women's Health Innovation and Staffing Enhancement (WHISE) Initiative**

**Purpose**

To address the growing number of women Veterans who are eligible for health care, VA is strategically improving services and access for women Veterans. The WHISE Initiative, by providing funds to the VA medical centers will enhance women's health programs through hiring of new staff and purchasing equipment specific for women's health care. The funding will support these new women's health positions for three years out, building the core staff required to answer the influx of women Veterans.

**Evidence**

*Primary Care*:

VA has continued to enhance the quality of care for women Veterans by requiring that women are offered assignment to designated Women's Health Primary Care Providers (WH-PCP). These providers offer general primary care and gender specific primary care in the context of a longitudinal patient/provider relationship. VA research has shown that women Veterans assigned to designated WH-PCPs have higher satisfaction and higher quality of care than women assigned to other providers. In addition, the Barriers to Care Survey completed in 2015 of over 8,000 women Veterans found that women assigned to women's health providers were more satisfied overall with their care, comfort, and safety in VA facilities.

*Gynecology*:

Women Veterans receive high quality gynecologic surgical care through VA. The numbers of women Veterans who require gynecologic and obstetrical services and coordination of their care are significant. In 2021, 39% of women Veterans were of childbearing age (between age 18 and 44), making the need for gynecologic services well-established. At the end of 2021, 80% of VA

health care systems had a gynecologist on site. While prenatal care and delivery is not provided in VA facilities, pregnant women seek care in VA for other conditions and may also need primary care, emergency care, and require coordination of Community Care services.

*Mental Health:*

VA has witnessed a 154% increase in the number of women Veterans accessing VA mental health care over the past decade. Over 40% of women Veterans who use VA have been diagnosed with at least one mental health condition and many struggle with multiple, clinically complex conditions, such as trauma, mood, and eating disorders.

VA's mental health programming for women Veterans is guided by the principles of gender-sensitive care. Gender-sensitive care is informed by known differences in how men and women experience emotional problems and treatment thereby recognizing the importance of offering choice, flexibility, and options for care. To ensure that VA mental health providers have the skills and expertise to meet women Veterans' unique and diverse treatment needs and preferences, Office of Mental Health and Suicide Prevention (OMHSP) has developed innovative clinical trainings and initiatives to strengthen mental health services for the growing population of women Veterans, such as a Reproductive Mental Health Consultation Program and a national infrastructure of Women's Mental Health Champions at each VA medical center.

*Care Coordination*:

VA is focusing on ensuring primary care providers, Patient Aligned Care Team (PACT) staffing, gynecologists, mental health providers, and care coordination personnel are available for women's health programs at each VAMC, particularly in the area of breast and cervical cancer. Breast and cervical cancer screening programs require meticulous tracking to ensure that all eligible women receive screening, results are received, and actionable results followed up with next step in care. VA policy requires that each facility have a process for tracking and timely follow-up, and breast and cervical cancer care coordination duties are assigned appropriately. To ensure accuracy and reliability, VA tracks the availability of breast and cervical cancer care coordinators across the system. In 2021, 84% of sites had a full or part time Breast Cancer Screening Coordinator and 73% of sites had a full or part time Cervical Cancer Screening Coordinator.

To support pregnant Veterans, every VA offers maternity care coordination. Every VA medical center (100% of sites) have a full or part time Maternity Care Coordinator. VA Maternity Care Coordinators (MCC) support pregnant Veterans through every stage of pregnancy. MCCs help pregnant Veterans navigate health care services both inside and outside of VA, connect to community resources, cope with pregnancy loss, connect to needed care after delivery, and answer questions about billing. Once a pregnancy is diagnosed, the MCC contacts and educates the Veteran on maternity benefits and the process for maternity care throughout the pregnancy. The MCC answers Veterans' questions and remains in communication with pregnant Veterans throughout their pregnancy and postpartum care.

## Performance Goal & Evaluation

Women's Health Services tracks quality of care and access by gender and these measures will be tracked nationally and assessed quarterly for improvement. Additionally, women's health satisfaction and trust with VA will be continually measured. Women's Health will continue close collaboration with researchers through QUERI, as well as the VHA Office of Research, and other projects to monitor success of the program. Ongoing tracking of non-VA care use and quality measures will be conducted.

## Implementation Plan

*Women's Health Program:* Additionally, to provide local leadership for the Women's Health Program, sites are required by policy to have a full-time Women Veteran Program Manager (WVPM) without collateral duties and a Women's Health Medical Director who is the clinical leader for the Women's Health Program at the facility. As of today, 135 sites have a full or part time WVPM. In addition, 138 sites have a Women's Health Medical Director.

*Women's Health Innovation and Staffing Enhancement*: Due to significant deficits in women's health personnel, including primary care providers, gynecologists, mental health providers, care coordinators and others, in 2021, VA launched the Women's Health Innovation and Staffing Enhancements (WHISE) program. WHISE provides an opportunity for sites to apply for specific purpose funding for women's health personnel or innovative programs such as pelvic floor physical therapy or lactation support, to mitigate local gaps in availability of women's health personnel.

Of the appropriated 2021 Budget, over $40.0 million was distributed to the field across all 18 Veteran Integrated Service Networks in support of over 400 positions and programs nationally. An additional $20.0 million in funding was distributed to the field to support projects such as advanced mammography equipment, specialty equipment for women Veterans with limited mobility to assist in transporting Veterans to and from exam tables in a safe manner, and to support Healthy Teaching Kitchens educational programs. In 2023 and 2024, Women's Health will continue to support the existing staffing position and will monitor additional staffing needs.

## Women Veterans Workload

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Advance Approp. | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|---|
| **Unique Patients** | | | | | | | | |
| Women Veterans Health-Gender-Specific Care 1/ | 332,377 | 358,933 | 358,933 | 380,836 | **380,836** | **402,302** | 21,903 | 21,466 |
| Women Veterans Health-All Care | 605,433 | 600,900 | 631,238 | 621,305 | **658,618** | **686,562** | 27,380 | 27,944 |

1/ Included in Women Veterans Total Unique Patients.

## *Gender-Specific Care 2/*

| | FY21 Actual | | FY22 Estimate | | FY23 Estimate | | FY24 Estimate | |
|---|---|---|---|---|---|---|---|---|
| **Category of Care** | **VA Care** | **Community Care** | **VA Care** | **Community Care** | **VA Care** | **Community Care** | **VA Care** | **Community Care** |
| Cancer and Screening | 61.8% | 38.2% | 61.6% | 38.4% | 61.7% | 38.3% | 61.7% | 38.3% |
| Genitourinary Care | 75.6% | 24.4% | 76.8% | 23.2% | 77.3% | 22.7% | 77.5% | 22.5% |
| Osteoporosis | 90.2% | 9.8% | 90.3% | 9.7% | 90.5% | 9.5% | 90.6% | 9.4% |
| Pregnancy and Postpartum | 15.3% | 84.7% | 16.6% | 83.4% | 18.0% | 82.0% | 19.5% | 80.5% |
| Womans Clinic | 100.0% | 0.0% | 100.0% | 0.0% | 100.0% | 0.0% | 100.0% | 0.0% |

[2/] Gender-Specific Care is included in Women Veterans Health-All Care. The above Women Veterans data reflects the percentages of the VA and Community care by gender-specific categories.

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# *Appropriation Language*

## Medical Services

*For necessary expenses for furnishing, as authorized by law, inpatient and outpatient care and treatment to beneficiaries of the Department of Veterans Affairs and veterans described in section 1705(a) of title 38, United States Code, including care and treatment in facilities not under the jurisdiction of the Department, and including medical supplies and equipment, bioengineering services, food services, and salaries and expenses of healthcare employees hired under title 38, United States Code, assistance and support services for caregivers as authorized by section 1720G of title 38, United States Code, loan repayments authorized by section 604 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111–163; 124 Stat. 1174; 38 U.S.C. 7681 note), monthly assistance allowances authorized by section 322(d) of title 38, United States Code, grants authorized by section 521A of title 38, United States Code, and administrative expenses necessary to carry out sections 322(d), and 521A of title 38, United States Code, and hospital care and medical services authorized by section 1781 of title 38, United States Code; $261,000,000, which shall remain available until September 30, 2024, and shall be in addition to funds previously appropriated under this heading that became available on October 1, 2022; and, in addition, $74,004,000,000, plus reimbursements, shall become available on October 1, 2023, and shall remain available until September 30, 2024: Provided, That, of the amount made available on October 1, 2023, under this heading, $2,000,000,000 shall remain available until September 30, 2025: 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.* Note—A full-year 2022 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating under the Continuing Appropriations Act, 2022 (Division A of Public Law 117-43, as amended). The amounts included for 2022 reflect the annualized level provided by the continuing resolution.

## Medical Community Care

*For necessary expenses for furnishing health care to individuals pursuant to chapter 17 of title 38, United States Code, at non-Department facilities, $4,300,000,000, which shall remain available until September 30, 2024, and shall be in addition to funds previously appropriated under this heading that became available on October 1, 2022; and, in addition, $33,000,000,000, plus reimbursements, shall become available on October 1, 2023, and shall remain available until September 30, 2025.* Note—A full-year 2022 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating under the Continuing Appropriations Act, 2022 (Division A of Public Law 117-43, as amended). The amounts included for 2022 reflect the annualized level provided by the continuing resolution).

## Medical Support and Compliance

*For necessary expenses in the administration of the medical, hospital, nursing home, domiciliary, construction, supply, and research activities, as authorized by law; administrative expenses in support of capital policy activities; and administrative and legal expenses of the Department for collecting and recovering amounts owed the Department as authorized under chapter 17 of title 38, United States Code, and the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), $1,400,000,000, which shall remain available until September 30, 2024, and shall be in addition to funds previously appropriated under this heading that became available on October 1, 2022; and, in addition, $12,300,000,000, plus reimbursements, shall become available on October 1, 2023, and shall remain available until September 30, 2024: Provided, That, of the amount made available on October 1, 2023, under this heading, $500,000,000 shall remain available until September 30, 2025.* Note—A full-year 2022 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating under the Continuing Appropriations Act, 2022 (Division A of Public Law 117-43, as amended). The amounts included for 2022 reflect the annualized level provided by the continuing resolution.

## Medical Facilities

*For necessary expenses for the maintenance and operation of hospitals, nursing homes, domiciliary facilities, and other necessary facilities of the Veterans Health Administration; for administrative expenses in support of planning, design, project management, real property acquisition and disposition, construction, and renovation of any facility under the jurisdiction or for the use of the Department; for oversight, engineering, and architectural activities not charged to project costs; for repairing, altering, improving, or providing facilities in the several hospitals and homes under the jurisdiction of the Department, not otherwise provided for, either by contract or by the hire of temporary employees and purchase of materials; for leases of facilities; and for laundry services; $1,500,000,000, which shall remain available until September 30, 2024, and shall be in addition to funds previously appropriated under this heading that became available on October 1, 2022; and, in addition, $8,800,000,000, plus reimbursements, shall become available on October 1, 2023, and shall remain available until September 30, 2024: Provided, That, of the amount made available on October 1, 2023, under this heading, $1,000,000,000 shall remain available until September 30,2025.* Note—A full-year 2022 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating

under the Continuing Appropriations Act, 2022 (Division A of Public Law 117-43, as amended). The amounts included for 2022 reflect the annualized level provided by the continuing resolution.

## Appropriations Language Requiring Authorizing Legislation Enactment

The following appropriations language is contingent on the enactment of authorizing legislation.

## Medical Services

*Contingent upon the enactment of legislation establishing a Department of Veterans Affairs Public Health Service Joint Scholarship Program in chapter 76 of title 38, United States Code, the Secretary of Veterans Affairs may carry out such program from within amounts appropriated under this heading, including amounts previously appropriated under this heading that became available on October 1, 2022.*

*In addition, contingent upon the enactment of authorizing legislation, the Secretary of Veterans Affairs may reimburse qualifying veterans for certain adoption expenses from within amounts appropriated under this heading, including amounts previously appropriated under this heading that became available on October 1, 2022.*

## Explanation

***Medical Services***

VA requests that the 2023 annual appropriation adjustment of $261 million and $2 billion from the 2024 advance appropriation be provided with two-year availability. Greater two-year availability of funding will minimize funding uncertainty and enable VA to better respond to new and emerging health care requirements unique to the Veteran population. Such unique requirements include research into and treatment for medical conditions resulting from environmental exposures during military service, acquisition of medical supplies and equipment, including prosthetics designed specifically for female veterans, and newly mandated programs. Additional two-year availability will also give VA flexibility in response to uncertainties in the post-pandemic medical care labor market and its effect on FTE growth trajectories.

The Budget includes a new legislative proposal that establishes the Veterans Affairs-Public Health Service Joint Scholarship Program. Upon enactment of this legislation, VA requests new appropriations language to use Medical Services appropriations for this purpose.

The Budget also includes a new legislative proposal to provide expanded access to assisted reproductive technology, including in vitro fertilization, and adoption reimbursement. Upon enactment of this legislation, VA requests new appropriations language to use the Medical Services appropriation for purposes of adoption reimbursement.

The legislative summary for this proposal can be found in Part 2 of the Department Affairs Volume I, Supplemental Information and Appendices.

***Medical Community Care***

VA requests that the 2023 annual appropriation adjustment of $4.3 billion, and the full 2024 advance appropriation, for Medical Community Care be provided with two-year availability. This change will reduce payment rejections and delays in processing of claims, which will improve VA's relationships with our Community Care partners. In addition, simplifying how funding is provided for this program will reduce the likelihood of lapsed funds or improper payments and result in more efficient use of funds for our Veterans' health care needs.

VA's financial and claims processing systems necessitate the designation, at the time the authorization is issued, which financial account that will eventually pay the community care claim once the claim is adjudicated and the obligation established. If funds are not available in the pre-designated account, payments will be rejected, delaying the payment to the Third-Party Administrators or Community Care providers. Given the current multiple periods of availability for this program and VA's account-designation system requirements, VA must do numerous cost transfers among its one-year and multi-year accounts to ensure adequate funding is available to accurately process claims. The complexity of managing the resources to ensure minimal lapse of funds under the current period-of-availability structure is heightened by the high-volume of locations issuing authorizations for care and recording eventual obligations. Claims rejections and workload could potentially decrease if VA is provided all Medical Community Care funding with two-year availability.

The administrative effort to manage the multiple funds within the Medical Community Care appropriation requires the assistance of the Financial Services Center (FSC), Veterans Affairs Medical Centers (VAMCs) and OCC staff. These organizations must monitor fund balances, process cost-transfers, identify and correct cost-transfer errors and assist in clearing rejects. Providing full two-year availability would eliminate the need for hundreds of thousands of financial transactions annually that move billions of dollars in cost-transfers and Transfers of Disbursing Authority (TDAs). This significant volume of transactions is inefficient and prone to errors and negatively impacts timeliness and accuracy of payment and thus Veteran care.

***Medical Support and Compliance***

VA requests that the 2023 annual appropriation adjustment of $1.4 billion and $500 million from the 2024 advance appropriation be provided with two-year availability. This request is largely due to anticipated increases in the contracting needs and local VAMC support to implement new logistics systems, a new financial management system and support for EHRM implementation training requirements. Due to the complexity of these systems migrations, VA wants to ensure these priorities remain adequately funded without rushing major decisions and change-management that could help their progress.

***Medical Facilities***

VA requests that the 2023 annual appropriation adjustment of $1.5 billion and $1 billion from the 2024 advance appropriation be provided with two-year availability. Over the last few years, VA major leases have faced unexpected delays due to the size and complexity of the sites being sought and ongoing churn in the real estate market. Greater two-year availability of funding will improve our lease contracting process by preventing funding uncertainty and allowing for unexpected delays in acquisition (i.e., additional traffic studies, hazardous waste abatement, etc.). The greater

two-year availability will also help alleviate late in the year execution deadline pressure surrounding Non-Recurring Maintenance obligations.

## 2021 Appropriation Transfers and Supplemental Appropriations

This section provides details on past year transfers, supplemental appropriations, rescissions and annual appropriation adjustments reflected on the funding crosswalk tables and budget authority tables.

**Explanation of American Rescue Plan Act of 2021**

On March 11, 2021, President Biden signed into law the American Rescue Plan (Public Law 117-2), which designated specific amounts ensuring Veterans have continued access to quality health care and protections against COVID-19 pandemic.

- **$14,482,000,000 Addition to the Veterans Medical Care and Health Fund.** The Veterans Medical Care and Health Fund was established to execute Public Law 117-2 § 8002 for medical care and health needs. The $14.5 billion was deposited into the Veterans Medical Care and Health Fund and allocated among Medical Services ($9,020,443,000), Medical Support and Compliance ($978,433,000), Medical Facilities ($2,572,928,000), Medical Community Care ($1,901,196,000) and Medical and Prosthetic Research ($9,000,000). The funding will remain available until September 30, 2023. Final funding allocations among account-level categories and among activities within each category may change based on 2022 actuals and in response to workload demand requirements throughout 2022 and 2023.

- **$250,000,000 Addition to the Medical Community Care Appropriation.** Public Law 117-2 § 8004(2), signed on March 11, 2021, designated specific amounts as one-time emergency payments to support state extended care facilities for Veterans to enhance treatment of Veterans during the pandemic. The funding will remain available until September 30, 2022.

- **$1,000,000 Addition to the Medical Services and Medical Community Care Appropriations.** Public Law 117-2 § 8007, signed on March 11, 2021, designated specific amounts to allow VA to waive copays that otherwise would be charged to Veterans for health care services, for the period beginning April 6, 2020 through September 30, 2021. Section 8007 further authorized VA to reimburse Veterans who had submitted payments during this period. The $1 million was allocated among Medical Services ($627,900,000), Medical Community Care ($72,100,000) and copay reimbursements ($300,000,000). The funding will remain available until expended.

- **$80,000,000 Addition to Emergency Department of Veterans Affairs Employee Leave Fund.** Public Law 117-2 §8008, signed on March 11, 2021, designated specific amounts for use by VA for use of paid leave by any covered employee who is unable to work because of the coronavirus pandemic. The funding will remain available until September 30, 2022.

**Annual Appropriation Adjustment in 2021**

- **$497,468,000 Addition to the Medical Services Appropriation.** This reflects an addition to the funds previously appropriated in the Advance Appropriation under Medical Services that became available on October 1, 2020. The authority for the addition to the Medical Services Appropriation is provided in the Consolidated Appropriations Act, 2021, (Public Law 116-260), Division J, Title II, signed on December 27, 2020.

- **$1,380,800,000 Addition to the Medical Community Care Appropriation.** This reflects an addition to the funds previously appropriated in the Advance Appropriation under Medical Community Care that became available on October 1, 2020. The authority for the addition to the Medical Community Care Appropriation is provided in the Consolidated Appropriations Act, 2021, (Public Law 116-260), Division J, Title II, signed on December 27, 2020.

- **$300,000,000 Addition to the Medical Support and Compliance Appropriation.** This reflects an addition to the funds previously appropriated in the Advance Appropriation under Medical Support and Compliance that became available on October 1, 2020. The authority for the addition to the Medical Support and Compliance Appropriation is provided in the Consolidated Appropriations Act, 2021, (Public Law 116-260), Division J, Title II, signed on December 27, 2020.

- **$150,000,000 Addition to the Medical Facilities Appropriation.** This reflects an addition to the funds previously appropriated in the Advance Appropriation under Medical Facilities that became available on October 1, 2020. The authority for the addition to the Medical Facilities Appropriation is provided in the Consolidated Appropriations Act, 2021, (Public Law 116-260), Division J, Title II, signed on December 27, 2020.

**Explanation of Rescissions in 2021**

- **$100,000,000 Rescission to the Medical Support and Compliance Appropriation.** This reflects a rescission of $100,000,000 from funds previously appropriated in the Advance Appropriation under Medical Services that became available on October 1, 2020. The authority for the rescission is provided in the Consolidated Appropriations Act, 2021, (Public Law 116-260), Division J, Title II, Section 254, signed on December 27, 2020.

- **$15,000,000 Rescission to the Medical Support and Compliance Appropriation.** This reflects a rescission of $15,000,000 from funds previously appropriated in the Advance Appropriation under Medical Support and Compliance that became available on October 1, 2020. The authority for the rescission is provided in the Consolidated Appropriations Act, 2021, (Public Law 116-260), Division J, Title II, Section 254, signed on December 27, 2020.

**Explanation of Transfers in 2021**

- **$15,000,000 Transfer to the DoD–VA Health Care Sharing Incentive Fund (JIF) from Medical Services Appropriation.** Title 38, section 8111(d)(2), states that, "To facilitate the incentive program, there is established in the Treasury a fund to be known as the 'DoD–VA Health Care Sharing Incentive Fund.' Each Secretary shall annually contribute to the fund a minimum of $15,000,000 from the funds appropriated to that Secretary's Department. Such funds shall remain available until expended and shall be available for any purpose authorized by this section." The authority for this transfer is provided in the Consolidated Appropriations Act, 2021, (Public Law 116-260), Division J, Title II, Section 222, signed on December 27, 2020.

- **$314,847,000 Transfer to Joint DoD–VA Medical Facility Demonstration Fund**. This reflects a transfer to the Joint DoD–VA Medical Facility Demonstration Fund from Medical Services ($215,945,000), Medical Community Care ($28,392,000), Medical Support and Compliance ($30,213,000) and Medical Facilities ($40,297,000). The authority for this transfer is provided in the Consolidated Appropriations Act, 2021, (Public Law 116-260), Division J, Title II, Section 219, signed on December 27, 2020. The Demonstration Fund supports the continuing operations of the Captain James A. Lovell Federal Health Care Center (JALFHCC), in North Chicago, which began operations on December 20, 2010.

- **$140,000,000 Transfer to Canteen Service Revolving Fund**. This reflects a transfer to the Canteen Service Revolving Fund from unobligated Medical Services balances ($140,000,000) made available under the Coronavirus Aid, Relief, and Economic Security Act, Division B, Title X (Public Law 116-136). The authority for this transfer is provided in the Continuing Appropriations Act, 2021, (Public Law 116-159), Division A, Section 163, signed on October 1, 2020, to offset the losses resulting from the coronavirus pandemic of Veterans Canteen Service collections.

- **$140,000,000 Transfer to General Operating Expenses, Veterans Benefits Administration**. This reflects a transfer to the General Operating Expenses, Veterans Benefits Administration from unobligated Medical Services balances ($140,000,000) made available under the Coronavirus Aid, Relief, and Economic Security Act, Division B, Title X (Public Law 116-136). The authority for this transfer is provided in the Consolidated Appropriations Act, 2021, (Public Law 116-260), Division J, Title II, Section 514, signed on December 27, 2020, for personnel costs and other expenses to prevent, prepare for and respond to coronavirus, domestically or internationally, including the elimination of backlogs that may have occurred.

- **$12,000,000 Transfer to National Cemetery Administration**. This reflects a transfer to the National Cemetery Administration from unobligated Medical Services balances ($12,000,000) made available under the Coronavirus Aid, Relief, and Economic Security Act, Division B, Title X (Public Law 116-136). The authority for this transfer is provided in the Consolidated Appropriations Act, 2021, (Public Law 116-260), Division J, Title V, Section 514, signed on December 27, 2020, for personnel costs and other expenses to

prevent, prepare for and respond to coronavirus, domestically or internationally, including the elimination of backlogs that may have occurred.

- **$1,000,000 Transfer to Departmental Administration, Board of Veterans Appeals**. This reflects a transfer to the Departmental Administration, Board of Veterans Appeals from unobligated Medical Services balances ($1,000,000) made available under the Coronavirus Aid, Relief, and Economic Security Act, Division B, Title X (Public Law 116-136). The authority for this transfer is provided in the Consolidated Appropriations Act, 2021, (Public Law 116-260), Division J, Title V, Section 514, signed on December 27, 2020, for personnel costs and other expenses to prevent, prepare for and respond to coronavirus, domestically or internationally, including the elimination of backlogs that may have occurred.

- **$198,000,000 Transfer to General Operating Expenses, Veterans Benefits Administration**. This reflects a transfer to the General Operating Expenses, Veterans Benefits Administration from unobligated Medical Services balances ($198,000,000) made available under the Coronavirus Aid, Relief, and Economic Security Act, Division B, Title X (Public Law 116-136). The authority for this transfer is provided in the Consolidated Appropriations Act, 2021, (Public Law 116-260), Division J, Title V, Section 515, signed on December 27, 2020, to prevent, prepare for and respond to coronavirus, domestically or internationally, to improve the Veterans Benefits Administration's education systems.

- **$45,000,000 Transfer to Departmental Administration, Information Technology Systems**. This reflects a transfer to the Departmental Administration, Information Technology Systems from unobligated Medical Services balances ($45,000,000) made available under the Coronavirus Aid, Relief, and Economic Security Act, Division B, Title X (Public Law 116-136). The authority for this transfer is provided in the Consolidated Appropriations Act, 2021, (Public Law 116-260), Division J, Title V, Section 515, signed on December 27, 2020, to prevent, prepare for and respond to coronavirus, domestically or internationally, to improve the Veterans Benefits Administration's education systems.

- **$100,000,000 Transfer to Medical Community Care**. This reflects a transfer to Medical Community Care from unobligated Medical Services balances ($100,000,000) made available under the Coronavirus Aid, Relief, and Economic Security Act, Division B, Title X (Public Law 116-136). The authority for this transfer is provided in the Consolidated Appropriations Act, 2021, (Public Law 116-260), Division J, Title V, Section 517, signed on December 27, 2020, to provide a one-time emergency payment to existing State Extended Care Facilities for Veterans to prevent, prepare for and respond to coronavirus.

- **$5,400,000,000 Transfer to Medical Community Care**. This reflects a transfer to Medical Community Care from unobligated Medical Services balances ($5,400,000,000) made available under the Coronavirus Aid, Relief, and Economic Security Act, Division B, Title X (Public Law 116-136). The authority for this transfer is provided in the Coronavirus Aid, Relief, and Economic Security Act, Division B, Title X, Section 20001 (Public Law 116-136) to support the increased demand for community care services during the coronavirus pandemic, including for emergency room and urgent care services.

- **$105,000,000 Transfer to Medical Support and Compliance**. This reflects a transfer to Medical Support and Compliance from unobligated Medical Services balances ($105,000,000) made available under the Coronavirus Aid, Relief, and Economic Security Act, Division B, Title X (Public Law 116-136). The authority for this transfer is provided in the Coronavirus Aid, Relief, and Economic Security Act, Division B, Title X, Section 20001 (Public Law 116-136) to support staff salaries and contracts to support VA medical centers' response to the coronavirus pandemic.

- **$140,000,000 Transfer to Medical Facilities.** This reflects a transfer to Medical Facilities from unobligated Medical Services balances ($140,000,000) made available under the Coronavirus Aid, Relief, and Economic Security Act, Division B, Title X, Section 20001 (Public Law 116-136) to support staff salaries, contracts and non-recurring maintenance projects to support VA medical centers' response to the coronavirus pandemic.

- **$10,000,000 Transfer to Joint DoD–VA Medical Facility Demonstration Fund.** This reflects a transfer to the Joint DoD-VA Medical Facility Demonstration Fund from unobligated Medical Services balances ($10,000,000) made available under the Coronavirus Aid, Relief, and Economic Security Act, Division B, Title X (Public Law 116-136). The authority for this transfer is provided in the Further Consolidated Appropriations Act, 2020, (Public Law 116-94), Division F, Title II, Section 219, signed on December 20, 2019, to cover increased consumable supplies, equipment and contracted personnel usage at the JALFHCC to respond to coronavirus.

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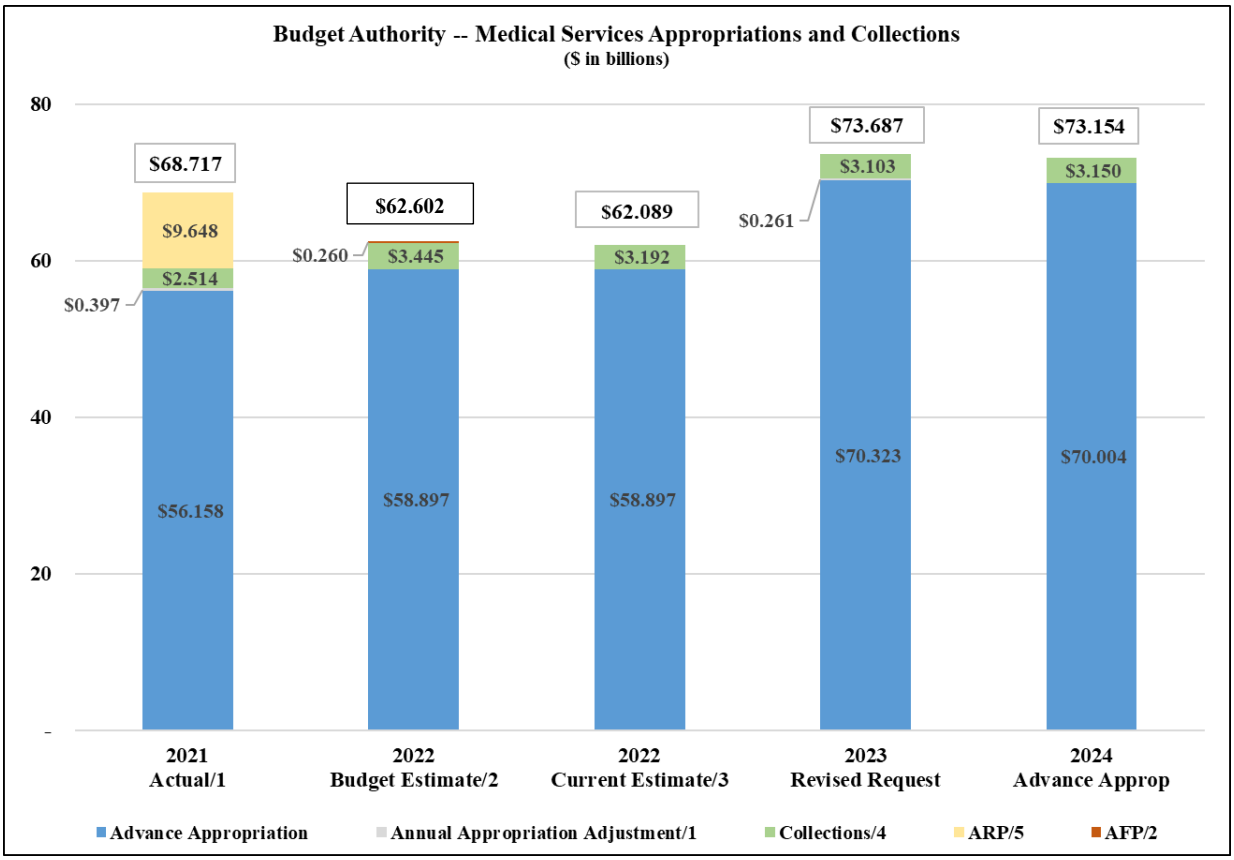
## Chart: Medical Services Appropriations and Collections




[1/] For display purposes only, 2021 Actual includes the $100 million rescission of unobligated balances in the Annual Appropriation Adjustment.

[2/] The 2022 Budget Estimate included a mandatory appropriation request of $260 million for the American Families Plan.

[3/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

[4/] Collections exclude the portion of Medical Care Collections Fund (MCCF) collections actually or anticipated to be transferred to Medical Community Care and the Joint DoD-VA Medical Facility Demonstration Fund, in support of the Captain James A. Lovell Federal Health Care Center (JALFHCC).

[5/] Medical Services American Rescue Plan Act includes the allocation from the Veterans Medical Care and Health Fund (VMCHF), established to execute Section 8002 of the American Rescue Plan Act, as well as the estimated allocation of funding provided by Section 8007 of the ARP Act for copayments not collected. Final allocations of Section 8002 funding among account-level categories may change based 2022 actuals and in response to workload demand requirements throughout 2022 and 2023.

# Table: Medical Services Discretionary Funding Crosswalk 2021-2024[1/]

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate 1/ | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Appropriation Medical Services (0160)** | | | | | | | |
| Advance Appropriation Medical Services (0160) | $56,158,015 | $58,897,219 | $58,897,219 | $70,323,116 | $74,004,000 | $11,425,897 | $3,680,884 |
| Annual Appropriation Adjustment Medical Services (0160) | $497,468 | $0 | $0 | $261,000 | $0 | $261,000 | ($261,000) |
| Rescission (P.L.116-260 §254) | ($100,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| Appropriations Request Subtotal | **$56,555,483** | **$58,897,219** | **$58,897,219** | **$70,584,116** | **$74,004,000** | **$11,686,897** | **$3,419,884** |
| Tranfers To: | | | | | | | |
| North Chicago Demo. Fund (0169) from Medical Services (0160) | ($215,945) | ($203,805) | ($203,805) | ($190,377) | ($191,968) | $13,428 | ($1,591) |
| DoD-VA Hlth Care Sharing Incentive Fund (0165) from Medical Services (0160) | ($15,000) | ($15,000) | ($15,000) | ($15,000) | ($15,000) | $0 | $0 |
| CARES Unob. Bal. to MCC (0140) (PL 116-260 §517) | ($100,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| CARES Unob. Bal. to VBA/GOE (PL 116-260 §515) | ($198,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| CARES Unob. Bal. to OI&T (PL 116-260 §515) | ($45,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| CARES Unob. Bal. to VBA/GOE (PL 116-260 §514) | ($140,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| CARES Unob. Bal. to NCA (PL 116-260 §514) | ($12,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| CARES Unob. Bal. to BVA (PL 116-260 §514) | ($1,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| CARES Unob. Bal. to Canteen (PL 116-159 §163) | ($140,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| Unob. Bal. to VBA/GOE (PL 117-43 §151) | $0 | $0 | ($178,000) | $0 | $0 | $178,000 | $0 |
| Unob. Bal. to BVA (PL 117-43 §151) | $0 | $0 | ($5,800) | $0 | $0 | $5,800 | $0 |
| Unob. Bal. to OI&T (PL 117-43 §151) | $0 | $0 | ($9,700) | $0 | $0 | $9,700 | $0 |
| Transfers To [Subtotal] | ($866,945) | ($218,805) | ($412,305) | ($205,377) | ($206,968) | $206,928 | ($1,591) |
| Collections: | | | | | | | |
| Transfer from Medical Care Collections Fund (5287) | $2,513,515 | $3,445,122 | $3,192,280 | $3,103,128 | $3,150,098 | ($89,152) | $46,970 |
| Collections [Subtotal] | $2,513,515 | $3,445,122 | $3,192,280 | $3,103,128 | $3,150,098 | ($89,152) | $46,970 |
| Budget Authority Total | $58,202,053 | $62,123,536 | $61,677,194 | $73,481,867 | $76,947,130 | $11,804,673 | $3,465,263 |
| Reimbursements Medical Services (0160) | $132,760 | $124,257 | $132,760 | $132,760 | $132,760 | $0 | $0 |
| | | | | | | $0 | $0 |
| Unobligated Balance (SOY): | | | | | | $0 | $0 |
| No-Year Medical Services (0160) | $1,218,064 | $1,323,000 | $2,350,381 | $1,662,997 | $0 | ($687,384) | ($1,662,997) |
| H1N1 No-Year (PL 111-32) | $7 | $0 | $7 | $0 | $0 | ($7) | $0 |
| 2-Year (Medical Services) | $853,823 | $1,500,000 | $837,241 | $0 | $0 | ($837,241) | $0 |
| 2-Year (P.L. 116-136) | $10,388,428 | $0 | $0 | $0 | $0 | $0 | $0 |
| 3-Year (P.L. 116-127) | $0 | $0 | $200 | $0 | $0 | ($200) | $0 |
| Unobligated Balance (SOY) [Subtotal] | $12,460,322 | $2,823,000 | $3,187,829 | $1,662,997 | $0 | ($1,524,832) | ($1,662,997) |
| Transfer of Unobligated Balance (PL 116-136 §20001) | | | | | | | |
| CARES Unob. Bal. to MCC (0140) (PL 116-136 §20001) | ($5,400,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| CARES Unob. Bal. to MSC (0152) (PL 116-136 §20001) | ($105,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| CARES Unob. Bal. to MF (0162) (PL 116-136 §20001) | ($140,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| CARES Unob. Bal. to JALFHCC (0169) | ($10,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (EOY): | | | | | | | |
| No-Year Medical Services (0160) | ($2,350,381) | $0 | ($1,662,997) | $0 | $0 | $1,662,997 | $0 |
| H1N1 No-Year (PL 111-32) | ($7) | $0 | $0 | $0 | $0 | $0 | $0 |
| 2-Year (Medical Services) | ($837,241) | $0 | $0 | $0 | $0 | $0 | $0 |
| 2-Year (P.L. 116-136) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 3-Year (P.L. 116-127) | ($200) | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (EOY) [Subtotal] | ($3,187,829) | $0 | ($1,662,997) | $0 | $0 | $1,662,997 | $0 |
| Lapse Medical Services (0160) | ($66,777) | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $61,885,529 | $65,070,793 | $63,334,786 | $75,277,624 | $77,079,890 | $11,942,838 | $1,802,266 |
| Prior Year Recoveries | $442,135 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations (0160) [Subtotal]** | **$62,327,664** | **$65,070,793** | **$63,334,786** | **$75,277,624** | **$77,079,890** | **$11,942,838** | **$1,802,266** |

[1/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

## Table: Medical Services Mandatory Funding Crosswalk 2021-2024

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Veterans Medical Care and Health Fund (0173MS) 1/** | | | | | | | |
| Mandatory Appropriation, Section 8002 | $9,020,443 | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (SOY) | $0 | $9,020,443 | $9,020,443 | $696,300 | $0 | ($8,324,143) | ($696,300) |
| Reapportionment of Unobligated Balances | $0 | $0 | ($3,370,212) | $0 | $0 | $3,370,212 | $0 |
| Unobligated Balance (EOY) | ($9,020,443) | $0 | ($696,300) | $0 | $0 | $696,300 | $0 |
| Obligations, ARP Act Section 8002 (0173MS) [Total] | $0 | $9,020,443 | $4,953,931 | $696,300 | $0 | ($4,257,631) | ($696,300) |
| **ARP Act Section 8007 (0160XP)** | | | | | | | |
| Mandatory Appropriation, Section 8007 | $627,900 | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (SOY) | $0 | $627,900 | $627,900 | $0 | $0 | ($627,900) | $0 |
| Unobligated Balance (EOY) | ($627,900) | $0 | $0 | $0 | $0 | $0 | $0 |
| Obligations, ARP Act Section 8007 (0160XP) [Total] | $0 | $627,900 | $627,900 | $0 | $0 | ($627,900) | $0 |
| **American Rescue Plan Act Obligations [Subtotal]** | **$0** | **$9,648,343** | **$5,581,831** | **$696,300** | **$0** | **($4,885,531)** | **($696,300)** |
| **American Families Plan** | | | | | | | |
| Mandatory Appropriation Request, AFP | $0 | $260,000 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (SOY) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (EOY) | $0 | ($230,000) | $0 | $0 | $0 | $0 | $0 |
| Obligations, AFP [Total] | $0 | $30,000 | $0 | $0 | $0 | $0 | $0 |
| **VACAA, Section 801 (0160XA)** | | | | | | | |
| Unobligated Balance (SOY): | | | | | | | |
| No-Year | $25,089 | $22,813 | $21,338 | $17,474 | $13,494 | ($3,864) | ($3,980) |
| Unobligated Balance (EOY): | | | | | | | |
| No-Year | ($21,338) | ($20,448) | ($17,474) | ($13,494) | ($9,395) | $3,980 | $4,099 |
| Subtotal | $3,751 | $2,365 | $3,864 | $3,980 | $4,099 | $116 | $119 |
| Prior Year Recoveries | $546 | $0 | $0 | $0 | $0 | $0 | $0 |
| Obligations (0160XA) [Total] | $4,297 | $2,365 | $3,864 | $3,980 | $4,099 | $116 | $119 |
| Mandatory Budget Authority [Subtotal] | $9,648,343 | $260,000 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$4,297** | **$9,680,708** | **$5,585,695** | **$700,280** | **$4,099** | **($4,885,415)** | **($696,181)** |
| Budget Authority [Grand Total] | $67,850,396 | $62,383,536 | $61,677,194 | $73,481,867 | $76,947,130 | $11,804,673 | $3,465,263 |
| **Obligations [Grand Total]** | **$62,331,961** | **$74,751,501** | **$68,920,481** | **$75,977,904** | **$77,083,989** | **$7,057,423** | **$1,106,085** |
| **FTE** | | | | | | | |
| Medical Services (0160) | 267,777 | 256,891 | 268,596 | 282,781 | 293,667 | 14,185 | 10,886 |
| Veterans Medical Care and Health Fund (0173MS) | 0 | 27,900 | 0 | 0 | 0 | 0 | 0 |
| American Families Plan | 0 | 160 | 0 | 0 | 0 | 0 | 0 |
| VACAA, Section 801 (0160XA) | 8 | 6 | 8 | 8 | 8 | 0 | 0 |
| FTE [Total] | 267,785 | 284,957 | 268,604 | 282,789 | 293,675 | 14,185 | 10,886 |

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

## Summary of 2023 Revised Request

VA requests an additional $261.0 million in discretionary resources for Medical Services above the 2023 Advance Appropriation of $70.3 billion. In 2023, VA projects obligating $696.3 million out of unobligated balances provided by section 8002 of the American Rescue Plan Act for activities traditionally funded by the Medical Services appropriation.

When these resources are combined with available anticipated collections, transfers, reimbursements and other net unobligated balances, Medical Services will meet the projected 2023 obligation level of $76.0 billion, as detailed in the tables below.

## Table: Update to the 2023 Advance Appropriation Request

(dollars in thousands)

| | | Available Discretionary Funding | | | | Available Mand. Funding Net Use of Unobl. Balances | | | |
|---|---|---|---|---|---|---|---|---|---|
| Description | 2023 Revised Estimate | Enacted AA Incl. Transfers | Collections | Reimb. | Use of Unobl. Balances Discretionary | VACAA 801 | Use of Unobl. Balances ARP - 8002 1/ | Subtotal | Discretionary Approp. Request |
| **Health Care Services:** | | | | | | | | | |
| **Health Care Services [Total]** | $68,037,354 | $62,593,138 | $2,858,390 | $132,760 | $1,491,786 | $3,980 | $696,300 | $67,776,354 | **$261,000** |
| *Non-Add included Throughout:* | | | | | | | | | |
| *Activations* | *$591,526* | *$591,526* | *$0* | *$0* | *$0* | *$0* | *$0* | *$591,526* | ***$0*** |
| *Beneficiary Travel* | *$1,488,378* | *$1,400,164* | *$88,214* | *$0* | *$0* | *$0* | *$0* | *$1,488,378* | ***$0*** |
| *Medical Contracts* | *$12,710,437* | *$11,617,105* | *$135,742* | *$0* | *$0* | *$290* | *$696,300* | *$12,449,437* | ***$261,000*** |
| *Medical Equipment* | *$2,514,904* | *$2,446,787* | *$68,117* | *$0* | *$0* | *$0* | *$0* | *$2,514,904* | ***$0*** |
| *Medical Staffing* | *$42,241,004* | *$39,742,684* | *$2,385,170* | *$109,460* | *$0* | *$3,690* | *$0* | *$42,241,004* | ***$0*** |
| *Pharmacy* | *$10,653,033* | *$10,224,497* | *$405,236* | *$23,300* | *$0* | *$0* | *$0* | *$10,653,033* | ***$0*** |
| *Prosthetics* | *$4,069,980* | *$4,049,331* | *$20,649* | *$0* | *$0* | *$0* | *$0* | *$4,069,980* | ***$0*** |
| **Long-Term Services and Supports:** | | | | | | | | | |
| **VA Long-Term Services and Supports [Total]** | $4,513,520 | $4,097,571 | $244,738 | $0 | $171,211 | $0 | $0 | $4,513,520 | **$0** |
| **Other Health Care Programs:** | | | | | | | | | |
| CHAMPVA Medical Staff, Pharmacy Costs, excludes Caregivers | $365,844 | $365,844 | $0 | $0 | $0 | $0 | $0 | $365,844 | **$0** |
| Caregivers (Including CHAMPVA)) | $1,811,210 | $1,811,210 | $0 | $0 | $0 | $0 | $0 | $1,811,210 | **$0** |
| Camp Lejeune - Family | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | **$0** |
| Homeless Grants | $970,341 | $970,341 | $0 | $0 | $0 | $0 | $0 | $970,341 | **$0** |
| Readjustment Counseling | $279,635 | $279,635 | $0 | $0 | $0 | $0 | $0 | $279,635 | **$0** |
| Other Health Care Programs [Total] | $3,427,030 | $3,427,030 | $0 | $0 | $0 | $0 | $0 | $3,427,030 | **$0** |
| **Obligations [Total]** | $75,977,904 | $70,117,739 | $3,103,128 | $132,760 | $1,662,997 | $3,980 | $696,300 | $75,716,904 | $261,000 |

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 may change in response to workload demand requirements throughout 2022 and 2023.

## Table: Medical Services Discretionary Obligations by Program

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Health Care Services:** | | | | | | | |
| Health Care Services without Families First Act and CARES Act | $51,388,830 | $58,236,587 | $55,910,435 | $67,337,074 | $68,334,360 | $11,426,639 | $997,286 |
| Health Care Services - Families First Act and CARES Act Only | $3,478,521 | $0 | $200 | $0 | $0 | ($200) | $0 |
| **Health Care Services [Total]** | **$54,867,351** | **$58,236,587** | **$55,910,635** | **$67,337,074** | **$68,334,360** | **$11,426,439** | **$997,286** |
| *Non-Add included above:* | | | | | | | |
| *Activations* | *$322,412* | *$609,608* | *$609,608* | *$591,526* | *$360,651* | *($18,082)* | *($230,875)* |
| *Beneficiary Travel* | *$1,328,750* | *$1,009,100* | *$1,385,278* | *$1,488,378* | *$1,540,378* | *$103,100* | *$52,000* |
| *Medical Contracts* | *$5,907,769* | *$9,381,659* | *$7,331,515* | *$12,013,847* | *$10,671,283* | *$4,682,332* | *($1,342,564)* |
| *Medical Equipment* | *$2,078,881* | *$0* | *$727,811* | *$2,514,904* | *$602,616* | *$1,787,093* | *($1,912,288)* |
| *Medical Staffing* | *$37,009,983* | *$36,642,142* | *$38,397,831* | *$42,237,314* | *$45,890,934* | *$3,839,483* | *$3,653,620* |
| *Pharmacy* | *$8,999,070* | *$9,349,216* | *$9,884,129* | *$10,653,033* | *$11,474,433* | *$768,904* | *$821,400* |
| *Prosthetics* | *$3,474,096* | *$4,934,098* | *$3,756,341* | *$4,069,980* | *$4,410,880* | *$313,639* | *$340,900* |
| **Long-Term Services and Supports VA Care:** | | | | | | | |
| LTSS without Families First Act and CARES Act | $4,180,161 | $4,029,567 | $4,641,272 | $4,513,520 | $4,683,917 | ($127,752) | $170,397 |
| LTSS - CARES Act Only | $266,399 | $0 | $0 | $0 | $0 | $0 | $0 |
| **VA Long-Term Services and Supports [Total]** | **$4,446,560** | **$4,029,567** | **$4,641,272** | **$4,513,520** | **$4,683,917** | **($127,752)** | **$170,397** |
| **Other Health Care Programs VA Care without Families First Act and CARES Act:** | | | | | | | |
| CHAMPVA Medical Staff, Pharmacy Costs, excludes Caregivers | $395,523 | $489,308 | $426,434 | $365,844 | $522,816 | ($60,590) | $156,972 |
| Caregivers (Including CHAMPVA) | $863,397 | $1,347,933 | $1,398,765 | $1,811,210 | $2,222,940 | $412,445 | $411,730 |
| Camp Lejeune - Family | $262 | $29 | $0 | $0 | $0 | $0 | $0 |
| Homeless Grants | $783,678 | $703,986 | $681,017 | $970,341 | $1,024,245 | $289,324 | $53,904 |
| Readjustment Counseling | $233,010 | $263,383 | $276,663 | $279,635 | $291,612 | $2,972 | $11,977 |
| Other Health Care Programs without FF Act and CARES Act [Total] | $2,275,869 | $2,804,639 | $2,782,879 | $3,427,030 | $4,061,613 | $644,151 | $634,583 |
| Homeless Grants - CARES Act Only | $295,749 | $0 | $0 | $0 | $0 | $0 | $0 |
| Obligations without Families First Act and CARES Act [Subtotal] | $57,844,860 | $65,070,793 | $63,334,586 | $75,277,624 | $77,079,890 | $11,943,038 | $1,802,266 |
| Obligations - Families First Act and CARES Act Only [Subtotal] | $4,040,669 | $0 | $200 | $0 | $0 | ($200) | $0 |
| **Obligations [Total]** | **$61,885,529** | **$65,070,793** | **$63,334,786** | **$75,277,624** | **$77,079,890** | **$11,942,838** | **$1,802,266** |
| VA Prior-Year Recoveries | $442,135 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Grand Total]** | $62,327,664 | $65,070,793 | $63,334,786 | $75,277,624 | $77,079,890 | $11,942,838 | $1,802,266 |

[1/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, together with updated estimates for transfers, reimbursements and medical care collections.

## Table: Medical Services Mandatory Obligations by Program

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Health Care Services:** | | | | | | | |
| Health Care Services - Veterans Medical Care and Health Fund | $0 | $8,047,753 | $4,584,431 | $696,300 | $0 | ($3,888,131) | ($696,300) |
| Health Care Services - American Rescue Plan Act, Section 8007 | $0 | $627,900 | $627,900 | $0 | $0 | ($627,900) | $0 |
| Health Care Services - VACAA Section 801 | $3,425 | $2,121 | $3,864 | $3,980 | $4,099 | $116 | $119 |
| **Health Care Services [Total]** | **$3,425** | **$8,677,774** | **$5,216,195** | **$700,280** | **$4,099** | **($4,515,915)** | **($696,181)** |
| *Non-Add included above and below:* | | | | | | | |
| *Activations* | *$0* | *$0* | *$0* | *$0* | *$0* | *$0* | *$0* |
| *Beneficiary Travel* | *$0* | *$0* | *$0* | *$0* | *$0* | *$0* | *$0* |
| *Medical Contracts* | *($94)* | *$2,443,769* | *$3,013,943* | *$696,590* | *$298* | *($2,317,353)* | *($696,292)* |
| *Medical Equipment* | *$238* | *$1,746,224* | *$1,746,224* | *$0* | *$0* | *($1,746,224)* | *$0* |
| *Medical Staffing* | *$3,429* | *$3,952,204* | *$3,528* | *$3,690* | *$3,801* | *$162* | *$111* |
| *Pharmacy* | *$178* | *$1,074,080* | *$0* | *$0* | *$0* | *$0* | *$0* |
| *Prosthetics* | *$0* | *$313* | *$0* | *$0* | *$0* | *$0* | *$0* |
| **Long-Term Services and Supports VA Care:** | | | | | | | |
| LTSS - Veterans Medical Care and Health Fund | $0 | $486,690 | $0 | $0 | $0 | $0 | $0 |
| LTSS - VACAA Section 801 | $326 | $244 | $0 | $0 | $0 | $0 | $0 |
| **VA Long-Term Services and Supports [Total]** | **$326** | **$486,934** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Other Health Care Programs VA Care - Veterans Medical Care and Health Fund** | | | | | | | |
| CHAMPVA Medical Staff, Pharmacy Costs, excludes Caregivers | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Caregivers (Including CHAMPVA) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Camp Lejeune - Family | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Homeless Grants | $0 | $486,000 | $369,500 | $0 | $0 | ($369,500) | $0 |
| Readjustment Counseling | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Health Care Programs - VCMF [Total] | $0 | $486,000 | $369,500 | $0 | $0 | ($369,500) | $0 |
| **VA Legislative Proposals 1/:** | | | | | | | |
| Total | $0 | $30,000 | $0 | $0 | $0 | $0 | $0 |
| Obligations - Veterans Medical Care and Health Fund [Subtotal] 2/ | $0 | $9,020,443 | $4,953,931 | $696,300 | $0 | ($4,257,631) | ($696,300) |
| Obligations - American Rescue Plan Act [Subtotal] | $0 | $627,900 | $627,900 | $0 | $0 | ($627,900) | $0 |
| Obligations - VACAA Section 801 [Subtotal] | $3,751 | $2,365 | $3,864 | $3,980 | $4,099 | $116 | $119 |
| **Obligations [Total]** | **$3,751** | **$9,650,708** | **$5,585,695** | **$700,280** | **$4,099** | **($4,885,415)** | **($696,181)** |
| VA Prior-Year Recoveries | $546 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Grand Total]** | $4,297 | $9,680,708 | $5,585,695 | $700,280 | $4,099 | ($4,885,415) | ($696,181) |

1/ For detail on the 2023 Legislative Proposals, please see the Legislative Proposals chapter in Volume 1.

2/ 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 may change in response to workload demand requirements throughout 2022 and 2023.

3/ The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, together with updated estimates for transfers, reimbursements and medical care collections.

## Table: Medical Services Total Obligations by Program

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Health Care Services:** | | | | | | | |
| **Health Care Services [Total]** | $54,870,776 | $66,914,361 | $61,126,830 | $68,037,354 | $68,338,459 | $6,910,524 | $301,105 |
| *Non-Add included above:* | | | | | | | |
| *Activations* | *$322,412* | *$609,608* | *$609,608* | *$591,526* | *$360,651* | *($18,082)* | *($230,875)* |
| *Beneficiary Travel* | *$1,328,750* | *$1,009,100* | *$1,385,278* | *$1,488,378* | *$1,540,378* | *$103,100* | *$52,000* |
| *Medical Contracts* | *$5,907,675* | *$11,825,428* | *$10,345,458* | *$12,710,437* | *$10,671,581* | *$2,364,979* | *($2,038,856)* |
| *Medical Equipment* | *$2,079,119* | *$1,746,224* | *$2,474,035* | *$2,514,904* | *$602,616* | *$40,869* | *($1,912,288)* |
| *Medical Staffing* | *$37,013,412* | *$40,594,346* | *$38,401,359* | *$42,241,004* | *$45,894,735* | *$3,839,645* | *$3,653,731* |
| *Pharmacy* | *$8,999,248* | *$10,423,296* | *$9,884,129* | *$10,653,033* | *$11,474,433* | *$768,904* | *$821,400* |
| *Prosthetics* | *$3,474,096* | *$4,934,411* | *$3,756,341* | *$4,069,980* | *$4,410,880* | *$313,639* | *$340,900* |
| **Long-Term Services and Supports VA Care:** | | | | | | | |
| **VA Long-Term Services and Supports [Total]** | $4,446,886 | $4,516,501 | $4,641,272 | $4,513,520 | $4,683,917 | ($127,752) | $170,397 |
| **Other Health Care Programs VA Care:** | | | | | | | |
| CHAMPVA Medical Staff, Pharmacy Costs, excludes Caregivers | $395,523 | $489,308 | $426,434 | $365,844 | $522,816 | ($60,590) | $156,972 |
| Caregivers (Including CHAMPVA) | $863,397 | $1,347,933 | $1,398,765 | $1,811,210 | $2,222,940 | $412,445 | $411,730 |
| Camp Lejeune - Family | $262 | $29 | $0 | $0 | $0 | $0 | $0 |
| Homeless Grants | $1,079,427 | $1,189,986 | $1,050,517 | $970,341 | $1,024,245 | ($80,176) | $53,904 |
| Readjustment Counseling | $233,010 | $263,383 | $276,663 | $279,635 | $291,612 | $2,972 | $11,977 |
| Other Health Care Programs [Total] | $2,571,618 | $3,290,639 | $3,152,379 | $3,427,030 | $4,061,613 | $274,651 | $634,583 |
| **VA Legislative Proposals 1/:** | | | | | | | |
| Total | $0 | $30,000 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Subtotal]** | **$61,889,280** | **$74,751,501** | **$68,920,481** | **$75,977,904** | **$77,083,989** | **$7,057,423** | **$1,106,085** |
| **VA Prior-Year Recoveries** | $442,681 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total Obligations** | $62,331,961 | $74,751,501 | $68,920,481 | $75,977,904 | $77,083,989 | $7,057,423 | $1,106,085 |

[1/] For detail on the 2023 Legislative Proposals, please see the Legislative Proposals chapter in Volume 1.

[2/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, together with updated estimates for transfers, reimbursements and medical care collections.

In 2023, total obligations are projected to increase by $7.1 billion above the 2022 current estimate in the following areas:

- **Health Care Services (+$6.9 billion).** Ongoing health care services are projected to increase due to revised actuarial trends based on the most recent data, which accounts for the latest demographic trends and modes of care delivery. For 2023, these updates include the impact of COVID-19 on the VA health care system which has led to a significant decline in nationwide health care utilization since mid-March 2020 as individuals chose to defer certain care. Some of that deferred care has returned as the effects of the pandemic began to diminish. 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 and specialty care and inpatient care. The budget request includes the following impacts to account for the projected increase in health care services:
    - **Medical Staffing (+$3.8 billion).** Medical Services full-time equivalents (FTE) are projected to increase by 14,185 (5.3% above the 2022 current estimate level), allowing VA to accelerate growth in projected appointments at VA facilities. The

increase includes support for precision oncology, suicide prevention, mental health and opioid abuse prevention initiatives and increased caregiver support staff.

- **Medical Contracts (+$2.4 billion).** Medical Services contracts are projected to directly support VA Medical Centers (VAMCs) in meeting their health care workload demand, post-COVID, as deferred care returns to the health care system, and to provide temporary support to VAMCs as they transition to the new electronic health record system (EHRM). This resource level will assist VAMCs' work to achieve the right balance between care provided through VA and care provided in the community to ensure Veterans have timely access to the highest quality health care services. Nearly half of the increase is anticipated to be funded by the Veterans Medical Care and Health Fund. Final funding allocations in the Veterans Medical Care and Health Fund among account-level categories and among activities within each category may change based on 2022 actuals and in response to workload demand requirements throughout 2022 and 2023.

- **Pharmacy (+$768.9 million).** Estimates are increased to reflect the latest actuarial and programmatic trends, which include growing outpatient prescription demand and price inflation.

- **Prosthetics (+$313.6 million).** Estimates are based on the latest programmatic trends.

- **Medical Equipment (+$40.9 million).** This adjustment reflects a return to recent historical levels of annual equipment purchases, following the significant increase in 2022 for high tech equipment purchases that will be paid for using ARP funds.

- **Long-Term Services and Support (-$127.8 million).** Estimates are projected to decrease due to latest demographic trends and modes of care delivery.

- **Other Health Care Programs (+$274.7 million).** VA-provided health service programs not projected by the Enrollee Health Care Projection Model (EHCPM) are expected to yield a net increase of $323 million, driven largely by Caregiver program costs associated with the MISSION Act expanded eligibility.

## Summary of the 2024 Advance Appropriation Request

The Medical Services discretionary advance appropriations request is $74.0 billion, an increase of $3.4 billion from the 2023 revised discretionary request. The 2024 request ensures continuity of Veterans' health care services and sustains VA's increased capacity for care following the pandemic. In 2024, total obligations are projected to be $1.1 billion more than total obligations in 2023. VA projects that a significant amount of health care that was delayed during the pandemic will return to the VA health care system in 2023, coupled with the return of care to pre-pandemic levels. The 2024 request sustains VA's capacity for care following the return of deferred care.

In 2024, total obligations are projected to increase by $1.1 billion from the 2023 revised request level in the following areas:

- **Health Care Services (+$301.1 million).** Significant drivers of this change include the following:

    - **Medical Staffing (+$3.7 billion).** Medical Services FTE are projected to increase by 10,886 over the 2023 level, and this increase accounts for Federal Employee Retirement System (FERS) adjustments, wage increases and change in experience levels of the recently onboarded staff.

    - **Medical Contracts (-$2.0 billion).** Medical Services contracts are projected to decrease by $2.0 billion from the projected 2023 level. The total amount requested reflected the projected increase in FTE and will continue to directly support VAMCs' work to achieve the right balance between care provided through VA and care provided in the community to ensure Veterans have timely access to the highest quality health care services.

    - **Pharmacy (+$821.4 million).** Estimates are increased to reflect the latest actuarial and programmatic trends which include growing outpatient prescription demand and price inflation.

    - **Prosthetics (+$340.9 million).** Estimates are based on the latest programmatic trends.

    - **Medical Equipment (-$1.9 billion).** This adjustment reflects funding required for VA to begin the fiscal year. The overall equipment needs of the agency will be reassessed during the 2024 budget cycle.

    - **Activations (-$230.9 million).** This adjustment reflects funding required for VA to begin the fiscal year. The overall activations need of the agency will be reassessed during the 2024 budget cycle.

- **Long-Term Services and Supports (+$170.4 million).** Estimates reflect the latest programmatic trends and modes of care delivery.

- **Other Health Care programs (+$634.6 million).** The increase is largely driven by the expanding Caregiver Program, which includes the remaining cohort of eligible Veterans for the Program of Comprehensive Assistance for Family Caregivers (PCAFC).

**Medical Services Program Funding Requirements**

VA is committed to providing the best access to care for Veterans. To deliver the full care spectrum as defined in VA's medical benefits package, VA will allocate resources based on the following principles:

- Enable VA to provide access to high-quality care for Veterans, whether in VA facilities, through community partners or using telehealth modalities, while accounting for Veterans' preferences and clinical needs, changing demands for care and resource limitations;
- Promote operational efficiency and simplicity, while supporting VA's clinical care, education and research missions; and
- Allow facilities to meet the changing needs of Veterans in a flexible way.

VA continues to execute a multi-pronged strategy in 2023 that will target resources to improve Veterans' access to timely, high-quality care through targeted hiring, improved care coordination and continued telehealth enhancements. These efforts will reduce the number of appointments that VA must refer to community care and enable VA to deliver in-house more efficiently and with higher quality and greater coordination.

- Improved Care Coordination: Through this initiative, Veterans will have more access to a greater variety of care options than ever before. Enhanced care coordination services, staffed in many cases by nurses and social workers in coordination with specialty care teams led by physicians, will help Veterans navigate their options and choose the most clinically-appropriate, convenient path to best meet their healthcare needs.

- Targeted Hiring: VA will use targeted hiring initiatives to ensure Veterans have timely access to high-quality primary and mental health throughout our infrastructure. The Budget will also support full staffing for VA's Patient Aligned Care Teams, which make VA a leader in providing robust quality primary care and preventing costly future interventions.

- Telehealth Enhancements: Many Veterans prefer the convenience, timeliness and efficiency of telehealth appointments, particularly after their more widespread use during the pandemic. VA will continue to augment its clinical resource telehealth hubs with additional Primary Care, Mental Health and Clinical Pharmacy Specialists who deliver care via VA Video Connect appointments. In addition, VA will expand the development of Specialty Care telehealth hubs, providing services such as cardiology, neurology, dermatology and inpatient intensive care unit (ICU) and stroke programs.

- Improve Veterans' Access to Same-Day Mental Health Care: Veterans are at higher risk for mental health and substance use challenges than the general population. Increasing their access to quality mental health care is the first step to closing this disparity. VA will reduce barriers to mental health access by fully implementing its Primary Care Mental Health Integration and Behavioral Health Interdisciplinary Program, which connects Veterans to same-day mental health care and improves the integration of these services into primary care settings.

## HR Modernization

The 2023 budget is focused on investing in VA's workforce and attracting and retaining new talent by leveraging investments and improvements in VA's human capital infrastructure. The budget supports VA's efforts to: continue to work with Congress on legislation such as the RAISE Act to invest in employee wages; maximize bonuses and retention incentives to reward employees for excellent work; increasing opportunities to advance at VA through leadership development programs; expediting the hiring process by simplifying the application requirements; investing in employee well-being through programs such as the VHA Reduce Burnout and Optimize Organizational Thriving (REBOOT) task force; investing in scholarship programs to offer educational opportunities to even more employees; and continuing to focus on keeping employee and visitor safety at the forefront, as VA navigates the evolving pandemic impacts.

## Providing Seamless and Coordinated Access to Care for Veterans

Veterans are getting more care through VA than ever, in VHA facilities and through community care. While managing COVID Delta and Omicron surges and keeping Veterans safe throughout 2021, VA completed more than 78 million Veteran visits, including more than 37 million in-person, 30 million by telephone and 10 million by video visits.

Even as Veterans return to in-person appointments for some clinical care, many clinical needs of our Veterans will continue to be delivered virtually. The 2023 Budget supports the continued build out enterprise-wide technology infrastructure that is enabling VA to provide 24/7 access to virtual care from regional clinical contact centers. This access is supplemental to care offered through our VA medical centers and Community Based Outpatient Clinics and for those eligible through VA's robust community care network. VA is creating the Office of Integrated Veteran Care (IVC) to align staff in the Office of Community Care (OCC) and Office of Veterans Access to Care (OVAC) as one team in VA Central Office to oversee the design and implementation of an integrated access and care coordination model for VA and community care. IVC will assure that the Veteran is at the center of his/her own care, so he/she is the ultimate decision-maker on where and how to receive care. IVC also seeks to achieve the right balance of care provided in VA and the community and to ensure timely access to the highest quality health care services.

The 2023 request supports meeting the workload demand created by the pandemic in 2023 by increasing staff and resources to ensure VA provides timely primary care, specialty care and care coordination with community providers.

The following tables provide additional detail on eight distinct activities of the Medical Services account: Activations, Medical Equipment, Medical Services Staffing, Long-Term Services Supports and Programs, Other Health Care Programs VA Care, Beneficiary Travel, Pharmacy and Prosthetics.

## Activations

**Activations 1/**
**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations | $322,412 | $609,608 | $609,608 | $591,526 | $360,651 | ($18,082) | ($230,875) |
| **Medical Services Obligations [Grand Total]** | **$322,412** | **$609,608** | **$609,608** | **$591,526** | **$360,651** | **($18,082)** | **($230,875)** |

1/ This table displays obligations for the Medical Services account only. See the Medical Care chapter for detail on all accounts that support the Activations program. In general, the Medical Services account provides for medical staffing and equipment, while the other budget accounts provide for administrative support, physical space and facility maintenance.

Facility activations provide non-recurring (equipment and supplies) and recurring (additional personnel) costs associated with the activation of completed construction of new or replacement medical care facilities. Resources include assumed rates for medical equipment and furniture reuse based on the facility type (renovation, replacement or new). VA's activation plans are sensitive to delays in construction schedules and lease awards. VA has recently taken steps to identify and more closely monitor the activations of new facilities and leases to assure that projects stay on schedule, which will promote better synchronization of budgetary resources with program needs.

## Medical Equipment

**VA Medical Equipment 1/**
**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations | $2,078,881 | $0 | $727,811 | $2,514,904 | $602,616 | $1,787,093 | ($1,912,288) |
| Mandatory Obligations (including VMCHF) | $238 | $1,746,224 | $1,746,224 | $0 | $0 | ($1,746,224) | $0 |
| **Obligations [Grand Total]** | **$2,079,119** | **$1,746,224** | **$2,474,035** | **$2,514,904** | **$602,616** | **$40,869** | **($1,912,288)** |

1/ This table only displays obligations for medical equipment; for total obligations on all types of equipment, including non-medical, please see the Obligations by Object table at end of the Budget Overview chapter.

Medical equipment used across VHA is the same equipment used in United States (U.S.) commercial healthcare. Medical Services equipment includes capitalized equipment such as diagnostic imaging equipment, radiation oncology equipment, surgical systems and intensive care monitoring systems, with a purchase price of $1 million or more; and non-capitalized equipment, such as biomedical devices, dentistry equipment, laboratory analyzers, hospital beds, scientific instruments and appliances, measuring and weighing instruments, surgical equipment and instruments and accessories that cost less than $1 million. Medical Services equipment includes clinical systems used in medical/surgical subspecialties for diagnostic interpretation, treatment planning, decision support and results reporting. Current medical equipment holdings across VHA have a value of approximately $10 billion.

The Assistant Under Secretary for Health for Support (AUSH-S) is responsible for national policies, standards and guidance related to medical equipment management and safety. AUSH-S provides leadership, consultation and expertise in technology configuration management and VHA medical equipment and clinical systems deployment, commissioning and technical sustainment and refresh. The Healthcare Technology Management Office manages this program on behalf of

the AUSH-S and is accountable for program execution and oversight through coordination with Biomedical Engineering field operations managers.

VHA deployed approximately 86,407 new medical devices, worth $965 million, during 2021 to refresh VHA's health technology infrastructure. VHA business process and systems re-engineering initiatives enhance clinical capabilities, patient safety, access to care and medical technology cybersecurity.

Medical Services funding in 2022 and 2023 will address medical equipment replacement deferred for replacement during the pandemic. Modernizing VHA's medical equipment, while improving its safety, cybersecurity and compatibility with VA's electronic health record (EHR), requires deliberate systems engineering and extensive collaboration across VA lines of business and VHA clinical programs.

**Plans for New and Replacement Equipment in 2022-2024**

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 Veterans Integrated Services Network (VISN) and fiscal year.

Additionally, VA will upgrade or replace medical equipment and clinical systems to comply with the new Cerner EHR interface requirements to correspond with medical center implementations and ensure medical device interoperability that align with clinical requirements.

**Impact of VA Medical Equipment on Medical Care and Staff Productivity**

Medical equipment is a foundational element of Veteran healthcare. Some examples of lifesaving equipment include linear accelerators to provide radiation treatment for cancer; computerized tomography scanners that provide imaging to screen for lung cancer; physiologic monitoring systems that display patient vital signs in real time; anesthesia delivery systems that induce and maintain anesthesia in surgical patients; and laboratory analyzers that determine blood glucose measurements.

VA deployed new medical equipment at all medical centers in 2021 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. VA currently uses approximately 1,034,513 discrete medical devices across the enterprise to deliver healthcare to Veterans. Approximately 109,028 medical devices/clinical systems communicate on the VA information technology network and

must be specially managed and routinely updated to address known and emerging cybersecurity risks.

Medical equipment directly contributes to improving the Veteran experience by providing state-of-the art equipment in the VA healthcare environment. Medical equipment refresh supports VA's overarching modernization efforts by improving VHA's capabilities to provide high reliability healthcare to Veterans. Medical equipment plays a vital role in focusing VA resources more efficiently by enhancing and supporting the clinical staff through human factors design, training on technology use and systems integration. Medical equipment directly contributes to improving the service timeliness by ensuring VA Medical Centers have the technology essential to provide medical care to Veterans.

## Medical Services Staffing

**VA Medical Services Staffing 1/**
**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations | $37,009,983 | $36,642,142 | $38,397,831 | $42,237,314 | $45,890,934 | $3,839,483 | $3,653,620 |
| Mandatory Obligations - VACAA 801 | $3,429 | $1,604 | $3,528 | $3,690 | $3,801 | $162 | $111 |
| Mandatory Obligations - VMCHF | $0 | $3,950,600 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Grand Total]** | **$37,013,412** | **$40,594,346** | **$38,401,359** | **$42,241,004** | **$45,894,735** | **$3,839,645** | **$3,653,731** |

1/ For additional FTE details, please see the Employment Summary tables and the Obligations by Object table at the end of the Budget Overview chapter.

Medical Services FTE represents the largest share of VHA obligations by object class. They include:

- Physicians;
- Dentists;
- Registered Nurses;
- Licensed Practical Nurses (LPNs)/Licensed Vocational Nurses (LVNs)/ Nurse Assistants;
- Non-physician providers, such as podiatrists, physician assistants, psychologists, nurse practitioners, chiropractors and optometrists;
- Health Technicians/Allied Health, such as respiratory therapists, physical therapists, dietitians, social workers, radiology technologists, pharmacists, audiologist and speech pathologists, nuclear medicine technologists and laboratory aids and workers;
- Wage Board/Purchase & Hire; and
- All Other.

As part of VA's multi-pronged initiative in 2023 and 2024 to improve Veterans' access to timely, high-quality care, and to meet the health care needs presented by the pandemic, VA will increase VA hiring. Medical Services will have 282,789 FTE in 2023, an increase of 14,185 FTE over the 2022 current estimate. This FTE level sustains and builds on VA's capacity to provide care, given an anticipated growth in reliance on VA for care, and to meet the demand for pandemic-induced

deferred care. The 2024 FTE realizes the gains from onboarding staff throughout 2023, enabling VA to further meet Veteran demand for VA provided services.

**FTE by Type**
**Medical Services**

| Account | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary FTE** | | | | | | | |
| Physicians | 22,369 | 20,719 | 22,432 | 23,617 | 24,197 | 1,185 | 580 |
| Dentists | 1,205 | 1,175 | 1,209 | 1,273 | 1,283 | 64 | 10 |
| Registered Nurses | 66,211 | 59,172 | 66,416 | 69,923 | 73,023 | 3,507 | 3,100 |
| LP Nurse/LV Nurse/Nurse Assistant | 28,598 | 26,009 | 28,686 | 30,201 | 30,537 | 1,515 | 336 |
| Non-Physician Providers | 17,272 | 17,812 | 17,324 | 18,239 | 19,093 | 915 | 854 |
| Health Technicians/Allied Health | 80,639 | 82,770 | 80,888 | 85,160 | 88,791 | 4,272 | 3,631 |
| Wage Board/Purchase & Hire | 5,722 | 5,690 | 5,740 | 6,043 | 6,094 | 303 | 51 |
| All Other | 45,761 | 43,544 | 45,901 | 48,325 | 50,649 | 2,424 | 2,324 |
| **Discretionary Medical Service FTE [Subtotal]** | **267,777** | **256,891** | **268,596** | **282,781** | **293,667** | **14,185** | **10,886** |
| **Veterans Medical Care and Health Fund** | | | | | | | |
| **Mandatory FTE** | | | | | | | |
| Physicians | 0 | 1,960 | 0 | 0 | 0 | 0 | 0 |
| Dentists | 0 | 150 | 0 | 0 | 0 | 0 | 0 |
| Registered Nurses | 0 | 10,440 | 0 | 0 | 0 | 0 | 0 |
| LP Nurse/LV Nurse/Nurse Assistant | 0 | 5,175 | 0 | 0 | 0 | 0 | 0 |
| Non-Physician Providers | 0 | 950 | 0 | 0 | 0 | 0 | 0 |
| Health Technicians/Allied Health | 0 | 5,100 | 0 | 0 | 0 | 0 | 0 |
| Wage Board/Purchase & Hire | 0 | 225 | 0 | 0 | 0 | 0 | 0 |
| All Other | 0 | 3,900 | 0 | 0 | 0 | 0 | 0 |
| **VMCHF FTE [Subtotal]** | **0** | **27,900** | **0** | **0** | **0** | **0** | **0** |
| **American Families Plan** | | | | | | | |
| **Mandatory FTE** | | | | | | | |
| Non-Physician Providers | 0 | 160 | 0 | 0 | 0 | 0 | 0 |
| **American Families Plan FTE [Subtotal]** | **0** | **160** | **0** | **0** | **0** | **0** | **0** |
| **Veterans Choice Act (P.L. 113-146)** | | | | | | | |
| **Section 801** | | | | | | | |
| **Mandatory FTE** | | | | | | | |
| Physicians | 6 | 2 | 6 | 6 | 6 | 0 | 0 |
| Non-Physician Providers | 1 | 0 | 1 | 1 | 1 | 0 | 0 |
| All Other | 1 | 4 | 1 | 1 | 1 | 0 | 0 |
| **Veterans Choice Act FTE [Subtotal]** | **8** | **6** | **8** | **8** | **8** | **0** | **0** |
| **Total Medical Services FTE** | | | | | | | |
| Physicians | 22,375 | 22,681 | 22,438 | 23,623 | 24,203 | 1,185 | 580 |
| Dentists | 1,205 | 1,325 | 1,209 | 1,273 | 1,283 | 64 | 10 |
| Registered Nurses | 66,211 | 69,612 | 66,416 | 69,923 | 73,023 | 3,507 | 3,100 |
| LP Nurse/LV Nurse/Nurse Assistant | 28,598 | 31,184 | 28,686 | 30,201 | 30,537 | 1,515 | 336 |
| Non-Physician Providers | 17,273 | 18,922 | 17,325 | 18,240 | 19,094 | 915 | 854 |
| Health Technicians/Allied Health | 80,639 | 87,870 | 80,888 | 85,160 | 88,791 | 4,272 | 3,631 |
| Wage Board/Purchase & Hire | 5,722 | 5,915 | 5,740 | 6,043 | 6,094 | 303 | 51 |
| All Other | 45,762 | 47,448 | 45,902 | 48,326 | 50,650 | 2,424 | 2,324 |
| **Medical Services FTE [Grand Total[** | **267,785** | **284,957** | **268,604** | **282,789** | **293,675** | **14,185** | **10,886** |

**VA's Medical Provider Recruitment & Retention Practices**

As the Nation's largest integrated health care delivery system, VHA workforce challenges mirror those of the health care industry. VHA remains fully engaged in a competitive clinical recruitment market and, therefore, faces similar challenges as our private sector counterparts. Some factors include: the growing national shortage and availability of experienced, quality candidates who possess the competencies required for the position; the salaries typically paid by private industry for similar positions; employment trends and labor-market factors that may affect the ability to recruit candidates; and other supporting factors, such as rural/highly rural locations that may be considered less desirable.

VHA is the largest administration within VA, and in 2021 accounted for 362,346 FTE of the total 406,473 FTE (89.1%). VHA's annual turnover rate for full-time and part-time employees has typically averaged 9.3%. VHA turnover compares favorably with the healthcare industry turnover rate of 27-45%,[37] including those occupations identified as mission critical.[38] In addition, VHA hired approximately 42,700 new employees in 2021 for a net increase of almost 8,000 employees and a 2.2% annual growth rate, compared to the 5-year average annual growth rate of 3.0%.

Over the last five years (2017-2021), VHA grew by 50,379 additional health care providers and support staff, the majority of which (60.8%) was in clinical occupations. Of the clinical growth, 73.3% occurred in top clinical staffing shortage occupations. VHA typically hires approximately 2,700 physicians and upwards of 7,500 or more registered nurses annually to replace losses and grow the workforce to meet access standards and provide the best possible care to Veterans.

VA has a multi-year action plan to address the root causes of dissatisfaction for primary care physicians, psychiatrists and psychologists. Ongoing analysis includes a review of support staff ratios, workload, promotion potential and compensation. In addition, VA conducted a detailed compensation analysis of all physician specialties and updated its pay tables to ensure VA remains competitive with the private sector.

Critical resources used in VA to improve recruitment and retention include: increased maximum physician salaries; implementation of Stay in VA Touchpoints to strengthen employee engagement and retention through regularly scheduled supervisory-staff conversations; targeted use of recruitment, relocation and retention (3Rs) incentives; full utilization of the Education Debt Reduction Program (EDRP), Health Profession Scholarship Program (HPSP) and Specialty Education Loan Repayment Programs (SELRP), respectively; targeted nationwide recruitment advertising and marketing; virtual Trainee Recruitment Events to connect, match and place highly trained VA Health Professions Trainees in facilities with appropriate positions; expansion of scholarship programs; the DoD/VA Transitioning Military Program (TMP) to recruit transitioning service members in health care specialties; and exhibiting regularly at key healthcare conferences and job fairs.

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[37] BLS (Bureau of Labor Statistics) JOLTS (Job Openings and Labor Turnover Survey), https://www.bls.gov/jlt/

[38] The annual "National Health Care Retention and RN Staffing Report" published by NSI Nursing Solutions Inc. in March 2021 identified turnover rates for nurses and other health professionals. VHA's turnover rate for registered nurses, physician assistants, pharmacists, physical therapists and occupational therapists was lower than the industry average reported for these occupations.

In 2021, VHA invested over $148 million from the Offices of Community Care and Rural Health into expanding its existing "hub" model for telehealth clinical resource sharing with 18 Clinical Resource Hubs (CRH), each of which will provide primary care, mental health and specialty care services using telehealth across their VISN, with the capability of extending their services across the country, if needed. In addition, reducing time to hire remains a top priority for HR modernization in 2022. Continuation and expansion of these efforts will ensure that VA achieves its projected growth in 2023.

# VA Long-Term Services and Supports Programs

**VA Long-Term Services and Supports 1/**
**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary Obligations** | | | | | | | |
| Medical Services (0160) Institutional | | | | | | | |
| VA Community Living Centers (VA CLC) | $3,164,139 | $2,621,543 | $3,361,213 | $3,250,754 | $3,345,807 | ($110,459) | $95,053 |
| Medical Services (0160) Non-Institutional | | | | | | | |
| Community Residential Care | $65,566 | $80,534 | $63,349 | $60,438 | $59,341 | ($2,911) | ($1,097) |
| Home Telehealth | $222,077 | $182,113 | $232,481 | $219,003 | $226,574 | ($13,478) | $7,571 |
| Home-Based Primary Care | $795,821 | $856,508 | $860,362 | $885,583 | $952,663 | $25,221 | $67,080 |
| Spinal Cord Injury & Disability Home Care | $9,336 | $10,421 | $9,365 | $9,384 | $9,694 | $19 | $310 |
| VA Adult Day Health Care | $1,161 | $12,030 | $1,228 | $1,225 | $1,343 | ($3) | $118 |
| Non-Institutional [Subtotal] | **$1,093,961** | **$1,141,606** | **$1,166,785** | **$1,175,633** | **$1,249,615** | **$8,848** | **$73,982** |
| Care Coordination for Community Care LTSS programs | $188,461 | $266,418 | $113,274 | $87,133 | $88,495 | ($26,141) | $1,362 |
| **Discretionary Obligations [Subtotal]** | **$4,446,561** | **$4,029,567** | **$4,641,272** | **$4,513,520** | **$4,683,917** | **($127,752)** | **$170,397** |
| **Mandatory Obligations (including VMCHF)** | | | | | | | |
| Medical Services (0160) Institutional | | | | | | | |
| VA Community Living Centers (VA CLC) | $242 | $448,194 | $0 | $0 | $0 | $0 | $0 |
| Medical Services (0160) Non-Institutional | | | | | | | |
| Community Residential Care | $5 | $1,879 | $0 | $0 | $0 | $0 | $0 |
| Home Telehealth | $18 | $6,105 | $0 | $0 | $0 | $0 | $0 |
| Home-Based Primary Care | $60 | $29,659 | $0 | $0 | $0 | $0 | $0 |
| Spinal Cord Injury & Disability Home Care | $1 | $157 | $0 | $0 | $0 | $0 | $0 |
| VA Adult Day Health Care | $0 | $157 | $0 | $0 | $0 | $0 | $0 |
| Non-Institutional [Subtotal] | **$84** | **$37,957** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Care Coordination for Community Care LTSS programs | $0 | $783 | $0 | $783 | $0 | $783 | ($783) |
| **Mandatory Obligations [Subtotal]** | **$326** | **$486,934** | **$0** | **$783** | **$0** | **$783** | **($783)** |
| **Discretionary and Mandatory Obligations** | | | | | | | |
| Medical Services (0160) Institutional | | | | | | | |
| VA Community Living Centers (VA CLC) | $3,164,381 | $3,069,737 | $3,361,213 | $3,250,754 | $3,345,807 | ($110,459) | $95,053 |
| Medical Services (0160) Non-Institutional | | | | | | | |
| Community Residential Care | $65,571 | $82,413 | $63,349 | $60,438 | $59,341 | ($2,911) | ($1,097) |
| Home Telehealth | $222,095 | $188,218 | $232,481 | $219,003 | $226,574 | ($13,478) | $7,571 |
| Home-Based Primary Care | $795,881 | $886,167 | $860,362 | $885,583 | $952,663 | $25,221 | $67,080 |
| Spinal Cord Injury & Disability Home Care | $9,337 | $10,578 | $9,365 | $9,384 | $9,694 | $19 | $310 |
| VA Adult Day Health Care | $1,161 | $12,187 | $1,228 | $1,225 | $1,343 | ($3) | $118 |
| Non-Institutional [Subtotal] | **$1,094,045** | **$1,179,563** | **$1,166,785** | **$1,175,633** | **$1,249,615** | **$8,848** | **$73,982** |
| Care Coordination for Community Care LTSS programs | $188,461 | $267,201 | $113,274 | $87,916 | $88,495 | ($25,358) | $579 |
| **Obligations [Grand Total]** | **$4,446,887** | **$4,516,501** | **$4,641,272** | **$4,514,303** | **$4,683,917** | **($126,969)** | **$169,614** |

1/ This table only displays obligations for Medical Services for VA-provided LTSS; for total obligations across all appropriations please see the Medical Care chapter.

The Medical Services portions of the VA-provided Long-Term Services and Supports programs

include VA Community Living Centers, Community Residential Care, VA Adult Day Care, Home-Based Primary Care, Spinal Cord Injury Home Care and Home Telehealth. Please see the Medical Care chapter for more information about these programs.

## Other Health Care Programs VA Care

**Other Health Care Programs VA Care 1/**
**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary** | | | | | | | |
| CHAMPVA Medical Staff, Pharmacy Costs, excludes Caregivers..... | $395,523 | $489,308 | $426,434 | $365,844 | $522,816 | ($60,590) | $156,972 |
| Caregivers (Including CHAMPVA)..... | $863,397 | $1,347,933 | $1,398,765 | $1,811,210 | $2,222,940 | $412,445 | $411,730 |
| Camp Lejeune - Family..... | $262 | $29 | $0 | $0 | $0 | $0 | $0 |
| Homeless Grants..... | $1,079,427 | $703,986 | $681,017 | $970,341 | $1,024,245 | $289,324 | $53,904 |
| Readjustment Counseling..... | $233,010 | $263,383 | $276,663 | $279,635 | $291,612 | $2,972 | $11,977 |
| **Discretionary Obligations [Subtotal]**..... | $2,571,618 | $2,804,639 | $2,782,879 | $3,427,030 | $4,061,613 | $644,151 | $634,583 |
| **Mandatory (including VMCHF)** | | | | | | | |
| Homeless Grants..... | $0 | $486,000 | $369,500 | $0 | $0 | ($369,500) | $0 |
| **Obligations [Total]**..... | **$2,571,618** | **$3,290,639** | **$3,152,379** | **$3,427,030** | **$4,061,613** | **$274,651** | **$634,583** |

1/ This table only displays obligations for Medical Services; for total obligations across all appropriations please see the Medical Care chapter.

Medical Services costs associated with the CHAMPVA program remaining in the Medical Services Appropriation include implementing the CHAMPVA In-house Treatment Initiative (CITI) as well as Pharmacy costs associated with the CHAMPVA program. CITI is a voluntary program that allows treatment of beneficiaries of CHAMPVA at VAMCs that have elected to participate in the initiative. Additionally, costs for Caregivers' stipend payments, including the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act expansion, and the Medical Services costs for the Readjustment Counseling program remain in the Medical Services appropriation. Please see the Medical Community Care chapter for more information about these programs.

## Medical Services Support for VA- and Community-Provided Care

## Beneficiary Travel

**Beneficiary Travel 1/**
**(dollars in thousands)**

| Description | 2021 Actual 1/ | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Non-CARES Act Obligations..... | $1,312,851 | $1,009,100 | $1,385,278 | $1,488,378 | $1,540,378 | $103,100 | $52,000 |
| Discretionary CARES Act Obligations..... | $15,899 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Grand Total]**..... | **$1,328,750** | **$1,009,100** | **$1,385,278** | **$1,488,378** | **$1,540,378** | **$103,100** | **$52,000** |

1/ This table displays obligations only in Medical Services. A breakout of the $1.3 billion in total 2021 obligations for the Beneficiary Travel program can be found in the Medical Care Chapter, Obligations by Object table.

**Beneficiary Travel by Type**
**(dollars in thousands)**

| | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Beneficiary Travel-Mileage..... | $269,949 | $474,818 | $333,195 | $356,027 | $368,748 | $22,832 | $12,721 |
| Beneficiary Travel-Special Mode..... | $1,006,031 | $470,048 | $1,010,534 | $1,088,915 | $1,126,511 | $78,381 | $37,596 |
| All Other Beneficiary Travel..... | $66,264 | $64,234 | $41,549 | $43,436 | $45,119 | $1,887 | $1,683 |
| **Beneficiary Travel Total.....** | **$1,342,244** | **$1,009,100** | **$1,385,278** | **$1,488,378** | **$1,540,378** | **$103,100** | **$52,000** |

## Description of the Program

VA administers a Beneficiary Travel (BT) Program to help alleviate the costs of travel to medical appointments for eligible Veterans. Travel benefit eligibility for Veterans is based on either the characteristics of the Veteran, the type of medical appointment or a combination of the two. Others who are not Veterans, including family members or those accompanying Veterans to appointments, may also be eligible for the benefit, based on qualifying criteria. Travel costs are reimbursed to beneficiaries, usually after a deductible. Costs covered by the program include a per-mile rate for travel in private vehicles; "special mode" (e.g., ambulance) travel in certain circumstances; and in some cases, airfare, meals and lodging.

Title 38 United States Code (U.S.C.), § 111, "Payments or allowances for beneficiary travel," as regulated in 38 Code of Federal Regulations (CFR) §§ 70.1 – 70.50, authorizes VA to provide or reimburse to certain eligible Veterans and other beneficiaries for:

- Mileage (currently $0.415), or when medically indicated, special mode (ambulance, wheelchair van, etc.) transport and common carrier (plane, train, bus, taxi, light rail, etc.) transport;
- The actual cost of bridge tolls, road and tunnel tolls, parking and authorized luggage fees when supported by a receipt; and
- The actual cost, in limited circumstances, of meals, lodging or both, not to exceed 50% of the local Federal employee rate.

Eligibility is based upon receipt of VA disability compensation service connection and/or low income (VA pension thresholds) or special administrative authority. The current BT regulations only provide authorization for BT within the States, Territories and possessions of the United States, the District of Columbia and the Commonwealth of Puerto Rico.

# Pharmacy

**Pharmacy 1, 2/**
**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Medical Services:** | | | | | | | |
| Discretionary Non-CARES Act Obligations | $7,762,747 | $9,349,977 | $9,558,957 | $10,303,084 | $11,134,680 | $744,127 | $831,596 |
| Discretionary CARES Act Obligations | $922,363 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$8,685,110** | **$9,349,977** | **$9,558,957** | **$10,303,084** | **$11,134,680** | **$744,127** | **$831,596** |
| **Medical Community Care:** | | | | | | | |
| Discretionary Non-CARES Act Obligations | $365,283 | $55,471 | $378,561 | $407,505 | $395,642 | $28,944 | ($11,863) |
| Discretionary CARES Act Obligations | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$365,283** | **$55,471** | **$378,561** | **$407,505** | **$395,642** | **$28,944** | **-$11,863** |
| **Medical Support and Compliance:** | | | | | | | |
| Discretionary Non-CARES Act Obligations | $500,418 | $653,300 | $528,800 | $712,900 | $777,600 | $184,100 | $64,700 |
| Discretionary CARES Act Obligations | $745 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$501,163** | **$653,300** | **$528,800** | **$712,900** | **$777,600** | **$184,100** | **$64,700** |
| **Medical Facilities:** | | | | | | | |
| Discretionary Non-CARES Act Obligations | $152,475 | $348,300 | $152,600 | $195,700 | $191,900 | $43,100 | ($3,800) |
| Discretionary CARES Act Obligations | $406 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$152,881** | **$348,300** | **$152,600** | **$195,700** | **$191,900** | **$43,100** | **-$3,800** |
| **Medical Services and Veterans Medical Care and Health Fund:** | | | | | | | |
| Veterans Medical Care and Health Fund | $0 | $1,073,319 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 | $683 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$683** | **$1,073,319** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Medical Community Care, Veterans Choice Fund, and Veterans Medical Care and Health Fund:** | | | | | | | |
| Veterans Medical Care and Health Fund | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8004 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| American Rescue Plan Act, Section 8007 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Veterans Choice Fund | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Medical Support and Compliance and Veterans Medical Care and Health Fund:** | | | | | | | |
| Veterans Medical Care and Health Fund | $0 | $54,796 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 | $170 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$170** | **$54,796** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Medical Facilities and Veterans Medical Care and Health Fund:** | | | | | | | |
| Veterans Medical Care and Health Fund | $0 | $228,381 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 | $553 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$553** | **$228,381** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Discretionary and Mandatory Obligations by Category:** | | | | | | | |
| Medical Services | $8,685,793 | $10,423,296 | $9,558,957 | **$10,303,084** | **$11,134,680** | $744,127 | $831,596 |
| Medical Community Care and Veterans Choice Fund | $365,283 | $55,471 | $378,561 | **$407,505** | **$395,642** | $28,944 | -$11,863 |
| Medical Support and Compliance | $501,333 | $708,096 | $528,800 | **$712,900** | **$777,600** | $184,100 | $64,700 |
| Medical Facilities | $153,434 | $576,681 | $152,600 | **$195,700** | **$191,900** | $43,100 | -$3,800 |
| **Obligations [Grand Total]** | **$9,705,843** | **$11,763,544** | **$10,618,918** | **$11,619,189** | **$12,499,822** | **$1,000,271** | **$880,633** |

[1/] This table displays all obligations in the Pharmacy program, not just Medical Services obligations, as total funding for this program is not displayed in any other chapter.

**Pharmacy Program Data**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Number of 30-Day RXs (Millions) | 303 | 309 | 309 | 313 | 314 | 4 | 1 |

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

**Key Pharmacy Benefits Management Service (PBM) Functions:**

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

**Consolidated Mail Outpatient Pharmacies (CMOP)-** VA automated and consolidated its prescription fulfillment processes for Veteran outpatients. Prescriptions are filled and mailed to the Veteran's home. CMOPs significantly improve customer service, reduce the potential for errors and improve efficiency by filling large volumes of prescriptions faster with continually improving technologies that require less staff than would be needed at individual VA medical centers. VA currently operates seven facilities across the nation and fills approximately 80% of all outpatient prescriptions via the CMOP system.

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

**VA Mobile Pharmacies-** VA mobile pharmacies provide acute and chronic medications to Veterans and potentially other Americans affected by a natural disaster. VA's four mobile pharmacies are capable of connecting via satellite to a CMOP, which can then dispense prescriptions for delivery to a central location within the disaster zone.

**Pharmacy Clinical Informatics and Re-engineering-** VA Pharmacy Informatics and Re-engineering program provides business owner oversight of pharmacy development activities to improve and transform health care through information technology. The primary initiative is to replace the Pharmacy VistA system component of VA's Electronic Health Record. VA's Pharmacy Product System/National Drug File Project (PPS/NDF) is the largest open-source drug file in the United States. The Drug File contains over 128,000 medications and product terms, and the system contains medication information that is provided to patients.

**Clinical Pharmacy Program Office-** The primary focus of this program office is to maximize the utilization of Clinical Pharmacists as advanced practice providers with a scope of practice, thus improving care by performing essential medication management services, enhancing medication safety and significantly improving chronic disease management in our Veteran population. Since the inception of this program office, there has been a 90% increase in Clinical Pharmacists practicing as advanced practice providers. Additionally, the program office has developed robust

and comprehensive data collection tools, including metrics that illustrate both the performance and quality of clinical pharmacy practice in VHA.

**Pharmacy Residency Program Office-** The Pharmacy Residency Program Office's (PRPO) mission is to train post-doctoral pharmacists for the VA and the profession, and, over the past 20 years, the program office has trained over 12,500 pharmacists in post-graduate years (PGY) 1 and 2 and fellowships. VA is the largest post-doctoral training program in the nation, with over 350 programs nationally, and has become the residencies-of-choice for the profession. The PRPO has won national recognition for its training programs through the American Society of Health-System Pharmacists (ASHP) Board of Excellence Award which recognizes strong influential programs nationwide.

**Academic Detailing-** The mission of the PBM National Academic Detailing Service (ADS) is to innovate strategies to promote evidence-based practices, build relationships with healthcare teams and resolve barriers to improve Veterans' care through academic detailing. The ADS provides central resources for VA clinical pharmacist specialists to deliver knowledge translation services and eliminate the gap between clinical practice and evidence-based care. The ADS core services include the development of educational resources, hands-on training and clinical informatics tools. The ADS' groundwork on VVC (VA Video Connect) prepared detailers to pivot from in-person, face-to-face visits to even more video virtual care during the onset of the COVID-19 pandemic. Each VISN was involved in e-detailing during 2020, and in the second half of the year, detailers more than doubled the number of video visits compared to the entirety of 2019.

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

**Meds by Mail Program-** The PBM Meds by Mail (MbM) Program provides comprehensive outpatient mail pharmacy services and call center support to qualifying beneficiaries of VHA's Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), including the CHAMPVA In-house Treatment Initiative (CITI) and Spina Bifida / Children of Women Vietnam Veterans (CWVV) programs. All prescriptions processed by MbM are filled by VA's CMOP and mailed directly to the beneficiary at no cost.

**Virtual Pharmacy Service Program-** The PBM Virtual Pharmacy Service (VPS) Program provides outpatient pharmacy support to VAMC pharmacies to process unverified prescriptions waiting for pharmacist review. Participating VAMC pharmacies (19) have an average outpatient prescription processing time of fewer than two days. The VPS program is staffed by pharmacists located at the MbM serving centers in Dublin, Georgia and Cheyenne, Wyoming.

**Pharmacy Compliance**- This program develops policy, guidance and central educational resources to support compliance with external entities' standards and federal regulations at VA medical facility pharmacies. This program collaborates with external entities such as the Drug Enforcement Agency (DEA), FDA, United States Pharmacopoeia (USP) and The Joint Commission to ensure policy and guidance are consistent with pharmacy practice regulations and

standards. Initiatives include providing Veterans free medication take back services through mail-back envelopes and on-site receptacles compliant with DEA regulations, developing pharmacy efficiency initiatives to promote an evidence-based and cost effective uniform pharmacy benefit to meet the medical needs of our nation's Veterans, developing educational resources consistent with USP standards for patient specific sterile compounding programs and guidance for handling hazardous drugs at VA medical facilities.

Population Covered - Overall, reliance on prescription drugs for the enrolled Veteran population was 58% in 2019. The enrollee population age 65 and over, for which the VHA collects detailed data, has prescription drug reliance by cohort is as follows:

| Cohort | 2019 Reliance |
|---|---|
| Enrollees with Medicare Part D | 31% |
| Enrollees with Medicare Retiree Drug Subsidy (RDS) Coverage | 27% |
| Enrollees without Medicare Part D or RDS Coverage | 60% |

Prescription drug reliance was projected to increase by approximately 0.56% in 2020 due to the 14-day Rx Urgent/Emergent adjustment. This amount then trends mildly each year, reaching 0.64% in 2023.

Recent Trends - Drug ingredient cost per outpatient prescription, the total cost of outpatient prescription drug ingredients and the total number of outpatient prescriptions filled all trended upward from 2019 to 2020 by 3.0%, 4.5% and 1.5%, respectively. Over this period, the number of Veterans receiving outpatient prescriptions trended down slightly by -1.6%.

Projected outpatient prescription workload through 2023 is largely driven by utilization trend, demographic changes and the MISSION Act.

Projected Trends - The impact of the underlying prescription drug utilization trend assumptions from 2020 to 2023 is approximately 3%.

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. The total workload impact from 2020 to 2023 due to demographic changes is approximately 7%.

MISSION Act - Prescription drug workload is projected to increase by approximately 3% from 2020 to 2023 as a result of the MISSION Act. As enrollees gain greater access to community care, the prescription drugs associated with that care are projected to be mostly filled by VHA.

# Prosthetics

**Prosthetics 1/**
**(dollars in thousands)**

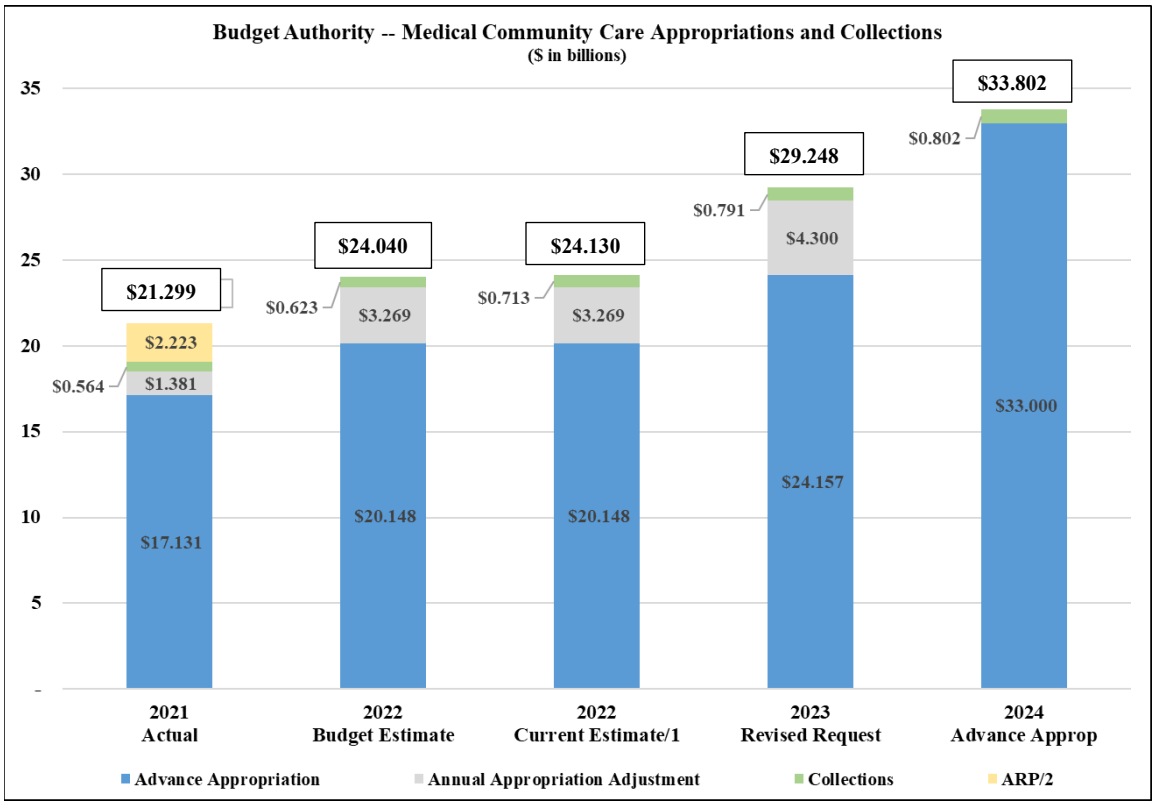
| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations | $3,474,096 | $4,934,098 | $3,756,341 | $4,069,980 | $4,410,880 | $313,639 | $340,900 |
| Mandatory Obligations (including VMCHF) | $0 | $313 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Grand Total]** | **$3,474,096** | **$4,934,411** | **$3,756,341** | **$4,069,980** | **$4,410,880** | **$313,639** | **$340,900** |

1/ With the exception of the 2022 Budget Estimate column, this table displays obligations for the Medical Services account, only. See the Medical Care chapter for detail on all accounts that support the Prosthetics program.

Nearly all prosthetics obligations will be in the Medical Services appropriation with the remaining obligations in the Veterans Choice Program. The Medical Community Care appropriation will not fund Prosthetic obligations. Prosthetic and Sensory Aids Services (PSAS) are foundational at the VA. Services provided include prosthetic and orthotic devices, sensory aids, medical equipment and support services for Veterans. PSAS serves Veterans with needs related to: amputation, spinal cord injury/disorders, polytrauma and traumatic brain injury, hearing and vision, podiatric care, cardio-pulmonary disease, speech and swallowing deficits, geriatric impairments, neurologic dysfunction, muscular dysfunction, women's health, orthopedic care, diabetes/metabolic disease, peripheral vascular disease, cerebral vascular diseases and other medical disorders. For more information, please see the Medical Care chapter.

# *Medical Community Care*

## Chart: Medical Community Care Appropriations and Collections



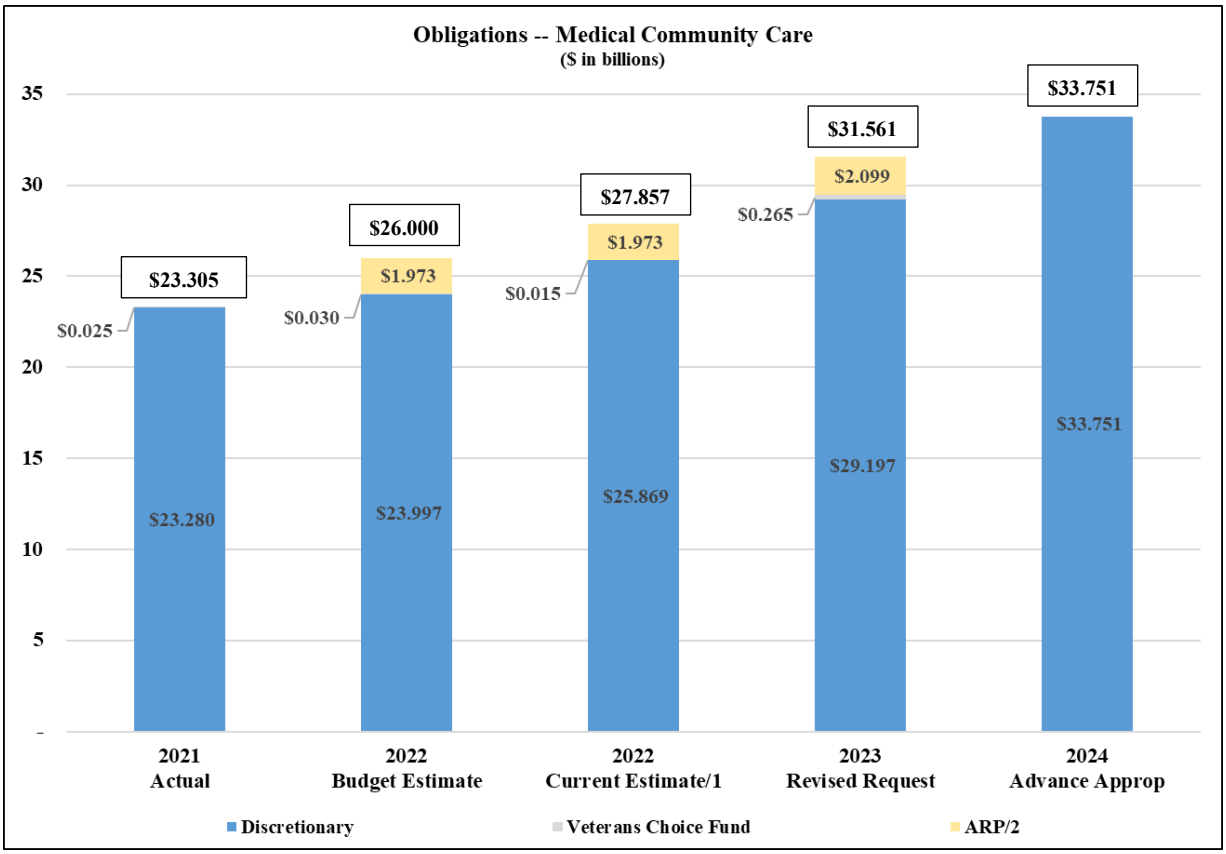

[1/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

[2/] The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the chart displays the estimated allocation for the Medical Community Care category. Final funding allocations among account-level categories may change in response to workload demand requirements throughout 2022 and 2023.

Providing Veterans with timely access to high quality health care is absolutely essential through a Department of Veterans Affairs (VA) facility or community provider. It is clear that community care will continue to be a key part of how the Department cares for its Veterans. VA will continue to use a combination of care at VA facilities and in the community to meet the needs of Veterans. With the Veteran at the center of their own care, VA will work to achieve the right balance between care provided in the community and care provided through VA to ensure Veterans have timely access to the highest quality health care services.

VA is requesting an additional $4.3 billion to supplement the enacted 2023 advance appropriation (AA) and funds made available by the American Rescue Plan Act and other resources, to fund a revised estimate of community care costs based on 2021 actuals and updated actuarial projections.

**Chart: Medical Community Care Obligations**




[1/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

[2/] Included in this total is the Veterans Medical Care and Health Fund which was established to execute section 8002 of the American Rescue Plan Act, and the chart includes the estimated allocation for the Medical Community Care category. Final funding allocations among account-level categories may change in response to workload demand requirements throughout 2022 and 2023.

**Tables: Community Care Funding Crosswalks 2021-2024**
(dollars in thousands)

The following four tables show funding crosswalks for 2021 through 2024 for the VA community care program, separately by funding sources as follows:

- Medical Community Care (MCC), discretionary funding, including emergency discretionary funding provided by the Coronavirus Aid, Relief and Economic Security Act (CARES) Act and the Families First Coronavirus Response Act
- Veterans Choice Fund (VCF), mandatory funding for Medical Care only
- American Rescue Plan Act, mandatory funding
- MCC, VCF and American Rescue Plan Act, grand total all funding sources

## Table: Medical Community Care (0140) Discretionary Funding Crosswalk 2021-2024

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Appropriation Medical Community Care (0140)** | | | | | | | |
| Advance Appropriation Medical Community Care (0140) | $17,131,179 | $20,148,244 | $20,148,244 | $24,156,659 | 33,000,000 | $4,008,415 | $8,843,341 |
| Annual Appropriation Adjustment Medical Community Care (0140) | $1,380,800 | $3,269,000 | $3,269,000 | $4,300,000 | $0 | $1,031,000 | ($4,300,000) |
| Families First Coronavirus Response Act (P.L. 116-127) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| CARES Act (P.L. 116-136) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Appropriations Request Subtotal | $18,511,979 | $23,417,244 | $23,417,244 | $28,456,659 | $33,000,000 | $5,039,415 | $4,543,341 |
| Tranfers To: | | | | | | | |
| North Chicago Demo. Fund (0169) from Medical Community Care (0140) | ($28,392) | ($43,768) | ($43,768) | ($50,768) | ($51,291) | ($7,000) | ($523) |
| Transfers To [Subtotal] | ($28,392) | ($43,768) | ($43,768) | ($50,768) | ($51,291) | ($7,000) | ($523) |
| Transfers From: | | | | | | | |
| CARES Unob. Bal.fr.to MCC (0160) (PL 116-260 §517) | $100,000 | $0 | $0 | $0 | $0 | $0 | $0 |
| Veterans Choice Fund (0172) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Transfers From [Subtotal] | $100,000 | $0 | $0 | $0 | $0 | $0 | $0 |
| Collections: | | | | | | | |
| MCCF Transfer to Medical Community Care (0140) | $564,329 | $623,228 | $712,750 | $791,075 | $802,047 | $78,325 | $10,972 |
| Collections [Subtotal] | $564,329 | $623,228 | $712,750 | $791,075 | $802,047 | $78,325 | $10,972 |
| Budget Authority Total | **$19,147,916** | **$23,996,704** | **$24,086,226** | **$29,196,966** | **$33,750,756** | **$5,110,740** | **$4,553,790** |
| Unobligated Balance (SOY): | | | | | | | |
| No-Year Medical Community Care (0140) | $9,075 | $0 | $439,288 | $0 | $0 | ($439,288) | $0 |
| Pre P.L. 116-260 Title XVI section 1601 | ($5,007,990) | $0 | $0 | $0 | $0 | $0 | $0 |
| Post P.L. 116-260 Title XVI section 1601 | $5,007,990 | $0 | $0 | $0 | $0 | $0 | $0 |
| 2-Year | $173,389 | $0 | $1,332,887 | $0 | $0 | ($1,332,887) | $0 |
| 2-Year (P.L. 116-136) | $131,132 | $0 | $0 | $0 | $0 | $0 | $0 |
| 3-Year (P.L. 116-127) | $30,000 | $0 | $0 | $0 | $0 | $0 | $0 |
| 4-Year Base Year 2018 | $7,699 | $0 | $0 | $0 | $0 | $0 | $0 |
| 4-Year Base Year 2019 | $73,988 | $0 | $10,532 | $0 | $0 | ($10,532) | $0 |
| 5-Year Base Year 2018 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (SOY) [Subtotal] | $425,283 | $0 | $1,782,707 | $0 | $0 | ($1,782,707) | $0 |
| **Transfer of UNOBLIGATED BALANCE** | | | | | | | |
| CARES Unob. Bal. from MS (0160C2) to MCC (0140C2) (PL 116-136 §20001) | $5,400,000 | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (EOY): | | | | | | | |
| No-Year Medical Community Care (0140) | ($439,288) | $0 | $0 | $0 | $0 | $0 | $0 |
| 2-Year | ($1,332,887) | $0 | $0 | $0 | $0 | $0 | $0 |
| 2-Year (P.L. 116-136) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 3-Year (P.L. 116-127) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 4-Year Base Year 2018 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 4-Year Base Year 2019 | ($10,532) | | | | | | |
| 5-Year Base Year 2018 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (EOY) [Subtotal] | ($1,782,707) | $0 | $0 | $0 | $0 | $0 | $0 |
| **LAPSE** | ($2) | | | | | | |
| Subtotal | $23,190,492 | $23,996,704 | $25,868,933 | $29,196,966 | $33,750,756 | $3,328,033 | ($62,947,722) |
| Prior Year Recoveries | $89,736 | $0 | $0 | $0 | $0 | $0 | $0 |
| Obligations (0140) [Total] | **$23,280,228** | **$23,996,704** | **$25,868,933** | **$29,196,966** | **$33,750,756** | **$3,328,033** | **$4,553,790** |

[1/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

[2/] Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to healthcare providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Antideficiency Act (ADA) violation that would have occurred in 2020 absent its enactment. To implement the law, VA made an accounting adjustment in 2021, the year Public Law 116-260 was enacted.

## Table: Veterans Choice Fund (0172) Medical Care Only Crosswalk 2021-2024

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate 1/ | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Appropriation Veterans Choice Fund (0172)** | | | | | | | |
| Appropriation | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Appropriation [Subtotal]** | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Budget Authority Total | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (SOY): | | | | | | | |
| Pre P.L. 116-260 Title XVI section 1601 | ($397,400) | $0 | $0 | $0 | $0 | $0 | $0 |
| Post P.L. 116-260 Title XVI section 1601 | $397,400 | $0 | $0 | $0 | $0 | $0 | $0 |
| No-Year | $149,690 | $30,000 | $280,382 | $265,088 | $0 | ($15,294) | ($265,088) |
| Unobligated Balance (SOY) [Subtotal] | $149,690 | $30,000 | $280,382 | $265,088 | $0 | ($15,294) | ($265,088) |
| Transfer of Unobligated Balance To Medical Community Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Transfer of Unobligated Balances within Veterans Choice Fund | $0 | $0 | $171 | $0 | $0 | ($171) | $0 |
| Unobligated Balance (EOY): | | | | | | | |
| No-Year | ($280,382) | $0 | ($265,088) | $0 | $0 | $265,088 | $0 |
| Unobligated Balance (EOY) [Subtotal] | ($280,382) | $0 | ($265,088) | $0 | $0 | $265,088 | $0 |
| Subtotal | ($130,692) | $30,000 | $15,465 | $265,088 | $0 | $249,623 | ($265,088) |
| Prior Year Recoveries | $155,872 | $0 | $0 | $0 | $0 | $0 | $0 |
| Obligations (0172) [Total] | **$25,180** | **$30,000** | **$15,465** | **$265,088** | **$0** | **$249,623** | **($265,088)** |

1/ Excludes OI&T Obligations

2/ The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

3/ Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to healthcare providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Antideficiency Act (ADA) violation that would have occurred in 2020 absent its enactment. To implement the law, VA made an accounting adjustment in 2021, the year Public Law 116-260 was enacted.

## Table: Medical Community Care American Rescue Plan Act Crosswalk 2021-2024

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate 1/ | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Mandatory Appropriations** | | | | | | | |
| Veterans Medical Care and Health Fund | | | | | | | |
| Community Care (Section 8002)/1 | $1,901,196 | $0 | $0 | $0 | $0 | $0 | $0 |
| Section 8004 - Medical Community Care | $250,000 | $0 | $0 | $0 | $0 | $0 | $0 |
| Section 8007 - Medical Community Care | $72,100 | $0 | $0 | $0 | $0 | $0 | $0 |
| Funds Available [Subtotal] | $2,223,296 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total Budget Authority** | **$2,223,296** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **UNOBLIGATED BALANCE (SOY)** | | | | | | | |
| ARP Act § 8002 | $0 | $1,901,196 | $1,901,196 | $2,098,805 | $0 | $197,609 | ($2,098,805) |
| ARP Act § 8004 - 2 year | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ARP Act § 8004 - no year | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ARP Act § 8007 | $0 | $72,100 | $72,100 | $0 | $0 | ($72,100) | $0 |
| ARP Act § 8008 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Unobligated Balance (SOY) [Subtotal]** | **$0** | **$1,973,296** | **$1,973,296** | **$2,098,805** | **$0** | **$125,509** | **($2,098,805)** |
| **REAPPORTIONMENT of § 8002** | | | | | | | |
| ARP Act § 8002 | $0 | $0 | $2,098,805 | $0 | $0 | ($2,098,805) | $0 |
| ARP Act § 8007 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **UNOBLIGATED BALANCE (EOY)** | | | | | | | |
| ARP Act § 8002 - 3 year | ($1,901,196) | $0 | ($2,098,805) | $0 | $0 | $2,098,805 | $0 |
| ARP Act § 8004 - 2 year | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ARP Act § 8004 - no year | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ARP Act § 8007 - no year | ($72,100) | $0 | $0 | $0 | $0 | $0 | $0 |
| ARP Act § 8008 - 2 year | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Unobligated Balance (EOY) [Subtotal]** | **($1,973,296)** | **$0** | **($2,098,805)** | **$0** | **$0** | **$2,098,805** | **$0** |
| **LAPSE** | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **OBLIGATIONS** | **$250,000** | **$1,973,296** | **$1,973,296** | **$2,098,805** | **$0** | **$2,224,314** | **($2,098,805)** |

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

[2/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

[3/] Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to healthcare providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Antideficiency Act (ADA) violation that would have occurred in 2020 absent its enactment. To implement the law, VA made an accounting adjustment in 2021, the year Public Law 116-260 was enacted.

## Table: Medical Community Care, Veterans Choice Fund (Medical Care Only) and American Rescue Plan Act Crosswalk 2021-2024

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary Obligations** | | | | | | | |
| Medical Community Care (0140) - Non COVID Supplemental... | $17,529,360 | $23,996,704 | $25,868,933 | $29,196,966 | $33,750,756 | $3,328,033 | $4,553,790 |
| Families First Act | $30,000 | $0 | $0 | $0 | $0 | $0 | $0 |
| CARES Act | $5,631,132 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discretionary Obligations [SubTotal] | $23,190,492 | $23,996,704 | $25,868,933 | $29,196,966 | $33,750,756 | $3,328,033 | $4,553,790 |
| Prior-Year Recoveries | $89,736 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Total]** | **$23,280,228** | **$23,996,704** | **$25,868,933** | **$29,196,966** | **$33,750,756** | **$3,328,033** | **$4,553,790** |
| **Mandatory Obligations** | | | | | | | |
| **Veterans Choice Act (P.L. 113-146)** | | | | | | | |
| **Veterans Choice Fund, Medical Care** | | | | | | | |
| Administration (0172XA) | ($3,517) | $2,900 | $0 | $0 | $0 | $0 | $0 |
| Medical Care (0172XB) | ($127,032) | $27,000 | $0 | $0 | $0 | $0 | $0 |
| Emergency Hepatitis C (0172XC) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Emergency Community Care (0172XE) | ($144) | $100 | $0 | $0 | $0 | $0 | $0 |
| Medical Community Care (0172XG) | $0 | $0 | $15,465 | $265,088 | $0 | $249,623 | ($265,088) |
| Veterans Choice Fund Prior-Year Recoveries | $155,872 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Veterans Choice Fund [Subtotal]** | **$25,179** | **$30,000** | **$15,465** | **$265,088** | **$0** | **$249,623** | **($265,088)** |
| **American Rescue Plan (ARP) Act** | | | | | | | |
| Veterans Medical Care and Health Fund | | | | | | | |
| Community Care (Section 8002) 1/ | $0 | $1,901,196 | $1,901,196 | $2,098,805 | $0 | $197,609 | ($2,098,805) |
| Section 8004 - Medical Community Care | $250,000 | $0 | $0 | $0 | $0 | $0 | $0 |
| Section 8007 - Medical Community Care | $0 | $72,100 | $72,100 | $0 | $0 | ($72,100) | $0 |
| **American Rescue Plan [Subtotal]** | **$250,000** | **$1,973,296** | **$1,973,296** | **$2,098,805** | **$0** | **$125,509** | **($2,098,805)** |
| **Mandatory Obligations [Total]** | **$275,179** | **$2,003,296** | **$1,988,761** | **$2,363,893** | **$0** | **$375,132** | **($2,363,893)** |
| **Obligations [Grand Total]** | **$23,555,408** | **$26,000,000** | **$27,857,694** | **$31,560,859** | **$33,750,756** | **$3,703,165** | **$2,189,897** |

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the chart displays the estimated allocation for the Medical Community Care category. Final funding allocations among account-level categories may change in response to workload demand requirements throughout 2022 and 2023.

2/ The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

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## Summary of 2023 Revised Request

The 2023 President's Budget request of an additional $4.3 billion helps support an overall projected budget requirement of $31.6 billion in 2023 for the community care category. This adjustment reflects the following increases to help purchase the following types of care from community providers:

- $1.7 billion for ambulatory care claims;
- $160.8 million for dental care claims;
- $1.5 billion for inpatient care claims;
- $111.5 million for mental health care claims;
- $58.6 million for pharmacy;
- $745.8 million for long-term services and supports (LTSS)

### Table: Update to the 2023 Advance Appropriation Request

(dollars in thousands)

| | | Available Discretionary Funding | | | Available Mand. Funding | | | |
|---|---|---|---|---|---|---|---|---|
| Description | 2023 Revised Request | Enacted AA Incl. Transfer | Collections | Use of Unobl. Balances Discretionary | Use of Unobl. Veterans Choice Fund | Use of Unobl. Balances ARP - 8002 1/ | Subtotal | Annual Approp. Adjust Required |
| **Health Care Services:** | | | | | | | | |
| Ambulatory Care | $12,151,511 | $8,777,391 | $321,230 | $0 | $265,088 | $1,041,709 | $10,405,418 | **$1,746,093** |
| Dental Care | $1,118,905 | $928,547 | $29,579 | $0 | $0 | $0 | $958,126 | **$160,779** |
| Inpatient Care | $10,280,801 | $7,474,645 | $271,777 | $0 | $0 | $1,057,096 | $8,803,518 | **$1,477,283** |
| Mental Health Care | $775,972 | $643,957 | $20,513 | $0 | $0 | $0 | $664,470 | **$111,502** |
| Prosthetics | $0 | $0 | $0 | $0 | $0 | $0 | $0 | **$0** |
| Pharmacy | $407,505 | $338,176 | $10,773 | $0 | $0 | $0 | $348,949 | **$58,556** |
| Rehabilitation Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 | **$0** |
| **Health Care Services [Subtotal]** | *$24,734,694* | $18,162,716 | $653,872 | *$0* | *$265,088* | *$2,098,805* | *$21,180,481* | **$3,554,213** |
| **Long-Term Services and Supports:** | | | | | | | | |
| Institutional Care | $2,933,652 | $2,434,554 | $77,552 | $0 | $0 | $0 | $2,512,106 | **$421,546** |
| Non-Institutional Care | $2,256,481 | $1,872,589 | $59,651 | $0 | $0 | $0 | $1,932,240 | **$324,241** |
| **VA Long-Term Services and Supports [Total]** | $5,190,133 | $4,307,143 | $137,203 | $0 | $0 | $0 | $4,444,346 | **$745,787** |
| **Other Health Care Programs:** | | | | | | | | |
| CHAMPVA, Spina Bifida, FMP, & CWVV | $1,632,224 | $1,632,224 | $0 | $0 | $0 | $0 | $1,632,224 | **$0** |
| Caregivers | $0 | $0 | $0 | $0 | $0 | $0 | $0 | **$0** |
| Camp Lejeune Family | $3,808 | $3,808 | $0 | $0 | $0 | $0 | $3,808 | **$0** |
| Other Health Care Programs [Total] | $1,636,032 | $1,636,032 | $0 | $0 | $0 | $0 | $1,636,032 | **$0** |
| **Obligations [Total]** | $31,560,859 | $24,105,891 | $791,075 | $0 | $265,088 | $2,098,805 | $27,260,859 | **$4,300,000** |

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

### Tables: Community Care Obligations by Program

The following six tables show community care obligations by program, separately by funding sources as follows:

- Medical Community Care (MCC)
- Families First and CARES Act
- American Rescue Plan Act
- MCC, CARES Act and ARP Act
- Veterans Choice Fund (VCF)
- MCC, Families First and CARES Act, American Rescue Plan Act and VCF

**Medical Community Care Obligations by Program**
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Health Care Services MISSION Act Affected:** | | | | | | | |
| Ambulatory Care | $5,945,184 | $7,855,774 | $9,646,728 | $10,844,714 | $13,250,901 | $1,197,986 | $2,406,187 |
| Dental Care | $552,140 | $378,057 | $871,525 | $1,118,905 | $1,186,326 | $247,380 | $67,421 |
| Inpatient Care | $4,556,699 | $8,070,496 | $8,019,194 | $9,223,705 | $11,013,950 | $1,204,511 | $1,790,245 |
| Mental Health Care | $445,088 | $579,327 | $709,156 | $775,972 | $827,605 | $66,816 | $51,633 |
| Prosthetics | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Pharmacy | $365,283 | $55,471 | $378,561 | $407,505 | $395,642 | $28,944 | ($11,863) |
| Rehabilitation Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Health Care Services [Subtotal]** | $11,864,393 | $16,939,125 | $19,625,164 | $22,370,801 | $26,674,424 | $2,745,637 | $4,303,623 |
| **Long-Term Services and Supports Community Care:** | | | | | | | |
| Community Nursing Home | $1,133,113 | $1,670,206 | $1,305,367 | $1,443,170 | $1,552,581 | $137,803 | $109,411 |
| Community Non-Institutional Care | $1,728,933 | $1,901,292 | $2,022,427 | $2,206,100 | $2,337,633 | $183,673 | $131,533 |
| State Nursing Home | $1,156,216 | $1,705,051 | $1,403,639 | $1,490,482 | $1,496,039 | $86,843 | $5,557 |
| State Home Domiciliary | $41,237 | $56,357 | $51,632 | $49,095 | $48,729 | ($2,537) | ($366) |
| State Home Adult Day Care | $397 | $4,734 | $1,034 | $1,286 | $1,086 | $252 | ($200) |
| **Community Long-Term Services and Supports [Total]** | $4,059,896 | $5,337,640 | $4,784,099 | $5,190,133 | $5,436,068 | $406,034 | $245,935 |
| **Other Health Care Programs Community Care:** | | | | | | | |
| CHAMPVA, Spina Bifida, FMP, & CWVV | $1,602,073 | $1,717,159 | $1,456,351 | $1,632,224 | $1,636,307 | $175,873 | $4,083 |
| Caregivers | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Camp Lejeune Family | $2,996 | $2,780 | $3,319 | $3,808 | $3,957 | $489 | $149 |
| Other Health Care Programs community care [Total] | $1,605,069 | $1,719,939 | $1,459,670 | $1,636,032 | $1,640,264 | $176,362 | $4,232 |
| **Obligations [Subtotal]** | **$17,529,358** | **$23,996,704** | **$25,868,933** | **$29,196,966** | **$33,750,756** | **$3,328,033** | **$4,553,790** |
| **VA Prior-Year Recoveries** | $89,736 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Total]** | **$17,619,094** | **$23,996,704** | **$25,868,933** | **$29,196,966** | **$33,750,756** | **$3,328,033** | **$4,553,790** |

**Families First and CARES Act Obligations by Program**
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Health Care Services MISSION Act Affected:** | | | | | | | |
| Ambulatory Care | $2,519,306 | $0 | $0 | $0 | $0 | $0 | $0 |
| Dental Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Inpatient Care | $2,851,317 | $0 | $0 | $0 | $0 | $0 | $0 |
| Mental Health Care | $181,979 | $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]** | $5,552,601 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Long-Term Services and Supports Community Care:** | | | | | | | |
| Community Nursing Home | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Community Non-Institutional Care | $9,672 | $0 | $0 | $0 | $0 | $0 | $0 |
| State Nursing Home | $98,078 | $0 | $0 | $0 | $0 | $0 | $0 |
| State Home Domiciliary | $779 | $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]** | $108,529 | $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]** | **$5,661,130** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **VA Prior-Year Recoveries** | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Total]** | **$5,661,130** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |

**ARP Act Obligations by Program 1/**
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Health Care Services MISSION Act Affected:** | | | | | | | |
| Ambulatory Care | $0 | $1,550,266 | $979,415 | $1,041,709 | $0 | $62,294 | ($1,041,709) |
| Dental Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Inpatient Care | $0 | $400,453 | $993,881 | $1,057,096 | $0 | $63,215 | ($1,057,096) |
| Mental Health Care | $0 | $20,170 | $0 | $0 | $0 | $0 | $0 |
| Prosthetics | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Pharmacy | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Rehabilitation Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Health Care Services [Subtotal]** | $0 | $1,970,889 | $1,973,296 | $2,098,805 | $0 | $125,509 | ($2,098,805) |
| **Long-Term Services and Supports Community Care:** | | | | | | | |
| Community Nursing Home | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Community Non-Institutional Care | $0 | $2,407 | $0 | $0 | $0 | $0 | $0 |
| State Nursing Home | $247,920 | $0 | $0 | $0 | $0 | $0 | $0 |
| State Home Domiciliary | $2,080 | $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]** | $250,000 | $2,407 | $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]** | **$250,000** | **$1,973,296** | **$1,973,296** | **$2,098,805** | **$0** | **$125,509** | **($2,098,805)** |
| **VA Prior-Year Recoveries** | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Total]** | **$250,000** | **$1,973,296** | **$1,973,296** | **$2,098,805** | **$0** | **$125,509** | **($2,098,805)** |

**Medical Community Care, CARES Act and ARP Act Obligations by Program**
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Health Care Services MISSION Act Affected:** | | | | | | | |
| Ambulatory Care | $8,464,492 | $9,406,040 | $10,626,143 | $11,886,423 | $13,250,901 | $2,480,383 | $1,364,478 |
| Dental Care | $552,140 | $378,057 | $871,525 | $1,118,905 | $1,186,326 | $740,848 | $67,421 |
| Inpatient Care | $7,408,016 | $8,470,949 | $9,013,075 | $10,280,801 | $11,013,950 | $1,809,852 | $733,149 |
| Mental Health Care | $627,066 | $599,497 | $709,156 | $775,972 | $827,605 | $176,475 | $51,633 |
| Prosthetics | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Pharmacy | $365,283 | $55,471 | $378,561 | $407,505 | $395,642 | $352,034 | ($11,863) |
| Rehabilitation Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Health Care Services [Subtotal]** | $17,416,997 | $18,910,014 | $21,598,460 | $24,469,606 | $26,674,424 | $5,559,592 | $5,075,964 |
| **Long-Term Services and Supports Community Care:** | | | | | | | |
| Community Nursing Home | $1,133,113 | $1,670,206 | $1,305,367 | $1,443,170 | $1,552,581 | ($227,036) | $109,411 |
| Community Non-Institutional Care | $1,738,604 | $1,903,699 | $2,022,427 | $2,206,100 | $2,337,633 | $302,401 | $131,533 |
| State Nursing Home | $1,502,214 | $1,705,051 | $1,403,639 | $1,490,482 | $1,496,039 | ($214,569) | $5,557 |
| State Home Domiciliary | $44,096 | $56,357 | $51,632 | $49,095 | $48,729 | ($7,262) | ($366) |
| State Home Adult Day Care | $397 | $4,734 | $1,034 | $1,286 | $1,086 | ($3,448) | ($200) |
| **Community Long-Term Services and Supports [Total]** | $4,418,425 | $5,340,047 | $4,784,099 | $5,190,133 | $5,436,068 | ($149,914) | $245,935 |
| **Other Health Care Programs Community Care:** | | | | | | | |
| CHAMPVA, Spina Bifida, FMP, & CWVV | $1,602,073 | $1,717,159 | $1,456,351 | $1,632,224 | $1,636,307 | ($84,935) | $4,083 |
| Caregivers | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Camp Lejeune Family | $2,996 | $2,780 | $3,319 | $3,808 | $3,957 | $1,028 | $149 |
| Other Health Care Programs community care [Total] | $1,605,069 | $1,719,939 | $1,459,670 | $1,636,032 | $1,640,264 | ($83,907) | ($1,636,032) |
| **Obligations [Subtotal]** | **$23,440,490** | **$25,970,000** | **$27,842,229** | **$31,295,771** | **$33,750,756** | **$5,325,771** | **$2,454,985** |
| **VA Prior-Year Recoveries** | $89,736 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [SubTotal]** | $23,530,226 | $25,970,000 | $27,842,229 | $31,295,771 | $33,750,756 | $3,453,542 | $2,454,985 |
| **Obligations [Total]** | **$23,530,226** | **$25,970,000** | **$27,842,229** | **$31,295,771** | **$33,750,756** | **$3,453,542** | **$2,454,985** |

**Veterans Choice Fund Obligations by Program**
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Health Care Services MISSION Act Affected:** | | | | | | | |
| Ambulatory Care | ($139,446) | $24,300 | $15,465 | $265,088 | $0 | $249,623 | ($265,088) |
| Dental Care | $16 | $0 | $0 | $0 | $0 | $0 | $0 |
| Inpatient Care | $3,803 | $0 | $0 | $0 | $0 | $0 | $0 |
| Mental Health Care | $597 | $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]** | ($135,030) | $24,300 | $15,465 | $265,088 | $0 | $249,623 | ($265,088) |
| **Long-Term Services and Supports Community Care:** | | | | | | | |
| Community Nursing Home | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Community Non-Institutional Care | $4,338 | $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]** | $4,338 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Other Health Care Programs Community Care:** | | | | | | | |
| CHAMPVA, Spina Bifida, FMP, & CWVV | $0 | $5,700 | $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 | $5,700 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Subtotal]** | **($130,692)** | **$30,000** | **$15,465** | **$265,088** | **$0** | **$249,623** | **($265,088)** |
| **VA Prior-Year Recoveries** | $155,872 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total Obligations** | **$25,180** | **$30,000** | **$15,465** | **$265,088** | **$0** | **$249,623** | **($265,088)** |

**Medical Community Care, VCF, CARES Act and ARP Act Obligations by Program**
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Health Care Services MISSION Act Affected:** | | | | | | | |
| Ambulatory Care | $8,325,048 | $9,430,340 | $10,641,608 | $12,151,511 | $13,250,901 | $1,509,903 | $1,099,390 |
| Dental Care | $552,156 | $378,057 | $871,525 | $1,118,905 | $1,186,326 | $247,380 | $67,421 |
| Inpatient Care | $7,411,819 | $8,470,949 | $9,013,075 | $10,280,801 | $11,013,950 | $1,267,726 | $733,149 |
| Mental Health Care | $627,663 | $599,497 | $709,156 | $775,972 | $827,605 | $66,816 | $51,633 |
| Prosthetics | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Pharmacy | $365,283 | $55,471 | $378,561 | $407,505 | $395,642 | $28,944 | ($11,863) |
| Rehabilitation Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Health Care Services [Subtotal]** | $17,281,968 | $18,934,314 | $21,613,925 | $24,734,694 | $26,674,424 | $3,120,769 | $1,939,730 |
| **Long-Term Services and Supports Community Care:** | | | | | | | |
| Community Nursing Home | $1,133,113 | $1,670,206 | $1,305,367 | $1,443,170 | $1,552,581 | $137,803 | $109,411 |
| Community Non-Institutional Care | $1,742,943 | $1,903,699 | $2,022,427 | $2,206,100 | $2,337,633 | $183,673 | $131,533 |
| State Nursing Home | $1,502,214 | $1,705,051 | $1,403,639 | $1,490,482 | $1,496,039 | $86,843 | $5,557 |
| State Home Domiciliary | $44,096 | $56,357 | $51,632 | $49,095 | $48,729 | ($2,537) | ($366) |
| State Home Adult Day Care | $397 | $4,734 | $1,034 | $1,286 | $1,086 | $252 | ($200) |
| **Community Long-Term Services and Supports [Total]** | $4,422,763 | $5,340,047 | $4,784,099 | $5,190,133 | $5,436,068 | $406,034 | $245,935 |
| **Other Health Care Programs Community Care:** | | | | | | | |
| CHAMPVA, Spina Bifida, FMP, & CWVV | $1,602,073 | $1,722,859 | $1,456,351 | $1,632,224 | $1,636,307 | $175,873 | $4,083 |
| Caregivers | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Camp Lejeune Family | $2,996 | $2,780 | $3,319 | $3,808 | $3,957 | $489 | $149 |
| **Other Health Care Programs community care [Total]** | $1,605,069 | $1,725,639 | $1,459,670 | $1,636,032 | $1,640,264 | $176,362 | $4,232 |
| **Obligations [Subtotal]** | **$23,309,800** | **$26,000,000** | **$27,857,694** | **$31,560,859** | **$33,750,756** | **$3,703,165** | **$2,189,897** |
| **VA Prior-Year Recoveries** | $245,608 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Subtotal]** | $23,555,408 | $26,000,000 | $27,857,694 | $31,560,859 | $33,750,756 | $3,703,165 | $2,189,897 |
| **Obligations [Total]** | **$23,555,408** | **$26,000,000** | **$27,857,694** | **$31,560,859** | **$33,750,756** | **$3,703,165** | **$2,189,897** |

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

[2/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

In 2023, total obligations are projected to increase by $3.7 billion above the 2022 current estimate in the following areas:

- **Health Care Services (+$3.1 billion).** Estimates are projected to increase due to revised actuarial trends based on the most recent data, which accounts for the latest demographic trends and modes of care delivery. For 2023, these updates include the impact of COVID-19 on the VA health care system which has led to a significant decline in nationwide health care utilization since mid-March 2020 as individuals chose to defer certain care; some of that deferred care has returned as the effects of the pandemic began to diminish. 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 (+$406.0 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 (+$176.4 million).** VA-provided health service programs not projected by the Enrollee Health Care Projection Model (EHCPM) are expected to yield a net increase of $176 million, driven largely by CHAMPVA program costs.

## Summary of the 2024 Advance Appropriation Request

The Medical Community Care discretionary 2024 advance appropriations request is $33.8 billion, an increase of $4.5 billion from the 2023 revised discretionary request. The 2024 request ensures continuity of Veterans' health care services and sustain VA's increased capacity for care following the pandemic. In 2024, total obligations are projected to be $2.2 billion more than total obligations in 2023. VA projects that a significant amount of health care that was delayed during the pandemic will return to the VA community care network system by the end of 2024 and coupled with the pre-pandemic trends following the passage of the MISSION Act, will require additional total resources in 2024.

In 2024, total obligations are projected to increase by $2.2 billion from the 2023 revised request estimate in the following areas:

- **Health Care Services (+$1.9 billion).** Estimates are projected to increase following a return to the pre-pandemic trajectory.

- **Long-Term Services and Support (+$245.9 million).** Estimates are projected to increase due latest demographic trends and modes of care delivery.

- **Other Health Care Programs (+$4.2 million).** VA-provided health service programs not projected by the EHCPM are expected to yield a net increase of $4 million, driven largely by Civilian Health and Medical Program (CHAMPVA) program costs.

## Medical Community Care Description

VA provides health care for Veterans from providers in the local community. Veterans may be eligible to receive care from a community provider when VA cannot provide the care needed. This care is provided on behalf of and paid for by VA. Community care is available to Veterans based on certain conditions and eligibility requirements, and in consideration of a Veteran's specific needs and circumstances. In general, community care must be first authorized by VA before a Veteran can receive care from a community provider.

VA also provides health care to Veterans' family members and dependents through programs like the of the Department of Veterans Affairs CHAMPVA. This care is also provided based on specific eligibility requirements, which varies by program. Additional information regarding these health care programs can be found in the "Medical Community Care Programs" section below.

In addition to funding payments for health care services to non-VA providers, the MCC account funds clinical service delivery requirements for community care, such as care coordination including referrals, eligibility verification, enrollment and establishing care network requirements such as developing contracts that serve as vehicles for VA to purchase care for Veterans from community providers as well as development and maintenance of IT functions. MCC also funds short-term prescription medications for a 14-day or fewer supply that are filled at a non-VA pharmacy.

Some obligations related to VA's provision of community care are funded through the Medical Support and Compliance and Information Technology accounts. These accounts fund administrative expenses such as claims processing performed by the Third-Party Administrator (TPA) and the Veterans Health Administration (VHA) and software required to meet system requirements. The list below depicts some of the key IT systems that support the Office of Community Care and planned enhancements.

## Medical Community Care Programs

## Camp Lejeune Family Member Program (CLFMP)

### Authority for Action

The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154)

### Population Covered

The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154) extended eligibility for VA hospital care and medical services to certain Veterans who were stationed at Camp Lejeune, North Carolina, for at least 30 days between 1957 and 1987. Family members of such Veterans who resided, or were in utero, at Camp Lejeune for at least 30 days during that period are eligible for reimbursement of hospital care and medical services for 15 specified illnesses and conditions, and VA is the payer of last resort. Hospital care and medical services may only be furnished to family members to the extent and in the amount provided in advance in appropriations Acts for such purpose. In addition, VA may only provide reimbursement for such hospital care and medical services provided to a family member after all other claims and remedies against third parties for such care and services have been exhausted. The Consolidated and Further Continuing Appropriations Act of 2015 (P.L. 113-235), which was signed on

December 16, 2014, changed the Camp Lejeune exposure period from beginning January 1, 1957 to beginning August 1, 1953.

VA began providing care to Camp Lejeune Veterans on August 6, 2012, the day the initial law was enacted, and published regulations supporting implementation of this statutory requirement on September 11, 2013. VA began enrolling and reimbursing family members for medical care related to treatment of the Camp Lejeune conditions on October 24, 2014, 30 days after the family member interim final rule was published in the Federal Register and became effective. Qualified family members with at least 30 days of Camp Lejeune residency from 1957-1987 may receive reimbursement for treatment received up to two years prior to the date on their eligibility determination. For family members with at least 30 days of Camp Lejeune residency from August 1, 1953 – December 31, 1956, VA may only provide claims reimbursement for covered treatment received on or after December 16, 2014. VA may not reimburse family members for Camp Lejeune related care prior to March 26, 2013, the date when Congress provided funding to Camp Lejeune Family Member Program (CLFMP).

**Type of Services Provided**

VA Office of Community Care currently provides reimbursement for medical care received by family members related to approved treatment of the Camp Lejeune conditions. CLFMP also represents the VA at the Agency for Toxic Substance Disease Registry (ATSDR) Community Assistance Panel (CAP) quarterly meetings. Camp Lejeune clinicians provide subject-matter expertise to the War Related Illness and Injury Study Center (WRIISC). CLFMP conducts training to ensure VA employees involved in operation and administration of the Camp Lejeune Family Member Program are fully educated on the eligibility, enrollment and claims processes, systems and procedures, including coordinating with physicians to conduct clinical analysis on the determination of individual applicant eligibility for CLFMP. VA continues to use numerous communication channels to reach out to these key stakeholders, including websites, social media, handouts, stakeholder briefings, call centers, newsletters and traditional media. Briefings and information papers have been provided to members of the Camp Lejeune Community Action Panel, concerned Veterans and their family members, Veterans Service Organizations, congressional staff and the media.

**Recent Trends**

The current trend shows an annual increase of 19% from October 2020 to October 2021 in new enrollment for both administrative and clinical eligibility. Administrative eligibility determinations show the family member was a dependent to an eligible Veteran during the covered timeframe and resided (including in-utero) on Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987. Clinical eligibility determinations show the family member is administratively eligible AND has one or more of the 15 qualifying health conditions. There are 2,525 administratively eligible family members and 826 clinically eligible family members that receive medical reimbursement for one or more of the 15 approved conditions. A relatively small number of family members lived on Camp Lejeune or have contracted one of the specified illnesses or conditions. The program continues to communicate with family members and their concerns.

**Projections for the Future**

VA will continue to promptly reimburse family members for care related to the 15 conditions. Future goals include expanding outreach efforts to continue to educate Veterans and family members about CLFMP. The expectation is that CLFMP will experience small growth based on historical program data and known expectations. Medical claims obligations are expected to

increase from $3.0 million in 2021 to an estimated $3.3 million in 2022. VHA anticipates a similar annual increase of approximately 10.8% in obligations for both 2023 and 2024.

## Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and Other Dependent Programs

A provides healthcare benefit administration for the beneficiaries of the following programs: CHAMPVA, Foreign Medical Programs, Spina Bifida Program and Children of Women Vietnam Veterans. This includes reimbursement for Inpatient, Outpatient, Durable Medical, Pharmacy, travel and limited dental. Covered medical claims are reimbursed to the provider or the beneficiary directly.

**Authority for Action**

- Title 38 U.S.C. § 1781, Medical care for survivors and dependents of certain Veterans
- Title 38 U.S.C. § 1802, Spina bifida conditions covered
- Title 38 U.S.C. § 1803, Health care
- Title 38 U.S.C. § 1821, Benefits for children of certain Korea service veterans born with spina bifida
- Title 38 U.S.C. § 1822, Benefits for children of certain Thailand service veterans born with spina bifida
- Title 38 U.S.C. § 1811, Definitions
- Title 38 U.S.C. § 1812, Covered birth defects
- Title 38 U.S.C. § 1813, Health care
- Title 38 U.S.C. § 1724, Hospital care, medical services and nursing home care abroad
- Title 38 U.S.C. § 5104C, Options following decision by agency of original jurisdiction
- Title 38 U.S.C. § 1724, Hospital care, medical services and nursing home care abroad

**Population Covered**

***Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA):*** The Veterans Health Care Expansion Act of 1973, Public Law 93-82, authorized VA to provide a health benefits program that shares the cost of medical supplies and services with eligible beneficiaries. The Veterans' Survivor Benefits Improvements Act of 2001, Public Law 107-14, extended CHAMPVA benefits, as a secondary payer to Medicare, to CHAMPVA beneficiaries over age 65. To be eligible for CHAMPVA benefits, the beneficiary must be the spouse or child of a Veteran who has a total and permanent service-connected disability, or the widowed spouse or child of a Veteran who: (a) died as a result of a service-connected disability; (b) had a total, permanent disability resulting from a service-connected condition at the time of death; or (c) died on active duty and in all cases the family member is not eligible for medical benefits under the Department of Defense (DoD) TRICARE Program. CHAMPVA by law is a secondary payer to other health insurance plans to include Medicare. CHAMPVA assumes primary payer status for Medicaid, Indian Health Service and State Victims of Crime Compensation Programs.

The Veterans Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law 111-163, section 102, further expanded CHAMPVA to include primary family caregivers of

certain seriously injured Veterans. Eligible primary family caregivers are authorized to receive health care benefits through the existing CHAMPVA Program when the primary family caregiver is not eligible for any other health care coverage (including TRICARE, Medicare and Medicaid).

***Foreign Medical Program (FMP)*:** The Foreign Medical Program is a health care benefits program for United States Veterans with VA-rated service-connected conditions that are residing or traveling abroad, including the Philippines as of October 1, 2017. Under FMP, VA assumes payment responsibility for certain necessary medical services associated with the treatment of Veterans' service-connected conditions, with certain exclusions. The FMP program does not pay for Compensation and Pension exams.

***Spina Bifida Health Care Program*:** Under the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997, Public Law 104-204, section 421, VA administers the Spina Bifida Health Care Benefits Program for birth children of Vietnam Veterans diagnosed with spina bifida (excluding spina bifida occulta). Additionally, the Veterans Benefit Act of 2003, Public Law 108-183, section 102, authorized birth children with spina bifida of certain Veterans who served in Korea to be eligible for care under this program. Prior to October 10, 2008, the program provided reimbursement only for medical services associated with spina bifida; however, under the Veterans' Mental Health and Other Care Improvements Act of 2008, Public Law 110-387, the program provides reimbursement for comprehensive medical care. The Blue Water Navy Vietnam Veterans Act of 2019, Public Law 116-23, Section 1116B, authorizes birth children of certain Veterans who served in Thailand to be eligible for care under this program.

***Children of Women Vietnam Veterans Health Care Benefits Program (CWVV):*** Under the Veterans Benefits and Health Care Improvement Act of 2000, Public Law 106-419, section 401, VA administers the CWVV Program for children with certain birth defects born to women Vietnam Veterans. CWVV Program provides reimbursement only for covered birth defects.

**Recent Trends**

The number of enrolled beneficiaries in CHAMPVA has increased by 5.0% on an annual basis from 2015 to 2021, and the number of unique users of CHAMPVA has increased by 5.1% annually. In 2021, CHAMPVA served 433,909 unique beneficiaries, which amounted to an annual increase of 16,706 beneficiaries. The number of unique users of the Foreign Medical Program decreased from 128 in 2020 to 122 in 2021. This represented a 4.7% decrease. The Spina Bifida Health Care program also saw a decrease in unique users from 873 in 2020 to 871 in 2021. This represented a 0.23% decrease. The number of unique users in the Children of Women Vietnam Veterans program remained unchanged from 2020 to 2021 at two (2).

**CHAMPVA Consolidated Mail Outpatient Pharmacy (CMOP)**

The cost of CHAMPVA prescriptions fulfilled through VA's CMOP have been increasing each year. These prescription costs are paid from VA's Medical Services appropriation. VA estimates CHAMPVA costs of $403,420 in 2022 while 2023 and 2024 each assume a 9% annual increase.

## Indian Health Service / Tribal Health Programs / Urban Indian Organizations (ITU) Reimbursement Agreements Program

**Authority for Action**

Under the authority of 25 U.S.C. §1645(c) and 38 U.S.C §8153, VA established a national interagency sharing/ reimbursement agreement with the Department of Health and Human Services/Indian Health Service (HHS/IHS) in 2012 to reimburse IHS for the provision of Direct Care Services to eligible American Indian (AI)/Alaska Native (AN) Veterans. The National Reimbursement Agreement paved the way for VA to enter into individual agreements with Tribal Health Programs (THPs) to reimburse THPs for Direct Care Services provided to eligible AI/AN Veterans. Under these agreements, VA reimburses for Direct Care Services provided by IHS and THPs to eligible AI/AN Veterans that are included in the Medical Benefits Package under Title 38 Code of Federal Regulations (CFR) Section 17.38.

VA continues to establish individual agreements with THPs and has begun reaching out to UIO to increase health care options for all eligible AI/AN Veterans (especially those in remote, rural areas) facilitating access to culturally sensitive care, collaboration and resource-sharing between VA and IHS and/ or THPs. In addition to AI/AN Veterans and because of the highly rural nature of Alaska, agreements with Alaska THPs also cover non-Native Veterans.

In 2022, VA continued working with stakeholders to define the scope and processes to reimburse IHS and THPs for eligible purchased/referred care (PRC) provided to eligible AI/AN Veterans, as authorized in P.L. 116-311, the Proper and Reimbursed Care for Native Veterans Act. In 2022, VA expanded its partnerships to included Urban Indian Organizations (UIO), as authorized in Division FF, Title XI, Western Water and Indian Affairs, section 1113 of P.L. 116-260, Consolidated Appropriations Act, 2021. Two listening sessions were held to gain initial input into a new template (December 2021/January 2022) and a draft template will be brought to tribal consultation prior to adoption.

**Population Covered**

The population covered under the IHS/THP reimbursement agreements are eligible AI/AN Veterans and non-Native Veterans (Alaska only). Eligible AI/AN Veterans may choose to seek health care through IHS or THP facilities without preauthorization, while non-Native Veterans in Alaska need pre-authorization. Many of the AI/AN Veterans and non-Native Veterans in Alaska reside in highly rural areas where VA has limited presence. Thus, these reimbursement agreements provide better access to care closer to home. Also, these agreements allow AI/AN Veterans to seek care in a culturally sensitive environment.

**Type of Services Provided**

Direct Care Services are provided at IHS or THP facilities under the 38 CFR § 17.38, Medical Benefits Package. Examples of these services are basic and preventive care, outpatient, inpatient, ambulatory surgical services, prescription drugs, etc. These services are provided at IHS/THP hospitals, clinics, or facilities. Purchased/referred care services are provided away from an IHS or THP facility.

**Recent Trends**

The 2021 actual obligations were $27.9 million, which consists of $16.6 million in MCC funds and $11.3 million in COVID supplemental funding provided by the CARES Act and Families First Act.

In 2023, obligations are projected to be $34 million. In general, this funding supports an estimated 116 agreements with THPs, in addition to 74 IHS sites included in the National Reimbursement Agreement with IHS as well as a portion of the 41 potential UIOs that may onboard. VA anticipates providing reimbursement to more than 5,500 unique Veterans per year. The funding level supports the expansion of VA reimbursement to include UIOs as well as to reimburse IHS/THPs for eligible purchased/referred care.

**Administrative Costs Justification**

The Medical Community Care Programs includes funding for necessary costs incurred to operate the program, including several contracting and administration fees. VA's Community Care Network (CCN) contract operates in Regions 1-6, with limited exceptions. Notably, Region 6 operates under the Region 4 contract, which maintains its own negotiated rates. Additionally, when a provider is not available under CCN, VA continues its practice to utilize Veterans Care Agreements (VCA) to procure services.

**Community Care Network (CCN)**

The request for the Medical Community Care account includes the administrative cost associated with the CCN contract. The 2023 obligations of $990 million will be paid to a Third-Party Administrator (TPA) and cover regions 1 – 6. Administrative costs associated with the CCN contract include:

- Per Member Per Month administrative fees (PMPM) which is the negotiated contract rate multiplied by the number of veterans receiving care on a monthly basis.
- 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.

**Patient Centered Community Care (PC3)**

PC3 is assumed to be fully sunset by the end of 2022.

## State Home Per Diem Program

**Authority for Action**

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

The program is administered by Geriatrics and Extended Care (12GEC), VHA. Under the State Home Per Diem Program, states may provide care in a SVH for eligible veterans in need of care in three different levels of care: Nursing Home Care (NHC), Domiciliary (DOM) and Adult Day

Health Care (ADHC). Only facilities recognized by the Under Secretary for Health, under 38 CFR §51.30 for NHC and 38 CFR §52.30 for ADHC, or DOM programs recognized by the Secretary of Veterans Affairs, as set forth in 38 CFR §51, are SVHs and will receive per diem payments in accordance with 38 U.S.C. 1741-1745.

**Population Covered**

In 2021, there were 160 SVHs, 153 recognized NHs, 51 recognized DOMs and 3 ADHCs with an average daily census (average daily number of patients) of over 18,000 veterans and approximately 1,600 veteran spouses and Gold Star parents.

**Type of Services Provided**

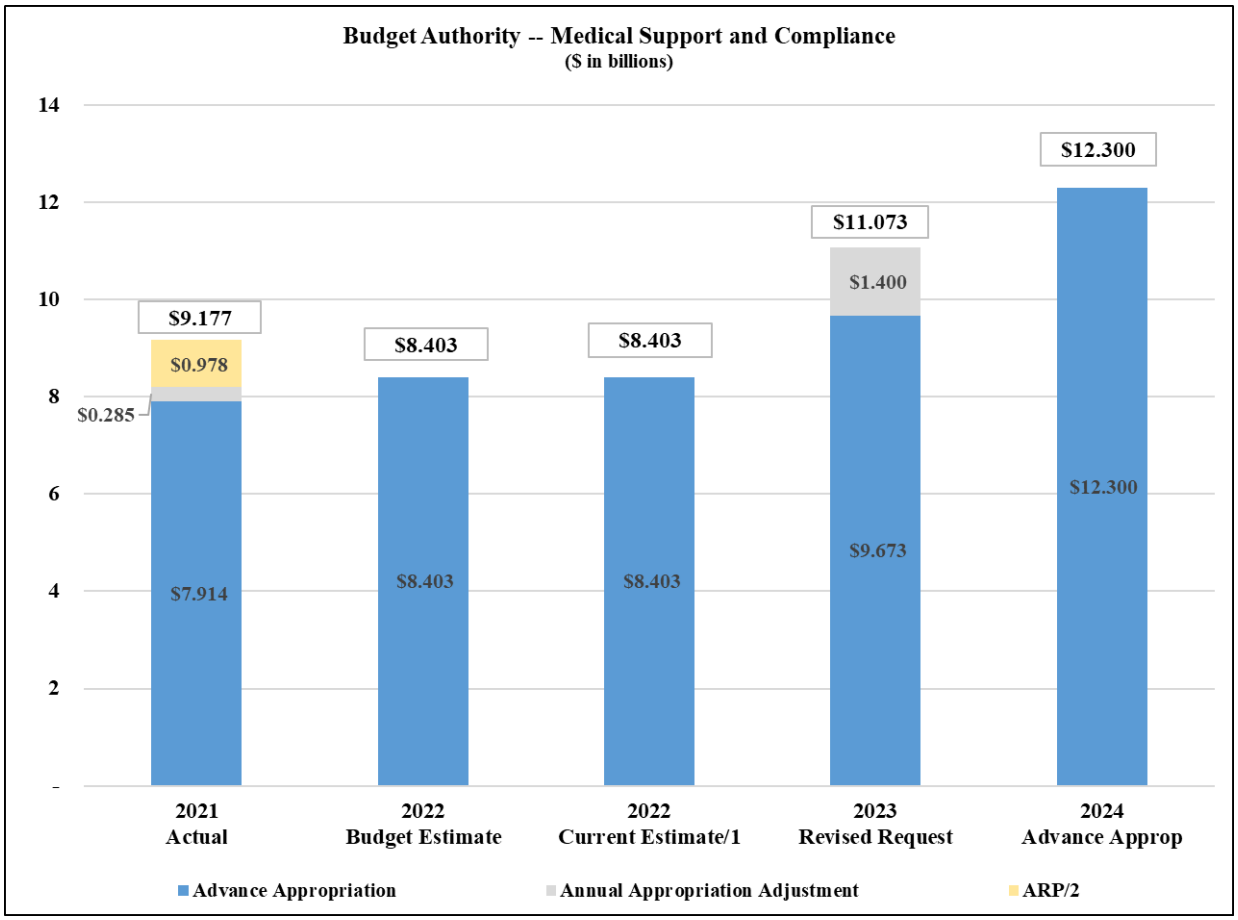
SHPD will continue to support eligible veterans with a basic rate for NHC, ADHC and DOM; and the prevailing rate for eligible Veterans that are in the SVH for NHC and ADHC with a service connection (SC) of 70% or greater SC or adjudicated as Individually Unemployable.

**Recent Trends**

The 2023 budget projects an increase of 5% or $1.4 billion. Per diem trends are influenced by the amount of new SVH construction and the number of Veterans that are admitted. Rates have significantly decreased over the past 2 years due to closing new admissions to prevent COVID-19 as opposed to the yearly increase within the 5 years prior.

In 2021 VA received $500 million from the American Rescue Plan (ARP) Act to provide funding for improvements of existing SVHs and construction of new SVHs. VA anticipates that 12 new SVHs will open in 2022, resulting in additional per diem costs.

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 late 2023. This will result in an increase in the number of approved admissions.




[1/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

[2/] The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the chart displays the estimated allocation for the Medical Support and Compliance category. Final funding allocations among account-level categories may change in response to workload demand requirements throughout 2022 and 2023.

## Update to the 2023 Advance Appropriations Request

The Department of Veterans Affairs (VA) is requesting an additional $1.4 billion for Medical Support and Compliance (MSC) above the enacted 2023 Advance Appropriation of $9.7 billion. In addition to the Advance Appropriation, VA intends to use $344.9 million of unobligated balances from the mandatory appropriation provided in the American Rescue Plan Act to meet projected requirements in 2023. This funding, combined with $63.4 million in projected

reimbursements, a transfer out of $30.6 million and $200.0 million in unobligated balances from discretionary appropriations, will provide a total resource level of $11.7 billion in 2022.

The 2023 MSC budget funds regional and medical facility administrators, including leadership teams; provides for community care claims processing and program management; supports VAMCs transition to a new financial management system; provides additional administrative support in areas such as acquisition and finance; demonstrates VA's continued commitment to the modernization of its supply chain and support systems throughout the nation; and further invests in its personnel management workforce enterprise-wide.

**Table: Update to the 2023 Advance Appropriations Request**

(dollars in thousands)

| | | Available Discretionary Funding | | | | Available Mand. Funding | | | |
|---|---|---|---|---|---|---|---|---|---|
| Description | 2023 Revised Estimate | Adv. Approp. Incl. Transfers | Transfers To | Reimb. | Use of Unobl. Balance | Sec 801 Use of Unobl. Balance | Veterans Medical Care and Health Fund Use of Unobl. Balance 1/ | Subtotal | Annual Approp. Adjust. Required |
| **VISN & Medical Center Based:** | | | | | | | | | |
| VAMC | $6,450,192 | $4,672,467 | ($30,613) | $63,438 | $0 | $0 | $344,900 | $5,050,192 | **$1,400,000** |
| VISN | $952,236 | $952,236 | $0 | $0 | $0 | $0 | $0 | $952,236 | **$0** |
| **VHA Central Office Based:** | | | | | | | | | |
| Community Care | $1,089,501 | $1,089,501 | $0 | $0 | $0 | $0 | $0 | $1,089,501 | **$0** |
| Clinical Services | $274,067 | $274,067 | $0 | $0 | $0 | $0 | $0 | $274,067 | **$0** |
| Discovery, Education and Affiliate Networks | $127,326 | $124,443 | $0 | $0 | $0 | $2,883 | $0 | $127,326 | **$0** |
| Operations | $255,917 | $255,917 | $0 | $0 | $0 | $0 | $0 | $255,917 | **$0** |
| Patient Care Services | $316,939 | $316,939 | $0 | $0 | $0 | $0 | $0 | $316,939 | **$0** |
| Quality and Patient Safety and Core Finance Administration | $205,955 | $205,955 | $0 | $0 | $0 | $0 | $0 | $205,955 | **$0** |
| Support Services | $688,777 | $688,777 | $0 | $0 | $0 | $0 | $0 | $688,777 | **$0** |
| Human Capital Management | $340,791 | $340,791 | $0 | $0 | $0 | $0 | $0 | $340,791 | **$0** |
| Health Informatics | $179,057 | $179,057 | $0 | $0 | $0 | $0 | $0 | $179,057 | **$0** |
| All Other Support and Program Offices | $773,259 | $573,259 | $0 | $0 | $200,000 | $0 | $0 | $773,259 | **$0** |
| **Central Office Based Obligations [Subtotal]** | $4,251,589 | $4,048,706 | $0 | $0 | $200,000 | $2,883 | $0 | $4,251,589 | **$0** |
| Obligations [Total] | $11,654,017 | $9,673,409 | ($30,613) | $63,438 | $200,000 | $2,883 | $344,900 | $10,254,017 | **$1,400,000** |

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 for the Medical Support and Compliance category. Final 2022 and 2023 funding allocations among categories may change in response to workload demand requirements throughout 2022 and 2023.

## 2023 Funding and 2024 Advance Appropriations Request

The MSC appropriation finances the supporting structures that underlie VHA's ability to deliver high-quality health care services to our Veterans. Approximately 64% of the 2023 total funding for this appropriation is designated for VAMCs and Veteran Integrated Service Networks (VISNs) direct allocations. The remaining 36% of the funding is designated for VHA Central Office Programs to support their staff as well as allocate to VAMCs for specific tasks. This funding ensures:

- leadership teams are in place to govern;
- appropriate oversight to safeguard quality of care for our Veterans is available;
- essential security services are provided;
- needed supplies and medications are ordered;
- health care provider vacancies are filled and
- financial services and oversight are provided, required medical equipment is procured and patient encounters are appropriately recorded.

The following tables display the discretionary, mandatory and combined sources of funds.

# Table: Medical Support and Compliance Crosswalk

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2023-2022 | +/- 2024-2023 |
|---|---|---|---|---|---|---|---|
| **Appropriation Medical Support & Compliance (0152)** | | | | | | | |
| Advance Appropriation | $7,914,191 | $8,403,117 | $8,403,117 | $9,673,409 | $12,300,000 | $1,270,292 | $2,626,591 |
| Annual Appropriation Adjustment | $300,000 | $0 | $0 | $1,400,000 | $0 | $1,400,000 | ($1,400,000) |
| Appropriations Request [Subtotal] | $8,214,191 | $8,403,117 | $8,403,117 | $11,073,409 | $12,300,000 | $2,670,292 | $1,226,591 |
| (PL 116-260 §254) | ($15,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| **Net Appropriation** | **$8,199,191** | **$8,403,117** | **$8,403,117** | **$11,073,409** | **$12,300,000** | **$2,670,292** | **$1,226,591** |
| Tranfers To | | | | | | | |
| JALFHCC (0169) | ($30,213) | ($30,613) | ($30,613) | ($30,613) | ($30,996) | $0 | ($383) |
| Transfers To [Subtotal] | ($30,213) | ($30,613) | ($30,613) | ($30,613) | ($30,996) | $0 | ($383) |
| Budget Authority [Total] | $8,168,978 | $8,372,504 | $8,372,504 | $11,042,796 | $12,269,004 | $2,670,292 | $1,226,208 |
| Reimbursements | $63,438 | $47,610 | $63,438 | $63,438 | $63,438 | $0 | $0 |
| Unobligated Balance (SOY) | | | | | | | |
| No-Year | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| H1N1 No-Year (PL 111-32) | $111 | $0 | $111 | $0 | $0 | ($111) | $0 |
| 2-Year | $98,481 | $100,000 | $149,880 | $200,000 | $0 | $50,120 | ($200,000) |
| 2-Year (P.L. 116-136) | $172,544 | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (SOY) [Subtotal] | $271,136 | $100,000 | $149,991 | $200,000 | $0 | $50,009 | ($200,000) |
| Transfer of Unobligated Balance (PL 116-136 §20001) | | | | | | | |
| From Medical Services CARES Unob. Bal. | $105,000 | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (EOY) | | | | | | | |
| No-Year | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| H1N1 No-Year (PL 111-32) | ($111) | $0 | $0 | $0 | $0 | $0 | $0 |
| 2-Year (Other) | ($149,880) | $0 | ($200,000) | $0 | $0 | $200,000 | $0 |
| 2-Year (P.L. 116-136) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (EOY) [Subtotal] | ($149,991) | $0 | ($200,000) | $0 | $0 | $200,000 | $0 |
| Lapse | ($247,676) | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $8,210,885 | $8,520,114 | $8,385,933 | $11,306,234 | $12,332,442 | $2,920,301 | $1,026,208 |
| Prior Year Recoveries | $2,139 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations (0152) [Total]** | **$8,213,024** | **$8,520,114** | **$8,385,933** | **$11,306,234** | **$12,332,442** | **$2,920,301** | **$1,026,208** |
| **Veterans Medical Care and Health Fund (0173SC) 1/** | | | | | | | |
| Funding made available by VMCHF | $978,433 | $0 | $0 | $0 | $0 | $0 | $0 |
| | | | | | | $0 | $0 |
| Unobligated Balance (SOY) | $0 | $978,433 | $978,433 | $344,900 | $0 | ($633,533) | ($344,900) |
| Unobligated Balance (EOY) | ($978,433) | $0 | ($344,900) | $0 | $0 | $344,900 | $0 |
| **Obligations (0173SC) [Total]** | **$0** | **$978,433** | **$633,533** | **$344,900** | **$0** | **($288,633)** | **($344,900)** |
| **VACAA, Section 801 (0152XA)** | | | | | | | |
| Unobligated Balance (SOY) | $13,134 | $11,736 | $10,417 | $7,618 | $4,735 | ($2,799) | ($2,883) |
| Unobligated Balance (EOY) | ($10,417) | ($10,283) | ($7,618) | ($4,735) | ($1,766) | $2,883 | $2,969 |
| Subtotal | $2,717 | $1,453 | $2,799 | $2,883 | $2,969 | $84 | $86 |
| Prior Year Recoveries | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations (0152XA) [Total]** | **$2,717** | **$1,453** | **$2,799** | **$2,883** | **$2,969** | **$84** | **$86** |
| **Obligations [Grand Total]** | **$8,215,741** | **$9,500,000** | **$9,022,265** | **$11,654,017** | **$12,335,411** | **$2,631,752** | **$681,394** |
| **FTE** | | | | | | | |
| Medical Support & Compliance (0152) | 49,081 | 57,725 | 59,829 | 67,351 | 69,735 | 7,522 | 2,384 |
| CARES Act | 8,098 | 0 | 0 | 0 | 0 | 0 | 0 |
| Veterans Medical Care and Health Fund (0173SC) | 0 | 500 | 0 | 0 | 0 | 0 | 0 |
| VACAA, Section 801 (0152XA) 1/ | 24 | 11 | 24 | 24 | 24 | 0 | 0 |
| **FTE [Total]** | **57,203** | **58,236** | **59,853** | **67,375** | **69,759** | **7,522** | **2,384** |

[1/] The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the column displays the estimated allocation for the Medical Support and Compliance category. Final 2022 and 2023 funding allocations may change in response to workload demand requirements throughout 2022 and 2023.

[2/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

The funding levels shown below include the program's total discretionary budget authority plus reimbursements, as well as the budget authority available due to unobligated start-of-year mandatory balances from Sec. 801 of the Choice Act and the Veterans Medical Care and Health Fund. The programmatic funding levels are shown with both funding sources combined to allow for a comprehensive picture of the program's operations.

## Program Resources

- **$11.7 billion in 2023**
- **$12.3 billion in 2024**

To provide better visibility into the spending under this appropriation, additional detail on obligations by the following categories are reflected in the following charts.

## Table: Summary of Obligations by Functional Area

(dollars in thousands)

| Description: | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Annual Appropriations** | | | | | | | |
| **VISN & Medical Center Based:** | | | | | | | |
| VAMC | $4,281,256 | $5,175,652 | $4,095,277 | $6,105,292 | $6,931,560 | $2,010,015 | $826,268 |
| VISN | $874,634 | $650,084 | $914,732 | $952,236 | $989,373 | $37,504 | $37,137 |
| **VHA Central Office Based:** | | | | | | | |
| Community Care | $987,881 | $1,037,856 | $1,054,365 | $1,089,501 | $1,129,068 | $35,136 | $39,567 |
| Clinical Services | $85,537 | $172,040 | $169,626 | $274,067 | $284,756 | $104,441 | $10,689 |
| Discovery, Education and Affiliate Networks | $48,675 | $42,687 | $46,087 | $124,443 | $129,323 | $78,356 | $4,880 |
| Operations | $155,672 | $188,867 | $192,387 | $255,917 | $265,898 | $63,530 | $9,981 |
| Patient Care Services | $141,399 | $194,174 | $208,325 | $316,939 | $329,300 | $108,614 | $12,361 |
| Quality and Patient Safety 1/ | $122,128 | $453,789 | $131,738 | $205,955 | $213,987 | $74,217 | $8,032 |
| Support Services | $427,435 | $0 | $676,262 | $688,777 | $715,639 | $12,515 | $26,862 |
| Human Capital Management | $230,255 | $233,778 | $234,695 | $340,791 | $354,082 | $106,096 | $13,291 |
| Health Informatics | $112,164 | $109,403 | $105,877 | $179,057 | $186,040 | $73,180 | $6,983 |
| All Other Support and Program Offices | $489,205 | $261,784 | $556,562 | $773,259 | $803,416 | $216,697 | $30,157 |
| **Central Office Based Obligations [Subtotal]** | $2,800,351 | $2,694,378 | $3,375,924 | $4,248,706 | $4,411,509 | $872,782 | $162,803 |
| **Prior Year Recoveries** | $2,139 | $0 | $0 | $0 | $0 | $0 | $0 |
| **CARES Act:** | | | | | | | |
| VAMC & VISN | $165,284 | $0 | $0 | $0 | $0 | **$0** | **$0** |
| Central Office | $89,360 | $0 | $0 | $0 | $0 | **$0** | **$0** |
| **MSC Obligations - Discretionary Funds [Total]** | **$8,213,024** | **$8,520,114** | **$8,385,933** | **$11,306,234** | **$12,332,442** | **$2,920,301** | **$1,026,208** |

1/ The 2022 Budget Estimate contained funds for Core Finance Administration, which belong to the All Other Support and Program Offices line item. The 2021 Actuals, 2022 Current Estimate, 2023 Revised Request and 2024 Advance Appropriation have Core Finance Administration funds within the All Other Support and Program Office line items.

### Medical Support & Compliance Obligations by Activity - Mandatory Funds

(dollars in thousands)

| Description: | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Veterans Medical Care and Health Fund 1/** | | | | | | | |
| VAMC | $0 | $300,000 | $633,533 | $344,900 | $0 | ($288,633) | ($344,900) |
| Support Services | $0 | $678,433 | $0 | $0 | $0 | $0 | $0 |
| **VMCHF Obligations [Subtotal]** | **$0** | **$978,433** | **$633,533** | **$344,900** | **$0** | **($288,633)** | **($344,900)** |
| **Section 801** | | | | | | | |
| VAMC | $2,717 | $0 | $0 | $0 | $0 | $0 | $0 |
| Discovery, Education and Affiliate Networks | $0 | $1,453 | $2,799 | $2,883 | $2,969 | $84 | $86 |
| **Section 801 Obligations [Subtotal]** | **$2,717** | **$1,453** | **$2,799** | **$2,883** | **$2,969** | **$84** | **$86** |
| **MSC Obligations - Mandatory Funds [Total]** | **$2,717** | **$979,886** | **$636,332** | **$347,783** | **$2,969** | **($288,549)** | **($344,814)** |

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

**Medical Support & Compliance Obligations by Activity - Total**
(dollars in thousands)

| Description: | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **VISN & Medical Center Based:** | | | | | | | |
| VAMC | $4,445,817 | $5,475,652 | $4,728,810 | $6,450,192 | $6,931,560 | $1,721,382 | $481,368 |
| VISN | $878,074 | $650,084 | $914,732 | $952,236 | $989,373 | $37,504 | $37,137 |
| **VHA Central Office Based:** | | | | | | | |
| Community Care | $987,890 | $1,037,856 | $1,054,365 | $1,089,501 | $1,129,068 | $35,136 | $39,567 |
| Clinical Services | $89,361 | $172,040 | $169,626 | $274,067 | $284,756 | $104,441 | $10,689 |
| Discovery, Education and Affiliate Networks | $54,175 | $44,140 | $48,886 | $127,326 | $132,292 | $78,440 | $4,966 |
| Operations | $156,579 | $188,867 | $192,387 | $255,917 | $265,898 | $63,530 | $9,981 |
| Patient Care Services | $141,897 | $194,174 | $208,325 | $316,939 | $329,300 | $108,614 | $12,361 |
| Quality and Patient Safety 1/ | $126,206 | $453,789 | $131,738 | $205,955 | $213,987 | $74,217 | $8,032 |
| Support Services | $440,307 | $678,433 | $676,262 | $688,777 | $715,639 | $12,515 | $26,862 |
| Human Capital Management | $230,255 | $233,778 | $234,695 | $340,791 | $354,082 | $106,096 | $13,291 |
| Health Informatics | $136,614 | $109,403 | $105,877 | $179,057 | $186,040 | $73,180 | $6,983 |
| All Other Support and Program Offices | $526,427 | $261,785 | $556,562 | $773,259 | $803,416 | $216,697 | $30,157 |
| **Central Office Based Obligations [Subtotal]** | **$2,889,711** | **$3,374,264** | **$3,378,723** | **$4,251,589** | **$4,414,478** | **$872,866** | **$162,889** |
| **Prior Year Recoveries** | $2,139 | $0 | $0 | $0 | $0 | $0 | $0 |
| **MSC Obligations [Total]** | **$8,215,741** | **$9,500,000** | **$9,022,265** | **$11,654,017** | **$12,335,411** | **$2,631,752** | **$681,394** |

1/ The 2022 Budget Estimate contained funds for Core Finance Administration, which belong to the All Other Support and Program Offices line item. The 2021 Actuals, 2022 Current Estimate, 2023 Revised Request and 2024 Advance Appropriation have Core Finance Administration funds within the All Other Support and Program Office line items.

## Medical Support and Compliance Program Office Narratives

The MSC activity supports care provided at VA medical facilities and through community providers. The following twelve narratives describe VHA's main support office functions.

## VA Medical Center (VAMC) and Veteran Integrated Service Networks (VISN) Based Activities

The obligations shown in the tables below reflect discretionary and mandatory budget authority plus reimbursements.

### VA Medical Centers (VAMCs)

**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations | $4,443,100 | $5,175,652 | $4,095,277 | $6,105,292 | $6,931,560 | $2,010,015 | $826,268 |
| Mandatory Obligations 1/ | $2,717 | $300,000 | $633,533 | $344,900 | $0 | ($288,633) | ($344,900) |
| Obligations [Total] | $4,445,817 | $5,475,652 | $4,728,810 | $6,450,192 | $6,931,560 | $1,721,382 | $481,368 |

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

### Program Description

Funding in this account for VAMC based activities supports the management, operation, oversight, security and administration of the VA's health care system. This includes medical center leadership teams (Director, Chief of Staff, Chief Medical Officer and Chief Nurse), medical center support functions (quality of care oversight, security services, legal services, billing and coding activities, acquisition, procurement and logistics activities), human resource management, logistics and supply chain management and financial management. Of the many functions required to operate VHA facilities, one essential function is revenue generation. This begins at the medical centers and clinics with the verification of insurance and the coding of inpatient and outpatient encounters. The increase in obligation projections for 2022-2024 are directly related to inflationary and programmatic growth for implementing initiatives such as those relating to the increases in acquisition, financial and other administrative staff in support of a new electronic health record, transition to a new logistical and support system, a new financial management system and further investment in personnel management workforce.

### Veteran Integrated Service Networks (VISN)

**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations [Total] | $878,074 | $650,084 | $914,732 | $952,236 | $989,373 | $37,504 | $37,137 |

### Program Description

These funds provide the necessary resources for the VISN offices that provide regional support, management and oversight to the medical centers, clinics and other field activities within their regions. This includes but is not limited to network leadership teams (Network Director, Deputy Network Director, Chief Financial Officer, Chief Medical Officer and Chief Information Officer) and clinical and administrative functional leads, that are centrally located to provide leadership to those programs within each VISN. Each VISN office is responsible for coordinating the delivery of health care to Veterans by leveraging and integrating operations at all of the VA health care facilities within the VISN. The increase in obligation projections for 2022-2024 are directly related to inflationary and programmatic growth for implementing initiatives.

# VHA Central Office (VHACO) Based Activities

## Community Care
**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations [Total] | $987,890 | $1,037,856 | $1,054,365 | $1,089,501 | $1,129,068 | $35,136 | $39,567 |

### Program Description

The Office of Community Care (OCC) was established in 2015 by the VHA Under Secretary for Health. The goal of OCC is to deliver a program that is easy to understand, simple to administer and meets the needs of Veterans and their families, community providers and VA staff. OCC provides Veterans access to health care by community providers when services are not available at a VA facility, are not available within a clinically appropriate timeframe, or when distance makes these services inaccessible. OCC currently uses multiple programs to increase Veterans access to high-quality care outside of VA. For more information on Community Care, please see the Medical Community Care chapter.

### Assistant Under Secretary for Health for Community Care & Deputy Assistant Under Secretary for Health for Community Care

The offices of the Assistant Under Secretary for Community Care and Deputy Assistant Under Secretary for Community Care serve Veterans by collaborating with colleagues and stakeholders to provide excellence in health care operations and administration. OCC leads VA in advancing business practices that support patient care and delivery of health benefits and provides executive program support to the Under Secretary for Health on a wide range of health benefit administration programs, activities, development of administrative processes, policy, regulations and directives associated with the delivery of VA health benefit programs.

### Business Operations and Administration (BOA)

BOA is a shared service organization that provides key supporting infrastructure for OCC, with executive oversight for development of administrative regulations and processes; budgeting for salary, travel and payroll; employee protections, communications and congressional correspondence. The following offices are aligned under BOA: Policy and Planning, Financial Management, Equal Employment Opportunity, Communications, Program Administration Support Services, Project and Portfolio Services and Congressional Correspondence. Each office is led by a senior manager and is staffed with professionals responsible for delivering core services throughout the VHA OCC organization, VA and directly to Veterans and their families.

### Clinical Integration and Field Operations (CIFO)

The Office of CIFO develops and guides the field with implementation of OCC's standardized operating model. This includes standard processes for how resources (people, process, technology and data) should be organized and operate within their local VA Community Care departments to best enable community care for Veterans. The following offices are aligned under CIFO: Administrative Field Operations, Clinical Field Operations and Medical Policy, Quality and Safety.

### Chief Health Informatics Officer (CHIO)

The Chief Health Informatics Executive Directorate is an integral OCC component that provides support services to areas that have high impact to the OCC organization and its mission. Operationally, CHIO is responsible for consultation and data-driven analysis. The following offices are aligned under CHIO: Office of Informatics and Data Analytics (IDA) and Medical Cost Management (MCM). Through these organizations, CHIO plays a strategic role in supporting advanced technology implementations, informs future planning and budget formulations.

### Delivery Operations (DO)

DO administers congressional mandated healthcare programs that allow Veterans and their family members to receive care and services through community providers outside of VA (i.e., Veterans Community Care) and manages Veteran and family member programs that pay for care outside of VA (i.e., Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and Foreign Medical Program (FMP). The following offices are aligned under DO: Payment Operations & Management, Customer Experience, Resource Management and Family Member & Special Veteran Programs.

### Network Management (NM)

NM develops and oversees contracts for Veteran healthcare services within the United States. The directorate ensures quality network providers are enrolled to serve Veterans and provides contract/agreement administration and support for those community healthcare services. NM ensures contracted/agreement health care under the Veterans Community Care Program (CCN, PC3, VCAs and National Dialysis) provides the best health care to our Veterans. In addition, NM further supports the contracts with provider education and outreach, along with detailed responses to customers and community stakeholders. NM also updates contracts as necessary with modifications to ensure the best health coverage for our Veterans. The following offices are aligned under NM: Provider Experience, Contracts & Agreements Management, Acquisition, Network Support and Operations & Administrations.

**Clinical Services**
**(dollars in thousands)**

| | | 2022 | | 2023 | 2024 | | |
|---|---|---|---|---|---|---|---|
| Description | 2021 Actual | Budget Estimate | Current Estimate | Revised Request | Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
| Discretionary Obligations [Total] | $89,361 | $172,040 | $169,626 | $274,067 | $284,756 | $104,441 | $10,689 |

### Program Description

The Office of the Assistant Under Secretary for Health for Clinical Services and the Chief Medical Officer (AUSH/CS) provides leadership for the many VHA clinical programs and their necessary coordination with clinical and administrative leadership within the VISNs, integrated clinical community committees and service-based communities of practice. The Office of the AUSH/CS strives to provide Veterans and their families with high quality, integrated and standardized clinical services that serve as the benchmark for health care excellence and value.

**Dentistry**

The Office of Dentistry utilizes MSC funds for salary support comprising of the Assistant Under Secretary for Health for Dentistry, the Deputy Dental Program Director and staff assigned under the Directorates of Dental Operations, Dental Informatics and Analytics, Dental Laboratory Operations, Homeless Veterans Dental Program, Dental Education, Dental Research, Oral Health Quality Group and Dental Administration.

**Diagnostics**

Diagnostic Services uses MSC funds to fund staff payroll, travel and contract services at VHACO and field based medical support staff. The funds are used to establish national policy and provide clinical operational oversight and enforcement functions. The medical support funds are for national contracts providing services for accreditation, inspections, licenses to operate, proficiency assessments, education and training, agreements, program analytics and data management and reporting. The MSC funds are used to promote Veteran access to services, safety initiatives, quality improvement and communication for clinical standards of practice.

**Homeless**

The VHA Homeless Programs Office manages an annual MSC budget of nearly $31 million which supports 91 total FTE and over $9 million in contractual services. Of the 91 FTE, 63 FTE provide direct support to eight Homeless Programs Initiatives: HUD-VASH, a collaborative program between HUD and VA where eligible homeless Veterans receive a Housing Choice rental voucher from HUD, paired with VA-provided case management and supportive services; Health Care for Homeless Veterans (HCHV), which provides contract residential services, outreach and case management to Veterans who are homeless or at-risk of homelessness; Veterans Justice Outreach (VJO), which aims to prevent homelessness and avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans; Homeless Veterans Community Employment Services, which assists Veterans with accessing employment opportunities to support their housing needs, improve the quality of their lives and assist in their community reintegration efforts; the Grant and Per Diem (GPD) program that awards grants to community-based agencies to create transitional housing programs and offer per diem payment to GPD funded organization; the Supportive Services for Veteran and Families (SSVF) program that provides supportive services to homeless and at-risk Veteran families; the Veterans National Homeless Registry**,** which maintains a comprehensive repository of Veterans who have been identified as homeless or at risk for homelessness; and the Homeless Patient Aligned Care Teams (HPACT) which provides a multi-disciplinary, population-tailored medical home designed around the unique needs and distinct challenges homeless Veterans face both accessing and engaging in health care. The remaining 28 FTE constitute Homeless Programs Central Office leadership and administrative staff, in addition to leadership and support staff for other Homeless Program administrative offices. Please see the Homeless Programs section in the Medical Care chapter for more information.

**Mental Health and Suicide Prevention**

The Office of Mental Health and Suicide Prevention (OMHSP) employs national and international subject matter experts to provide oversight and deploy national guidance in VA medical facilities throughout the country, enabling VHA to provide a full continuum of Veteran-centered, high-quality outpatient, residential and inpatient mental health services and suicide prevention programming. VA's top clinical priority is preventing Veteran suicide. OMHSP has operationalized the VA National Strategy to Prevent Veteran Suicide in *Suicide Prevention NOW*

and *Suicide Prevention 2.0*, short and long-term efforts combining community prevention and clinical intervention strategies as part of a public health approach.

OMHSP's Program Evaluation Centers track, analyze and report on hundreds of data points, which are used to create dashboards and tools to facilitate evidence-based decision-making at the provider and facility levels and promote more effective, cost-efficient and Veteran-centered care. In addition, OMHSP manages some of the Department's largest outreach campaigns, such as #BeThere, Make the Connection, AboutFace and other public-facing resources. OMHSP's National Center for Post-Traumatic Stress Disorder (PTSD), VA's Center of Excellence in research and education on PTSD, developed the COVID Coach app and other tools for dealing with stressors. Please see the Mental Health, Suicide Prevention and National Center for PTSD sections in the Medical Care chapter for more information.

**Primary Care and Disability and Medical Assessment**

The National Primary Care Office provides national oversight and monitoring of primary care delivery and develops policies and programs to direct clinical operations and research and educational program activities. The office facilitates the delivery of quality-oriented, efficient, timely, safe and effective primary care within VHA facilities.

The Office of Disability and Medical Assessment is also aligned under the National Primary Care Office, whereby it provides executive leadership to VHA's disability programs worldwide, including both the traditional Compensation and Pension (C&P) and the Integrated Disability Evaluation System (IDES) programs. These responsibilities include securing and execution of funding, quality performance improvement, clinician certification and training, providing analytics support and development of national C&P policy.

**Specialty Care**

Specialty Care Services uses MSC funds to fund VHACO and field-based medical administrative staff that support field-based clinical operations and policy work. The support is salary, travel and all other for national contracts that are administrative in nature such as licensing agreements; inspections; program analyses work; and the collection, review and reporting of data. The national programs' assigned work is not for clinical care but involves clinical administrative staff and clinical operations.

**Spinal Cord Injuries and Disorders (SCI/D)**

The SCI/D national program office utilizes MSC funding to support salary expenses, travel, education/conferences for staff and printing expenses. In addition to the above, the MSC funding also supports contracts for Long Term Care Institute surveys, uSPEQ 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 selected special purpose funds for the delivery of transplant and related services.

**Discovery, Education and Affiliate Networks**
**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations | $54,175 | $42,687 | $46,087 | $124,443 | $129,323 | $78,356 | $4,880 |
| Mandatory Obligations | $0 | $1,453 | $2,799 | $2,883 | $2,969 | $84 | $86 |
| Obligations [Total] | $54,175 | $44,140 | $48,886 | $127,326 | $132,292 | $78,440 | $4,966 |

## Program Description

The Office of Discovery, Education and Affiliate Networks (DEAN) ensures that Veterans have access to the most innovative health care solutions by promoting medical research initiatives, training health care professions and developing community partnerships. DEAN is responsible for managing education and training programs for health profession students and residents to enhance the quality of care provided to Veteran patients as required by Title 38 Section 7302; applying basic, translational, clinical, health services and rehabilitative research to apply scientific knowledge to develop effective care solutions for Veterans; and providing innovative project management of the design, evaluation and diffusion of new processes that facilitate healthcare innovations in the field to better serve Veterans. This year's increase is largely driven by realigning some of the administrative functions and funding them centrally within the Medical Support and Compliance account.

## Academic Affiliations

As one of four statutory missions of VA, the Office of Academic Affiliations (OAA) utilizes its MSC funding to support the statutory mission of health professions education as outlined in Title 38 United States Code Section 7302. OAA's effective execution of MSC funding in support of this mission contributes substantially to VA's ability to deliver cost-effective, high quality patient care for Veterans and has a major impact on the healthcare workforce in VA. OAA's MSC funding supports (1) OAA staff salaries and travel; (2) Funding for mission critical conferences and committees (e.g., National Academic Affiliations Council, National Designated Education Officer Conference and Request for Proposal Review Committees); (3) Funding for National Coordinating Centers for VA-based advanced fellowships; and (4) Fees and payments for accreditation of VA-based health professions programs.

## Community Engagement

The Office of Community Engagement (OCE) program office utilizes its MSC funding to accomplish VHA's mission to honor America's Veterans by cultivating public private partnerships and exploring emerging therapies when other treatments have not been successful. This MSC funding supports salaries, travel and training for staff, in addition to supporting a communications contract. This contract provides strategic support to OCE and includes a quarterly newsletter, more than 75 feature articles, more than 25 programmatic short documents (press releases, outreach

materials, fact sheets, white papers, brochures, flyers and toolkits) campaigns, social media and web support and an annual report.

### Innovation Ecosystem

The Office of Healthcare Innovation and Learning (OHIL) brings together VHA Innovation Ecosystem (VHA IE), the Simulation Learning, Evaluation, Assessment and Research Network (SimLEARN) and the Center for Care and Payment Innovation (CCPI). Through these core programs, HIL advances VHA healthcare delivery and service by (1) fostering the discovery and spread of grassroots and strategic innovative solutions, practices and products across VA; (2) promoting competencies in innovation and simulation; (3) combining clinical simulation and training to further enhance the utilization and uptake of emerging healthcare technology in clinical practice; (4) developing innovative approaches to testing payment and service delivery models; and (5) advancing the use of clinical training and simulation to further VHA's mission of becoming a high reliability organization.

### Research and Development

The Office of Research and Development program office supports the Research mission by utilizing its MSC funding for salary support and sustainment of the Medicare Data Merge initiative at the Edward Hines Jr. VAMC located in Hines, Illinois. The VA Information Resource Center (VIReC) at Hines serves as the data custodian for Centers for Medicare and Medicaid Services (CMS) and United States Renal Data System (USRDS) data for VA research use. The project warehouses and provides data from CMS and USRDS to VA researchers. In addition, the project serves the VA research community by providing education and assistance to VA researchers using these data and conducting research on Veterans' use of Medicare and Medicaid services.

### SimLEARN

The SimLEARN sub-office utilizes its MSC funding for salaries, travel, training for staff, in addition to several contracts in support of the Simulation Training Program. These include the Video Simulation Management System (VSMS) operations support, Human Ultrasound Models, Training Modules for Emergency Nursing, Virtual Interview Skills Training System and Fundamentals of Critical Care Support courseware license.

## Operations

**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations [Total] | $156,579 | $188,867 | $192,387 | $255,917 | $265,898 | $63,530 | $9,981 |

### Program Description

The Office of the Assistant Under Secretary for Health for Operations (AUSHO) is responsible for overseeing the delivery of health care services. The Office of the Assistant Under Secretary for Health for Operations provides oversight for 18 VISNs, 172 VAMCs and over 1,000 outpatient sites of care. The following program offices make up the Office of the AUSHO: Office of Veterans

Access to Care; Office of Emergency Management; Member Services; and the Healthcare Operations Center.

**Access**

The Office of Veterans Access to Care (OVAC) MSC funds are utilized to offer Veterans timely and quality access to care activities and operations across VACO, VISNs and VAMCs. The funds are used to advance VA access priorities: support and sustain the MISSION Act, oversee the virtual care delivered through the clinical contact centers and video-to-home, expand and sustain same-day services in Primary Care and Mental Health, offer Patient-Centered Scheduling, expand direct scheduling, modernize patient scheduling and provide the oversight and accountability for access improving solutions in emerging technology and the community. OVAC uses MSC funds to collaborate with the OCC, Office of Healthcare Transformation and other VHA Program Offices, which directly supports the tenets of the myVA Access Declaration that outlines a consistent set of expectations regarding what a Veteran deserves when he or she enters any VHA facility.

**Office of Emergency Management (OEM)**

Funding supports the VHA enterprise through the integration of emergency management programs, functions and supporting activities to prevent, protect, mitigate, respond and recover from all hazards. OEM provides support in the form of personnel, finances, materials and processes during these five overlapping phases of internal and external disasters and military contingencies.

**Healthcare Operations Center**

These funds support the centralized management and support of operations across the VHA enterprise. This includes daily operational support to and management of the VISNs; routine monitoring and analytics of operational, quality and productivity metrics; and implementation of enterprise-wide initiatives. The Healthcare Operations Center provides rapid, near real-time information and analyses to support senior leader decision-making, problem-solving and improve VHA's ability to provide Veterans timely access to the highest quality care.

**Member Services**

Member Services' (MS) mission is to facilitate access to health care, benefits and support services for Veterans and their families. MS is comprised of four national programs: Health Eligibility Center (HEC) – enrolls eligible Veterans who apply for VA health care in addition to providing other enrollment and related services; Health Resource Center (HRC) – assists Veterans in understanding and obtaining benefits; Veterans Transportation Program (VTP) – helps alleviate the costs of travel to medical appointments for eligible Veterans; and Pharmacy Services (PS) – assists Veterans with management of prescription issues and co-payments through the Pharmacy Customer Care and Clinical Pharmacy Resources efforts, respectively. Allocation from the MSC appropriation is used to fund multiple Veteran-facing initiatives within these national programs as well as supporting administrative offices and staff.

**Patient Care Services**
**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations [Total] | $141,897 | $194,174 | $208,325 | $316,939 | $329,300 | $108,614 | $12,361 |

**Program Description**

The Office of Patient Care Services leads VHA in delivering the highest quality, Veteran-centric care, supporting health and well-being through leveraging technology and providing clinical services across the continuum of care. The Assistant Under Secretary for Health for Patient Care Services also serves as the Chief Nursing Officer (CNO). The CNO is the Senior Advisor to the Under Secretary for Health and to key VHA and Department officials on all matters relating to VA Nursing and the delivery of patient care services. The CNO collaborates inter-professionally to enhance and support evidence-based professional practice, workforce research and education and the VA nursing workforce to strengthen leadership and teamwork to provide quality, patient-driven care for the Nation's Veterans. The Office of PCS is comprised of the following health care services/programs:

**Care Management and Social Work Services (CM/SW)**

This office leads VA's transformation towards a Veteran-Centric organization by providing personalized care management, clinical interventions and supportive programming for Veterans, their families and caregivers. These goals are achieved through the coordination of care, services and benefits afforded to Veterans by VA programs and in collaboration with community partners. CM/SW provides oversight and leadership of clinical and supportive programming across the VHA focusing on assisting wounded, injured and ill Service members, Veterans, their family members and caregivers with resolving Social Determinants of Health challenges to health and well-being.

The programs that fall under CM/SW are the Intimate Partner Violence Assistance Program; VA Liaison Program; Caregiver Program; the Fisher House and Family Hospitality Program that encompasses policy development and implementation, construction planning, activation and operations oversight and community engagement for all non-clinical temporary lodging programs including: VA Fisher Houses and other Temporary Lodging; Social Work, which assists Veterans, their families and caregivers in resolving Social Determinants of Health challenges to health and well-being, using a person in environment perspective; and the Transition and Care Management Program, which provides comprehensive transition assistance and longitudinal case management to Post 9/11-era wounded, ill and injured Service members and Veterans.

**Chaplain Services**

MSC funds are utilized for necessary expenses (Personnel Compensation, Travel and Transportation of Persons, Printing and Reproduction and other contractual services) in the provision of oversight and management of the National Chaplain Services and the planning and directing a Spiritual and Pastoral Care Program consistent with the overall mission of health care delivery in VHA.

**Connected Care**

This program provides VA digital technology to Veterans and health care professionals, through virtual technology. VA is able to deliver care to patients where and when they need it. MSC funds are used for Program Office salaries, contracts, travel supplies and MOU) to support services that improve convenience to Veterans by providing access to care from their homes or local communities. Additionally, the office provides support for some field cost which represents the gap between current state and strategic plan standards at the VISN, facilities and CBOCs for Telehealth (TH) Technology Managers, Connected Health (CH) Coordinators, CH Assistants, Facility Telehealth Coordinators, Home Telehealth leads and VISN TH leads. Funding would be

provided to field as directed funding in conjunction with a Connected Care Staffing policy that requires the positions.

**Geriatrics and Extended Care**

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 & Community Based and Purchased Care Programs and the Data Analytics, Quality Improvement and Research support. GEC manages the Community Living Centers (CLC) and State Veteran Home (SVH) Surveys, SVH Per Diem and Construction Grant programs, Community Nursing Homes and Purchased Long-term Services and Support, Medical Foster Homes and Home-Based Primary Care. GEC also provides support for Veteran Community Partnerships, Geriatric Research and Education Centers, Palliative and Hospice Care and other aging initiatives. MSC funds are used for Program Office salaries and contracts to support these quality surveys and other Veteran-centric programs.

**Patient Centered Care and Cultural Transformation**

The office utilizes MSC funds to support the development and sustainment of Whole Health in VHA. The majority of the office's MSC funds fund salaries, travel and training for staff who support the strategic direction and implementation of Whole Health in VHA. These staff work in Whole Health Education, Complementary & Integrative Health, Whole Health Research and Evaluation, Whole Health Communications and Strategic Partnership, Employee Whole Health and Whole Health System Development.

**Pharmacy Benefits Management Services**

Pharmacy Benefits Management (PBM) Services utilizes MSC funds for several programs decentralized throughout the country to provide organizational and clinical leadership to VHA Pharmacies, as well as support to other healthcare providers to facilitate the highest quality care to Veterans by ensuring safe, effective and medically necessary management of medications. This is accomplished by creating a practice environment that fosters education, professional development, progressive practice initiatives and innovative technologies to ensure consistent, accurate and reliable medication distribution and information systems.

**Physician Assistant Services**

The Director of Physician Assistant Services advises the VA senior management of all matters relating to the employment and effective utilization of the 2,600 Physician Assistants (PA) in VHA. Responsibilities include: policy development, consultation on the PA role in various settings and capacities, recruitment strategies, credentialing requirements and ongoing educational needs, congressional inquiries, constituent and external organization, coordination and collaboration with external federal and state regulatory agencies and local and national organizations, succession planning, monitoring trending data, academic preparation for qualified professionals and current community practice patterns.

**Population Health**

Population Health aims to transform VA into a system that assists Veterans and their families to achieve their health goals through accessible, evidence-based, equitable and high value Veteran-centric interactions. The office has oversight for the Office of Rural Health, Post Deployment Health Services; Health Equity, which identifies disparities experienced by different groups of Veterans, develops quality improvement tools to help VA facilities reduce disparities through the Equity Guided Improvement Strategy and partners with stakeholders to share equity knowledge

and tools; the Lesbian, Gay, Bisexual and Transgender Health Program that oversees policy, education, consultation and implementation of best clinical practices to reduce health disparities in sexual and gender minority Veterans; the National Center for Health Promotion and Disease Prevention, which provides programs, resources, training and guidance to promote health promotion, disease prevention and health education for Veterans through the Veterans Health Library and the HealtheLiving Assessment; Public Health, which leads public health activities, surveillance and investigations for high consequence infections through the VA National Public Health Laboratory, staff and technology to conduct investigations and surveillance, VHA's All-Hazards Emergency Cache program and interagency activities; and Health Solutions, which deploys and refines electronic medical record solutions to monitor and optimize health care delivery as exemplified by Clinical Case Registries, Cerner HealtheRegistries and Health Maintenance and interfaces to State/Territory Public Health Immunization Information Systems.

**Rehabilitation and Prosthetic Services**

Rehabilitation and Prosthetic Services oversees program and policy development for rehabilitation services for VHA, coordinating the provision of the full continuum of medical rehabilitative and prosthetic services to promote the health, independence and quality of life for Veterans with disabilities. This office administers program and policy development for eight national programs with 11 different rehabilitation disciplines: Physical Medicine & Rehabilitation; Blind Rehabilitation; Chiropractic Care; Audiology and Speech Pathology; Recreation Therapy; Orthotic, Prosthetic and Pedorthic Clinical Services; Prosthetics and Sensory Aids; and the National Veterans Sports Program. The office aligns clinical expertise, clinical and practice guidance and specialized procurement resources to provide comprehensive rehabilitation, prosthetic and orthotic services across the VHA health care system in the most economical and timely manner.

**Sterile Processing Services (SPS)**

The National Program Office of Sterile Processing utilizes MSC funds to support consultative contracts such as the current contract with Booz Allen Hamilton in the development of a Risk Identification Triage Mitigation Sustainment (RiTMS) tool. This tool supports early identification of risk and major vulnerabilities faced by SPS departments and provides opportunities to mitigate in advance of an adverse event.

## Quality and Patient Safety
**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate 1/ | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations [Total]..... | $126,206 | $453,789 | $131,738 | $205,955 | $213,987 | $74,217 | $8,032 |

1/ The 2022 Budget Estimate contained funds for Core Finance Administration, which belong to the All Other Support and Program Offices line item. The 2021 Actuals, 2022 Current Estimate, 2023 Revised Request and 2024 Advance Appropriation have Core Finance Administration funds within the All Other Support and Program Office line items.

### Program Description

The Office of Quality and Patient Safety (QPS) provides oversight, expertise and support to advance the highest standards of care, innovation, responsible stewardship and ethical practice within the VA health care system.

### National Center for Patient Safety

The National Center for Patient Safety (NCPS) establishes policy and provides oversight for the VHA National Patient Safety Program, including the development of guidance and measurement to mitigate Veteran harm and the fostering of a just and safe culture. Furthermore, NCPS is responsible for maintaining a database for patient safety events and root cause analysis reports, curriculum delivery for two post-graduate patient safety educational programs, promoting the VHA High Reliability Organization (HRO) Journey to Zero Harm through clinical team and just culture training, oversight and administration of the Patient Safety Centers of Inquiry to advance patient safety science, evaluation of healthcare solutions, technology, innovations from a patient safety and value-based perspective and oversight of the VHA alerts and recall program for medical products, drugs and food. The offices of Product Effectiveness and Utilization Management report directly to NCPS.

### Analytics and Performance Integration

The Office of Analytics and Performance Integration (API) mission delivers innovative and authoritative performance measurement, analytic and reporting tools and capabilities throughout VHA to enhance the value and quality of care for Veterans. API utilizes its MSC funding for staff salaries, travel and education to enable the entire VHA health system use data to drive high-value and Veteran-Centric care through areas such as but not limited to: the Center for Strategic Analytic Reporting (CSAR), which develops the Strategic Analytics for Improvement and Learning (SAIL) report to measure, evaluate and benchmark quality and efficiency at VA medical facilities, in addition to utilizing data from the Centers for Medicare and Medicaid Services (CMS) for comparisons to the private sector; the Inpatient Evaluation Center (IPEC), which produces innovative products focused on tracking and improving the outcomes of hospitalized Veterans; and the Office of Productivity, Efficiency and Staffing, which is dedicated to enhancing VHA healthcare effectiveness using standard industry practices and external practice benchmarks for monitoring and improving clinical productivity and effectiveness.

Additionally, API supports legislative requirements such as the Survey of Healthcare Experiences of Patients (SHEP) to measure patient experiences in the VA; the External Peer Review Program contract to operate a system of external review of identified medical records in alignment with external comparators in order to assess the quality of VHA inpatient and outpatient care.

## Quality Management

The Office of Quality Management (OQM) supports the ongoing assessment and improvement of healthcare outcomes and healthcare delivery processes. OQM program offices help ensure VHA is hiring the right providers, identifying evidence-based practices, screening for deviations from standards of care and keeping facilities in a continuous state of readiness and compliance with industry standards. In addition, OQM provides education, training and competency build for quality professionals across the VHA to further enhance data knowledge and use, leadership skills and quality competencies. OQM Programs working to achieve these goals include External Accreditation Services and Programs, Systems Redesign and Improvement, the Center for Improvement Coordination, Evidenced-Based Practice Program, Medical Staff Affairs, Clinical Risk Management and the Office of Medical-Legal Affairs.

**Support Services**
**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations | $440,307 | $0 | $676,262 | $688,777 | $715,639 | $12,515 | $26,862 |
| Mandatory Obligations 1/ | $0 | $678,433 | $0 | $0 | $0 | $0 | $0 |
| Obligations [Total] | $440,307 | $678,433 | $676,262 | $688,777 | $715,639 | $12,515 | $26,862 |

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

## Program Description

The Office of the Assistant Under Secretary for Health for Support provides facilities, engineering, equipment, occupational safety and health and procurement/logistics support services, expertise and program oversight to enable effective and efficient medical facility Operations, Clinical Services and Patient Care Services.

The 2023 budget allows VA to further its commitment to a new electronic health record that will move toward a single common health record that has full integration with the Department of Defense, VA and community providers, which will provide Veterans a single, accurate, lifetime health record with improved patient care and safety. This budget provides funds to recruit for increased acquisition workforce capacity at VAMCs in order to assist with developing, awarding and managing construction contracts related to EHRM without schedule delays. Additionally, this budget will allow for the hiring for increased administrative Healthcare Environment and Facilities staff to facilitate the development of engineering requirements and provision of oversight at each VAMC as it relates to increased workload for EHRM. Finally, as the new electronic health record requires medical devices that have an existing interface with the CERNER software along with the administrative staff needed to handle related workflows and processes, this 2023 budget will allow for administrative assistance to facilitate the replacement of these non-conforming medical devices with appropriate medical devices for EHRM specifically.

As part of its continued commitment to the modernization of its supply chain and support systems, the 2023 budget further allows VA to recruit for and hire a workforce of skilled VHA supply chain, healthcare technology and facilities management staff. VHA will increase healthcare logistics staff

capacity at each VAMC to ease and facilitate the transition to a new integrated logistics and medical support services system enterprise wide. Moreover, this increases capacity will also ensure that healthcare logistics support in our VAMCs fully supports the needs of Veterans and staff nationwide, in addition to furthering VA's commitment to its fourth Strategic Goal to transform business operations by modernizing systems and focusing resources more efficiently to be competitive and to provide world-class customer service to Veterans and VA employees.

In accordance with VA's investment in its workforce and focus on employee education, the 2023 President's Budget allows VHA to establish and operate the Healthcare Environment and Facilities Training Center of Excellence. A National Academies Study of the VA Healthcare Engineering Workforce identified a significant need for detailed and sequential provision of technical skills training, inclusive of a structured path for critical succession planning to guarantee the continuity of a skilled and effective workforce. The Healthcare Environment and Facilities Training Center of Excellence will provide competency enhancement for essential staff, including engineers, engineering trades, safety specialists, industrial hygienists, environmental protection, environmental services and other health environment of care related professionals.

**Healthcare Environment and Facilities Programs**

Healthcare Environment and Facilities Programs (HEFP) uses MSC funds to provide oversight in the areas of capital asset management, healthcare engineering, environmental management and occupational safety and health across the VHA enterprise in support of medical facility infrastructure. Each of these specialty areas works together to ensure operational compliance with Codes, standards, regulations, statutes and Executive Orders. MSC funds directly support the salaries and training requirements of VISN-level Green Environmental Management Systems Program Managers and Energy Engineers.

**Acquisitions, Technology and Logistics**

The Acquisitions, Technology and Logistics office is the new office resulting from the merging on the offices formerly known as Procurement and Logistics (P&LO) and Healthcare Technology Management (HTM). This office uses MSC funds to recruit and retain the best qualified acquisition workforce to provide support to all of VHA in purchasing high quality, cost-effective healthcare products and services for all facilities; provide world-class logistics and acquisition services to VHA's integrated healthcare system and medical facilities; and develops, implements and oversees policies and processes compliant with all applicable laws and regulations. Additionally, this office uses MSC funds to employ biomedical engineers and other support staff to provide oversight to Biomedical Engineering (BME) programs across VHA field operations regarding the commissioning, technical sustainment and systematic technical refresh of medical equipment used across VHA. Please see the Medical Equipment section in the Medical Services chapter for more information.

**Veterans Canteen Service**

Since 1946 Veterans Canteen Service (VCS) has been serving America's Veterans, caregivers, family members, visitors and volunteers as the commercial retail, café and coffee shop service across 200 VAMCs & facilities as a self-sustaining entity with one Mission; "Providing Comfort and Well-being." VCS is an integral part of the VA community driven to be efficient, innovative and customer focused giving back to Veterans with support for Rehabilitation events, homelessness programs, suicide prevention and emergency support during natural disasters. VCS

does not use MSC funds. Please see the Veterans Canteen Service Revolving Fund section in the Revolving and Trust Activities chapter for more information.

### VA Logistics Redesign

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

**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations [Total] | $230,255 | $233,778 | $234,695 | $340,791 | $354,082 | $106,096 | $13,291 |

### Program Description

The Office of Human Capital Management (HCM) is committed to achieving individual and organizational high performance for VHA workforce to serve our nation's Veterans. HCM supports the human capital needs of VHA employees and health professions trainees. HCM provides guidance, information and consultation to VHACO components, VHA health care facilities, VISNs and external entities such as health professional organizations, Congress and other Federal agencies. HCM oversees VHA's succession and workforce planning; identifies and monitors talent needs and trends within the organization and links succession planning and business strategies, presenting VHA with the opportunity to reach long-term goals and achieve human capital objectives. To drive change and the long-term development of people and culture to address future challenges as VA continues its modernization transformation, HCM conducts a department-wide assessment of organizational health annually providing data analytics and action planning consultation to ensure results are used to improve the workplace. HCM consists of the following program offices: Employee Education System (EES), Healthcare Leadership Talent Institute (HLTI), National Center for Organization Development (NCOD), Workforce Management and Consulting (WMC). MSC funds support additional HCM functions including administrative, financial and logistical oversight for all VHA headquarters Program Offices and staff.

The 2023 budget further invests in VHA Human Resources (HR) due to its vital role in delivering on our mission and enabling implementation of workforce enhancements. A 2016 Government Accountability Office (GAO) report, *Management Attention is Needed to Address System, Long-standing Human Capital Challenges*, indicated VHA is facing key human capital challenges that hamper its ability to effectively serve Veterans. As a result of these findings, VHA began a transformation in 2018 to shift decentralized field HR operations to VISN HR Shared Services, supported by a VHACO HR Center of Expertise and local HR Strategic Business Partners. In a large integrated health care system like VHA, shared services can flex and scale to support local health care delivery needs and identify meaningful performance improvement opportunities to help organizations achieve strategic goals. With the consolidation of HR being completed, there is now increased focus on standardizing and optimizing operations prioritized by customer needs and agency expectations.

VHA will create HR staffing models, which will ensure human capital resources are adequately and appropriately allocated. These staffing models will focus on productivity and efficiency metrics, which will draw upon existing production measures and outcomes, to determine optimal HR staffing levels for each functional area of HR. A data system audit is underway and, once completed, this staffing model is expected to have a profound impact on Time to Hire and therefore address a significant concern among HR's customers. To further improve customer service, VHA is also piloting a call center for HR to respond to customer inquiries and issues that require assistance, with the ultimate goal of further enabling leadership at all levels and HR professionals hire and onboard medical professionals and support staff in a timely manner. Funding for the operational and logistical capabilities, in addition to staffing, will be needed once metrics and results from the pilot are complete.

To further assist VAMCs and VISNs in their hiring capabilities, VHA is updating and realigning its position categorization structure to enable VAMCs and VISNs to better define and track their staffing requirements in addition to enabling predictive staffing power on the part of VAMCs and VISNs. Additionally, it will simultaneously allow for the flow of staffing requirements to the enterprise level, facilitating national recruitment efforts and driving more accurate workforce planning and analysis outcomes. Moreover, VHA is expanding the Physician/Provider Recruiter role by adding this specialty to local infrastructure to recruit hard-to-find physicians and advanced practice providers in the nation's most scarce specialties. Additionally, in order to supplement and support our expanded specialized recruitment function, VHA is investing in expanding its national recruitment and sourcing capabilities to build and leverage what would become the nation's largest database of practicing physicians and advanced practice providers that would be provided to VAMCs for immediate consideration and appointment at our hospitals and outpatient clinics. These actions allow VA to expand the healthcare workforce pipeline with continued focus on mental health, long-term care and rural communities. These expanded capabilities provide VHA a market advantage by generating large actionable and diverse talent pools of candidates for current and future needs, thus solidifying our readiness to meet emerging clinical workforce demands.

VHA will stand up a Talent Team that will include a combination of new and existing highly talented individuals with strong leadership skills and a working knowledge of HR policy and operational practices with the goal of helping facilitate and validate custom technical and behavioral assessments based on job analysis workshop results. Furthermore, rapid process improvement and standardization teams have been established and are working to enhance HR operational processes such as but not limited to onboarding; creation of national standard protocols; and expansion of training for hiring managers and their designees. Additionally, baseline service delivery performance data is being collected to prepare for monitoring improvement efforts, as trends in service delivery performance coupled with customer satisfaction at all stages within the employee journey enable refined targets for operational improvements. Growth of these teams would enable a shorter design period by analysis of multiple HR processes at once, resulting in faster time to implement for identified improvements and allow for dedicated resources to monitor and analyze service delivery performance.

As part of its effort to integrate HR Information Technology systems, VHA is partnering with the Department of Defense and Office of Personnel Management to improve interoperability, facilitate data exchange, eliminate duplicate and out-of-sync information and enhance workflows and training. An acquisition strategy and timeline for implementation will be pursued once preparations are in place.

In accordance with VA's investment in its workforce and focus on employee education, VHA is implementing a high-volume accelerated training program to focus on the HR Professional occupation development and candidate pool, which would vastly expand the number of trainees in the program that would receive focused training, on the job training and preceptor mentoring. VHA is also procuring training space for learning labs, workshops and other simulations to ensure experiential learning and development for HR professionals is ongoing at all levels, not just the foundational level.

**Employee Education System (EES)**

Employee Education System (EES) provides training solutions and services to empower VA's development of a high performing workforce that delivers exceptional care to our Veterans. EES serves as the largest single provider of accredited learning in alignment with major health care accrediting bodies. EES partners with VA, VHA program offices, VISNs and medical facilities to provide quality workforce education and training to improve outcomes in Veteran clinical care, health care operations and administration. VHA employees rely upon EES for high-quality, impactful education and training support. Together with partners in learning across the administration, EES learning consultants, project teams and support staff assess learning requirements, design curricula and courses and deliver and evaluate education and training to meet the workforce development and continuing education needs of clinical, administrative and technical employees. EES serves as managing partner for the Federal Healthcare Training Partnership, consisting of agencies (including DoD) that collaborate and share continuing medical education training programs among partner organizations with a clinical and public health training mission. EES shares, at no cost to the learner, continuing medical education/continuing education in the health professions training programs on the VHA Training Finder Real-time Affiliated Integrated Network (TRAIN). A service of Public Health Foundation, TRAIN operates through collaborative partnerships with state and Federal agencies, local and national organizations and educational institutions. MSC funds support overhead costs associated with maintaining the program and administrative support costs for training, travel, equipment and supplies.

**Healthcare Leadership Talent Institute (HLTI)**

Healthcare Leadership Talent Institute (HLTI) develops and implements an integrated talent management system from the local to the national level. HLTI is responsible for linking together talent planning and talent development processes and programs into a single system characterized by informed, structured, ongoing and deliberate processes to identify, develop and leverage the leadership talents of the VHA workforce. The result is a cadre of ready, willing, diverse and capable leaders to step into VHA's most demanding roles. HLTI promotes and manages leadership programs and developmental opportunities that maximize the acquisition of leadership and healthcare leadership competencies through growth activities that are 70% experiential (e.g., activities, details, assignments, committees), 20% exposure (e.g., coaching, mentoring, shadowing) and 10% traditional didactic training. HLTI oversees VHA leadership succession planning, identifies and monitors talent needs and trends within the organization and links succession planning and business strategies to present VHA with the opportunity to reach long-term goals and achieve human capital objectives. MSC funds support leadership development of VHA staff throughout the organization at all levels.

### National Center for Organization Development

National Center for Organization Development (NCOD) collaborates with leaders throughout VA enabling them to create a highly engaged workforce to increase the long-term growth and performance of the Department of Veterans Affairs. NCOD administers, analyzes and presents results of the annual All Employee Survey to leaders and assists with action planning across VA. NCOD conducts consultative engagements designed to support services/workgroups by working with individual leaders virtually and/or in person. NCOD provides services designed to strengthen executive leadership teams to better overcome challenges and grow their organizations together. NCOD offers 360° assessments as well as executive coaching to current and developing leaders within the organization and conducts the VA internal coach training program to build a broader cadre of coaches that are eligible for the International Coaching Federation (ICF) credential.

NCOD reaches out to leaders at sites considered at risk related to employee engagement offering foundation approaches aimed at improving the work environment for employees. NCOD oversees VA Voices, which is designed to engage employees and promote collaboration to achieve the shared mission of serving Veterans. The aim is twofold: to engage employees and to create an organizational climate that sustains engagement over time. NCOD has developed several programs, services and resources focused on engagement to support leaders in creating a workplace where employees want to work and Veterans want to receive care. MSC funds support additional NCOD functions including oversight and coordination of travel for the VA Voices Program, assisted logistical support and facilitation of the VHA Governance Board and direct support of enterprise-wide VA All Employee Survey Administration and related consultative services.

### Workforce Management and Consulting

Workforce Management and Consulting (WMC) provides VHA-wide leadership for workforce operations and administration management through strategic human capital planning, senior executive recruitment, performance and advisory services, labor management and labor relations and training and career development. WMC ensures the recruitment and retention of a highly skilled, motivated and effective workforce and provides advice and assistance to VHA leadership on human resources issues. WMC provides full-service HR operations for VA employees (including VHACO, specific VA staff office organizations and VA's Office of Information and Technology) and serves as the delegated examining unit for all VHA. WMC also provides Personnel Security and Credentialing oversight to VISNs and Medical Centers through issuance of policy, technical guidance and consultative services focused on establishing consistency in suitability and credentialing-related practices. MSC funds support essential human resources staff salaries, human capital recruitment and retention programs such as employee scholarship programs and critical human resources contracts and services supporting VHA employees nationwide.

## Health Informatics

**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations [Total] | $136,614 | $109,403 | $105,877 | $179,057 | $186,040 | $73,180 | $6,983 |

**Program Description**
Office of Health Informatics (OHI) oversees the collection, exchange and use of Electronic Health Record (EHR) data, optimizes the current EHR to promote evidence based decision-making and patient-centered care and delivers health information technology (HIT) solutions that increase Veteran access to care and supports participation in their health care by:

- Ensuring that health care information systems are implemented in a manner that meets the requirements of VHA users, including the Electronic Health Record Modernization (EHRM).
- Enhancing heath information exchanges with federal and private partners.
- Providing national policy and guidance to Health Informatics, Freedom of Information Act (FOIA), Privacy, Health Information Management, Records Management and Library personnel nationwide.
- Facilitating sound decision-making for development, acquisition and maintenance of health IT investments through business requirements, IT strategy and priorities and investment analysis.
- Developing, delivering and implementing virtual and digital technologies that help Veterans communicate with their VA care teams and coordinate, track and manage their health care.
- Partnering with VHA Programs and VA's Office of Information and Technology to deploy enterprise applications and databases to support strategic goals and objectives for VHA.

**Program Support Operations**

Program Support Operations (PSO), manages the business functions for OHI, providing guidance and support in such areas as planning and strategy, budget, human resources and contracting.

**Clinical Informatics and Data Management Office**

Clinical Informatics and Data Management Office (CIDMO), formerly known as Health Informatics (HI), is the focal point for advancing VA's EHR and information systems. CIDMO serves as the primary advocate for field clinicians regarding HIT. The office provides program support to HIT solutions such as the Veterans Health Information Exchange (VHIE) and the enterprise Health Management Platform (eHMP).

**Health Information Governance**

Health Information Governance (HIG) represents VA on national and international health care policy initiatives regarding Veterans' data. HIG serves as VHA's subject matter and policy expert regarding privacy, health care security and on data contained in Veterans' EHR and in national data systems. They provide compliance monitoring, management of national data systems and knowledge-based library services. The office develops and implements policy and regulations in accordance with FOIA, Privacy Act, Title 38 confidentiality statutes and HIPAA Privacy Rule. HIG provides national guidance, policy and training to VHA field-based professionals on health

information management, library, privacy, FOIA, records management, identity management and health care security topics.

### Strategic Investment Management

Strategic Investment Management (SIM) facilitates sound decision-making for the development, acquisition and maintenance of health-focused IT investments by providing leadership with a comprehensive understanding of needed VHA business capabilities including business requirements, processes, information needs, IT strategy and priorities and investment analysis. SIM provides a wide range of services including, business requirements/architecture development for health IT solution development or acquisition, business process re-engineering, software release management, health IT governance management, health IT analysis and budget development, health IT strategic planning and business transformation, as well as VistA Standardization coordination with the open-source communities.

### Office of Nursing Informatics

Office of Nursing Informatics (ONI) fulfills the sacred obligation to care for Veterans by supporting Nurses throughout the care continuum to link science, technology and the use of electronic medical records, tools and processes to improve health. Nurses are the largest group of healthcare professionals and the main users of technology and spend the most time with Veterans.

Nurses are responsible for implementing evidence-based interventions to promote health lifestyles and use these interventions to guide care. 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. A healthcare transformation is not possible without nurses. As Nursing Informatics leaders, we are tasked with building and developing Nursing Informatics within the VHA. Office of Nursing Informatics is made up of the best NI leaders nationwide. By working with us to right size, build our office, the community of Nursing will be supported and learn from the best.

ONI measures outcomes based on what Nurses caring for Veterans are experiencing and what solutions mean to Veterans. The ONI vision is to transform healthcare through Nursing Informatics by leveraging HRO principles to lead modernization and Veteran Health Delivery to:

- Advance process and technology standardization
- Implement data driven culture

## All Other Support and Program Offices

**All Other Support and Program Offices**
**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate 1/ | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Obligations [Total] | $526,427 | $261,785 | $556,562 | $773,259 | $803,416 | $216,697 | $30,157 |

1/ The 2022 Budget Estimate had Core Finance Administration funds within the Quality and Patient Safety line item. The 2021 Actuals, 2022 Current Estimate, 2023 Revised Request and 2024 Advance Appropriation have Core Finance Administration funds within the All Other Support and Program Office line items.

## Program Description

The VHA program offices in this line include: Patient Advocacy, Readjustment Counseling, Women's Health, Healthcare Transformation, Finance, Strategy, Risk Management, the Chief of Staff, Office of the Deputy Under Secretary for Health and the Office of the Under Secretary for Health.

## Veterans Choice Act, Public Law 113-146, Medical Support and Compliance, Section 801 (0152XA)

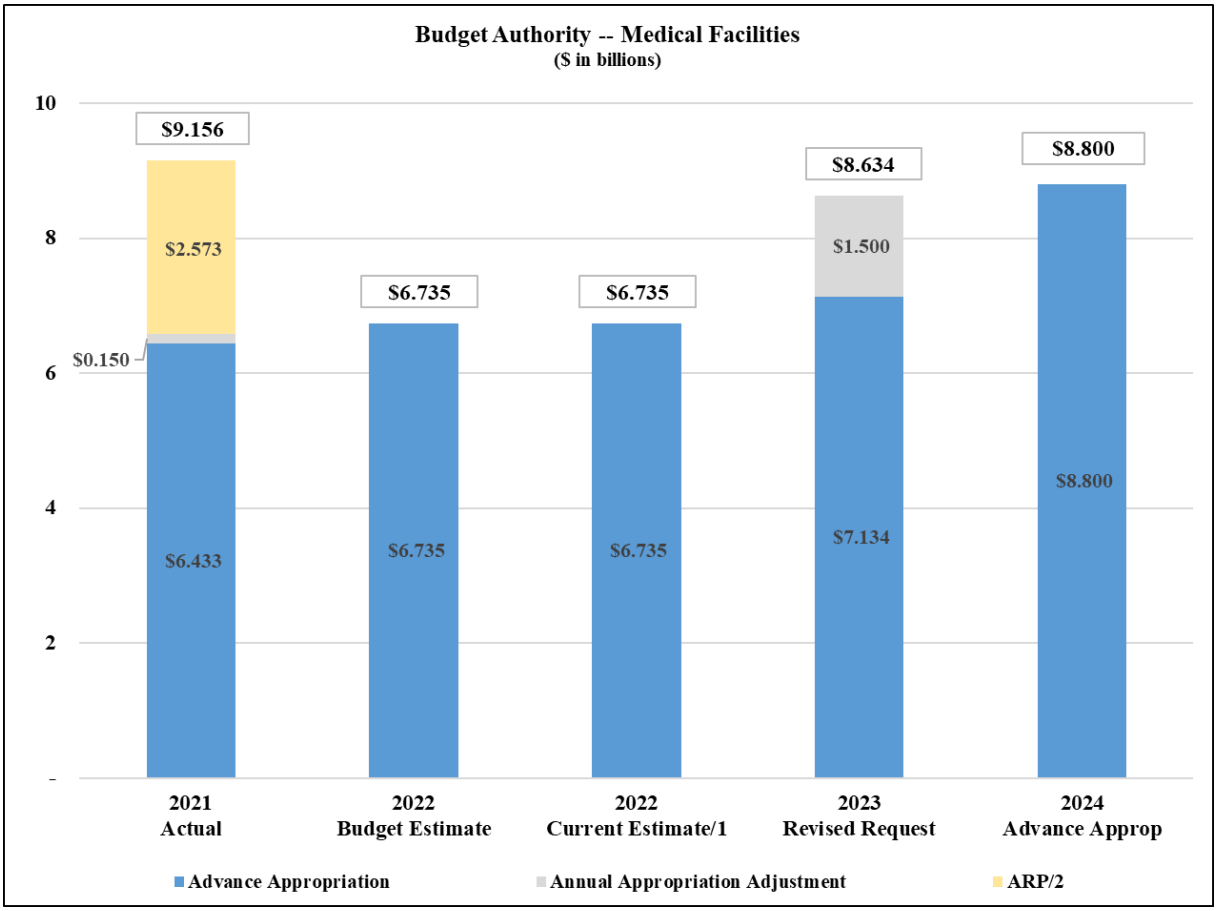
**Veterans Choice Act - Section 801**
**Medical Support and Compliance**
**(dollars in thousands)**

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Mandatory Obligations [Total] | $2,717 | $1,453 | $2,799 | $2,883 | $2,969 | $84 | $86 |

Within the Medical Support and Compliance appropriation, estimates of obligations for 2023 and 2024 are $2.9 million and $3.0 million respectively. The obligations will be spent on staffing and contracts to support Section 301 (GME).

# Section G: Medical Facilities

## Chart: Medical Facilities Appropriations




[1/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, together with updated estimates for transfers, reimbursements and medical care collections.

[2/] The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the chart displays the estimated allocation for the Medical Facilities category. Final funding allocations among account-level categories may change based on 2022 actuals in response to workload demand requirements throughout 2022 and 2023.

The following tables display the discretionary, mandatory and combined sources of funds for the Medical Facilities category.

# Table: Medical Facilities Crosswalk, 2020-2023

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Appropriation Medical Facilities (0162)** | | | | | | | |
| Advance Appropriation | $6,433,265 | $6,734,680 | $6,734,680 | $7,133,816 | $8,800,000 | $399,136 | $1,666,184 |
| Annual Appropriation Adjustment | $150,000 | $0 | $0 | $1,500,000 | $0 | $1,500,000 | ($1,500,000) |
| Appropriations Request [Subtotal] | $6,583,265 | $6,734,680 | $6,734,680 | $8,633,816 | $8,800,000 | $1,899,136 | $166,184 |
| **Net Appropriation** | **$6,583,265** | **$6,734,680** | **$6,734,680** | **$8,633,816** | **$8,800,000** | **$1,899,136** | **$166,184** |
| Tranfers To | | | | | | | |
| JALFHCC (0169) | ($40,297) | ($92,830) | ($92,830) | ($50,297) | ($40,570) | $42,533 | $9,727 |
| Transfers To [Subtotal] | ($40,297) | ($92,830) | ($92,830) | ($50,297) | ($40,570) | $42,533 | $9,727 |
| Budget Authority [Total] | $6,542,968 | $6,641,850 | $6,641,850 | $8,583,519 | $8,759,430 | $1,941,669 | $175,911 |
| Reimbursements | $24,739 | $18,420 | $24,739 | $24,739 | $24,739 | $0 | $0 |
| Unobligated Balance (SOY) | | | | | | | |
| No-Year | $12,985 | $0 | $18,489 | $0 | $0 | ($18,489) | $0 |
| P.L. 115-141 sec 255 (NRM) | $299,657 | $0 | $115,406 | $0 | $0 | ($115,406) | $0 |
| P.L. 115-244 sec 248 (NRM) | $512,199 | $61,302 | $336,087 | $0 | $0 | ($336,087) | $0 |
| H1N1 No-Year (PL 111-32) | $5 | $0 | $5 | $0 | $0 | ($5) | $0 |
| 2-Year | $137,079 | $200,000 | $158,634 | $350,000 | $0 | $191,366 | ($350,000) |
| 2-Year CARES Act (P.L. 116-136) | $293,204 | $0 | $0 | $0 | $0 | $0 | $0 |
| 5-Year Base Year 2019 - P.L. 116-20 (Disaster Relief) | $46,071 | $0 | $41,538 | $0 | $0 | ($41,538) | $0 |
| Unobligated Balance (SOY) [Subtotal] | $1,301,200 | $261,302 | $670,159 | $350,000 | $0 | ($320,159) | ($350,000) |
| Transfer of Unobligated Balance (PL 116-136 §20001) | | | | | | | |
| From Medical Services CARES Unob. Bal. | $140,000 | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (EOY) | | | | | | | |
| No-Year (Other) | ($18,489) | $0 | $0 | $0 | $0 | $0 | $0 |
| P.L. 115-141 sec 255 (NRM) | ($115,406) | $0 | $0 | $0 | $0 | $0 | $0 |
| P.L. 115-244 sec 248 (NRM) | ($336,087) | $0 | $0 | $0 | $0 | $0 | $0 |
| H1N1 No-Year (PL 111-32) | ($5) | $0 | $0 | $0 | $0 | $0 | $0 |
| 2-Year | ($158,634) | $0 | ($350,000) | $0 | $0 | $350,000 | $0 |
| 2-Year CARES Act (P.L. 116-136) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 5-Year Base Year 2019 - P.L. 116-20 (Disaster Relief) | ($41,538) | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (EOY) [Subtotal] | ($670,159) | $0 | ($350,000) | **$0** | **$0** | $350,000 | $0 |
| Lapse | ($4,108) | $0 | | | | $0 | $0 |
| Subtotal | $7,334,640 | $6,921,572 | $6,986,748 | $8,958,258 | $8,784,169 | $1,971,510 | ($174,089) |
| Prior Year Recoveries | $42,851 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations (0162) [Total]** | **$7,377,491** | **$6,921,572** | **$6,986,748** | **$8,958,258** | **$8,784,169** | **$1,971,510** | **($174,089)** |
| **Veterans Medical Care and Health Fund (0173MF) 1/** | | | | | | | |
| Mandatory Appropriations | $2,572,928 | $0 | $0 | $0 | $0 | $0 | $0 |
| | | | | | | $0 | $0 |
| Unobligated Balance (SOY) | $0 | $2,572,928 | $2,572,928 | $392,200 | $0 | ($2,180,728) | ($392,200) |
| Unobligated Balance (EOY) | ($2,572,928) | $0 | ($392,200) | $0 | $0 | $392,200 | $0 |
| **Obligations (0173MF) [Total]** | **$0** | **$2,572,928** | **$2,180,728** | **$392,200** | **$0** | **($1,788,528)** | **($392,200)** |
| **VACAA, Section 801 (0162XA)** | | | | | | | |
| Unobligated Balance (SOY) | $30,437 | $24,753 | $16,095 | $1,323 | $0 | ($14,772) | ($1,323) |
| Unobligated Balance (EOY) | ($16,095) | ($18,847) | ($1,323) | $0 | $0 | $1,323 | $0 |
| Subtotal | $14,342 | $5,906 | $14,772 | $1,323 | $0 | ($13,449) | ($1,323) |
| Prior Year Recoveries | $12,178 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations (0162XA) [Total]** | **$26,520** | **$5,906** | **$14,772** | **$1,323** | **$0** | **($13,449)** | **($1,323)** |
| Mandatory Budget Authority | $2,572,928 | $0 | $0 | $0 | $0 | $0 | $0 |
| Mandatory Obligations [Total] | **$26,520** | **$2,578,834** | **$2,195,500** | **$393,523** | **$0** | **($1,801,977)** | **($393,523)** |
| **Obligations [Grand Total]** | **$7,404,011** | **$9,500,406** | **$9,182,248** | **$9,351,781** | **$8,784,169** | **$169,533** | **($567,612)** |
| **FTE** | | | | | | | |
| Medical Facilities (0162) | 24,657 | 26,654 | 25,668 | 28,626 | 29,557 | 2,958 | 931 |
| CARES Act | 1,144 | 0 | 0 | 0 | 0 | 0 | 0 |
| Veterans Medical Care and Health Fund | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| VACAA, Section 801 (0162XA) | 1 | 0 | 1 | 1 | 0 | 0 | (1) |
| **FTE [Total]** | **25,802** | **26,654** | **25,669** | **28,627** | **29,557** | **2,958** | **930** |

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

[2/]The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

## Summary of 2023 Revised Request

VA is requesting an additional $1.5 billion for Medical Facilities above the 2023 Advance Appropriation request of $7.1 billion.

When these resources are combined with available transfers, reimbursements and other net unobligated balances, Medical Facilities will meet the projected 2023 obligation level of $9.4 billion, as detailed in the tables below.

**Table: Update to the 2023 Advance Appropriation Request**
(dollars in thousands)

| | | Available Discretionary Funding | | | Available Mand. Funding | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Use of Unobligated Balance | | | |
| Description | 2023 Revised Estimate | Enacted Approp. Incl. Transfers | Reimb. | Use of Unobl. Balance | VACAA Sec. 801 | Veterans Medical Care And Health Fund 1/ | Subtotal | Annual Approp. Adjust. Required |
| Engineering & Environmental Management | $1,236,911 | $919,711 | $0 | $0 | $0 | $317,200 | $919,711 | $0 |
| Engineering Service | $1,302,419 | $852,517 | $24,739 | $350,000 | $163 | $75,000 | $1,227,256 | $0 |
| Ground Maintenance & Fire Protection | $138,910 | $138,910 | $0 | $0 | $0 | $0 | $138,910 | $0 |
| Leases | $1,500,000 | $1,498,840 | $0 | $0 | $1,160 | $0 | $1,498,840 | $0 |
| Non-Recurring Maintenance | $2,505,000 | $1,005,000 | $0 | $0 | $0 | $0 | $1,005,000 | $1,500,000 |
| Operating Equipment Maintenance & Repair | $398,495 | $398,495 | $0 | $0 | $0 | $0 | $398,495 | $0 |
| Other Facilities Operation Support | $122,660 | $122,660 | $0 | $0 | $0 | $0 | $122,660 | $0 |
| Plant Operation | $970,901 | $970,901 | $0 | $0 | $0 | $0 | $970,901 | $0 |
| Recurring Maintenance & Repair | $698,290 | $698,290 | $0 | $0 | $0 | $0 | $698,290 | $0 |
| Textile Care Processing & Maintenance | $234,051 | $234,051 | $0 | $0 | $0 | $0 | $234,051 | $0 |
| Transportation | $244,144 | $244,144 | $0 | $0 | $0 | $0 | $244,144 | $0 |
| Obligations [Total] | $9,351,781 | $7,083,519 | $24,739 | $350,000 | $1,323 | $392,200 | $7,458,258 | $1,500,000 |

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

## Table: Discretionary Obligations by Program

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Discretionary Program (0162) - Excluding CARES Act** | | | | | | | |
| Engineering & Environmental Management | $746,027 | $1,092,481 | $955,416 | $919,548 | $2,233,812 | ($35,868) | $1,314,264 |
| Engineering Service | $956,711 | $1,204,840 | $1,254,199 | $1,227,419 | $1,350,639 | ($26,780) | $123,220 |
| Ground Maintenance & Fire Protection | $117,257 | $139,805 | $129,349 | $138,910 | $148,471 | $9,561 | $9,561 |
| Leases | $1,014,710 | $1,293,601 | $1,285,384 | $1,498,840 | $1,200,000 | $213,456 | ($298,840) |
| Non-Recurring Maintenance | $1,855,418 | $491,374 | $881,565 | $2,505,000 | $995,000 | $1,623,435 | ($1,510,000) |
| Operating Equipment Maintenance & Repair | $338,422 | $349,511 | $371,603 | $398,495 | $425,387 | $26,892 | $26,892 |
| Other Facilities Operation Support | $46,617 | $140,932 | $106,336 | $122,660 | $138,984 | $16,324 | $16,324 |
| Plant Operation | $842,868 | $937,884 | $909,729 | $970,901 | $1,032,073 | $61,172 | $61,172 |
| Recurring Maintenance & Repair | $587,264 | $767,798 | $649,877 | $698,290 | $746,703 | $48,413 | $48,413 |
| Textile Care Processing & Maintenance | $189,409 | $269,462 | $214,387 | $234,051 | $253,715 | $19,664 | $19,664 |
| Transportation | $210,373 | $233,884 | $228,903 | $244,144 | $259,385 | $15,241 | $15,241 |
| Obligations Before Prior Year Recoveries (0162) | $6,905,076 | $6,921,572 | $6,986,748 | $8,958,258 | $8,784,169 | $1,971,510 | ($174,089) |
| Prior Year Recoveries | $36,952 | $0 | $0 | $0 | $0 | $0 | $0 |
| Obligations After Prior Year Recoveries [Subtotal] | **$6,942,028** | **$6,921,572** | **$6,986,748** | **$8,958,258** | **$8,784,169** | **$1,971,510** | **($174,089)** |
| **Discretionary Program (0162) - CARES Act** | | | | | | | |
| Engineering & Environmental Management | $45,725 | $0 | $0 | $0 | $0 | $0 | $0 |
| Engineering Service | $116,006 | $0 | $0 | $0 | $0 | $0 | $0 |
| Ground Maintenance & Fire Protection | $2,531 | $0 | $0 | $0 | $0 | $0 | $0 |
| Leases | $836 | $0 | $0 | $0 | $0 | $0 | $0 |
| Non-Recurring Maintenance | $187,250 | $0 | $0 | $0 | $0 | $0 | $0 |
| Operating Equipment Maintenance & Repair | $6,278 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Facilities Operation Support | $43,237 | $0 | $0 | $0 | $0 | $0 | $0 |
| Plant Operation | $5,689 | $0 | $0 | $0 | $0 | $0 | $0 |
| Recurring Maintenance & Repair | $13,819 | $0 | $0 | $0 | $0 | $0 | $0 |
| Textile Care Processing & Maintenance | $4,904 | $0 | $0 | $0 | $0 | $0 | $0 |
| Transportation | $3,288 | $0 | $0 | $0 | $0 | $0 | $0 |
| CARES Act Obligations Before Prior Year Recoveries [Subtotal] | **$429,563** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Prior Year Recoveries | $5,899 | $0 | $0 | $0 | $0 | $0 | $0 |
| Obligations After Prior Year Recoveries [Subtotal] | **$435,462** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Discretionary Obligations [Total] (0162)** | **$7,377,490** | **$6,921,572** | **$6,986,748** | **$8,958,258** | **$8,784,169** | **$1,971,510** | **($174,089)** |

[1/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, together with updated estimates for transfers, reimbursements and medical care collections.

## Table: Medical Facilities Mandatory Obligations by Program

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Mandatory Program (0173MF) - Veterans Medical Care and Health Fund 1/** | | | | | | | |
| Engineering & Environmental Management | $0 | $0 | $0 | $317,200 | $0 | $317,200 | ($317,200) |
| Engineering Service | $0 | $0 | $0 | $75,000 | $0 | $75,000 | ($75,000) |
| Leases | $0 | $800,406 | $408,176 | $0 | $0 | ($408,176) | $0 |
| Non-Recurring Maintenance | $0 | $1,772,522 | $1,772,552 | $0 | $0 | ($1,772,552) | $0 |
| Obligations Veterans Medical Care and Health Fund | $0 | $2,572,928 | $2,180,728 | $392,200 | $0 | ($1,788,528) | ($392,200) |
| **Mandatory Program (0162) -VACAA Sec. 801** | | | | | | | |
| Engineering & Environmental Management | $152 | $24 | $156 | $163 | $0 | $7 | ($163) |
| Engineering Service | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Ground Maintenance & Fire Protection | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Leases | $23,579 | $5,882 | $14,616 | $1,160 | $0 | ($13,456) | ($1,160) |
| Non-Recurring Maintenance | ($10,347) | $0 | $0 | $0 | $0 | $0 | $0 |
| Operating Equipment Maintenance & Repair | $11 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Facilities Operation Support | $156 | $0 | $0 | $0 | $0 | $0 | $0 |
| Plant Operation | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Recurring Maintenance & Repair | $381 | $0 | $0 | $0 | $0 | $0 | $0 |
| Textile Care Processing & Maintenance | $410 | $0 | $0 | $0 | $0 | $0 | $0 |
| Transportation | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Obligations Before Prior Year Recoveries [Subtotal] | **$14,342** | **$5,906** | **$14,772** | **$1,323** | **$0** | **($13,449)** | **($1,323)** |
| Prior Year Recoveries | $12,178 | $0 | $0 | $0 | $0 | $0 | $0 |
| Obligations After Prior Year Recoveries [Subtotal] | **$26,520** | **$5,906** | **$14,772** | **$1,323** | **$0** | **($13,449)** | **($1,323)** |
| Mandatory Obligations [Total] (0162) | **$26,520** | **$2,578,834** | **$2,195,500** | **$393,523** | **$0** | **($1,801,977)** | **($393,523)** |

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

[2/]The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, together with updated estimates for transfers, reimbursements and medical care collections.

## Table: Medical Facilities Total Obligations by Program

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| **Program:** | | | | | | | |
| Engineering & Environmental Management | $791,904 | $1,092,505 | $955,572 | $1,236,911 | $2,233,812 | $281,339 | $996,901 |
| Engineering Service | $1,072,717 | $1,204,840 | $1,254,199 | $1,302,419 | $1,350,639 | $48,220 | $48,220 |
| Ground Maintenance & Fire Protection | $119,788 | $139,805 | $129,349 | $138,910 | $148,471 | $9,561 | $9,561 |
| Leases | $1,039,125 | $2,099,889 | $1,708,176 | $1,500,000 | $1,200,000 | ($208,176) | ($300,000) |
| Non-Recurring Maintenance 1/ | $2,032,321 | $2,263,896 | $2,654,117 | $2,505,000 | $995,000 | ($149,117) | ($1,510,000) |
| Operating Equipment Maintenance & Repair | $344,711 | $349,511 | $371,603 | $398,495 | $425,387 | $26,892 | $26,892 |
| Other Facilities Operation Support | $90,011 | $140,932 | $106,336 | $122,660 | $138,984 | $16,324 | $16,324 |
| Plant Operation | $848,557 | $937,884 | $909,729 | $970,901 | $1,032,073 | $61,172 | $61,172 |
| Recurring Maintenance & Repair | $601,464 | $767,798 | $649,877 | $698,290 | $746,703 | $48,413 | $48,413 |
| Textile Care Processing & Maintenance | $194,723 | $269,462 | $214,387 | $234,051 | $253,715 | $19,664 | $19,664 |
| Transportation | $213,661 | $233,884 | $228,903 | $244,144 | $259,385 | $15,241 | $15,241 |
| Obligations Before Prior Year Recoveries (0162) | $7,348,982 | $9,500,406 | $9,182,248 | $9,351,781 | $8,784,169 | $169,533 | ($567,612) |
| Prior Year Recoveries | $55,029 | $0 | $0 | $0 | $0 | $0 | $0 |
| Obligations Total After Prior Year Recoveries (0162) | **$7,404,011** | **$9,500,406** | **$9,182,248** | **$9,351,781** | **$8,784,169** | $169,533 | ($567,612) |

1/ The 2021 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.

2/ The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, together with updated estimates for transfers, reimbursements and medical care collections.

In 2023, total obligations are projected to increase by $169.5 million above the 2022 current estimate in the following areas:

- **Leases (-$208.2 million).** Leases are projected to decrease based on revised estimates for the space necessary for VA system delivered care.
- **Non-Recurring Maintenance (-$149.1 million)**. Non-Recurring Maintenance is projected to decrease to reflect engineer capacity to update existing VA system space for care delivery.
- **Engineering Services (+$48.2 million)**. Engineering Services is projected to increase by to expand oversight and management of engineering environmental management services.
- **Engineering and Environmental Management (+$281.3 million)**. Engineering and Environmental Management is projected to increase to expand project management.
- **Plant Operations (+$61.2 million)**. Plant Operations are projected to increase for utility costs.
- **All Other Increases (+$136.1 million)**. This amount covers the projected increased cost of textile care processing, transportation, maintenance and repairs.

## Summary of the 2024 Advance Appropriation Request

The Medical Facilities discretionary advance appropriations request is $8.8 billion, an increase of $166.0 million from the 2023 revised discretionary request. The 2024 request ensures continuity of Veterans' health care services. In 2024, total obligations are projected to decrease by $567.6 million from the 2023 revised request level in the following areas:

- **Leases (-$300.0 million)**. Leases are projected to decrease as the need for additional space becomes less necessary. Space needs will be reassessed as part of the 2024 President's Budget.
- **Non-Recurring Maintenance (-$1.5 billion)**. Non-Recurring Maintenance (NRM) is projected to decrease after updating existing VA system space in 2023. NRM needs will be reassessed as part of the 2024 President's Budget.
- **All Other Increases (+$1.2 billion).** This amount covers the projected increased cost of engineering, operations, textile care processing, transportation, maintenance and repairs.

**Medical Facilities Program Funding Requirements**

The Medical Facilities appropriation supports the operation and maintenance of Department of Veterans Affairs (VA) hospitals, community-based outpatient clinics (CBOCs), community living centers, domiciliary facilities, Vet Centers and the health care corporate offices. The appropriation also supports the administrative expenses of planning, designing and executing construction or renovation projects at these facilities. The Veterans Health Administration (VHA) operates a portfolio of approximately 5,646 owned buildings with a total of 152.9 million square feet of space on 16,154 acres of land. The portfolio also includes 1,726 leases with a total of 20.1 million square feet of space. A detailed explanation of the types and numbers of VHA health care facilities can be found in the Medical Facilities by Type chapter.

The staff and associated funding supported by this appropriation are responsible for: keeping the VA hospitals and clinics climate controlled; maintaining a clean and germ- and pest- free environment; sanitizing and washing hospital linens, surgical scrubs and clinical coats; cleaning and sterilizing the medical equipment; keeping the hospital signage clear and current; maintaining the trucks, buses and cars in good operating condition; ensuring the parking lots and walk ways are sanded and free of snow and ice; cutting the grass; keeping the boiler plants and air conditioning units operating effectively; and undertaking certain repairs and alterations to the buildings to keep them in good condition.

Construction of new or replacement facilities are paid for under the Major Construction or Minor Construction appropriations. See Volume 4 for additional detail.

VA requests an additional $1.5 billion for Medical Facilities above the 2023 Advance Appropriation request of $7.1 billion. When combined with available carryover balances, including Veterans Medical Care and Health Fund Medical Facilities category and anticipated collections, transfers and reimbursements, Medical Facilities has $9.4 billion in resources to meet projected 2023 Medical Facilities obligations, as detailed in the tables below.

Each section below details the operations of each of the account's 11 programs.

## Engineering and Environmental Management Services

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Non-CARES Act Obligations | $746,027 | $1,092,481 | $955,416 | $919,548 | $2,233,812 | ($35,868) | $1,314,264 |
| Discretionary CARES Act Obligations | $45,725 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$791,752** | **$1,092,481** | **$955,416** | **$919,548** | **$2,233,812** | **-$35,868** | **$1,314,264** |
| Veterans Medical Care and Health Fund 1/ | $0 | $0 | $0 | $317,200 | $0 | $317,200 | -$317,200 |
| VACAA, Section 801 | $152 | $24 | $156 | $163 | $0 | $7 | -$163 |
| **Mandatory Obligations [Subtotal]** | **$152** | **$24** | **$156** | **$317,363** | **$0** | **$317,207** | **-$317,363** |
| **Obligations [Total]** | **$791,904** | **$1,092,505** | **$955,572** | **$1,236,911** | **$2,233,812** | **$281,339** | **$996,901** |

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

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.

VHA is increasing the number of engineering, contracting and program staff at the VISN and VAMC levels in order to efficiently manage its construction program. VHA engineering, contracting and program staff are directly responsible for the successful execution of over $2.5 billion in planned non-recurring maintenance and over $500 million in minor construction in 2023 and also indirectly support the major construction program.

## Engineering Service

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Revised Request | 2024 Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Non-CARES Act Obligations | $956,711 | $1,204,840 | $1,254,199 | $1,227,419 | $1,350,639 | ($26,780) | $123,220 |
| Discretionary CARES Act Obligations | $116,006 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$1,072,717** | **$1,204,840** | **$1,254,199** | **$1,227,419** | **$1,350,639** | **-$26,780** | **$123,220** |
| Veterans Medical Care and Health Fund 1/ | $0 | $0 | $0 | $75,000 | $0 | $75,000 | -$75,000 |
| VACAA, Section 801 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$75,000** | **$0** | **$75,000** | **-$75,000** |
| **Obligations [Total]** | **$1,072,717** | **$1,204,840** | **$1,254,199** | **$1,302,419** | **$1,350,639** | **$48,220** | **$48,220** |

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

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) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Non-CARES Act Obligations..... | $117,257 | $139,805 | $129,349 | $138,910 | $148,471 | $9,561 | $9,561 |
| Discretionary CARES Act Obligations..... | $2,531 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal].....** | **$119,788** | **$139,805** | **$129,349** | **$138,910** | **$148,471** | **$9,561** | **$9,561** |
| Veterans Medical Care and Health Fund..... | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801..... | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal].....** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Obligations [Total].....** | **$119,788** | **$139,805** | **$129,349** | **$138,910** | **$148,471** | **$9,561** | **$9,561** |

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.

## Major Leases

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Non-CARES Act Obligations..... | $1,014,710 | $1,293,601 | $1,285,384 | $1,498,840 | $1,200,000 | $213,456 | ($298,840) |
| Discretionary CARES Act Obligations..... | $836 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal].....** | **$1,015,546** | **$1,293,601** | **$1,285,384** | **$1,498,840** | **$1,200,000** | **$213,456** | **($298,840)** |
| Veterans Medical Care and Health Fund 1/..... | $0 | $800,406 | $408,176 | $0 | $0 | ($408,176) | $0 |
| VACAA, Section 801..... | $23,579 | $5,882 | $14,616 | $1,160 | $0 | ($13,456) | ($1,160) |
| **Mandatory Obligations [Subtotal].....** | **$23,579** | **$806,288** | **$422,792** | **$1,160** | **$0** | **($421,632)** | **($1,160)** |
| **Obligations [Total].....** | **$1,039,125** | **$2,099,889** | **$1,708,176** | **$1,500,000** | **$1,200,000** | **($208,176)** | **($300,000)** |

[1/] The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the table displays the estimated allocation for the Medical Facilities 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.

Leases can have many functions, including clinical space for Community Based Outpatient Clinics (CBOC); 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 2023 request seeks authorization for thirty-one major leases. The new VA's Strategic Capital Investment Planning (SCIP) major lease request consists of twenty-one leases being resubmitted from 2022, as well as eight new leases and six replacement leases in 2023. 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 (VA) and administrative space for VA use. When VA procures the lease, it is through a delegation that is granted on a lease-by-lease basis by GSA. These leases are critical to meeting Veterans' needs by allowing VA to operate clinics or other necessary services close to Veteran populations while maintaining flexibility, so these points of service can be relocated or resized on a regular basis due to shifting demographic trends.

## Non-Recurring Maintenance (NRM)

| | | 2022 | | **2023** | **2024** | | |
|---|---|---|---|---|---|---|---|
| | 2021 | Budget | Current | **Revised** | **Advance** | +/- | +/- |
| Description (dollars in thousands) | Actual | Estimate | Estimate | **Request** | **Approp.** | 2022-2023 | 2023-2024 |
| Discretionary Obligations - All Other | $1,495,055 | $430,072 | $430,072 | $2,443,698 | $995,000 | $2,013,626 | ($1,448,698) |
| Discretionary P.L. 115-141 sec 255 | $184,251 | $0 | $115,406 | $0 | $0 | ($115,406) | $0 |
| Discretionary P.L. 115-244 sec 248 | $176,112 | $61,302 | $336,087 | $61,302 | $0 | ($274,785) | ($61,302) |
| Discretionary CARES Act Obligations | $187,250 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$2,042,668** | **$491,374** | **$881,565** | **$2,505,000** | **$995,000** | **$1,623,435** | **-$1,510,000** |
| Veterans Medical Care and Health Fund 1/ | $0 | $1,772,522 | $1,772,552 | $0 | $0 | ($1,772,552) | $0 |
| VACAA, Section 801 | ($10,347) | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **($10,347)** | **$1,772,522** | **$1,772,552** | **$0** | **$0** | **($1,772,552)** | **$0** |
| **Obligations [Total]** | **$2,032,321** | **$2,263,896** | **$2,654,117** | **$2,505,000** | **$995,000** | **($149,117)** | **($1,510,000)** |

[1/]The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the table displays the estimated allocation for the Medical Facilities 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.

Note: The 2021 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.

Non-recurring maintenance program funds additions, alterations and modifications to land, buildings, other structures, nonstructural improvements of land and fixed equipment (when the equipment is acquired under contract and becomes permanently attached to or part of the building or structure) to maintain and modernize existing campus facilities, buildings and building systems; replace existing building system components; provide for adequate future functional building system capacity without constructing any new building square footage for functional program space; and/or provide for environmental remediation and abatement and building demolition.

VHA uses the NRM program as its primary means of addressing its most pressing infrastructure needs as identified by Facility Condition Assessments. These assessments are performed at each facility every three years and highlight a building's most pressing and mission critical repair and maintenance needs. VHA specifically supports research and development infrastructure projects by ensuring that the Office of Research and Development is involved in the identification of gaps

to support the Strategic Capital Investment Planning (SCIP) process. This inclusion ensures a research focus for mitigation within a ten-year window of identified research infrastructure deficiencies.

VHA projects obligations of $505 million in Electronic Health Record Modernization (EHRM) related NRM in 2023, a decrease of $738 million from the 2022 President's Budget request of $1.2 billion and in alignment with the current EHRM implementation schedule. The 2021 Non-Recurring Maintenance actual related to EHRM was $289 million.

NRM projects are broken into three categories, as discussed and defined below.

***Sustainment projects:***

NRM sustainment projects involve the provision of resources that will convert functional space to a different program function within existing buildings or spaces, without adding any new space. Each sustainment project must be equal to, or less than, the amount outlined in title 38, United States Code, section 8104 (currently $20 million). The total project cost includes all amounts and expenditures associated with design, impact, contingency and construction costs.

***Infrastructure Modernization projects:***

NRM infrastructure modernization projects involve the provision of resources to repair, modernize, replace, renovate and provide for new "building systems," and do not convert functional space to a different program function. Such projects have no project cost limitation; however, any work to be done beyond the underlying building system must be ancillary to the overall total project cost (not exceed 25% of the total project cost). The overall total project cost includes all amounts and expenditures associated with design, impact, contingency and construction costs. The 2023 request supports continued implementation of EHRM with $505 million for NRM projects that will support infrastructure modifications at VA facilities that are necessary prerequisites to the completion of the Initial Operating Capacity phase and broader nationwide rollout.

The types of "building systems" permitted for NRM infrastructure projects consist of the following: building thermal and moisture protection; doors and windows; interior finishes only directly related with building system work; conveyance and transport systems; fire suppression; plumbing; heating, ventilation and air conditioning; electrical systems; communication systems; safety and security systems; utility systems, boiler plants, chiller plants, water filtration and treatment plants, cogeneration plants, central energy plants, elevator towers, connecting corridors and stairwells.

***Clinical Specific Initiative Projects:***

Clinical Specific Initiative (CSI) projects are emergent projects that cannot be planned due to dynamic health care environments. Associated funding for these projects is distributed to the Veteran Integrated Service Networks (VISNs) at the beginning of each year, to obligate towards existing clinical building space and address workload gaps, or support access within the following VHA high-profile categories:

- Women's Health
- Mental Health
- High-Cost/High Tech Medical Equipment Site Prep/Installations
- Reduce the Footprint Reduction (includes building demolition or conversion of under-utilized space to clinical functions)
- Donated Building Site Preparation (e.g., Fisher House) when constructed on VHA land
- Other Emergent Need Categories may be added to CSI program based on direction from the Under Secretary for Health.

*For CSI projects, only high-cost/high-tech medical equipment site prep/installation projects may involve the construction of new program functional building space.

## Operating Equipment Maintenance and Repair

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Non-CARES Act Obligations..... | $338,422 | $349,511 | $371,603 | $398,495 | $425,387 | $26,892 | $26,892 |
| Discretionary CARES Act Obligations..... | $6,278 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]..... ** | **$344,700** | **$349,511** | **$371,603** | **$398,495** | **$425,387** | **$26,892** | **$26,892** |
| Veterans Medical Care and Health Fund..... | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801..... | $11 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]..... ** | $11 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Obligations [Total]..... ** | **$344,711** | **$349,511** | **$371,603** | **$398,495** | **$425,387** | **$26,892** | **$26,892** |

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) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Non-CARES Act Obligations | $46,617 | $140,932 | $106,336 | $122,660 | $138,984 | $16,324 | $16,324 |
| Discretionary CARES Act Obligations | $43,237 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$89,854** | **$140,932** | **$106,336** | **$122,660** | **$138,984** | **$16,324** | **$16,324** |
| Veterans Medical Care and Health Fund | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 | $156 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$156** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Obligations [Total]** | **$90,010** | **$140,932** | **$106,336** | **$122,660** | **$138,984** | **$16,324** | **$16,324** |

This function includes other costs associated with inpatient and outpatient providers and miscellaneous benefits and services.

## Plant Operations

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Non-CARES Act Obligations | $842,868 | $937,884 | $909,729 | $970,901 | $1,032,073 | $61,172 | $61,172 |
| Discretionary CARES Act Obligations | $5,689 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$848,557** | **$937,884** | **$909,729** | **$970,901** | **$1,032,073** | **$61,172** | **$61,172** |
| Veterans Medical Care and Health Fund | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Obligations [Total]** | **$848,557** | **$937,884** | **$909,729** | **$970,901** | **$1,032,073** | **$61,172** | **$61,172** |

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) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Non-CARES Act Obligations | $587,264 | $767,798 | $649,877 | $698,290 | $746,703 | $48,413 | $48,413 |
| Discretionary CARES Act Obligations | $13,819 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$601,083** | **$767,798** | **$649,877** | **$698,290** | **$746,703** | **$48,413** | **$48,413** |
| Veterans Medical Care and Health Fund | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 | $381 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$381** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Obligations [Total]** | **$601,464** | **$767,798** | **$649,877** | **$698,290** | **$746,703** | **$48,413** | **$48,413** |

Recurring Maintenance and Repair services encompass all projects where the minor improvement is below $25,000, such as maintenance service contracts and routine repair of facilities and the upkeep of land. Examples include painting interior and exterior walls, the repair of water leaks in pipes and roofs and the replacement of light bulbs, carpet, ceiling and floor tiles.

## Textile Care Processing and Management

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Non-CARES Act Obligations | $189,409 | $269,462 | $214,387 | $234,051 | $253,715 | $19,664 | $19,664 |
| Discretionary CARES Act Obligations | $4,904 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]** | **$194,313** | **$269,462** | **$214,387** | **$234,051** | **$253,715** | **$19,664** | **$19,664** |
| Veterans Medical Care and Health Fund | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801 | $410 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]** | **$410** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Obligations [Total]** | **$194,723** | **$269,462** | **$214,387** | **$234,051** | **$253,715** | **$19,664** | **$19,664** |

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) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|
| Discretionary Non-CARES Act Obligations..... | $210,373 | $233,884 | $228,903 | $244,144 | $259,385 | $15,241 | $15,241 |
| Discretionary CARES Act Obligations..... | $3,288 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Discretionary Obligations [Subtotal]..... ** | **$213,661** | **$233,884** | **$228,903** | **$244,144** | **$259,385** | **$15,241** | **$15,241** |
| Veterans Medical Care and Health Fund..... | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| VACAA, Section 801..... | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Mandatory Obligations [Subtotal]..... ** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Obligations [Total]..... ** | **$213,661** | **$233,884** | **$228,903** | **$244,144** | **$259,385** | **$15,241** | **$15,241** |

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.

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# *Actuarial Model Projections*

## Models Used to Inform the Budget Request

The Department of Veterans Affairs (VA) uses three actuarial models to support formulation of the majority of the VA health care budget, to conduct strategic and capital planning and to assess the impact of potential policies and changes in a dynamic health care environment. The three actuarial models are the VA Enrollee Health Care Projection Model (EHCPM), the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) Model and the Program of Comprehensive Assistance for Family Caregivers (PCAFC) Model.

Activities and programs that are not projected by any of these three models are called "non-modeled" and can change from year to year. In general, they include non-recurring maintenance (NRM), community care network contract administration, state-based long-term services and supports programs (LTSS), readjustment counseling, recently enacted programs, some components of CHAMPVA programs (Camp Lejeune family member program, spina bifida, foreign medical program, children of women Vietnam Veterans) and some components for the PCAFC program.

## VA Enrollee Health Care Projection Model

The VA EHCPM supports approximately 90% of the VA medical care budget. The EHCPM, which was first developed in 1998, is a sophisticated health care demand projection model that uses actuarial methods and approaches to project Veteran demand for VA health care. These approaches are consistent with the actuarial methods employed by the Nation's insurers and public providers, such as Medicare and Medicaid.

The EHCPM projects enrollment, utilization and expenditures for the enrolled Veteran population in more than 140 categories of health care services 20 years into the future. The EHCPM consists of three main components.

- **Enrollment.** VA uses the EHCPM to project how many Veterans will be enrolled in VA health care each year and their age, gender, priority level and geographic location.
- **Utilization.** VA uses the EHCPM to project the total health care services needed by those enrollees and then estimates the portion of that care that those enrollees will demand from VA (known as "reliance").
- **Expenditures.** Total health care expenditures are developed by multiplying the expected VA utilization by the anticipated cost per service.

The projections are supported by extensive research and analyses of the Veteran enrollee population and the drivers of demand for VA health care. VA program, field and research staff provide expertise on program strategies and initiatives, the unique needs of the enrollee population and the VA health care system.
The 2021 EHCPM (Base Year 2020), was used to build the 2023 and 2024 Medical Care budget request. Typically, the EHCPM is tied to the previous fiscal year's actual enrollment, utilization and expenditures (the Base Year). However, due to the COVID-19 pandemic, the 2021 EHCPM is not based solely on 2020 data. Rather, it uses a "hybrid" modeling approach that begins with assumptions developed using workload through 2019, then updates selected key inputs and assumptions and finally calibrates to 2020 and 2021 workload and expenditures at a high level. See additional details in the section "Impact of the 2021 EHCPM Update." The expenditure basis used to build the projections includes the Medical Services, Medical Community Care, Medical Support & Compliance and Medical Facilities appropriations but excludes non-recurring maintenance. The projections include all care provided in VA facilities or paid for by VA (community care).

**Key Drivers of Growth in Projected Resource Requirements**
In projecting future Veteran demand for VA health care, the EHCPM accounts for the unique characteristics of the Veteran population and the VA health care system, as well as environmental factors that impact Veteran enrollment and use of VA health care services.

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

Since its implementation in June 2019, the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act impacted the VA health care system by driving growth in the use of VA health care services. The 2021 EHCPM incorporated the actual experience and projected impact of the MISSION Act, including changes to eligibility to receive care in the community based on geographic access standards, grandfathered Veterans Choice and Accountability (Choice) Act of 2014 enrollees, wait time standards, urgent care benefits and emergency room pre- authorization.

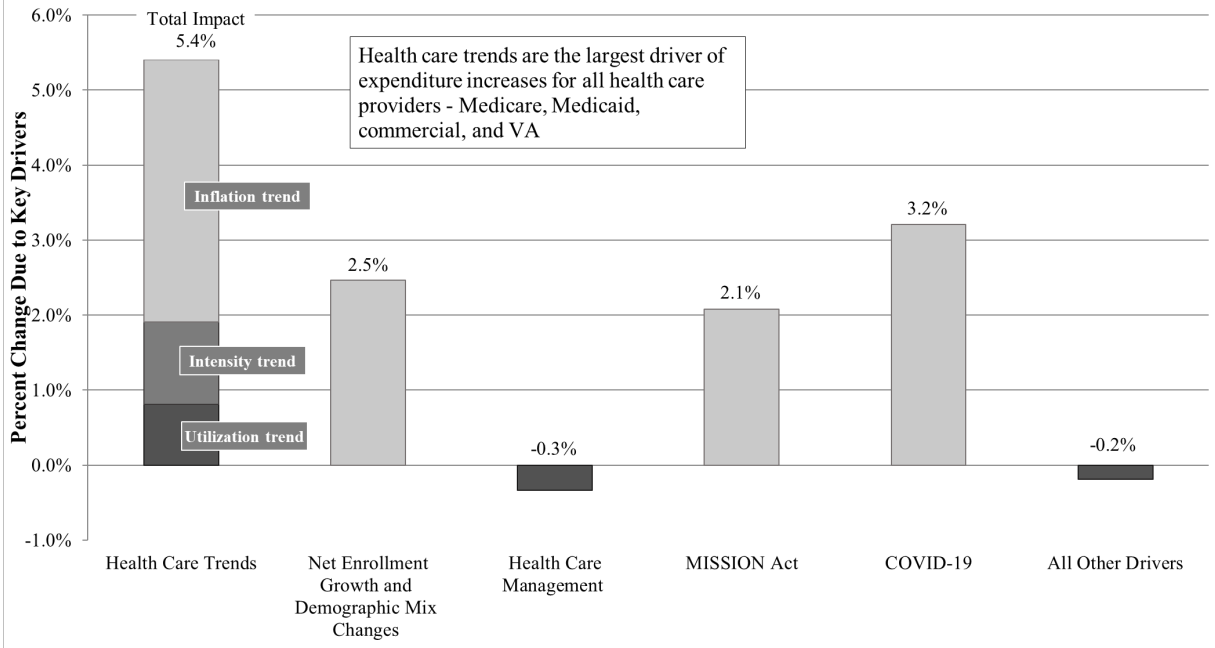
The MISSION Act policies continue to drive increases in services available in both VA facilities and the community, particularly the use of outpatient primary and specialty care and inpatient care. The MISSION growth assumptions were increased and extended to reflect higher than anticipated growth in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

The COVID-19 pandemic continued to have a significant impact on VA health care in 2021 and is expected to impact the amount of care provided for the next few years. During the pandemic, nationwide health care utilization saw a reduced amount of care provided in 2020 and 2021 as individuals chose to defer certain care. It is anticipated that less care will be deferred in 2022 and

that care previously deferred started to return in 2021 and will continue through 2023. Additionally, the stay-at-home orders and social distancing mandates have had an impact on the United States economy, which is expected to increase reliance on VA for health care. The impact of the pandemic on health care utilization in general and on mortality confounded analysis of 2020 enrollee reliance and morbidity; therefore, reliance and morbidity assumptions were not updated from 2019.

Figure A quantifies the key drivers of the projected increase in expenditure requirements for 2023 for all modeled services. Health care trends, net enrollment growth and demographic mix changes and health care management and their impact on the resources required to provide health care to enrolled Veterans are discussed in detail in the following sections.

**Figure A. Key Drivers of Projected Expenditure Change, 2022–2023**




- Scenario BRD0 Modeled Services
- MISSION impacts include provisions for geographic access, wait times, urgent care, emergency room pre-authorization, and 14-day community care urgent prescription fills. Impacts for the MISSION standards for timeliness or quality and organ and bone marrow transplant policies are provided as national estimates and have not been incorporated in the 2021 EHCPM.
- The projections do not include requirements for several activities / programs that are not projected by the VA EHCPM, including administration cost for the Community Care Network contract, non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the Homeless program.

## Health Care Trends

Health care trends represent a significant driver of growth in the cost of health care in the United States and in the VA health care system. Health care trends (inflation, utilization and intensity) represent anticipated changes in health care utilization and cost due to advances in technology, including new diagnostics, drugs and treatments, as well as price inflation. Health care trends increase VA's projected expenditure requirements independent of any enrollment growth or demographic mix changes. The health care trends incorporated into the EHCPM are informed by federal policy and anticipated trends in Medicare, together with VA-specific trends for pharmacy and prosthetics and private sector trends for services that VA routinely purchases (e.g., maternity services).

Inflation is comprised of personnel and non-personnel components. Inflation on VA's personnel costs is determined by federal wage policy, including wage increases and freezes. VA's projected inflation for pharmacy and prosthetics products reflects VA's well managed purchasing programs for these products. VA's expected inflation on supplies, utilities, etc., is based on projected Consumer Price Index - Urban (CPI-U) and Producer Price Index (PPI) inflation trends for these items.

Utilization and intensity (cost) trends increase health care costs due to changes in health care practice and new technology. VA's costs are driven by these trends similar to other health care insurers and providers because Veterans expect access to these advances in the VA health care system. Utilization trends reflect expected changes in utilization of services due to changes in health care practice, such as updates to the clinical guidelines for preventive screenings. Intensity trends reflect changes in costs for services as technology advances; for example, the new high-cost PCSK9 inhibitor drugs offer an alternative cholesterol management option for patients who do not respond well to less expensive conventional statin treatments, which increases VA's prescription drug costs.

VA's utilization and intensity trends for Medicare-covered medical services are informed by anticipated Medicare utilization and intensity trends, as projected by the Center for Medicare & Medicaid Services' Office of the Actuary. They have been adjusted downward for efficiencies in the VA health care system as compared to Medicare's primarily fee-for-service environment. VA's pharmacy and prosthetics trends are set by VA workgroups to reflect VA's unique practice patterns for these services.

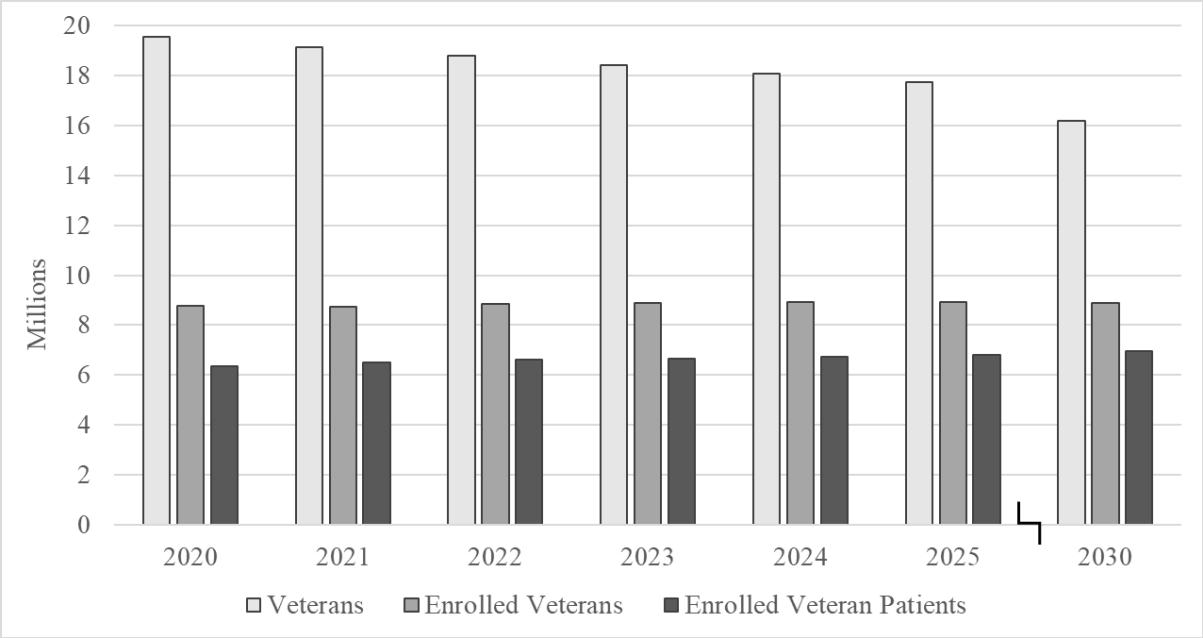
**Net Enrollment Growth and Demographic Mix Changes**

Veteran demand for VA health care is influenced by the following demographic characteristics of the Veteran population and environmental factors. Many of these factors are dynamic and are expected to change over time. Some can be anticipated (e.g., changing demographics) and some cannot (e.g., future economic downturns, pandemics, future military conflicts).

- Growth of the Post-9/11 Era Combat Veteran and female enrolled population.
- Enrollee age, gender, mortality, income, travel distance to VA facilities and geographic migration patterns.
- Increases in prevalence of service-connected conditions and changes in enrollee income levels. These are associated with transitions between enrollment priorities.
- Health care utilization patterns of Post-9/11 Era Combat Veteran, female, disabled, new enrollees and other enrollee cohorts with unique utilization patterns for particular services.
- Economic conditions, including changes in local unemployment rates and home values (as a proxy for asset values) over time.
- Policies, presidential executive orders, regulations and new legislation, such as the elimination of net worth from the VA Means Test, automatic income verification through tax records, expanding eligibility for Blue Water Navy Veterans and MISSION Act.

Using current assumptions, the 2021 EHCPM projects Veteran enrollment in VHA to remain relatively steady from 2020 to 2030, even though the Veteran population is declining (Figure B).

**Figure B. National Veterans, Enrollees and Patients, 2020-2030**




High enrollment rates for Post-9/11 Era Combat Veterans and Gulf War Veterans are largely causing the steady enrollment level despite the declining Veteran population. After 2026 enrollment is projected to decline slightly as the impact of mortality in the enrollee population begins to outweigh new enrollment. As described below, costs for VA health care are dependent not just on the number of enrollees but on the demographics of the enrolled Veteran population.

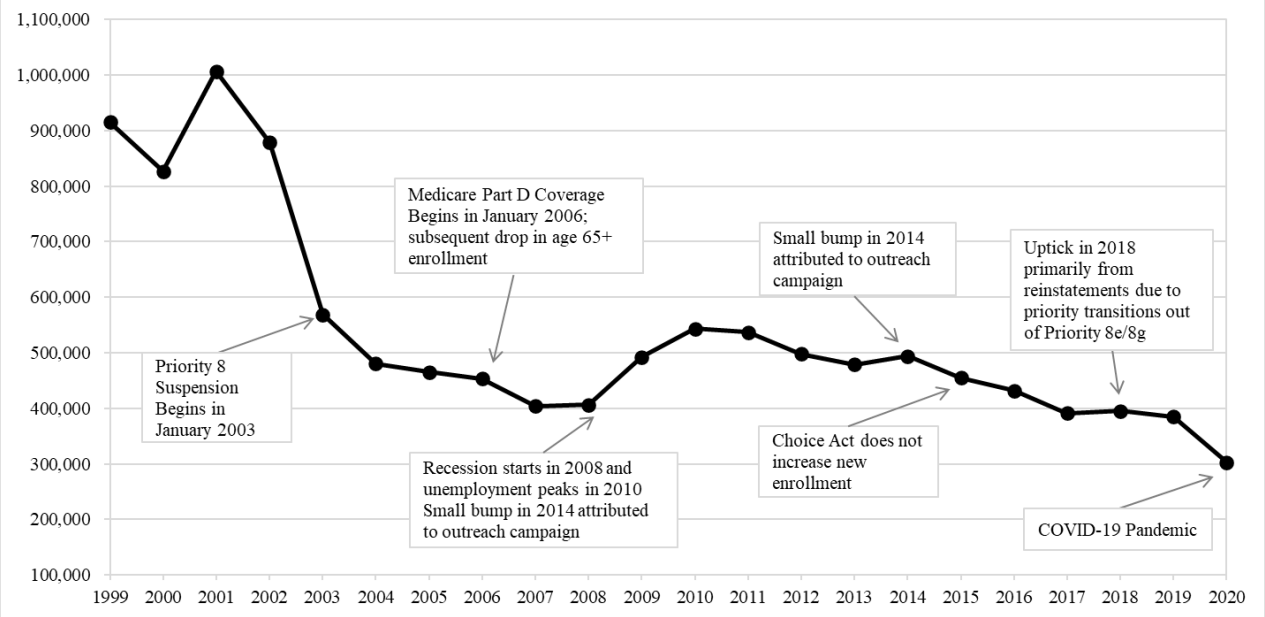
Veteran enrollment in VA is dynamic and responds to all of the demographic factors discussed above. Changes in the broader environment also impact Veterans' decisions to enroll. The lower new enrollment in 2007 and 2008 seen in Figure C was partially driven by the availability of the new Medicare drug benefit (Part D). The chart also shows the growth in new enrollment as a result of the 2008 economic recession and the decline in new enrollment as the economy recovered. The slight uptick in 2014 was driven by VHA enrollment outreach efforts related to the Affordable Care Act. Of note, it is sometimes difficult to ascertain causal impacts due to the multiple factors changing over any given time period.

As can be seen in Figure C, new enrollment declined between 2015 and 2017. Thus, even in the Veterans Choice Act environment, greater than expected new enrollment was not the driver of the growth in enrollee use of VA health care. This growth was the result of current enrollees increasing their reliance on VA versus their other health care options (Medicare, Medicaid, commercial insurance, etc.). Similar enrollee behavior is expected as a result of the MISSION Act policies. See the section on Enrollee Reliance in this chapter for details.

The new enrollment counts in Figure C include Veterans who successfully enroll in VHA the first time they apply and also Veterans who were previously determined to be ineligible for enrollment but subsequently are deemed eligible (reinstatements). Reinstatements can happen for many reasons, such as Veterans becoming eligible due to a change in income. Actual new enrollment in 2018 was slightly higher due to a higher rate of reinstatements.

The rate of new enrollment decreased significantly during the initial response to COVID-19 in 2020 and remained suppressed to varying degrees through 2021. However, rates for new enrollment are expected to increase and surpass pre-COVID-19 levels as pent-up demand for enrollment is fulfilled over time, returning to more normal levels by 2025.

**Figure C. New Enrollment Over Time**

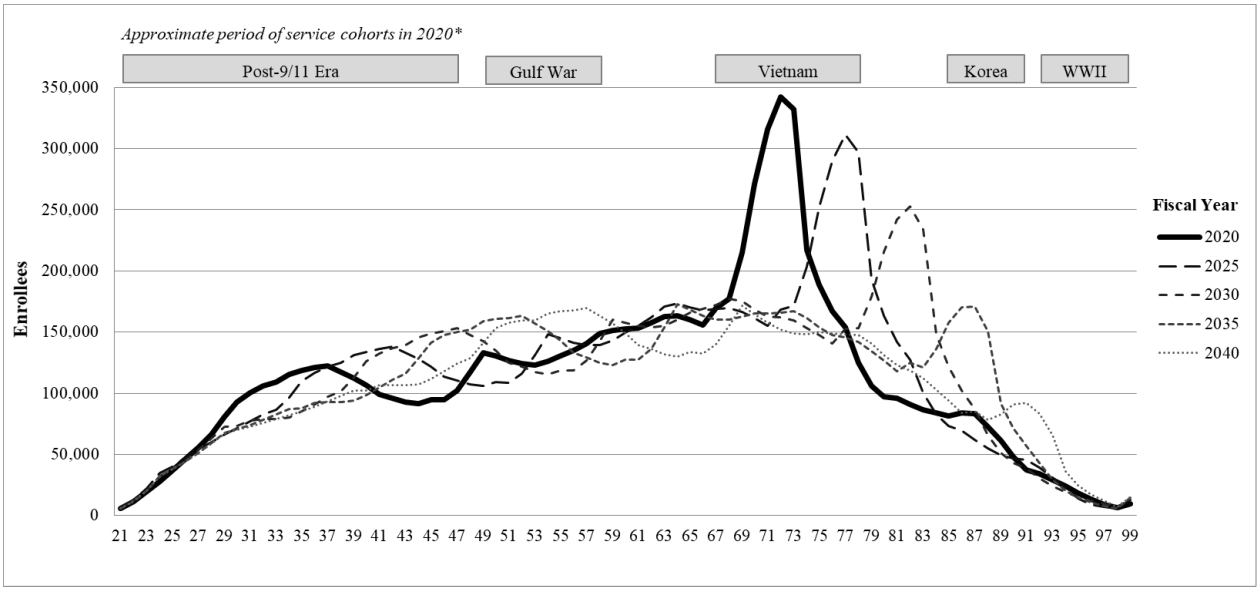



Net enrollment growth (new enrollment minus deaths) is not a significant driver of increases in annual expenditure requirements for VA health care. Enrollees who are dying are generally sicker and need more VA health care than new enrollees, so even modest increases in the number of enrollees can end up being budget neutral over the near term. However, the cost of caring for enrollees can change due to other demographic factors (e.g., priority transitions) and changes in the broader environment (e.g., economic recession).

Within the enrollee population, two dynamic demographic trends are impacting the projected future cost of VA health care more than other demographic factors: the aging of the Vietnam Era enrollee population and the increasing number of enrollees being adjudicated for service- connected disabilities, which increases the number of enrollees in Priorities 1, 2 and 3. These demographic trends combine in the Vietnam Era enrollee population with particular implications for demand for LTSS.

Figure D shows actual enrollment in 2020 and projected enrollment by age and highlights the relative size of the Vietnam Era enrollee cohort compared to other period-of-service cohorts.

**Figure D. Enrollment by Age**



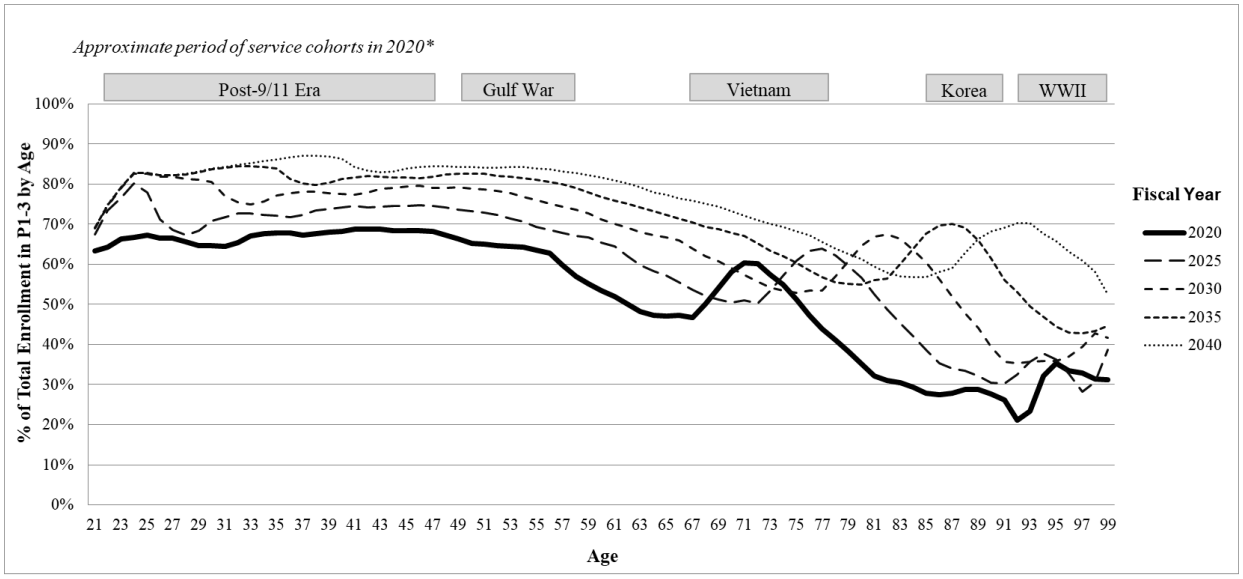

*Approximated by enrollee age in 2020 based on dates of conflict and ages at time of conflict. Enrollees can be in the age range for a cohort and not have served in the conflict.

Aging has less of an impact on expenditures than might be expected because reliance on VA for health care decreases beginning at age 65 as enrollees become eligible for Medicare coverage (see section on Enrollee Reliance below). Although the large Vietnam Era enrollee cohort that has mostly become Medicare eligible magnifies this effect, enrollees who have become Medicare eligible more recently have shown a slightly lower decline in reliance than older enrollees. Aging is driving growth in 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 29% of new enrollees transitioned to a new priority level within three years of enrolling. Enrollees transition between Priorities 5, 7 and 8 due to changes in income. Enrollees also transition into Priorities 1, 2 and 3 as a result of adjudication for service-connected disabilities by the Veterans Benefits Administration. The number of enrollees being adjudicated for service-connected disabilities has escalated in recent years. This is largely a result of the scope and definitions of service-connected conditions broadening over time and the improved capture of service-connected conditions at the time of military separation. These enrollees are expected to increase their reliance on VA health care, resulting in an increase in VA medical care costs.

Figure E shows the significant projected growth in service-connected status for Post-9/11 Era Combat Veteran, Gulf War and Vietnam enrollee populations over the next 20 years. As a result of the increasing numbers of enrollees moving into Priorities 1-3, projected enrollment is declining in Priorities 5, 7 and 8.

**Figure E. % of Enrollees in Priority 1-3, by Age**




*Approximated by enrollee age in 2020 based on dates of conflict and ages at time of conflict. Enrollees can be in the age range for a cohort and not have served in the conflict.

As a result of the previously mentioned trend of enrollees being adjudicated to higher service-connected priorities, as of 2020, 7% of enrollees had transitioned into Priority 1a (70% or higher service-connected disability) over the previous three years, compared with 4% as of 2010. The Priority 1a population is projected to continue to grow by 21% between 2020 and 2023 and 63% between 2020 and 2030.

Aging and the changes in the Priority 1a population are significant drivers of projected expenditure increases for LTSS. VA is mandated by law to provide continuing care nursing home services to Priority 1a enrollees. Additionally, World War II and Korean War era enrollees are in the age bands (greater than age 75) that are the highest users of LTSS and are driving the recent and near-term annual growth in LTSS expenditure requirements, and Vietnam Era Veterans will be an increasing driver of LTSS expenditures, with most having aged beyond age 75 by 2026.

### *Enrollee Morbidity*

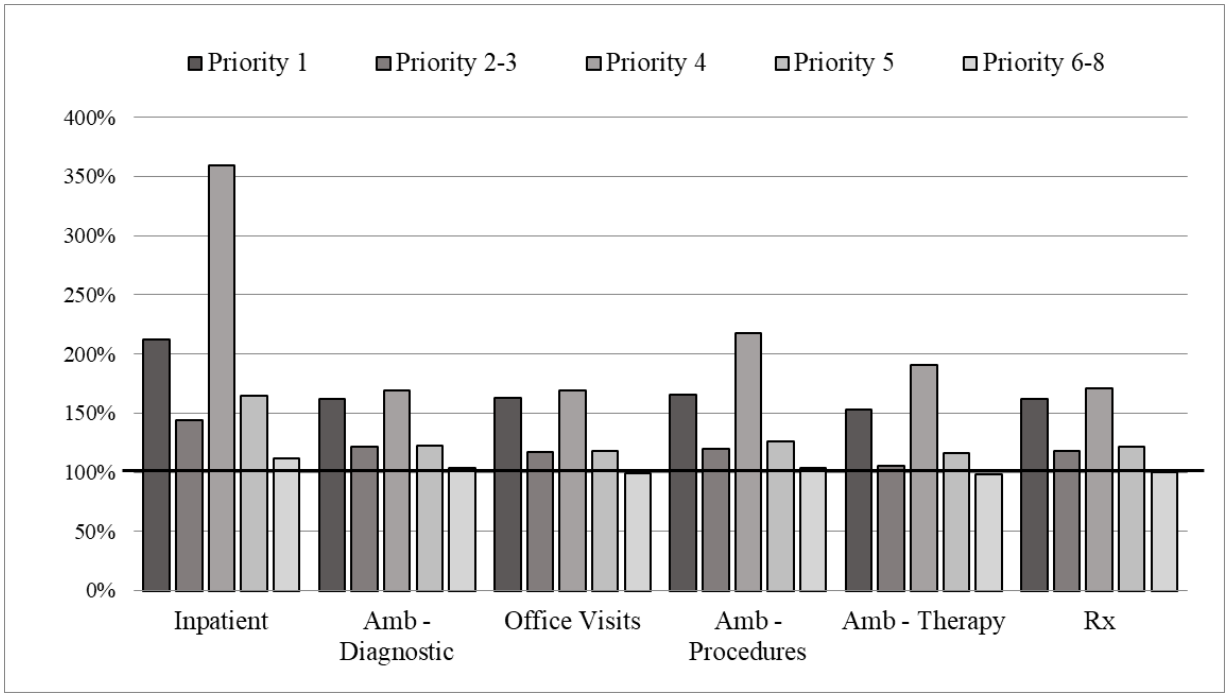
The VA enrollee population consists largely of older males, which is typically the segment of the population with the highest health care costs. Even after accounting for the age and gender mix of the enrollee population, the VA enrollee population is significantly more morbid (sicker) than the general population in the U.S.; and this higher morbidity further increases VA's cost of providing care.

In the 2019 VA Survey of Veteran Enrollees' Health and Use of Health Care, 34% of enrollees rated their health as "fair" or "poor" compared to other people their age. Only 16% of the U.S. adult population responded similarly in the Centers for Disease Control's (CDC) National Center for Health Statistics' 2019 National Health Interview Survey. Similarly, only 25% of enrollees rated their health as "excellent" or "very good" compared to 56% of the U.S. population in the CDC

survey. Using a diagnosis-based methodology, the average morbidity of the VA enrollee population is estimated to be approximately 32% higher than that of the general U.S. population.

Morbidity varies significantly by priority level and health care service. For example, the morbidity of Priority 4 (catastrophically disabled) enrollees results in inpatient care costs that are three and a half times that of the general U.S. population, even after accounting for the age and gender differences in the populations. Figure F shows the relative morbidity of enrollees by priority compared to the general population for several large categories of health care services. In the figure, 100% reflects the cost of health care based on the morbidity of the general U.S. population.

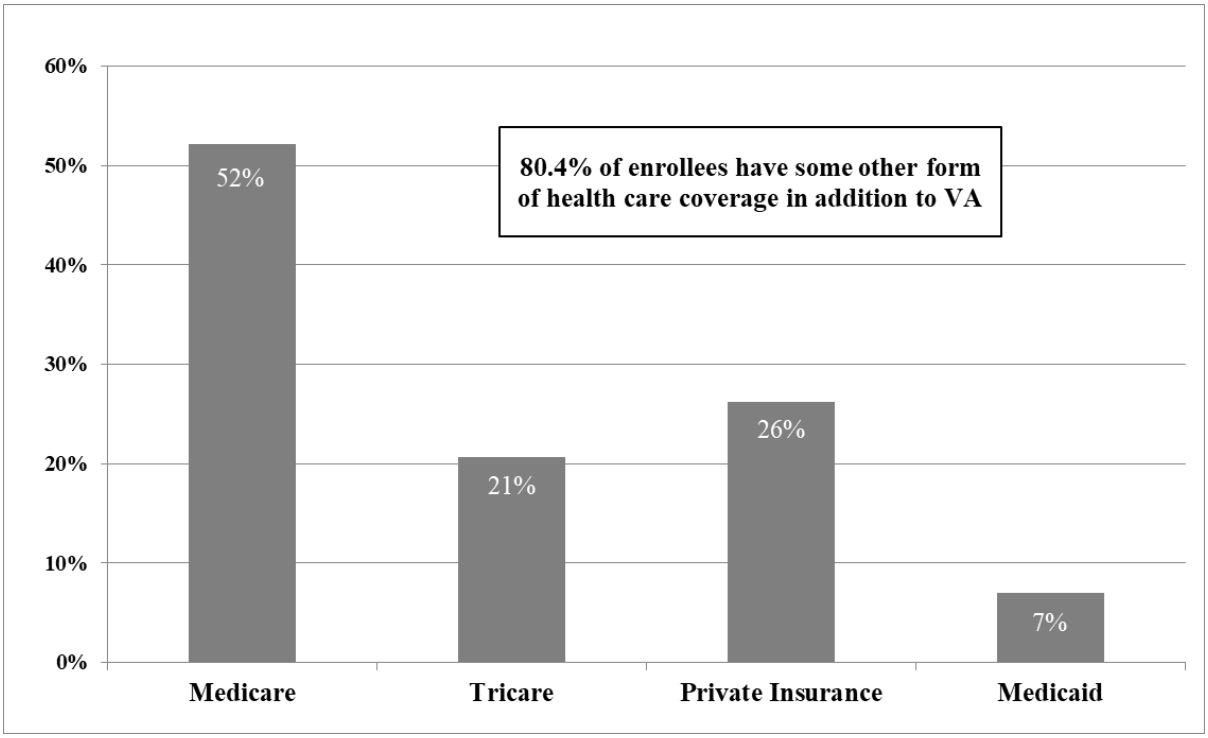
**Figure F. Relative Morbidity of Veteran Enrollees vs. General Population**




### *Enrollee Reliance on VA Health Care*

Reliance refers to the portion of an enrollee's total health care needs that are paid for by VA, either in VA facilities or through community care. A unique aspect of the enrolled Veteran population is that enrollees have many options for health care coverage in addition to VA: Medicare, Medicaid, TRICARE, Indian Health Service and private insurance. According to the VHA Survey of Enrollees, in 2019 approximately 80% of enrollees had one or more other sources of public or private health care coverage in addition to VA (Figure G).

**Figure G. Enrollee Insurance Coverage**



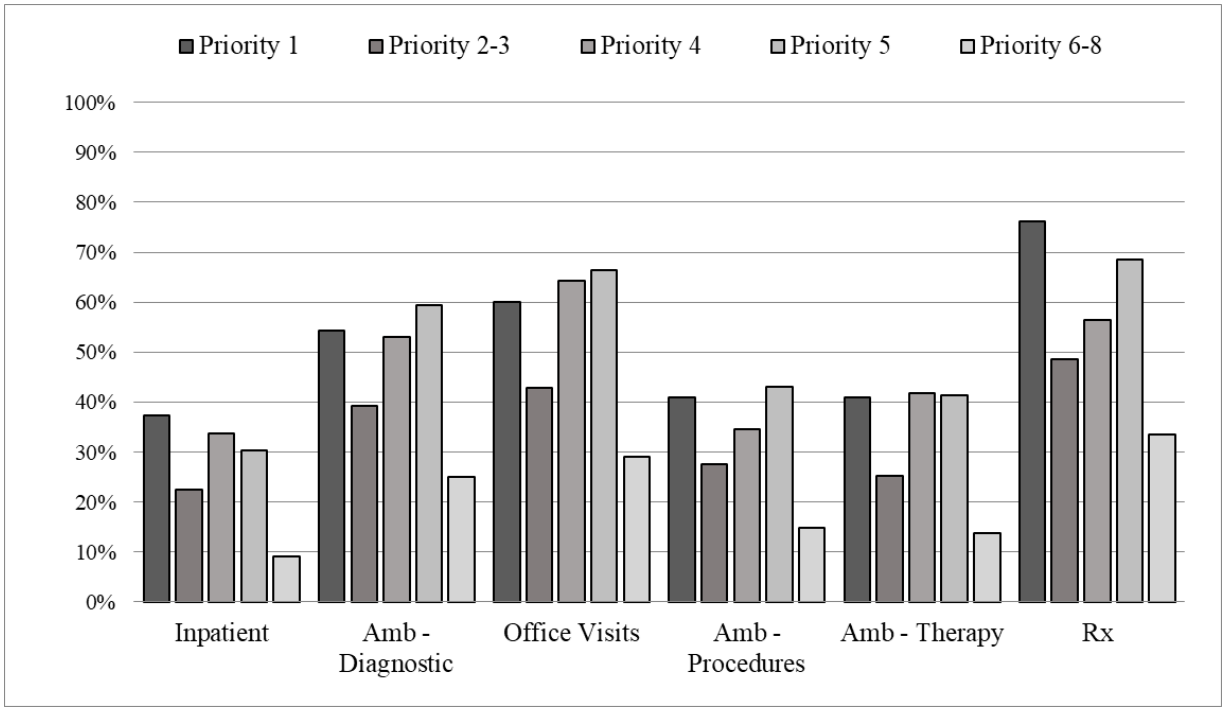

As a result, most enrollees do not use VA as their sole source of health care. On average, enrollees rely on VA for only 38% of their health care needs (excluding LTSS). This represented $75 billion in 2019. If the Veterans enrolled in 2019 had chosen to receive all of their health care in VA (100% reliance), this would have required an additional $129 billion for a total of $204 billion in 2019.

Like Veteran enrollment and demographics, enrollee reliance on VA health care is dynamic. Changes in enrollee reliance occur as a result of many factors: enrollee movement into service-connected priorities; changing economic conditions; VA's efforts to provide Veterans access to the services they need (e.g., mental health and homeless initiatives); VA's efforts to enhance its practice of health care; the opening of new or expanded facilities; and the cost sharing associated with services (e.g., dialysis) in the private sector compared to VA.

In the past few years, the Veterans Choice Act and MISSION Act have significantly expanded enrollee access to care in the community paid for by VA, thus increasing their overall reliance on VA health care. VA expects this impact to continue as enrollees continue to get more of their care through VA versus their other health care options. Additionally, enrollees have exhibited a "generational shift" in their reliance on VA, slowly increasing reliance on VA over time. For example, enrollees aged 65-69 in 2019 had, on average, higher reliance than enrollees aged 65-69 in 2014, at 34% in 2019 versus 31% in 2014 for inpatient medical services. VA expects this impact to continue as younger (and more reliant) enrollees age and older (and less reliant) enrollees leave VA.

Figure H shows reliance by priority for several large categories of health care services. For example, Priority 4 enrollees get approximately 34% of the inpatient care they need in VA.

**Figure H. Reliance of Veteran Enrollees**




**Enrollee Cohorts**

Within the enrollee population, several cohorts of enrollees exhibit unique health care utilization patterns that reflect their morbidity and/or reliance on VA health care. These include Post-9/11 Era Combat Veteran, enrollees Pre, post-Vietnam Era, Vietnam Era, World War II Era and female enrollees.

- Post-9/11 Era Combat Veteran enrollees have different utilization rates than non-Post-9/11 Era Combat Veteran enrollees of the same age for many services. For some services, the difference is attributable to the higher utilization rates typically experienced by new enrollees and, therefore, is not expected to persist over time. Post-9/11 Era Combat Veterans represented 21% of the enrollee population in 2020 and are expected to grow to 26% in 2030.
- Enrollees who used VA prior to the Eligibility Reform Act of 1996 (enrollees Pre) differ from those who enrolled after (enrollees Post). Enrollees Pre are both sicker and more reliant on VA for health care and, therefore, have higher utilization rates. These higher utilization rates are observed even after accounting for the higher average age of the enrollees Pre. Enrollees Pre represented only 14% of enrollees in 2020 but accounted for 27% of modeled expenditures. Since there are no new enrollees Pre, this group is declining over time due to mortality; enrollees Pre are projected to decline to 8% of the population by 2030, but still account for 16% of expenditures.

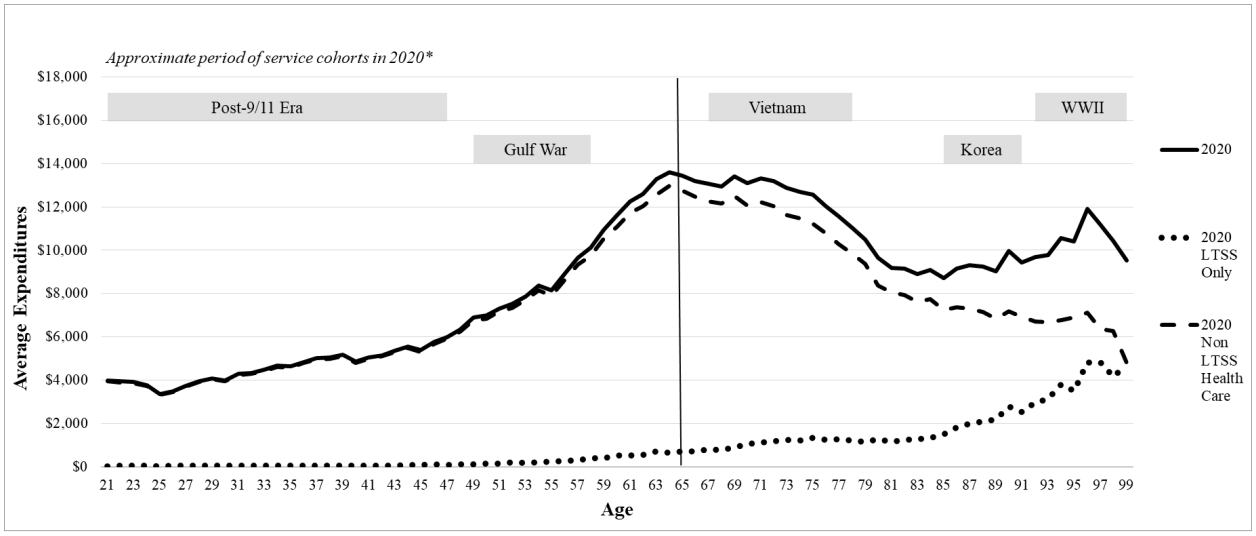
- Enrollees who served immediately after Vietnam have the highest health care utilization relative to other enrollees when they were at the same age. These enrollees exhibit higher than expected needs for almost all mental health and substance abuse services. This cohort represents about 18% of the enrollee population in 2020.
- Younger Vietnam Era enrollees represent a cohort that has largely aged into Medicare eligibility with a corresponding drop in reliance on VA health care. As they age and transition into Priority 1a, Vietnam Era enrollees are expected to be significant users of LTSS. Vietnam Era enrollees represent 30% of the enrollee population in 2020.
- World War II Era enrollees are high utilizers of LTSS, since those services are typically provided to older enrollees. This cohort represents about 2% of overall enrollment in 2020.
- Women are one of the fastest growing enrollee cohorts. Women comprised 9% of the enrollee population in 2020 and are expected to grow to 12% by 2030. 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 cardiovascular services.

***Expenditure Requirements by Enrollee Age***

As discussed, many demographic and environmental factors influence Veteran demand for VA health care and the resources required to provide that care. Some of these factors increase VA's resource requirements and some decrease VA's resource requirements. Figure I shows the net impact of all the factors on expenditures.

In Figure I, the actual 2020 expenditures by age highlight the impact of key factors influencing the cost per enrollee. For the under age 65 enrollee population, the figure shows the impact of the increase in the need for health care services as enrollees age. It also highlights how the impact of aging is mitigated by a decline in reliance on VA health care beginning at age 65 when enrollees typically become eligible for Medicare. However, enrollees who have become Medicare eligible more recently have shown a slightly lower decline in reliance than older enrollees. The impact of providing LTSS to enrollees (services that are generally not covered by Medicare) on expenditures by age is also illustrated.

**Figure I. Average Expenditures per Enrollee by Age**




*Approximated by enrollee age in 2020 based on dates of conflict and ages at time of conflict. Enrollees can be in the age range for a cohort and not have served in the conflict.

### *Dynamics of the VA Health Care System*

The VA health care system is continually evolving due to VA's efforts to enhance its practice of health care, provide Veterans access to the services they need and improve its level of health caremanagement.

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; and
- Admission appropriateness and continued stay reviews through the National Utilization Management Initiative (NUMI).

Assumptions for improvement in VA's level of health care management may increase or decrease ambulatory utilization projections depending on the service. Generally, well-managed organizations provide more preventative services and fewer diagnostic services. Improvements in management may also reduce the projected growth in utilization for inpatient acute bed days and admissions.

## Expenditure Requirements by Service Category

The following sections discuss the non-MISSION Act key drivers of increases in expenditure requirements for categories of health care services in a non-COVID-19 environment because COVID-19 is anticipated to be a temporary disruption to the provision of health care services. The MISSION Act policies are driving increases in services available in both VA facilities and the community, particularly the use of outpatient primary and specialty care and inpatient care.

### *Ambulatory Primary and Specialty Care*

Ambulatory care projections are developed for the full range of services provided under a typical private sector health plan (e.g., office visits, radiology, pathology, surgeries) as well asspecialized 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 2023 and 2024. 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

**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
- Ambulatory Surgery - Ambulatory Surgery Center Setting
- Ambulatory Surgery - Office Setting
- Ambulatory Surgery - Outpatient Setting
- Emergency Room Visits

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 (cont'd)**

Professional Services and Procedures cont'd

- Eye Glasses Services
- Hearing Aid Services
- Prosthetics and Orthotics Services
- Maternity
- Nutritional Counseling
- Observation Care
- Ambulance

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

Changes in enrollee reliance are increasing VA's expenditure requirements for providing dialysis services. Enrollee reliance on VA for dialysis services increased from 29% in 2011 to an estimated 45% in 2019 and is expected to continue to increase through 2028. This increase in reliance is due in part to lower cost sharing in VA compared to Medicare.

***Pharmacy – Outpatient Prescriptions***
Pharmacy workload projections are developed for prescription drugs that are typically 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 increasein the coming years. VA moderates the impact of inflation on prescription drugs with its well managed pharmacy benefit management program and contracting practices; however, inflation is still increasing VA's cost of providing prescription drugs. The prescription drug pipeline is monitored regularly, and potential impacts of emerging treatments are assessed in collaboration with the VA Pharmacy Benefits Management (PBM) Services. This information is considered when setting the trend assumptions for

prescription drugs. As most enrollees with Hepatitis C have now been treated, the volume of the expensive drugs used to treat this condition has stabilized at a lower level.

**Modeled Inpatient Acute Care**

Inpatient Acute

- Medicine
- Surgery
- Maternity Deliveries
- Maternity Non-Deliveries

*Inpatient Encounters*

- Cardiovascular
- Colonoscopy
- Dermatology Services and Diagnostic Exams
- Dialysis and Related Services
- Emergency Room Visits
- 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
- Ophthalmology Services and Diagnostic Exams
- Pathology
- Prosthetic and Orthotic Services
- Pulmonology Svcs, Diag Exams, Ventilator Mgmt
- 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
- Rehabilitation Case Management
- Recreational Therapy
- Surgical Procedures
- Vision Exams

### *Inpatient Acute Care*

Inpatient projections are developed for acute bed days of care for medicine, surgery and maternity. In order to support workforce planning, the EHCPM also projects utilization for inpatient encounters that occur during inpatient stays. The inpatient encounters projected by the EHCPM include diagnostics, therapies, professional services and procedures provided in an inpatient environment. The cost of all inpatient encounters is included in the cost of acute bed days of care.

Expenditures required to provide inpatient acute services to enrolled Veterans are expected to grow in both 2023 and 2024. The projected increase in expenditures is largely due to the impact of health care trends. VA's cost of providing acute inpatient services is expected to increase due to inflation and changes in health care practice that increases the cost of services (intensity trends). For example, as more surgeries are performed in an ambulatory environment, the average cost per service of the remaining inpatient surgeries, which are more complex, is expected to increase.

Although expenditures are increasing, utilization is stable with growth dampened due to several factors:

- Aging and priority transitions are increasing utilization projections but are largely offset by a negative impact of net enrollment growth (new enrollment minus deaths). Net enrollment growth is reducing inpatient utilization because the enrollees who are

dying are generally sicker than new enrollees.

- Improvements in VA's level of management in inpatient care reduces utilization by improving management processes (e.g., early discharge planning), reducing hospitalizations for ambulatory care sensitive conditions and readmissions through care coordination, disease management, expansion of home telehealth services, etc. and the continuing transition of care from an inpatient to outpatient environment.

VA's cost of providing inpatient maternity care is increasing due to high health care trends for maternity services in the private sector (most maternity care is purchased) and an increase in utilization due to the growth in enrollment for younger, female Veterans.

### *Mental Health Care*

Mental health projections are developed for a continuum of mental health services, including general outpatient mental health, evidence-based psychotherapies, intensive outpatient programs, residential rehabilitation treatment and inpatient mental health care (the cost of mental health inpatient encounters includes diagnostics, therapies, professional services and procedures provided in the inpatient environment). These services treat a variety of common mental health conditions as well as conditions requiring more specialized and/or intensive interventions including the most severe and persisting mental health conditions.

Expenditures required to provide mental health services to enrolled Veterans are expected to grow in both 2023 and 2024. The projected increase in expenditures is due to the impact of health care trends, primarily inflation, on the cost per service and VA's initiatives to expand access to mental health care. The growth in expenditure requirements slows after 2023 as the access initiatives end and utilization changes are primarily based on the demographics of the enrollee population.

**Modeled Mental Health Care**

Mental Health Inpatient
- Inpatient Acute Mental Health
- Inpatient Acute Mental Health Extended Stays
- Acute Substance Abuse
- Mental Health Residential Rehab
- Compensated Work Therapy/Transitional Residence (CWT/TR)
- Sustained Treatment and Rehabilitation (STAR)

*Mental Health Inpatient Professional Services*
- Mental Health
- Mental Health Inpatient E&M Services
- Psychotherapy
- Substance Abuse
- Psychosocial Rehabilitation and Recovery Centers
- Intensive Community Mental Health Recovery Services
- Work Therapy
- Mental Health Residential Rehabilitation Treatment Program Inpatient Encounters
- Homeless

Mental Health Outpatient
- Outpatient Mental Health
- Psychotherapy
- Outpatient Substance Abuse
- Mental Health Office Visits
- Psychosocial Rehabilitation and Recovery Centers
- Intensive Community Mental Health Recovery Services (ICMHR)
- Work Therapy
- Mental Health Residential Rehabilitation Treatment Program Outpatient and Residential Stay
- Homeless

Utilization of mental health services is expected to grow (independent of any change due to enrollment dynamics) due to VA's initiatives to increase capacity and patient referrals. For example, Mental Health Residential Rehabilitation is projected to grow 3% through 2023 due to these access initiatives. Also recognizing the need for additional care to treat increasing nationwide substance use disorders, including care to combat the opioid crisis, the 2021 EHCPM includes a multi-year positive trend in utilization (included as utilization trend, not specifically a program change). The overall effect is a 5% increase in utilization via community care and 2% increase in utilization via VA facility care from 2020 through 2023. 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 (11% from 2020 to 2023) and their increase in service-connected conditions (almost 75% of these enrollees are projected to be in service-connected Priorities 1-3 by 2023) are driving increases in utilization for this population. From 2020 to 2023, the utilization of Mental Health services by this population is expected to increase by 60% for inpatient services and increase by 46% for ambulatory. This growth varies by service, ranging between 5% and 53% from 2019 to 2023, except for Inpatient STAR which is being replaced by other mental health treatment programs.
- In addition, post-Vietnam Era enrollees use a significant amount of inpatient mental healthand substance abuse services.

However, the aging of the non-Post-9/11 Era Combat Veteran enrollee population is mitigating the projected growth in utilization of mental health services because use of mental health services declines at older ages. For example, utilization of Mental Health Residential Rehabilitation and Compensated Work Therapy services peaks between ages 50 and 60 then drops off dramatically by age 65.

***Rehabilitative Care***

Projections are developed for two special rehabilitative care inpatient services provided by VA: Blind Rehabilitation and Spinal Cord Injury/ Disorders (SCI/D) services. These services promote the health, independence, quality of life and productivity of individuals.

**Modeled Inpatient Rehabilitative Care**

- Blind Rehabilitation Services
- Spinal Cord Injury and Disorders

VA operates 13 Blind Rehabilitation Centers, which provide 4-6 weeks of inpatient adjustment-to-blindness training to help blinded Veterans achieve a realistic level of independence. VA operates 25 Spinal Cord Injury Centers. These provide expertise in treating new and longstanding spinal cord injuries and disorders and provide rehabilitation, medical care, prosthetics and training in skills needed to live and work with SCI/D and maintain quality of life.

Expenditures required to provide Rehabilitative Care to enrolled Veterans are expected to grow in both 2023 and 2024. The projected increase in expenditures is largely due to the impact of inflation on the cost per bed day for rehabilitative care.

Priority transitions are also driving increases in expenditure requirements for these services. Aging is driving growth in utilization for Blind Rehabilitation inpatient services, as diagnoses of vision problems increase with age.

SCI/D utilization rates are highest for enrollees aged 60 – 80 and that population is projected to decrease as a portion of the total enrolled population within the next few years. This, in combination with enrollment growth at younger ages, means the overall SCI/D utilization rate is expected to fall in each projection year.

***Prosthetics***

VA provides a full range of medically-prescribed medical equipment and products to enrolled Veterans. VA is the largest and most comprehensive provider of prosthetic devices and sensory aids in the country. Although the term "prosthetic device" may suggest images of artificial limbs, it actually refers to any device that supports or replaces a body part or function.

These include devices worn by the Veteran, such as an artificial limb or hearing aid; those that improve accessibility, such as wheelchairs, ramps and vehicle modifications; and implants surgically placed in the Veteran, such as hips and pacemakers. The relative cost of these devices varies dramatically, e.g., basic medical supplies cost very little while sophisticated implant and artificial limbs are much more expensive.

**Modeled Prosthetics**

- Glasses/Contacts
- Hearing Aids
- Surgical Implants
- Cardiothoracic Surgical Implants
- Medical Equipment & Supplies (e.g., diabetic socks, blood pressure monitors, dressing aids)
- Home Telehealth Devices
- Oxygen
  Respiratory Equipment
- Wheeled Mobility Devices
- Orthotics
- Artificial Limbs
- Blind Aids (e.g., magnifiers, talking products, training computer software)
- VA Specialized Products and Services (e.g., environmental modifications (ramps), services for service dogs)

Requirements to provide prosthetic services to enrolled Veterans are expected to grow in both 2023 and 2024. The projected increase in expenditures is due to health care trends.

The cost of prosthetic devices generally grows each year due to inflation and changes in health care practice. Extensive development and use of national committed-use contracts, as well as regional and local contracts, are expected to mitigate the expected inflation trends for prosthetics to some extent. These contracts provide quality assurance through active participation of clinicians and subject matter experts in developing requirements of the devices and the ability to obtain bestvalue for VA. The cost of prosthetic devices such

as glasses, surgical implants, oxygen, orthotics and wheeled mobility devices is also expected to increase due to advancements in technology (intensity trends).

Changes in health care practice may also drive growth in prosthetics utilization independent of any changes in enrollee demographics. With the increased use of technologies in all aspects of health care, more clinical specialties are using advanced prosthetic technology and devices to treat patients. Clinicians are better informed about the availability of technologies and are becoming more comfortable with prescribing these devices to treat and assist patients with specific conditions.

As a result, VA has observed an increase in the number of purchase orders, work actions and associated prosthetic devices that are prescribed and provided per unique patient. In recent years, VA has seen the portfolio of prosthetic devices expand and the types of available and prescribed devices diversity. For example, wireless communication devices and other devices compatible with hearing aids are being prescribed and provided in conjunction with hearing aids with wireless capabilities. The increased diversity of prosthetic devices coupled with technological advances is driving material increases in utilization of prosthetic devices.

The increasing number of enrollees being adjudicated for service-connected disabilities is also driving increases in prosthetics utilization. As enrollees transition from non-service-connected priorities into Priorities 1-3, they are expected to reflect the significantly higher utilization rates of enrollees in Priorities 1-3, particularly for blind aids, artificial limbs, wheeled mobility devices and VA specialized products and services.

Overall aging has a large impact on prosthetic services but does vary by service. For example, the use of hearing aids (which are not covered by private insurance or Medicare) increases significantly with age, while utilization of surgical implants shows minor increases as enrollees elect to use Medicare for surgical procedures. Aging is driving material increases in utilization of hearing aids, blind aids, wheelchairs, VA specialized products and services and oxygen.

The continued growth of the Post-9/11 Era Combat Veteran enrollee population (11% from 2020 – 2023), their aging and their increase in service-connected conditions (and the resulting transition into service-connected Priorities 1-3) is driving significant growth in utilization for prosthetics services for this population. Since this population is not yet eligible for Medicare (with the corresponding decline in reliance on VA), aging is driving increases in this population's use of prosthetics, particularly for oxygen, VA specialized products and services and hearing aids.

### *Long-Term Services and Supports*

LTSS include the full range of services provided to help Veterans with functional limitations and chronic health conditions in non-acute settings. These services are provided through facility- based care or via home and community based services (HCBS).

Facility-based care is provided in VA Community Living Centers (CLC), Community Nursing Homes (CNH) and State Veterans Homes for durations of both short-stay (90 days or less) and long-stay (more than 90 days). HCBS are provided through both VA and via purchased care. State Veterans Homes provide both facility-based care and HCBS but are not projected by the EHCPM.

**Modeled Long-Term Services and Supports**

Facility Based Services

- VA Community Living Centers, long-stay (>90 days)
- VA Community Living Centers, short-stay
- Community Nursing Homes, long-stay
- Community Nursing Homes, short-stay

Home and Community Based Services

- VA Adult Day Health Care
- Community Adult Day Health Care
- Home Based Primary Care
- Home Respite Care
- Purchased Skilled Home Care
- Home Hospice Care
- Homemaker/ Home Health Aide Programs
- Spinal Cord Injury & Disorders Home Care
- Community Residential Care
- Home Telehealth

Expenditures required to provide LTSS to enrolled Veterans are expected to increase in both 2023 and 2024. The projected growth for expenditures is primarily the impact of two enrollment dynamics that are having a very significant impact on LTSS in both facility and HCBS settings: priority transitions and the aging of the enrollee population. Inflation is also driving some growth for these services.

Enrollees transitioning into service-connected priorities are driving significant growth in utilization for facility-based LTSS as well as HCBS. In particular, the growth in Priority 1a enrollees (70% service-connected or more) is driving significant growth for long-stay facility-based LTSS. VA is legislatively mandated by the Veterans Millennium Health Care and Benefits Act (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-connecteddisability, or who have a rating of total disability based on individual un-employability.

The aging of the enrollee population is also having a significant impact on expenditures and utilization. Unlike other modeled services, reliance on certain LTSS does not decline after Medicare eligibility, due to limited Medicare coverage for long-stay facility-based services and HCBS. Currently World War II and Korea era enrollees are in the age bands that are the highest users of LTSS. Vietnam era Veterans will be an increasing driver of LTSS, with most having aged beyond 75 by 2026. CLC short-stay, which is used primarily for post-acute care and hospice care, is impacted less by aging than the other facility-based care categories.

Projected utilization for LTSS reflects programmatic changes in delivery of these services. Reflecting similar shifts in the health care system at large, VA is focusing efforts

to provide care in the most appropriate setting for enrollees. This change includes deliberate shifts to CLC short-stay care for those who are in an inpatient setting and are not ready to be discharged to home, but no longer need acute care. It also includes VA's initiative to provide care through HCBS rather than in facility-based LTSS when appropriate. These efforts are driving some growth for short-stay facility-based care and HCBS but are mitigating expected growth for long-stay facility-based care.

### *Dental*

Projections are developed for three categories of dental care services based on the intensity and complexity of the service. By law, VA provides dental care to enrollees based on special eligibility criteria, which are different than eligibility criteria for other VA medical care benefits. Providing preventive and basic dental services to enrollees aligns with VA's 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.

**Modeled Dental Care**

- Preventive and Basic Dental Services
- Minor Restorative Dental Services
- Major Restorative Dental Services

Expenditures required to provide dental services to enrolled Veterans are expected to grow in both 2023 and 2024. The projected increase is primarily due to the increase in service-connected conditions (and the transition into service-connected Priorities 1-3) and the resulting increase in eligibility for dental services. VA's cost of providing dental services is also expected to increase due to inflation.

## Impact of 2021 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 2021 EHCPM was used to build the 2023 and 2024 VHA Medical Care budget requests. The EHCPM was updated to 2020 and partial 2021 experience, but only some EHCPM assumptions were updated based on 2020 and 2021 data. Typically, the EHCPM is updated annually to reflect emerging information on the enrollee population and their utilization of VHA health care. These analyses are generally tied to the most recent fiscal years of data and establish assumptions that are based on this recent information, which then persist throughout the full EHCPM projection period. However, due to the significant impact of the COVID-19 pandemic on 2020 and 2021 utilization and enrollment patterns, which are not expected to remain in the long-term, many EHCPM modeling assumptions

in the 2021 EHCPM were developed using data through 2019, rather than updated to use 2020 and 2021 experience, then adjusted over time to remove the COVID-19 effects, creating a hybrid model. No adjustments have been made to account for the Omicron, or future, variants of COVID-19.

The newly incorporated VetPop 2018 projections have approximately 700,000 more total Veterans across all budget years than VetPop 2016. The increase in the base period with a further increase over the long term leads to a compounding increase to enrollment projections. VetPop provides the latest official Veteran population projection from the VA. It is a deterministic projection model developed by the office of Predictive Analytics to estimate and project the Veteran Population from 2018 to 2048. Using the best available Veteran data at the end of 2018 as the base population, VetPop 2018 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.

Historically, the most significant factors changing the EHCPM's projections have been external and could not have been anticipated in advance, such as the COVID-19 pandemic and associated COVID-19 recession, the MISSION Act, the civilian wage freeze policy and American Reinvestment and Recovery Act (ARRA) funding. Please see the section entitled "Uncertainty Associated with Actuarial Projections in the VA Enrollee Health Care Projection Model" later in this chapter for more information on the impact of COVID-19 on the VHA health care system as well as on sources of risk inherent in modeling.

**Table: 2023 Revised Estimate and 2024 Advance Appropriation EHCPM Model & Non-Model Obligations**

(dollars in thousands)

| Description | 2023 Revised Estimate | | | 2024 Advance Appropriation | | |
|---|---|---|---|---|---|---|
| | EHCPM | Non-EHCPM | Total | EHCPM | Non-EHCPM | Total |
| Health Care Services | $104,546,261 | $6,618,476 | $111,164,737 | $109,996,132 | $3,395,873 | $113,392,005 |
| *Non-Add Included Above:* | | | | | | |
| *Non-Recurring Maintenance* | *$0* | *$2,263,896* | *$2,263,896* | *$0* | $700,000 | $700,000 |
| *Non-Veterans* | *$0* | *$316,278* | *$316,278* | *$0* | $335,722 | $335,722 |
| Long-Term Care | $10,214,102 | $1,871,251 | $12,085,353 | $10,703,112 | $1,888,573 | $12,591,685 |
| *Non-Add Included Above:* | | | | | | |
| *State Home Programs* | *$0* | *$1,768,542* | *$1,768,542* | *$0* | *$1,797,512* | *$1,797,512* |
| Other Health Care Programs: | | | | | | |
| Camp Lejeune Families (P.L. 112-154) | $0 | $3,808 | $3,808 | $0 | $3,957 | $3,957 |
| Caregivers (Including CHAMPVA) | $0 | $1,846,210 | $1,846,210 | $0 | $2,259,305 | $2,259,305 |
| CHAMPVA & Other Dependent Prgs | $0 | $2,164,071 | $2,164,071 | $0 | $2,329,485 | $2,329,485 |
| Homeless Program Grants | $0 | $970,341 | $970,341 | $0 | $1,024,245 | $1,024,245 |
| Readjustment Counseling | $0 | $340,041 | $340,041 | $0 | $353,643 | $353,643 |
| Obligations [Grand Total] | $114,760,363 | $13,814,198 | $128,574,561 | $120,699,244 | $11,255,081 | $131,954,325 |

## 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 2020, CHAMPVA covered 526,979 beneficiaries. The number of beneficiaries is expected to rise to approximately 630,000 in 2023 and 668,000 in 2024.

The 2021 CHAMPVA Model was developed using data from 2011 to 2020, publicly available research and input from a development team (including subject matter experts from VHA and VHA's CHAMPVA program). The CHAMPVA Model consists of two major components: the enrollment model and the claims cost model. The enrollment model projects the number of beneficiaries enrolled in CHAMPVA, and the claims cost model projects expenditures for providing care to beneficiaries.

The enrollment model projects the number of CHAMPVA sponsors and beneficiaries. For each fiscal year, sponsors are projected and then the beneficiaries of those sponsors are projected. Within a given fiscal year, sponsors are projected at an individual level, with modeled individual beneficiaries linked to each sponsor. Three categories of beneficiaries are projected: spouses, children and helpless children. Beneficiaries eligible for CHAMPVA as a primary caregiver enrolled in the Program of Comprehensive Assistance for Family Caregivers (PCAFC) (i.e., are not also an eligible spouse or child of a sponsor) are not modeled in the CHAMPVA projection model. Such caregivers are projected as part of the 2020 PCAFC Model. The Veteran population basis underlying the enrollment assumptions and projections is primarily based on VetPop 2018.

The claims cost model is driven by several factors including: enrollment counts produced from the enrollment model, assumed annual claim cost trends, age/gender cost relativity factors and actual historical CHAMPVA paid claims data. The projected beneficiaries from the enrollment model are then linked to the claims cost model to generate expenditures. These projections also include assumptions for the impact of COVID-19 on deferred care and returning care during 2020 through 2022.

## The Program of Comprehensive Assistance for Family Caregivers (PCAFC) Model

Historically, the Program of Comprehensive Assistance for Family Caregivers (PCAFC) has provided comprehensive assistance to caregivers of certain Veterans and Service members who were seriously injured during service on or after September 11, 2001. For enrolled Veterans, their primary caregivers are eligible for a monthly stipend payment, 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 and travel, lodging and per diem expenses in order to attend required caregiver training and to travel to and from the Veteran's medical appointments. Following program changes required by the MISSION Act, the eligibility requirements were updated to include, over a two-year period, eligible Veterans that were seriously injured prior to September 11, 2001. Additional information regarding the PCAFC program can be found in the Caregiver Support Program section of the 2023 budget submission.

The PCAFC model was first developed in 2015 and has been updated each year since then. The PCAFC model includes projections for unique Veteran sponsor counts, unique primary caregiver counts, stipend payment costs, CHAMPVA benefit costs, mental health benefit costs and respite care benefit costs. The stipend cost projections make up the majority of total PCAFC costs. The CHAMPVA benefit cost projection in the PCAFC is limited to primary caregivers who qualify for CHAMPVA purely through their involvement in the PCAFC; CHAMPVA beneficiaries who qualify for CHAMPVA by being eligible spouses or children of a Veteran are projected as part of the CHAMPVA Model. The PCAFC model does not include other PCAFC program expenses such as training, travel, lodging and per diem.

Projections are developed using a combination of historical program experience, projected enrollment pattern assumptions, stipend payment and cost trends, projected health care cost trends, projected payment tier/level enrollment distribution and assumptions regarding policy decisions to implement the MISSION Act.

PCAFC costs are largely driven by projected enrollment into the PCAFC program. From PCAFC inception in May 2011 through 2016, there was a steady increase in the number of caregivers enrolled in the PCAFC. From 2017 to 2019, the program saw a reduced number of total Veteran sponsors and caregivers. However, due to program expansion to include Vietnam service era Veterans and Pre-Vietnam service era Veterans beginning October 1, 2020, and Post-Vietnam service era Veterans beginning October 1, 2022, the number of caregivers is expected to grow.

## Uncertainty Associated with Actuarial Projections in the VA Enrollee Health Care Projection Model

VA develops the 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 2023 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 the risk of emerging experience differing from projections. Understanding the key drivers enables greater insight into the sources of risk and how they contribute to uncertainty.

The EHCPM produces projections of enrollment, utilization and expenditures based on numerous model assumptions about how the future will be the same or different from past experience. There is uncertainty about how actual emerging experience will compare with these assumptions. A framework for assessing actuarial projection uncertainty involves identifying, analyzing and responding to underlying risks, consistent with Principal 7 of the Government Accountability Office's "Standards for internal control in the federal government" (see Appendix A).

The EHCPM is a projection model, which is based on a set of assumptions that affect the projection output over time. Because the assumptions are specified for each scenario, the projection output is a single estimate, usually referred to as the "best estimate." This type of model is referred to as a deterministic model. By contrast, a stochastic model uses assumptions that are sampled randomly from preset distributions, resulting in projection outputs that land in a random distribution. The decision to make the EHCPM a deterministic model, wherein each scenario results in a single "best estimate," is driven by practical purposes, including having the ability to explain the contribution of each assumption to the budget projection. In this approach, the projection output does not state the expected variability around the "best estimate". Instead, variability is communicated to

stakeholders using alternate "what if" scenarios, sensitivity testing where practical and through a qualitative discussion of the risks that contribute to uncertainty.

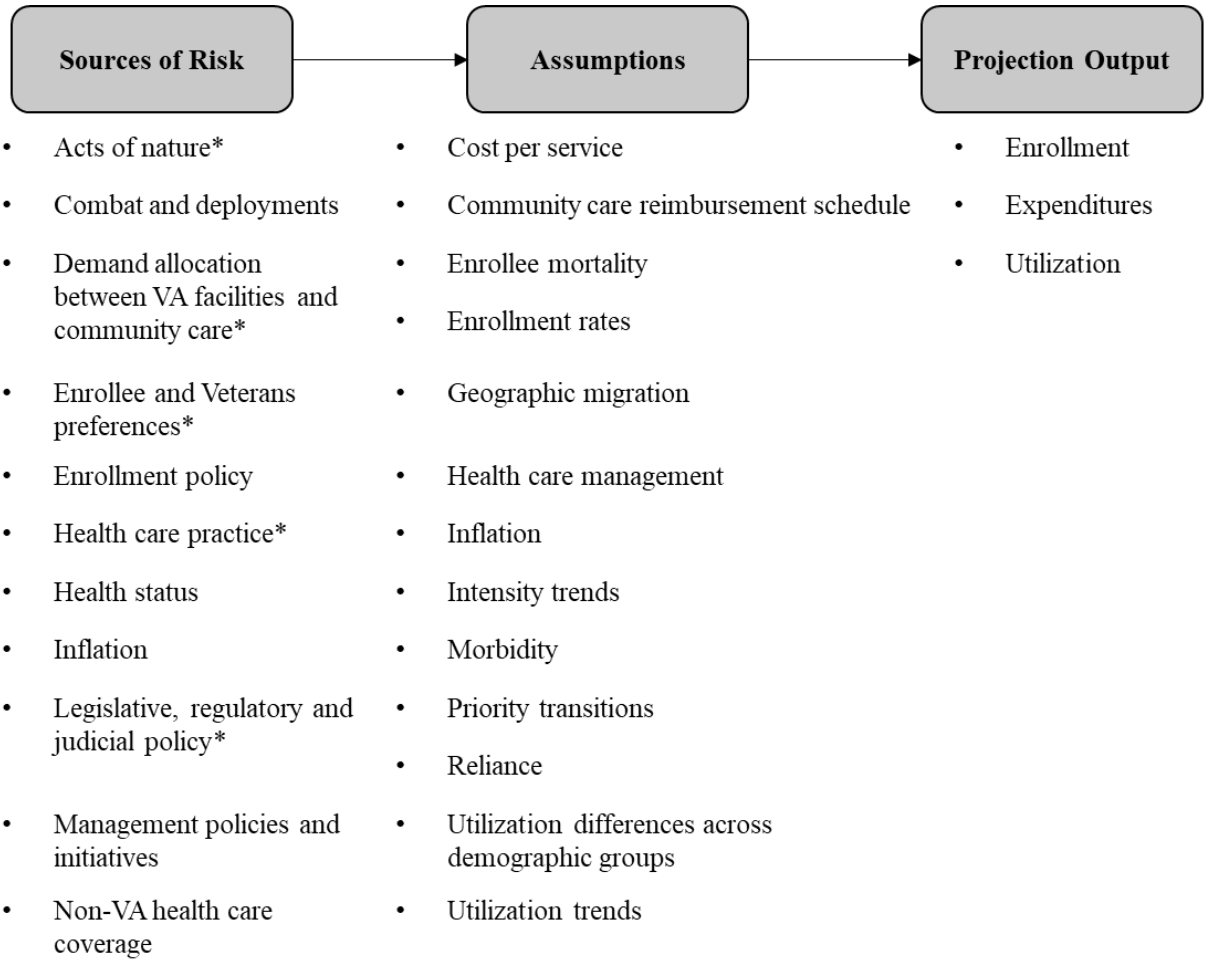
Many of the sources of risk that create uncertainty in the projections cannot be statistically measured in the first place. For example, there is uncertainty about future combat operations and deployment levels, which can have a material impact on long term enrollment levels and morbidity. Yet, VA cannot ascribe a probability to these future events. This is another reason why the EHCPM is not a stochastic model that produces a statistical range of projection results. Instead, variation is presented using scenarios that vary based on changing selected assumptions. This approach allows stakeholders to understand how the projection changes when underlying assumptions are changed and to understand the magnitude of their impact.

Within the EHCPM, a sudden event can occur that can have a large impact on enrollment, utilization or expenditures. In addition, there are ongoing factors that can differ from expectations and these changes can also have a large impact on the projections. These sources create a risk that the model assumptions will not unfold as expected, thereby increasing uncertainty in the projection outputs. For example, the uncertainty about future combat operations and deployments creates uncertainty in the EHCPM's enrollment and utilization projections primarily by affecting two key model assumptions: the size of the future Veteran population and the health status of newly separating Veterans.

***Identification of Risks Causing Projection Uncertainty***

Sources of risk manifest in uncertainty about projection model output by affecting assumptions that are the key drivers of enrollment, utilization and expenditure change over time. For example, an economic downturn is an event that can lead to higher enrollment and greater enrollee reliance. Consequently, the potential for an economic recession can manifest in greater uncertainty about future enrollment and utilization levels. The underlying sources of risk which affect the EHCPM's assumptions and projection outputs are outlined below.

**Identified Sources of Risk, Affected EHCPM Assumptions and Projection Outputs**




*Indicates a source of risk with the highest impact for the Budget Scenario.

***Role of Reliance in Risk and Uncertainty in the Model***

VA estimates that 80% of enrollees have some type of public or private health care coverage other than VA. Enrollees with multiple sources of coverage can choose to use their VA or non-VA coverage for each health care service. Reliance is defined as the portion of enrollees' total health care needs expected from the VA health care system, including both VA facility care and community care paid by VA, versus other health care options. For example, if an enrollee received 4 office visits from VA and 6 through Medicare, that enrollee would be considered 40% reliant on VA for office visits (4/10).

Note that reliance is not the percentage of enrollees that receive health care from VA. Most enrollees who use VA health care are only partially reliant; that is, they use VA for some of their care but rely on other health care sources such as Medicare or private health insurance for their remaining care.

In 2019, average reliance was approximately 38% across all enrollees for their health care needs (excluding LTSS). The large portion of enrollee care that is not currently funded by VA creates a significant model risk since events that may cause only small increases in reliance can generate significant additional expenditures. A 3% unexpected increase in reliance levels is estimated to cause the EHCPM's budget projection to increase by around 8%, or around $6 billion from a 2019 baseline.

***Characterizing the Degree of Uncertainty***

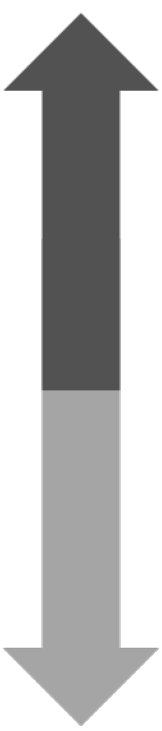
There are different ways to categorize sources of risk in terms of the type of uncertainty each brings into the model.

- Likelihood – Some events are very rare, and others occur more frequently. For example, a major overhaul to health care law is relatively rare, whereas unexpected changes in the inflation rate are nearly guaranteed, regular occurrences (though the magnitude and direction of the unexpected change are not known in advance).
- Magnitude – Notwithstanding the likelihood of an event occurring, the magnitude of the event is very important. For example, a pandemic is a rare, but high impact event.
- Single vs. Recurring Impact – Some events will create a one-time upward or downward shift in an assumption or the model projections (e.g., opening a new facility). Other sources of risk will lead to recurring changes in cost, therefore bending the expenditure curve upward or downward (e.g., expansion of enrollment eligibility).
- Time Horizon - The EHCPM projections serve two primary purposes:
    - First, there is the 3-4 year projection to support the budget submission 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**



| Level of Uncertainty Due to Risks | Assumptions | Contributes most to which projection output |
|---|---|---|
| | Reliance | Utilization |
| | Utilization trends | Utilization |
| | Inflation | Expenditures |
| | Intensity trends | Expenditures |
| | Morbidity | Utilization |
| | Utilization differences across demographic groups | Utilization |
| | Health care management | Utilization |
| | Priority transitions | Enrollment |
| | Enrollment rates | Enrollment |
| | Cost per service | Expenditures |
| | Community care reimbursement schedule | Expenditures |
| | Enrollee mortality | Enrollment |
| | Geographic migration | Enrollment |

**Approaches to Assess and Reduce Modeling Uncertainty**

There are several important activities that are undertaken prior to developing the projections, which are focused on collecting historical data and identifying sources of risk that have led to model uncertainty in the past.

***Baselining the Model***

VA gathers data from multiple sources, such as workload information from different facilities and information stored in multiple databases. Each year, the EHCPM is updated to reflect historical enrollment, utilization and expenditure information. Historical information over several years is used to estimate important model assumptions, such as utilization trends by service category, enrollment rates and reliance. The EHCPM is calibrated so that it projects the enrollment, utilization and expenditures that actually occurred during the model's base year. For example, the base year of the 2020 EHCPM was fiscal year 2019. This process is referred to as "baselining," and is an important step toward reducing model uncertainty.

One of the challenges in baselining is to obtain accurate and comprehensive data through the base year. VA works extensively to collate data from within the department and to organize it in a timely manner. Great care is taken to evaluate the completeness and accuracy of each data source. This is accomplished by reconciling data to other sources, testing it for both internal consistency and the validity of data entries and through discussions with key subject matter experts.

***Integrating Data Sources from Outside VA***

VA also obtains important data from outside of the Department to help understand the base year. A Medicare data match is available to assist in the review of overall health care utilization for Veterans ages 65 and over. This information is very helpful in understanding a more complete picture of medical conditions, overall utilization and reliance on VA health care for many enrollees ages 65 and over. There is no corresponding data set for Veterans under age 65, since health care data is generally spread across numerous private sector and government programs. As a result, modeling for Veterans under age 65 is primarily based on VA health care and supplemented by VA's annual Survey of Enrollees, which provides self-reported responses on enrollee reliance. Through this process, VA arrives at an effective means of assessing overall utilization and reliance for enrollees under age 65.

Other outside data sources include date of death files from the Social Security Administration (SSA). Since many Veteran enrollees may die outside of VA facilities and there is no direct requirement for their families or physicians to report this to VA, it is important to supplement dates of death that are reported within VA with information from outside sources, including SSA. This allows for a more up to date and accurate count of current enrollees.

***Reducing the Impact of Reporting Lag***

Most data sources have at least some degree of reporting lag. Enrollee deaths are not all immediately reported to VA and, therefore, there is a lag in complete reporting of enrollee deaths. For community care, VA, like other payers, experiences a gap between the provision of the service and the date of payment. This is an unavoidable feature of some data sources. Where the impact is expected to be material, adjustments are made to arrive at a more complete model of the base

period experience. A primary benefit of making adjustments for reporting lag is that more recent, relevant data can be used to develop model assumptions. By contrast, waiting an extended period of time for a data source to be free of reporting lag can make it less relevant for identifying emerging trends.

As time passes, the information on prior periods develops and a more complete picture is formed. This development pattern is evaluated for older periods so that the impact of reporting lag can be modeled and applied to the most recent base year information.

The Medicare data match is usually about two years old by the time it is available for analysis, so additional review on trends is performed to better estimate key assumptions such as morbidity and reliance during the base year.

***Other Steps to Reduce Uncertainty***

Some events or processes give rise to uncertainty that cannot be reduced through deeper analysis alone; for example, it is not possible to predict natural disasters or new military conflicts. Other risks that create uncertainty are more accurately measured by accessing better sources of data and gathering data that is more representative of the base year experience. Sometimes, sources of uncertainty, such as a new law, can be anticipated before their impacts show up in actual experience data, prompting model assumptions to be initially established and refined over time.

As an example, the model historically assumed that reliance for a given enrollee demographic profile was stable over time. As additional longitudinal data emerged, VA identified changes in enrollee reliance due to a "generational shift:" enrollees in younger generations are more reliant than those in older generations. Using this data, VA developed and refined assumptions to more accurately project reliance changes over time due to the generational shift and reduce model uncertainty.

The first step in assessing projection uncertainty is to identify the underlying sources of risk. Actuarial, clinical, policy and operational expertise are continually consulted to identify new sources of risk and reassess the importance of previously known sources.

The second step is to analyze each source of risk and evaluate its significance. A source of risk is considered significant if it can have a material impact on the accuracy of model projections. Often in these situations, alternative projection scenarios are presented along with a discussion of key causes of uncertainty (e.g., sensitivity testing).

The third step is to take appropriate action in response to the risk analysis. If a source of risk is contributing significant uncertainty, then it warrants deeper analysis, more data investigations and other efforts to arrive at a better estimate of the model assumptions involved. As part of this work, the level of uncertainty is communicated with stakeholders along with the best estimate.

An important part of this framework involves monitoring emerging experience and comparing it to prior projections. When material deviations are found, they are analyzed so that the underlying cause can be identified. Through this process, new sources of risk can be identified as being material and relevant to the projection uncertainty. This activity is accomplished in several ways:

- Monthly monitoring of enrollment – Identifies changing trends and potential data quality issues. Relevant experts within VA are consulted depending on the issue being discussed. Material deviations in emerging experience can be communicated with leadership and changes in enrollment projection methodology are considered.
- Comprehensive annual analysis of prior year enrollment relative to projections – Establishes a new starting point for the enrollment projections and creates a new data set for evaluating projection assumptions. Key model assumptions are tested against the new data and changes are made where appropriate. These include monitoring separate drivers of enrollment change on a monthly basis, such as new enrollment, mortality and transitions in priority level. As a result, material deviations from the projected enrollment trajectory can be isolated to the specific assumption that is causing the deviation to occur. This assumption can then be investigated in more detail using the most appropriate data and in collaboration with subject matter experts within VA.
- Comprehensive annual analysis of prior year utilization and expenditures – Establishes a new starting point for the utilization and expenditure projections and creates a new data set for evaluating projection assumptions and differences in utilization patterns across demographic categories. Key model assumptions are tested against the new data and changes are made where appropriate. Utilization and expenditure projections are affected by a multitude of assumptions. Through this review, material deviations from projections can be isolated to the specific assumption that is causing the deviation to occur. This assumption can then be investigated in more detail using the most appropriate data and in collaboration with subject matter experts within VA.
- Ad hoc interim utilization review – Identifies material deviations at the service category level on a periodic basis. These deviations are investigated and stakeholders alerted to the new observations. Oftentimes, the interim results are not sufficiently conclusive to warrant an immediate change in the projections but are incorporated into later model scenarios as appropriate.
- Consultation with work groups of subject matter experts on major model components (e.g., mental health, women's health, pharmacy, health care economics) – Evaluates differences between historical experience and prior projections and updates methodology where appropriate. Emerging developments in care delivery and other information are collated to develop a new estimate of future trends. Emerging sources of risks are discussed (e.g., unknown outcomes of new blockbuster drugs, proposed legislation, impact of changing economic forecasts) in order to better understand uncertainty in the projections.

There are several important examples for assessing uncertainty, which inform the approach that is taken with the EHCPM. These include government and private industry examples for risk analysis:

- Comptroller General of the United States published standards for internal control for the Federal Government
- National Association of Insurance Commissioners Risk Based Capital Plan and Own Risk and Solvency Assessment Summary Report
- State Medicaid Agencies
- Actuarial Standards Board of the American Academy of Actuaries Actuarial Standards of Practice

For detailed information on VA's approach to using these examples in the development of the EHCPM, please see Appendix A.

***Approaches to Address Evolving Events and Policies***

Many risks are difficult to predict and occur suddenly, such as combat deployments, pandemics and economic recessions. In addition, new policy directions can be considered by leadership or influenced by judicial decisions, such as the MISSION Act.

Depending on the timing of the event, the projections supporting the VA health care budget may not include estimates of the impact of the event or policy direction. However, as the event or policy unfolds, estimates are developed that provide high-level impacts to inform budgeting for these costs. These high-level estimates allow for flexibility when the policy is in flux or when detailed information is not available to support integration into the EHCPM. These estimates are revised as new information and/or analyses are available. For example, as the COVID-19 pandemic emerged, a high-level estimate of the resources required to respond to the pandemic was quickly provided to leadership. The Budget Scenario discussed in this document includes an updated estimate and future updates to the estimates are expected as the pandemic unfolds.

The EHCPM scenario documentation identifies policies that are included in the scenario, provided as a high-level estimate or not modeled.

**Assessment of EHCPM Projection Uncertainty from the Perspective of Underlying Sources of Risk**

All sources of risk are discussed below, including their impact on key model assumptions and potentially different impacts by projection time horizon. Sources of risk are listed in approximate order of the anticipated magnitude of their impact in the Budget Scenario. Sources of risk which have a specific impact to the scenario supporting the budget outside of the general impact on model assumptions will have an additional subsection labeled "Budget Scenario."

***Acts of Nature***

Acts of nature (e.g., hurricanes, tornadoes, wildfires, pandemics) affecting parts of or the entire nation are difficult to predict and can arrive suddenly, as was the case with Hurricane Katrina in 2005 and with the COVID-19 pandemic in 2020.

***Assumptions most affected***

Morbidity, mortality, reliance, enrollment rates, utilization trend, cost per service, community care reimbursement schedule:

- An act of nature is an unpredictable episode that can dramatically increase mortality and morbidity among vulnerable segments of the enrollee population until the disaster is contained.
- Uncertainty comes in part from the inability to predict the start of and severity of the act of nature. It also comes from unpredictable differences in how society responds. For example, the COVID-19 pandemic involves droplet transmission through the air and by touch, leading to social distancing and an abrupt reduction in common activities, including going

to the doctor. On the other hand, the response to the HIV pandemic did not disrupt most public interactions as HIV is primarily a sexually transmitted infection.

***Time horizon***

Short-term and long-term:

- The impact of acts of nature is modeled primarily within a 3-4-year period, anticipating a return to normal over longer time horizons. In the case of COVID-19, it is likely that there will be permanent changes to health care delivery as well, such as a faster and more widespread adoption of telemedicine, but those outcomes are much less certain.

***Budget Scenario***

COVID-19 has led to a significant decline in overall health care utilization since mid-March 2020. While the impact of the COVID-19 pandemic on health care utilization has lessened since its peak in spring 2020, it is continuing to add significant uncertainty to the model projections.

A portion of this deferred care will ultimately return at a future date rather than cancelled outright, and there is great uncertainty about how these two drivers will play out. If an unexpectedly larger portion of deferred care from 2020 and 2021 returns 2022 and 2023, in addition to normal levels of care in those years, then there will be an unexpectedly higher strain on VA facility and community care capacity at that time.

The scenario supporting the budget estimates the net impact of deferred and returning care will result in a $1.3 billion increase in expenditures in 2022 (relative to 2020) and a $5.6 billion increase in 2023, based on current deferred and returning care assumptions. If returning care increases from the budget scenario assumptions by 50 %, then 2022 expenditures could increase by an additional $0.6 billion and the 2023 expenditures could increase by an additional $1.3 billion. If the returning care is 50 % lower than budget scenario assumptions, then the 2022 and 2023 expenditures could be lower by these same amounts.

The results above are highly sensitive to changes in the rate and timing of care deferral and the eventual return of some of that deferred care. The 2022 and 2023 projections, include a significant deferral of care and returning care. If enrollees return to historical care patterns and have previously deferred care needs met sooner, this will cause some of the increase in expenditures currently projected in 2023 to instead occur in 2022. On the other hand, if deferred care returns more slowly than currently projected, then this could reduce 2022 expenditures, but cause further increases in projected 2023 and 2024 expenditures.

The reduction in health care utilization did not lead to proportional reductions in VA facility expenditures due to VA's fixed cost structure, e.g., staff salaries and facility maintenance costs. Therefore, the average cost per service at VA facilities has increased considerably during the pandemic, though it is expected to decline as care approaches pre-pandemic levels. The terms of reimbursement to community providers could change to a higher rate if community care providers look to recoup losses incurred during the pandemic or if new capacity constraints emerge due to a reduction in community providers.

An additional area of uncertainty is the degree to which post-pandemic health care utilization returns to the pre-pandemic projected trajectory. The scenario supporting the budget assumes deferrals and returns are essentially done by the end of 2024 and that health care utilization in 2024 and later years is largely at the same level as what would be expected had the COVID-19 pandemic never occurred. If instead there is a long-term reduction in health care demand, either due to a nationwide shift in healthcare utilization patterns or a shift in enrollee reliance to use more non-VA care, then this could have material impacts on VHA expenditures. For example, if demand for VHA care is permanently suppressed and utilization levels return to only 95% of pre-pandemic projections, then this could reduce 2023 expenditures by $5.5 billion and 2024 expenditures by $5.8 billion. These impacts assume fixed costs for VA facility care are reduced from the levels need to support the pre-pandemic projected trajectory, so that the full 5% reduction in VA facility expenditures is realized.

COVID-19 has also led to an economic downturn, which affects enrollment and reliance. See the Economic Conditions section for discussion. Even after the economy recovers, the pandemic could disrupt enrollee reliance patterns or preferences for VA facility vs. community care. See the Enrollee and Veteran Preferences section for discussion.

The pandemic could also affect enrollee health status and mortality and health care practice patterns. See the Health Status and Health Care Practice sections for discussion.

### ***Economic Conditions***

Economic conditions influence individual behavior primarily due to changes in employment (which in turn affect availability of non-VA health coverage) and a sense of financial security. These influences affect Veterans' propensity to enroll in VA and to use VA to satisfy their health care needs. It is difficult to predict future economic conditions, including the incidence and depth of recessions. Even when a recession has begun, it is difficult to forecast the recovery with precision.

#### *Assumptions most affected*

Reliance, enrollment rates, priority transitions:

- Most enrollees have other forms of health insurance, including employer-sponsored health coverage and individually purchased coverage. When unemployment increases, enrollees may lose other forms of insurance and begin to rely more on VA for their care. Conversely, as employment increases, enrollees may reduce their reliance as they become eligible for employer-sponsored coverage.
- There is significant uncertainty around how much reliance may change. A primary reason for this uncertainty is that reliance changes during previous recessions may not repeat in future recessions. For example, the Affordable Care Act introduced significant new safety nets for health coverage among unemployed and lower income individuals beginning in 2014. This safety net was not available during the economic downturn in 2008/2009. Therefore, there is more uncertainty about whether the potential reliance changes during a new economic downturn may be dampened.
- Enrollment rates may also increase as more Veterans decide to come to VA for the first time due to financial insecurity or lack of other health coverage options. Finally, priority

transitions between income-based priority levels (i.e., priority 5, 7, 8) may occur with major changes in employment and income.

***Time horizon***

Short-term:

- Most economic forecasts that include a downturn revert to typical economic conditions over time. For example, during the Great Recession, the economic forecasts included a gradual recovery of unemployment over several years. Reliance is the most material assumption that moves during an economic downturn, and it is expected to revert back to pre-recessionary levels as the recovery develops. Therefore, the long-term projections are less affected by current economic downturns and recoveries.
- The greatest uncertainty is over the short-term. In the early months and years of an economic downturn, the future path of the downturn and recovery is usually the most variable, and so these are the times where uncertainty is greatest. The four recessions that began in 1981, 1990, 2001 and 2008, respectively, took on average 22 months (ranging from 16 to 27) to reach their peak unemployment levels prior to gradual recovery lasting 19 to 71 months in order to reach pre-recession levels. These prior precedents illustrate the variability of paths an economic downturn and recovery can take, and they are also not necessarily representative of the current economic downturn. Hence, the uncertainty is greatest especially in the first year or two after a recession begins.

***Budget Scenario***

The scenario supporting this request uses the Office of Management and Budget November 2021 economic projections to assume that the unemployment rates will decline from 7.3% in 2020 to 3.6% in 2023, then increase slightly to 3.7% in 2024. This primary economic forecast is supplemented by the Bureau of Labor Statistics forecasted Civilian Non-institutional Population and the Milliman COVID-19 Advanced Population Shift (CAPS) model. This model projects expected changes in the mix of other health insurance (OHI) coverage due to the OMB economic forecast. The Milliman CAPS model is calibrated to the VHA enrollee population.

This projected change in the economy results in a $70 million decrease in projected 2024 expenditures, relative to a scenario in which the economic conditions in 2020 persist.

Higher reliance and enrollment rates are anticipated due to the spike in unemployment resulting from the pandemic. Modeling these changes is confounded by the much larger impact of deferred/cancelled care and hesitation to enroll, brought about by social distancing and other responses to COVID-19.

There is greater uncertainty about modeling the impact since starting assumptions are based on enrollee behavior changes during the downturn and recovery of the previous recession. There is a risk that enrollees today will respond differently. The factors driving the recession differ, sources of health care coverage have changed, and Federal stimulus and other measures have been much more significant than during the previous recession. All of these factors could change how enrollee reliance changes in the current environment.

With the unemployment rate decline happening so recently, there is much greater uncertainty about the path of recovery going forward. VA expects that forecasts of unemployment will be revised with greater changes than the previous forecasts, which were during a relatively stable and positive environment for employment.

***Legislative, Regulatory and Judicial Policies***

It is difficult to anticipate the decisions of current and future congresses, courts and administrations and they can have a substantial impact on expenditures. Also, there can be sweeping legislative changes or many small legislative or regulatory changes happening simultaneously leading to a large impact on VA's health care system.

***Assumptions most affected***

All changes to legislative, regulatory and judicial policies over time have the potential to impact VA enrollment, utilization and expenditures. Here is a list of examples:

- Medicare Modernization Act of 2003 – Among other Medicare reforms, this act expanded prescription drug coverage to seniors, thereby increasing the attractiveness of Medicare benefits. This created uncertainty about how seniors would change their use of VA over time. Ultimately, the rates of new enrollment into VA began to fall and reliance on VA pharmacy benefits change due to seniors having more options outside of VA.
- Affordable Care Act (ACA) of 2010 – Expanded guaranteed policy issuance (including for pre-existing conditions) and subsidized health care primarily for individuals under the age of 65 who are not otherwise eligible for Medicaid. Initially, the law included a mandate for individuals to obtain coverage. This created uncertainty about whether more Veterans would enroll with VA to satisfy the mandate. It also created uncertainty about whether Veterans would choose ACA coverage instead of VA in the future.
- Choice Act of 2014 and MISSION Act of 2018 – Among other reforms, these acts expanded access to community care. This introduced more uncertainty about how community care utilization and expenditures would trend over time. While the Choice Act did not significantly increase enrollment, it did create more demand on the system for the eligible groups of enrollees. The full impact of the MISSION Act is still uncertain, but it is expected drive increases in utilization and expenditures, similar to the Choice Act.
- Proposed Comprehensive and Overdue Support for Troops of War Act of 2021 (Cost of War Act) legislation – A bill introduced in the Senate would expand 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 legislation is expected to increase the number of enrollees, patients and overall expenditures of VA. The current model does not anticipate these higher expenditures, so most of the uncertainty centers around whether the Cost of War Act will become law. If passed, the first set of estimates that are made in the model will be uncertain as well. 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.
- Emerging experience from 2020 and 2021 shows a larger than initially expected increase in community care workload and costs. This follows 2019 which also had a larger than expected increase. This can be traced to an acceleration in growth beginning in June 2019 as the act became effective. The emerging 2020 and 2021 experience has also been significantly impacted by changes in claim processing speed and COVID-19 deferring or eliminating care. These impacts have obfuscated MISSION's impact on community care utilization growth. Based on currently available data, VA cannot definitively determine whether the higher-than-expected growth so far is an indication that the MISSION Act is increasing enrollee reliance more quickly than anticipated, that the MISSION Act will have a larger ultimate impact on enrollee reliance, or that another force unrelated to MISSION is having a role in changing enrollee behavior. This adds to overall model uncertainty.
- Enrollee reliance was projected to increase in 2021 as the program implementation and enrollee behavior matures. Projected reliance growth will then slow as it reaches an assumed steady state by 2023 and then level off. As of the time of this report, emerging experience (paid through September 2021) suggests 2021 community care claims are continuing to increase, though the growth rate is tapering. There is significant uncertainty as to how long enrollee reliance will continue to increase before reaching a steady state. This produces significant risk around the 2022 and later projections.

***Health Care Practice***

Advancements in medical technology and pharmaceuticals occur regularly, though the timing of these inventions is difficult to predict. Examples include the widespread introduction of magnetic resonance imaging over the past two decades, advancements in prosthetics for lost limbs and the discovery of more effective Hepatitis C treatments in the mid-2010s.

***Assumptions most affected***

Utilization trends, intensity trends, morbidity, mortality:

- The introduction of new treatments and devices can change the trend in utilization levels by introducing treatments for the first time or changing the price and effectiveness of existing treatments. Often, these advancements may be focused on a very specific service

category (e.g., prosthetics). Changes in cost will affect the cost per service (e.g., a more intense, higher cost service) as well. Uncertainty around the timing and impact of these advancements translates into uncertainty about these model assumptions.

- Improvements in health care, especially life-saving treatments, tend to reduce mortality rates over time, improve overall health (morbidity) and extend lifespans. The EHCPM specifically includes mortality improvement assumptions and uncertainty about the pace of future changes in mortality compounds over the long-term.
- The utilization and intensity trend assumptions incorporated into the model will, barring any specific information, account for average trend movements over time. These trends cannot anticipate rare and/or exceptional events.

***Time horizon***

Short-term and long-term:

- Due to the gradual nature of most innovations, whether it be changing practice patterns or the gradual adoption of new medical technologies, the uncertainty about their effect's compounds more significantly over the long-term.
- However, short-term breakthroughs, especially the introduction of new and expensive pharmaceuticals, contribute to uncertainty over the shorter-term budget horizon. For example, the introduction of Harvoni and related Hepatitis C drugs beginning in 2014, which had an initial price approaching $100,000 per patient, came to market quickly and within the time frame of the three-year budget projection.

***Budget Scenario***

COVID-19, in addition to the extensive disruptions to short-term care due to deferral of care and treatment of COVID patients, may also affect underlying health care practice trends. For example, resources directed toward the development of the vaccine could affect the speed with which other drugs come to market, the increase in video telehealth care could be sustained, or the significant disruption in regular care patterns could affect future treatment protocols. These possibilities, among others, cause a higher than usual level of uncertainty in emerging health care patterns. The Budget Scenario does not assume any long-term changes in health care practice due to COVID-19. VA continues to evaluate emerging experience and available information to assess this assumption and will revise the assumption if appropriate.

***Demand Allocation between VA Facility and Community Care***

The EHCPM projects enrollees' total enrollee demand for VA health care. Then, the total projected demand is allocated to VA facility and community care based on eligibility criteria for community care (e.g., MISSION Act) and operational guidelines.

***Assumptions most affected***

Reliance, cost per service:

- The projected resource requirements for VA facility and community care represent a division of the total enrollee demand projected by the EHCPM. Therefore, both care locations need to be funded at the projected expenditure levels to meet the total projected

enrollee demand for VA health care. For example, if VA facility care is not funded at the projected level, VA would need to purchase this care in the community, which would increase the projected resource requirements for community care.

In addition, the EHCPM projects significant growth for ambulatory care services in both VA facilities and in community care. If VA is not able to expand capacity in VA facilities to meet this growth due to resource constraints or the lack of available providers and/or space, this projected increase in services will need to be met in the community, which would increase the projected resource requirements for community care. Under the MISSION Act, if VA cannot provide care in VA facilities in a timely manner, enrollees are eligible to receive care in the community.

Likewise, if VA's community care network cannot expand to meet the projected growth in demand, VA may not be able to meet all of enrollees' projected demand. This would suppress enrollees' preferred reliance on VA health care.

Mismatches in resource availability or the inability to increase capacity in VA facilities or the community care network to meet the projected service growth could disrupt timely access to care for enrollees.

In addition, because these two locations of care require different funding streams and operational support, there is risk associated with the allocation of care between locations and not just the total amount of care provided by VA.

***Time horizon***

Short-term:

- The allocation of the total projected health care demand between VA facility and community care allows VA to budget and plan to meet enrollees total demand for VA health care. The short-term uncertainty is that emerging experience will be different than the allocation of care, causing operational disruption.

***Budget Scenario***

Assumes the projected future growth in services follows the historical split between VA facilities and community care except for the reliance growth due to the expanded eligibility criteria for community care under the MISSION Act. The pandemic has disrupted care patterns for almost all providers and enrollees. As that care resumes, there is an elevated risk of emerging care patterns differing from the historical pattern, particularly if VA facility care re-opens at a different pace than community care.

***Enrollee and Veteran Preferences***

Eligible Veterans have a choice to enroll with VA and, once enrolled, can choose how much of their health care to get through VA instead of through their other coverage. Because most Veterans have these choices, their individual preferences will influence the result.

***Assumptions most affected***

Enrollment rates, reliance:

- Enrollment with VA is free (i.e., there is no monthly premium like there is in Medicare and private insurance); yet not all eligible Veterans choose to enroll with VA. As a result, there can be large swings in new enrollment over time, affected by a wide variety of external factors and the individual preferences of Veterans (see Figure C). It should be noted, however, that new enrollment represents a small part of total enrollment. If approximately 400,000 new enrollees join in a year, it represents about 4.4% of the 9 million unique Veterans enrolled in that year. An unexpected increase of 4,000 new enrollees (i.e., 1% of the annual new enrollment) would only increase the total enrollment by 0.04% and budget requirements may increase by even less if the additional enrollees are younger and have fewer health care needs.

Similarly, those enrolled with VA may not get all of their care through VA. Indeed, enrollee reliance has been trending up gradually over the past few years. There is considerable room for increases in reliance if Veteran preferences were to change dramatically and this could have a large impact on utilization and expenditures.

**Average Reliance for All Enrollees Across All Services (Excluding LTSS)**

| | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|
| Estimated Aggregate Reliance | 35.6% | 36.5% | 37.0% | 38.3% |

Average expenditures per enrollee tend to increase with age, but the impact of reduced reliance on VA among older Veterans tends to outweigh this trend. Reliance has typically decreased over time for enrollees aging past 65 and as they gravitate toward Medicare coverage. This process is a direct expression of enrollee preference as new coverage options become available; and there is significant uncertainty around the pace of this change as well as whether younger enrollees will follow the same pattern after they reach age 65. If enrollee preferences begin to change more quickly than projected, then it can have a very large impact on the required budget.

VA has emphasized telehealth, increased accessibility to women Veterans, a focus on mental health issues specific to Veterans and pursued other innovations in its health care delivery. These efforts can translate into gradual preference shifts over time, resulting in longer-term shifts in enrollment rates and reliance.

***Time horizon***

Short-term and long-term:

- Events, like acts of nature or economic downturns, could affect Veteran preferences for VA compared to other health care systems over a short period of time. Longer-term trends in preferences may be identified directionally but are difficult to predict. Due to the significant slack in demand for new enrollment and reliance, even small changes in how these preferences trend over time can compound substantially over a long-term horizon.

***Budget Scenario***

The pandemic is causing a reduction in enrollment rates since enrollment often coincides with the need for health care services. While enrollment rates are likely to return to historical levels, it is less certain whether there will be a surge in enrollment as care deferral ends and enrollees begin to seek care.

Health care utilization patterns are subject to significant inertia. That is, health care users will tend to continue using the same care providers over time, even if changes in circumstances would suggest that choice is no longer optimal. The significant disruption of care due to the COVID-19 may cause more enrollees to re-evaluate their care patterns. This could lead to increases or decreases in reliance and changes to the demand for VA facility vs. community care.

***Enrollment policy***

VA has discretion over many aspects of enrollment eligibility. For example, VA can decide to expand enrollment to previously suspended income levels.[39]

***Assumptions most affected***

Enrollment rates, priority transitions:

- Changes in eligibility are likely to increase rates of new enrollment, especially if a large group of previously ineligible Veterans becomes newly eligible. Not all eligible Veterans choose to enroll because most have other health coverage options through Medicare, Medicaid, employer-sponsored coverage, TRICARE, individual health insurance and others. Therefore, there is uncertainty about how these Veterans will respond to changes in eligibility. The take-up rate usually cannot be directly observed in historical data and so the initial assumptions are likely to be revised substantially in subsequent model updates.
- VA removed the net worth test from the VA Means Test (VMT) in 2015 and also streamlined the annual means test requirement for enrollees beginning in mid-2014. This change caused shifts in priority levels, which took several years to adjust to the new policy. Most changes involved enrollees getting a priority upgrade, which may have induced some additional reliance on VA for care. For a change like this, uncertainty mostly comes from the change in categorization by priority rather than an underlying change in morbidity, a 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.

[39] New enrollment is suspended for Veterans with household incomes above the VA Means Test (VMT) and more than 10% greater than the Geographic Means Test (GMT), provided they do not meet other eligibility criteria, such as a service-connected disability rating.

## ***Health Status***

Acute illnesses among enrollees may require substantial care by VA and ongoing treatment for chronic medical conditions account for a significant part of VA facility and community care workload. However, due to the approximately 9 million Veterans currently enrolled, of which approximately 6 million are patients during the year, the uncertainty about the workload required for individuals is spread and diversified across a very large population. The impact of an individual enrollee's medical condition is even diversified across the patients of a particular VA facility. If, however, there are systematic changes in the prevalence and severity of medical conditions across a broader population, then diversification no longer reduces risk and the overall demand for health care will begin to change.

### *Assumptions most affected*

Morbidity, utilization trends, utilization differences across demographic groups:

- Systematic changes across large groups of enrollees will impact morbidity levels for specific service categories at the market and national level. For example, increases in opioid addiction raise uncertainty about how to model long term substance abuse disorder morbidity. These types of systematic changes in disease prevalence tend to be gradual and may be detected through ongoing monitoring of workload and through consultation with VHA program offices.

### *Time horizon*

Short-term and long-term:

- Due to the diversification of risks across a large enrollee population, short-term uncertainty arises more from systematic and sudden changes across a broad portion of the population, such as a pandemic. Uncertainty is greater over the long-term, as emerging trends in disease prevalence compound over a longer period of time.

### *Budget Scenario*

The long-term health status impacts of the pandemic are 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.

The Budget Scenario does not include any adjustments to reflect these factors. VA continues to consult with subject matter experts, reviewing literature and analyzing emerging data and will incorporate adjustments to the model as appropriate.

## ***Inflation***

The cost of goods and services tends to increase over time and the rate of inflation is difficult to forecast over long periods. VA's operational expenses are impacted by changes in the cost of supplies, equipment, software, buildings and maintenance. They are also impacted by federal wage and benefits policy, which drives the cost of medical and administrative staff for care provided in VA facilities.

***Assumptions most affected***

Inflation, cost per service, community care reimbursement rates:

- The inflation assumption reflects the cost of providing specific services, including payments for care purchased in the community and the consumption of specific supplies and pharmaceuticals at VA facilities. In addition, staff salaries, investments in medical equipment, infrastructure costs and other overhead expenses are allocated across all services provided during the year. Therefore, the cost of a specific medical service is modeled as a combination of direct and indirect costs in order to link utilization levels with overall VA budget expenditures.
- Staff salaries and benefit levels, including required retirement contributions, are a significant part of VA's expenditures that are determined by circumstances outside the Department. Assumptions are set regarding the trajectory of wage schedules and benefit levels for staff, though the actual amounts are uncertain.
- Community care claim costs are directly linked to the amounts paid to community providers for each service according to negotiated fee schedules. 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 model'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.

## ***Management Policies and Initiatives***

VA leadership exercises some discretion in how health care benefits are provided through program policies and initiatives; as leadership changes, so can the top priorities of the organization. Changes in management approach and policy can impact many aspects of how care is delivered. VA may pursue new ways to improve the provision of care, but it may be difficult to predict what specific initiatives will be implemented and how they might affect future capacity for budget, capital and strategic planning purposes.

***Assumptions most affected***

- Enrollment rates, health care management, cost per service, priority transitions, reliance, utilization trends.
- Changes in management policies and initiatives range from broad, sweeping transformations of the health care system through leadership priorities to detailed decisions by program offices that promote patient centered care. Examples of policies and initiatives that have impacted the EHCPM include:
- ***Programmatic adjustments for long-term services and supports (LTSS)*** – VA is required to meet the LTSS needs of Veterans by providing facility-based care for enrollees with service-connected disabilities of 70 % or greater as well as for those in need of such care due to service-connected conditions. Resources permitting, VA also must provide such care for enrollees who do not meet these criteria. VA is also required to provide home and community-based services to all enrollees as needed. Each year, the Office of Geriatrics and Extended Care provides policy assumptions to shift projected utilization to align with their initiative of keeping enrollees out of long-term facility-based care for as long as is feasible.
- ***Mental health and homeless staff hiring initiatives*** – VA places a high priority on ensuring that all enrolled Veterans have access to needed mental health services. VA also offers a wide array of special programs and initiatives specifically designed to help homeless Veterans live as self-sufficiently and independently as possible. Staffing for these programs and subsequently projected utilization, can be dependent on temporary special purpose funds targeted for hiring mental health providers or availability of Housing and Urban Development-VA Supportive Housing vouchers. Each year, the Office of Mental Health and Suicide Prevention and the Homeless Program Office provide guidance on the presence of external drivers impacting staffing so that appropriate adjustments can be made to projected utilization.
- ***Inpatient System Redesign*** – VA seeks to continuously improve its level of inpatient care management through initiatives such as the Flow Improvement Inpatient Initiative, full implementation of utilization management review programs and improvements in disease management and care coordination through the Patient Aligned Care Team initiative. The EHCPM incorporates assumptions about VA's current efficiency level and the impact of system redesign on its future level. These assumptions are incorporated into the EHCPM to project utilization. Any expected savings from increased efficiency are reported as clinical efficiencies in the budget impact analysis.

***Time horizon***

Long-term:

- The expectation is that changes in the organization will occur gradually. In the long-term, there is uncertainty about their efficacy.

***Non-VA Health Care Coverage***

Veterans have access to other forms of health care, including through Medicare, Medicaid, employer-sponsored coverage, TRICARE, individual health insurance and others. As the availability and affordability of external health care options changes, it can materially impact the choices available to a Veteran. For example, the ACA significantly expanded coverage options for individuals beginning in 2014 by regulating and subsidizing individual coverage and funding expansions to State Medicaid coverage. Even for those with coverage, gradual increases in cost sharing over time may cause enrollees to shift more care to VA, thereby increasing reliance.

Medicare and Medicaid programs are available to all seniors ages 65 and over and to lower income Veterans under age 65. Policy is set at the federal level for Medicare and is set by both the Federal government and the states for Medicaid programs. ACA affects the availability of health care through individual and employer-sponsored coverage. It is difficult to predict long-term changes to these programs.

***Assumptions most affected***

Reliance, enrollment rates, community care reimbursement schedule:

- The availability, affordability and scope of health insurance options outside of VA will affect both the likelihood that individual Veterans enroll with VA and once enrolled, may impact the portion of care and scope of services for which they rely on VA.
- Even if other sources of health insurance are unchanged, they will affect a Veteran's behavior in different ways as they age or as their life situation changes. The loss of health coverage from the Department of Defense upon separating from the military is a key motivator for new Veterans to enroll with VA. If a Veteran has not yet enrolled with VA, they may reconsider it at key points in their life, such as after the loss of a job, when nearing retirement or after losing health coverage from a spouse. Even when already enrolled, their reliance may change over time as they move from employer-sponsored coverage to Medicare, for example.
- Program changes may increase the benefit richness or generosity of Medicare and Medicaid. This can cause some enrollees to have less reliance for services. If a state expands Medicaid eligibility to higher income levels, then there could be a new portion of enrollees in that state who decide to get more of their care through Medicaid or who move over to Medicaid for the first time. Similarly, if subsidies for individual coverage under ACA are expanded, then these options will be more attractive when Veterans are deciding whether to get their care at VA.
- Projections of changes in reliance are hampered by incomplete data on enrollees' non-VA care, specifically, the lack of a comprehensive source to capture claims for enrollees under age 65 and a declining capture of non-VA utilization for enrollees ages 65 and over due to increasing Medicare Advantage enrollment.
- Community providers often derive a significant part of their income from serving Medicare and Medicaid beneficiaries; and so changes to the fee schedules under those programs can make providers more or less willing to participate in VA's community care contracts. Private insurance coverage, offered through ACA marketplaces or sponsored by

employers, often reimburses providers more than they get from Medicare and Medicaid. There could be more pressure from community providers to be reimbursed by VA at higher levels if they think Medicare, Medicaid and private insurance reimbursement levels are insufficient. Conversely, contractions in the scope of coverage by other health care coverages may reduce their workload and make them more willing to provide care purchased by VA. This increases uncertainty about future cost per service levels for community care.

- Much of the VA Community Care Network contract references Medicare reimbursement rates, so changes to Medicare's fee schedules will also directly affect community care reimbursement.

***Time horizon***

Short-term and long-term:

- There is uncertainty in the short-term due to Veteran responses to changes in their health care coverage and this can compound more substantially over the long-term horizon. Enrollment in other sources of coverage tends to be "sticky" in the sense that individuals tend to stay with their current health coverage and health care providers.
- Short-term changes in other sources of health insurance, such as during an economic downturn, can introduce uncertainty about reliance levels over the short-term budget horizon. For example, when a Veteran loses their job or insurance from an employer, they may consider a variety of options, including COBRA coverage, subsidized insurance through ACA marketplaces or Medicaid, in addition to VA. If their period of unemployment is short, then they may go back to employer-sponsored coverage without ever considering VA health care.
- Longer-term, there is much more uncertainty about insurance markets and public programs. Programs can become more or less attractive over time and gradual changes can compound over many years as Veteran decisions on where to get their care begin to change on an individual basis.

***Combat and deployments***

Military conflicts are difficult to predict. Yet, they can have a dramatic impact on the number of Service members, the timing of their separations from the military, the nature of medical conditions related to military service and the long-term relationship between former Service members and government agencies. In each conflict era, newly separating Service members initially represent a small and young cohort of the enrolled Veteran population. Over time, they may grow to be a more substantial portion of the population. Historical data from Veterans of earlier conflicts may be a guide but is not a perfect template for predicting the behaviors and health care needs of more recent Veterans.

Extended combat deployments can lead to greater morbidity and higher prevalence of service-connection disability which can lead greater health care needs after discharge. Furthermore, each period of combat gives rise to different types of disability due to the changing nature of warfare, changes in survivability of injuries and other factors.

***Assumptions most affected***

Enrollment rates, morbidity, reliance:

- Recently separated post-9/11 combat Veterans have much different health care needs and enrollment rates than Veterans of the earlier Gulf War era. Similarly, Vietnam era Veterans (representing about 30% of current enrollees) have different health care needs than WWII Veterans (currently representing about 2% of enrollees), even after adjusting for the passage of time and aging. For example, exposure to Agent Orange during the Vietnam War has led to a unique mix of medical conditions over the lifetime of those combat Veterans, requiring VA to develop a presumptive service-connected disability authority. In addition, battlefield injuries among surviving Veterans are different, causing morbidity differences by service category to differ. There are other generational differences that show up in various model assumptions, including enrollment rates and reliance.
- Women Veterans currently represent about 9% of enrollees, a share that continues to increase and which is projected to reach 12% by 2029. Women Veterans historically have enrolled at a lower rate than their male counterparts. However, women combat Veterans have enrolled at, or in some cases above, the level of their male counterparts. This development underscores the importance of monitoring emerging experience for evidence of large changes of assumptions such as this. There is relatively little historical data about the health care needs of women Veterans at older ages and VA does not expect those patterns to be predictive of the newer generation of women Veterans, especially those with combat theater experience. Therefore, the longer-term projection of women Veterans with combat experience is subject to greater uncertainty and must be monitored closely.

***Time horizon***

Long-term:

- It takes longer than the short-term budget horizon for active-duty Service members to separate and grow into a significant portion of the Veteran population. The uncertainty about how various demographic cohorts will behave as they age takes many years to unfold and increases the uncertainty over longer time horizons.

# APPENDIX A: Government and Private Industry Examples for Risk Analysis

## ***Standards for internal control in the Federal Government***

The Comptroller General of the United States publishes standards for internal control for Federal Government agencies.[40] A key principle of risk assessment is *Principle 7 - Identify, analyze and respond to risks*.

The Department of Veterans Affairs (VA) follows this principal of risk assessment when developing actuarial projections and communicating projection uncertainty to stakeholders. Risks are identified and their link to important projection drivers are modeled. Through the annual model update process, these risks are analyzed using historical data and actuarial models. Finally, through ongoing monitoring of emerging experience, changes in these risks and their impact on utilization and expenditure is measured and corrective actions taken where appropriate.

## ***Examples from private health insurer regulation***

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. NAIC creates guidance and model laws that many states adopt when regulating health insurance companies in their jurisdictions. Projection risk assessment is a significant component of two key guidelines:

- Risk based capital (RBC)[41,42]
- Own Risk and Solvency Assessment (ORSA)[43]

### *Risk monitoring in the RBC Plan*

The primary objective of RBC is to quantitatively measure solvency risk for a health insurance company and to establish minimum levels of required capital and surplus. While these capital and surplus requirements do not apply to VA in the same way due to the backing of the Federal government, RBC requirements set an important example for how to assess and manage risk. When a health insurer's capital and surplus level falls below a particular minimum level, they must prepare an RBC Plan for their regulator. The RBC Plan includes several components, but one in particular is a listing and discussion of key assumptions impacting the insurer's projections and the sensitivity of those projections to the assumptions. The purpose of this exercise is to demonstrate to the regulator that that company is aware of the risks to which it is exposed.

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[40] Standards for internal control in the Federal Government, Government Accountability Office, September 2014, https://www.gao.gov/assets/670/665712.pdf

[41] RBC Overview: https://content.naic.org/cipr_topics/topic_riskbased_capital.htm

[42] RBC Model Act: https://content.naic.org/sites/default/files/inline-files/MDL-312.pdf

[43] ORSA Guidance Manual: https://www.naic.org/documents/prod_serv_fin_recievership_ORSA-2014.pdf

VA's approach to monitoring actuarial projection uncertainty is consistent with this industry precedent. When a material difference between actual and projected utilization and expenditures is identified, the conditions leading to that difference are investigated. Key model assumptions that led to the difference are identified and adjusted, as appropriate. Other corrective action, including but not limited to operational and funding changes are considered.

***Risk assessment in the ORSA Summary Report***

Most health insurers must prepare an annual summary report documenting their assessment of risks. The primary goal of this assessment is for each insurer to identify, assess, monitor, prioritize and internally report on the material and relevant risks to the business. Included in this report is an assessment of risks on both a quantitative and qualitative basis and under both normal and stressed environments. The assessment considers a range of potential outcomes.

VA's approach to assessing actuarial projection uncertainty is consistent with this industry example. Where appropriate in communications of specific model assumptions, the sensitivity of final projections to these assumption inputs is discussed. Overall uncertainty of the model across all assumptions and risks is discussed in this report. Moreover, selected scenarios representing illustrative stress environments are discussed on a qualitative and quantitative basis.

***State Medicaid Agencies***

Medicaid programs are managed at the state level, including budget development, though there is federal oversight by Centers for Medicare & Medicaid Services (CMS) due to the significant federal match of state budget projections. CMS requires states to systematically think through the assumptions that can influence their Medicaid program costs. State Medicaid Agencies provide CMS with documentation of all the major risks affecting budget development using a consistent framework.

Managed care budgets are developed in accordance with generally accepted actuarial principals, such as actuarial standard of practice (ASOP) No 49 *Medicaid Managed Care Capitation Rate Development and Certification*, and they are documented to CMS using a rate development guide.[44] In the guide, each assumption is discussed in terms of its development, its source of uncertainty and its impact on the projection results. Through this process, the State Medicaid Agency takes stock of the most important sources of uncertainty in the projections.

VA's approach is similar in taking a systematic approach to evaluating assumptions and risks each time it does a scenario.

***Actuarial Standards of Practice***

Actuaries performing work relating to projecting health care utilization and expenditures are subject to ASOP promulgated by the Actuarial Standards Board of the American Academy of Actuaries. Among these are:

- *ASOP No. 5 Incurred Health and Disability Claims*

[44] https://www.medicaid.gov/medicaid/managed-care/guidance/rate-review-and-rate-guides/index.html

- *ASOP No. 12 Risk Classification*
- *ASOP No. 23 Data Quality*
- *ASOP No. 25 Credibility Procedures*
- *ASOP No. 41 Actuarial Communications*

These standards guide the analysis methodology and communications of actuaries that develop the VA Enrollee Health Care Projection Model. These standards also apply to the assessment and communication of uncertainty in the projections. In particular, the actuaries consider which cautions regarding possible uncertainty or risk in any results are disclosed in communications to stakeholders.

The model report sections include these communications on a topical basis for each major assumption in the model. Reports describing specific analyses or projection scenarios will include a discussion of key areas of uncertainty in the projections, including uncertainty about future trends as well as uncertainty about historical data quality and applicability.

# *Medical Facilities by Type*

As of September 30, 2021, the Veterans Health Administration (VHA) operates a portfolio of approximately 5,646 owned buildings with a total of 152.9 million square feet of space on 16,154 acres of land. The portfolio also includes 1,726 leases with a total of 20.1 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. The facilities included in these tables do not reflect impacts from the on-going Asset and Infrastructure Review (AIR) Commission process.

**Medical Care**
**Number of Installations**

| | | 2022 | | 2023 | | 2024 | | |
|---|---|---|---|---|---|---|---|---|
| Description | 2021 Actual 1/ | Budget Estimate | Current Estimate | Advance Approp. | Revised Request | Advance Approp. | +/- 2022-2023 | +/- 2023-2024 |
| **Veterans Integrated Service Networks (VISN)** | **18** | **18** | **18** | **18** | **18** | **18** | 0 | 0 |
| **VA Medical Centers (VAMC), Total** | **171** | **172** | **171** | **172** | **171** | **171** | 0 | 0 |
| Included in VA Medical Centers, Total: | | | | | | | | |
| VA Hospitals | 145 | 146 | 145 | 146 | 145 | 145 | 0 | 0 |
| Community Living Centers (CLC) | 134 | 134 | 135 | 134 | 135 | 135 | 0 | 0 |
| Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) | 117 | 120 | 119 | 124 | 124 | 129 | 5 | 5 |
| VAMC-Based Outpatient Care Sites | 171 | 172 | 171 | 172 | 171 | 171 | 0 | 0 |
| **Health Care Centers (HCC)** | **12** | **13** | **12** | **13** | **12** | **12** | 0 | 0 |
| **Community-Based Outpatient Clinics (CBOC)** | **727** | **783** | **739** | **783** | **740** | **740** | 1 | 0 |
| Multi-Specialty CBOC | 204 | 222 | 204 | 222 | 204 | 204 | 0 | 0 |
| Primary Care CBOC | 523 | 561 | 535 | 561 | 536 | 536 | 1 | 0 |
| **Other Outpatient Services (OOS) Sites, Total** | **376** | **321** | **377** | **321** | **377** | **377** | 0 | 0 |
| Included in OOS Sites, Total: | | | | | | | | |
| Dialysis Centers | 73 | 72 | 73 | 72 | 73 | 73 | 0 | 0 |
| Community Resource and Referral Centers (CRRC) | 32 | 32 | 32 | 32 | 32 | 32 | 0 | 0 |
| **Vet Centers** | **300** | **300** | **300** | **300** | **300** | **300** | 0 | 0 |
| **Mobile Vet Centers** | **83** | **83** | **83** | **83** | **83** | **83** | 0 | 0 |
| **Vet Center Outstations** | **19** | **19** | **22** | **19** | **22** | **22** | 0 | 0 |

1/ Reflects historical data as of September 30, 2021.

## Annual Changes in Medical Care Installations

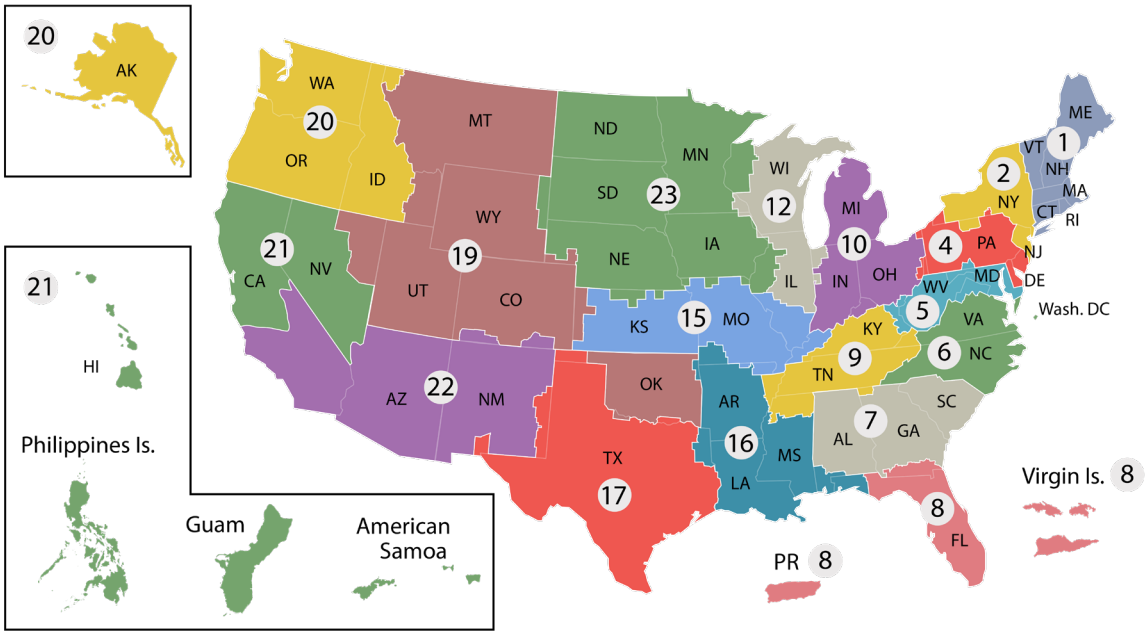
### Veterans Integrated Service Networks (VISN)

In the late 1990s, VHA was geographically separated into 21 areas known as Veterans Integrated Service Networks (VISNs) and was further modified in October 2015 in compliance with the VA Memorandum on VISN Realignment. As a result of the VISN realignment, VHA currently has five districts and 18 VISNs.

### VA Districts by VISN

| District | District Name | VISN |
|---|---|---|
| 1 | North Atlantic | 1,2,4,5,6 |
| 2 | Southeast | 7,8,9 |
| 3 | Midwest | 10,12,15,23 |
| 4 | Continental | 16,17,19 |
| 5 | Pacific | 20,21,22 |

***The Map with 18 VISNs:***




## VA Medical Centers (VAMC)

VAMCs are facilities that provide two or more categories of care (inpatient, outpatient, residential rehabilitation, or institutional extended care).

### *VA Hospitals*

A VA Hospital provides both inpatient acute care and outpatient care and may also provide residential rehabilitation care and/or institutional extended care.

VAMC changes in 2021

Based on 2020 workload data, 1 Extended Care Stand-Alone facility (Community Living Center) has been reclassified into VAMC (+1 VAMC); 2 VAMC sites have been reclassified into Other Outpatient Services (OOS) sites (-2 VAMC), resulting in a net decrease from 172 to 171 (-1 VAMC):

- +1 VAMC: VISN 19 Miles City VA Medical Center, Miles City, MT (436A4)
- -1 VAMC: VISN 8 Jacksonville Navy VA Medical Center, Jacksonville, FL (573A5)
- -1 VAMC: VISN 17 Garland VA Medical Center, Garland, TX (549A5)

Of the 171 VAMCs, 145 were classified as VA Hospitals in 2021. To meet the criteria of a VA Hospital, a facility must report over 500 inpatient acute bed days of care. The other 26 VAMCs provided a mix of other bed-care services, such as CLCs and/or residential rehabilitation care, thus meeting the VAMC criteria.

VA Hospital changes in 2021

Based on 2020 workload data, the following VAMC provided less than 500 bed days of acute inpatient care, thus no longer meeting the classification criteria of a hospital, resulting in a net decrease from 146 to 145 (-1 VA Hospital):

- -1 VA Hospital: VISN 4 Erie VA Medical Center, Erie, PA (562)

Please refer to the section titled "2021 VA Medical Centers and Hospitals" for the complete list of VA Medical Centers and Hospitals in 2021.

### *Community Living Centers (CLC)*

CLCs provide institutional extended care services and may be part of a VA Hospital (e.g., a wing), or a free-standing structure.

As of September 30, 2021, there were 134 active CLC facilities. Please refer to the section titled "2021 Community Living Centers (CLC)" for the complete list of CLCs in 2021.

CLC changes in 2022

In 2022, CLCs are projected to increase from 134 to 135 (+1 CLC):

- +1 CLC: VISN 23 Papillion VA Community Living Center, Papillion, NE (6369AA)

### *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 2021

Based on 2020 workload data, 2 sites of care have been activated, resulting in a net increase from 115 to 117 (+2 MH RRTP):

- +1 Domiciliary Substance Use Disorder (DOM SUD): VISN 5 Capitol Health Care VA Medical Center, Huntington, WV (581)
- +1 Domiciliary Substance Use Disorder (DOM SUD): VISN 15 Heartland VA Medical Center, Wichita, KS (589A7)

Please refer to the section titled "2021 Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)" for the complete list of MH RRTPs in 2021.

MH RRTP changes in 2022

In 2022, 3 sites of care are projected to be activated (+3 MH RRTP), 1 site will be deactivated (-1 MH RRTP), resulting in a net increase from 117 to 119 (+2 MH RRTP):

- +1 DOM SUD, Grand Junction, CO
- +1 Domiciliary Post-Traumatic Stress Disorder (DOM PTSD), Denver, CO
- +1 MH RRTP, West Haven, CT
- -1 MH RRTP, Cincinnati, OH

MH RRTP changes in 2023

In 2023, MH RRTPs are projected to increase from 119 to 124 (+5 MH RRTP):

- +1 General Domiciliary, San Juan, PR
- +1 DOM SUD, Oklahoma City, OK
- +1 Domiciliary Care for Homeless Veterans (DCHV), Houston, TX
- +1 DOM SUD, Alexandria, LA
- +1 DOM SUD, Poplar Bluff, MO

MH RRTP changes in 2024

In 2024, MH RRTPs are projected to increase from 124 to 129 (+5 MH RRTP):

- +1 MH RRTP, New Orleans, LA
- +1 DOM SUD, Togus, ME
- +1 MH RRTP, Beckley, WV
- +1 DOM SUD, Amarillo, TX
- +1 DOM SUD, Wilmington, DE

## VAMC-Based Outpatient Care Sites

A VAMC-Based Outpatient Care site is a VAMC that provides outpatient care. By definition, all VA Hospitals provide outpatient care, but some free-standing CLCs and/or MH RRTPs also provide outpatient care and are therefore included in this classification.

*Outpatient Classification Criteria*

| Outpatient Medical Facilities | Primary Care Encounters 1/ | Mental Health Encounters 1/ | Specialty Care Encounters 1/ | Ambulatory Surgery Services 2/ |
|---|---|---|---|---|
| Health Care Center (HCC) | Greater than 500 | Greater than 500 | Greater than 500 in any 2 or more Specialties | Yes |
| Multi-Specialty CBOC | Greater than 500 | Greater than 500 | Greater than 500 in any 2 or more Specialties | None |
| Primary Care CBOC | Greater than 500 | Greater than 500 | Greater than 500 in any 1 Specialty | None |
| Primary Care CBOC | Greater than 500 | Greater than 500 | 500 or less in 1 or more Specialties | None |
| Other Outpatient Service Site (OOS) | Greater than 500 | Less than 500 | Greater than 0 | None |
| Other Outpatient Service Site (OOS) | Less than or equal to 500 | Greater than 500 | None | None |
| Other Outpatient Service Site (OOS) | Less than or equal to 500 | Greater than 500 | Greater than 0 | None |
| Other Outpatient Service Site (OOS) | Less than or equal to 500 | Less than or equal to 500 | Greater than 0 | None |
| Other Outpatient Service Site (OOS) | None | Less than or equal to 500 | None | None |

1/ Source: VSSC Outpatient Encounters data

2/ Source: Surgery and Clinical Inventory data (Ambulatory Surgery Center, Ambulatory Surgery Services and / or Moderate Sedation)

There are four outpatient classifications: (1) Health Care Center (HCC); (2) Multi-Specialty Community Based Outpatient Clinic (MS CBOC); (3) Primary Care Community Based Outpatient Clinic (PC CBOC); and (4) Other Outpatient Services site (OOS).

Outpatient medical facilities are classified based on workload (encounters) by the following services: Primary Care, Mental Health, Specialty Care and Ambulatory Surgery. Please refer to the "Outpatient Classification Criteria" table below for complete detail.

### *Health Care Centers (HCC)*

HCCs are VA-owned, VA-leased, or contract clinics operated five days per week that provide primary care, mental health care, on-site specialty services and perform ambulatory surgery and/or invasive procedures which may require moderate sedation or general anesthesia.

HCC changes in 2021

Based on 2020 workload data, 1 HCC has been reclassified into MS CBOC, resulting in a net decrease from 13 to 12 (-1 HCC):

- -1 HCC: VISN 8 Jacksonville 1 VA Clinic, Jacksonville, FL (573BY)

Please refer to the section titled "2021 Health Care Centers (HCC)" for the complete list of HCCs in 2021.

### *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 one to seven 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 2021

Based on 2020 workload data, 3 MS CBOC has been activated, 1 HCC, 2 OOS sites and 7 PC CBOCs have been reclassified into MS CBOC (+13 MS CBOC), 3 MS CBOCs have been reclassified into OOS, 32 MS CBOCs have been reclassified into PC CBOC (-35 MS CBOC), resulting in a net decrease from 226 to 204 (-22 MS CBOC).

Activations (+3 MS CBOC):

- +1 MS CBOC: VISN 15 Lenexa VA Clinic, Lenexa, KS (589JG)
- +1 MS CBOC: VISN 21 Oakland VA Clinic, Oakland, CA (662GH)
- +1 MS CBOC: VISN 22 Sorrento Valley VA Clinic, San Diego, CA (664GF)

HCC reclassified into MS CBOCs (+1 MS CBOC):

- +1 MS CBOC: VISN 8 Jacksonville 1 VA Clinic, Jacksonville, FL (573BY)

OOS sites reclassified into MS CBOCs (+2 MS CBOC):

- +1 MS CBOC: VISN 2 Rochester Calkins VA Clinic, Rochester, NY (528QC)
- +1 MS CBOC: VISN 10 Colonel Demas T. Craw VA Clinic, Traverse City, MI (655GB)

PC CBOCs reclassified into MS CBOCs (+7 MS CBOC):

- +1 MS CBOC: VISN 10 Lima VA Clinic, Lima, OH (552GB)
- +1 MS CBOC: VISN 21 Chico VA Clinic, Chico, CA (612GG)
- +1 MS CBOC: VISN 21 Stockton VA Clinic, French Camp, CA (640BY)
- +1 MS CBOC: VISN 21 Modesto VA Clinic, Modesto, CA (640HB)
- +1 MS CBOC: VISN 23 North Platte VA Clinic, North Platte, NE (636GB)
- +1 MS CBOC: VISN 23 Quincy VA Clinic, Quincy, IL (636GG)
- +1 MS CBOC: VISN 23 Dubuque VA Clinic, Dubuque, IA (636GJ)

MS CBOCs reclassified into OOS sites (-3 MS CBOC):

- -1 MS CBOC: VISN 8 Lakeland VA Clinic, Lakeland, FL (673GB)
- -1 MS CBOC: VISN 10 Terre Haute VA Clinic, Terre Haute, IN (583GA)
- -1 MS CBOC: VISN 22 Gardena VA Clinic, Gardena, CA (600GF)

MS CBOCs reclassified into PC CBOCs (-32 MS CBOC):

- -1 MS CBOC: VISN 2 Rochester Clinton Crossing VA Clinic, Rochester, NY (528GE)
- -1 MS CBOC: VISN 2 Staten Island Community VA Clinic, Staten Island, NY (630GB)
- -1 MS CBOC: VISN 4 Sussex County VA Clinic, Georgetown, DE (460GA)
- -1 MS CBOC: VISN 4 Kent County VA Clinic, Dover, DE (460GC)
- -1 MS CBOC: VISN 5 Stephens City VA Clinic, Winchester, VA (613GC)
- -1 MS CBOC: VISN 7 Oakwood VA Clinic, Flowery Branch, GA (508GE)
- -1 MS CBOC: VISN 7 Lawrenceville VA Clinic, Lawrenceville, GA (508GH)
- -1 MS CBOC: VISN 7 Newnan VA Clinic, Newnan, GA (508GI)
- -1 MS CBOC: VISN 7 Blairsville VA Clinic, Blairsville, GA (508GJ)
- -1 MS CBOC: VISN 8 Sarasota VA Clinic, Sarasota, FL (516GA)
- -1 MS CBOC: VISN 8 Port Charlotte VA Clinic, Port Charlotte, FL (516GE)
- -1 MS CBOC: VISN 9 Newburg VA Clinic, Louisville, KY (603GE)
- -1 MS CBOC: VISN 10 Jackson VA Clinic, Michigan Center, MI (506GC)
- -1 MS CBOC: VISN 10 Marietta VA Clinic, Marietta, OH (538GC)
- -1 MS CBOC: VISN 10 Georgetown VA Clinic, Georgetown, OH (539GF)
- -1 MS CBOC: VISN 10 Pontiac VA Clinic, Pontiac, MI (553GB)
- -1 MS CBOC: VISN 10 Lt. Col Clement Van Wagoner VA Clinic, Alpena, MI (655GD)
- -1 MS CBOC: VISN 10 Grove City VA Clinic, Grove City, OH (757GB)
- -1 MS CBOC: VISN 12 Springfield VA Clinic, Springfield, IL (550GD)
- -1 MS CBOC: VISN 15 Marshfield VA Clinic, Marshfield, MO (589JD)
- -1 MS CBOC: VISN 15 Sikeston VA Clinic, Sikeston, MO (657GV)
- -1 MS CBOC: VISN 16 Eglin Air Force Base VA Clinic, Eglin Air Force Base, FL (520GC)
- -1 MS CBOC: VISN 16 Fort Smith VA Clinic, Fort Smith, AR (564GB)
- -1 MS CBOC: VISN 17 Wilson and Young Medal of Honor VA Clinic, Odessa, TX (519GA)
- -1 MS CBOC: VISN 17 North Central Federal VA Clinic, San Antonio, TX (671GO)
- -1 MS CBOC: VISN 17 Balcones Heights VA Clinic, San Antonio, TX (671GP)
- -1 MS CBOC: VISN 17 Corpus Christi VA Clinic, Corpus Christi, TX (740GC)
- -1 MS CBOC: VISN 20 Fairview VA Clinic, Fairview, OR (648GE)
- -1 MS CBOC: VISN 21 Guam VA Clinic, Agana Heights, GU (459GE)
- -1 MS CBOC: VISN 21 Oakhurst VA Clinic, Oakhurst, CA (570GC)
- -1 MS CBOC: VISN 23 Lane A. Evans VA Community Based Outpatient Clinic, Galesburg, IL (636GI)

- -1 MS CBOC: VISN 23 Cedar Rapids VA Clinic, Cedar Rapids, IA (636GN)

Please refer to the section titled "2021 Multi-Specialty Community Based Clinics (MS CBOC)" for the complete list of MS CBOCs in 2021.

***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 2021

Based on 2020 workload data, 15 PC CBOCs have been activated, 32 MS CBOCs and 7 OOS sites have been reclassified into PC CBOCs (+54 PC CBOC), 3 PC CBOCs have been deactivated, 7 PC CBOCs have been reclassified into MS CBOCs, 69 PC CBOCs have been reclassified into OOS sites (-79 PC CBOC), resulting in a net decrease from 548 to 523 (-25 PC CBOC).

Activations (+15 PC CBOC):

- +1 PC CBOC: VISN 6 Henrico County VA Clinic, Richmond, VA (652GC)
- +1 PC CBOC: VISN 6 Spotsylvania County VA Clinic, Fredericksburg, VA (652GI)
- +1 PC CBOC: VISN 7 Robins VA Clinic, Warner Robins, GA (557GG)
- +1 PC CBOC: VISN 7 Columbus Downtown VA Clinic, Columbus, GA (619GG)
- +1 PC CBOC: VISN 10 Adrian VA Clinic, Adrian, MI (506GF)
- +1 PC CBOC: VISN 10 Defiance VA Clinic, Defiance, OH (610GE)
- +1 PC CBOC: VISN 12 Gladstone VA Clinic, Gladstone, MI (585GG)
- +1 PC CBOC: VISN 16 Kingwood VA Clinic, Humble, TX (580GK)
- +1 PC CBOC: VISN 19 Union Boulevard VA Clinic, Colorado Springs, CO (554GK)
- +1 PC CBOC: VISN 20 Edmonds VA Clinic, Edmonds, WA (663GH)
- +1 PC CBOC: VISN 20 Olympia VA Clinic, Olympia, WA (663GI)
- +1 PC CBOC: VISN 20 Puyallup VA Clinic, Puyallup, WA (663GJ)
- +1 PC CBOC: VISN 20 East Front Avenue VA Clinic, Spokane, WA (668GC)
- +1 PC CBOC: VISN 21 Windward VA Clinic, Kaneohe, HI (459QC)
- +1 PC CBOC: VISN 23 Burlington VA Clinic, Burlington, CO (636GY)

MS CBOCs reclassified into PC CBOCs (+32 PC CBOC):

- +1 PC CBOC: VISN 2 Rochester Clinton Crossing VA Clinic, Rochester, NY (528GE)
- +1 PC CBOC: VISN 2 Staten Island Community VA Clinic, Staten Island, NY (630GB)
- +1 PC CBOC: VISN 4 Sussex County VA Clinic, Georgetown, DE (460GA)
- +1 PC CBOC: VISN 4 Kent County VA Clinic, Dover, DE (460GC)

- +1 PC CBOC: VISN 5 Stephens City VA Clinic, Winchester, VA (613GC)
- +1 PC CBOC: VISN 7 Oakwood VA Clinic, Flowery Branch, GA (508GE)
- +1 PC CBOC: VISN 7 Lawrenceville VA Clinic, Lawrenceville, GA (508GH)
- +1 PC CBOC: VISN 7 Newnan VA Clinic, Newnan, GA (508GI)
- +1 PC CBOC: VISN 7 Blairsville VA Clinic, Blairsville, GA (508GJ)
- +1 PC CBOC: VISN 8 Sarasota VA Clinic, Sarasota, FL (516GA)
- +1 PC CBOC: VISN 8 Port Charlotte VA Clinic, Port Charlotte, FL (516GE)
- +1 PC CBOC: VISN 9 Newburg VA Clinic, Louisville, KY (603GE)
- +1 PC CBOC: VISN 10 Jackson VA Clinic, Michigan Center, MI (506GC)
- +1 PC CBOC: VISN 10 Marietta VA Clinic, Marietta, OH (538GC)
- +1 PC CBOC: VISN 10 Georgetown VA Clinic, Georgetown, OH (539GF)
- +1 PC CBOC: VISN 10 Pontiac VA Clinic, Pontiac, MI (553GB)
- +1 PC CBOC: VISN 10 Lt. Col Clement Van Wagoner VA Clinic, Alpena, MI (655GD)
- +1 PC CBOC: VISN 10 Grove City VA Clinic, Grove City, OH (757GB)
- +1 PC CBOC: VISN 12 Springfield VA Clinic, Springfield, IL (550GD)
- +1 PC CBOC: VISN 15 Marshfield VA Clinic, Marshfield, MO (589JD)
- +1 PC CBOC: VISN 15 Sikeston VA Clinic, Sikeston, MO (657GV)
- +1 PC CBOC: VISN 16 Eglin Air Force Base VA Clinic, Eglin Air Force Base, FL (520GC)
- +1 PC CBOC: VISN 16 Fort Smith VA Clinic, Fort Smith, AR (564GB)
- +1 PC CBOC: VISN 17 Wilson and Young Medal of Honor VA Clinic, Odessa, TX (519GA)
- +1 PC CBOC: VISN 17 North Central Federal VA Clinic, San Antonio, TX (671GO)
- +1 PC CBOC: VISN 17 Balcones Heights VA Clinic, San Antonio, TX (671GP)
- +1 PC CBOC: VISN 17 Corpus Christi VA Clinic, Corpus Christi, TX (740GC)
- +1 PC CBOC: VISN 20 Fairview VA Clinic, Fairview, OR (648GE)
- +1 PC CBOC: VISN 21 Guam VA Clinic, Agana Heights, GU (459GE)
- +1 PC CBOC: VISN 21 Oakhurst VA Clinic, Oakhurst, CA (570GC)
- +1 PC CBOC: VISN 23 Lane A. Evans VA Community Based Outpatient Clinic, Galesburg, IL (636GI)
- +1 PC CBOC: VISN 23 Cedar Rapids VA Clinic, Cedar Rapids, IA (636GN)

OOS sites reclassified into PC CBOCs (+7 PC CBOC):

- +1 PC CBOC: VISN 5 Princeton VA Clinic, Princeton, WV (517QA)
- +1 PC CBOC: VISN 7 Covington VA Clinic, Covington, GA (508GN)
- +1 PC CBOC: VISN 7 Northeast Cobb County VA Clinic, Marietta, GA (508GO)
- +1 PC CBOC: VISN 8 Lecanto VA Clinic, Lecanto, FL (673GH)
- +1 PC CBOC: VISN 16 Little Rock VA Clinic, Little Rock, AR (598QA)
- +1 PC CBOC: VISN 19 Denver VA Clinic, Denver, CO (554GJ)
- +1 PC CBOC: VISN 21 Sierra Foothills VA Clinic, Auburn, CA (612GK)

Deactivations (-3 PC CBOC):

- -1 PC CBOC: VISN 19 Denver VA Clinic, Denver, CO (554GJ)
- -1 PC CBOC: VISN 20 Bellevue VA Clinic, Bellevue, WA (663GA)
- -1 PC CBOC: VISN 22 Gardena VA Clinic, Gardena, CA (691GC)

PC CBOCs reclassified into MS CBOCs (-7 PC CBOC):

- -1 PC CBOC: VISN 10 Lima VA Clinic, Lima, OH (552GB)
- -1 PC CBOC: VISN 21 Chico VA Clinic, Chico, CA (612GG)
- -1 PC CBOC: VISN 21 Stockton VA Clinic, French Camp, CA (640BY)
- -1 PC CBOC: VISN 21 Modesto VA Clinic, Modesto, CA (640HB)
- -1 PC CBOC: VISN 23 North Platte VA Clinic, North Platte, NE (636GB)
- -1 PC CBOC: VISN 23 Quincy VA Clinic, Quincy, IL (636GG)
- -1 PC CBOC: VISN 23 Dubuque VA Clinic, Dubuque, IA (636GJ)

PC CBOCs reclassified into OOS sites (-69 PC CBOC):

- -1 PC CBOC: VISN 1 Calais VA Clinic, Calais, ME (402GB)
- -1 PC CBOC: VISN 1 Lincoln VA Clinic, Lincoln, ME (402GF)
- -1 PC CBOC: VISN 1 Gloucester VA Clinic, Gloucester, MA (518GE)
- -1 PC CBOC: VISN 1 Framingham VA Clinic, Framingham, MA (523GA)
- -1 PC CBOC: VISN 1 Conway VA Clinic, Conway, NH (608GD)
- -1 PC CBOC: VISN 1 Worcester VA Clinic, Worcester, MA (631GE)
- -1 PC CBOC: VISN 1 Orange VA Clinic, Orange, CT (689GF)
- -1 PC CBOC: VISN 2 Fonda VA Clinic, Fonda, NY (528G6)
- -1 PC CBOC: VISN 2 Catskill VA Clinic, Catskill, NY (528G7)
- -1 PC CBOC: VISN 2 Morristown VA Clinic, Morristown, NJ (561GH)
- -1 PC CBOC: VISN 2 Paterson VA Clinic, Paterson, NJ (561GJ)
- -1 PC CBOC: VISN 2 Sussex VA Clinic, Newton, NJ (561GK)
- -1 PC CBOC: VISN 2 Poughkeepsie VA Clinic, Poughkeepsie, NY (620GG)
- -1 PC CBOC: VISN 6 Hillandale Road VA Clinic, Durham, NC (558GE)
- -1 PC CBOC: VISN 6 Clayton-East Raleigh VA Clinic, Clayton, NC (558GH)
- -1 PC CBOC: VISN 6 Jacksonville 4 VA Clinic, Jacksonville, NC (558GN)
- -1 PC CBOC: VISN 6 Portsmouth VA Clinic, Portsmouth, VA (590GE)
- -1 PC CBOC: VISN 8 Key Largo VA Clinic, Key Largo, FL (546GE)
- -1 PC CBOC: VISN 8 Middleburg VA Clinic, Middleburg, FL (573GO)
- -1 PC CBOC: VISN 9 Morehead VA Clinic, Morehead, KY (596GB)
- -1 PC CBOC: VISN 9 Mountain City VA Clinic, Mountain City, TN (621GO)
- -1 PC CBOC: VISN 9 Dover VA Clinic, Dover, DE (626GA)
- -1 PC CBOC: VISN 9 Tullahoma VA Clinic, Arnold Air Force Base, TN (626GG)
- -1 PC CBOC: VISN 9 Athens VA Clinic, Athens, TN (626GN)
- -1 PC CBOC: VISN 10 Wright-Patterson VA Clinic, Wright-Patterson Air Force Base, OH (552GF)
- -1 PC CBOC: VISN 10 Piquette Street VA Clinic, Detroit, MI (553QA)
- -1 PC CBOC: VISN 12 Baraboo VA Clinic, Baraboo, WI (607GD)
- -1 PC CBOC: VISN 12 Freeport VA Clinic, Freeport, IL (607GF)
- -1 PC CBOC: VISN 15 Dodge City VA Clinic, Dodge City, KS (589G2)
- -1 PC CBOC: VISN 15 Kirksville VA Clinic, Kirksville, MO (589GE)
- -1 PC CBOC: VISN 15 Shawnee VA Clinic, Shawnee, KS (589JC)
- -1 PC CBOC: VISN 15 Franklin County VA Clinic, Washington, MO (657GS)
- -1 PC CBOC: VISN 15 Pocahontas VA Clinic, Pocahontas, AR (657GW)
- -1 PC CBOC: VISN 16 Sugar Land VA Clinic, Sugar Land, TX (580GL)
- -1 PC CBOC: VISN 16 McComb VA Clinic, McComb, MS (586GG)

- -1 PC CBOC: VISN 17 Decatur VA Clinic, Decatur, TX (549GE)
- -1 PC CBOC: VISN 17 Greenville VA Clinic, Greenville, TX (549GH)
- -1 PC CBOC: VISN 17 North Bexar VA Clinic, San Antonio, TX (671GR)
- -1 PC CBOC: VISN 17 El Paso Westside VA Clinic, El Paso, TX (756GC)
- -1 PC CBOC: VISN 17 El Paso Northeast VA Clinic, El Paso, TX (756GC)
- -1 PC CBOC: VISN 19 Denver VA Domiciliary, Denver CO (554A5)
- -1 PC CBOC: VISN 19 Lamar VA Clinic, Lamar, CO (554GH)
- -1 PC CBOC: VISN 19 Clinton VA Clinic, Clinton, OK (635GH)
- -1 PC CBOC: VISN 19 Norman VA Clinic, Norman, OK (635GI)
- -1 PC CBOC: VISN 19 Yukon VA Clinic, Yukon, OK (635GJ)
- -1 PC CBOC: VISN 19 Cody VA Clinic, Cody, WY (666GD)
- -1 PC CBOC: VISN 19 Gillette VA Clinic, Gillette, WY (666GE)
- -1 PC CBOC: VISN 20 Juneau VA Clinic, Juneau, AK (463GE)
- -1 PC CBOC: VISN 20 Mountain Home VA Clinic, Mountain Home, AR (531GI)
- -1 PC CBOC: VISN 20 Salmon VA Clinic, Salmon, ID (531GJ)
- -1 PC CBOC: VISN 20 North Coast VA Clinic, Warrenton, OR (648GD)
- -1 PC CBOC: VISN 20 Newport VA Clinic, Newport, OR (648GH)
- -1 PC CBOC: VISN 20 North Seattle VA Clinic, Seattle, WA (663GG)
- -1 PC CBOC: VISN 20 La Grande VA Clinic, La Grande, OR (687GC)
- -1 PC CBOC: VISN 21 Yreka VA Clinic, Yreka, CA (612GJ)
- -1 PC CBOC: VISN 21 Carson Valley VA Clinic, Gardnerville, NV (654GB)
- -1 PC CBOC: VISN 21 Lahontan Valley VA Clinic, Fallon, NV (654GB)
- -1 PC CBOC: VISN 21 Diamond View VA Clinic, Susanville, CA (654GD)
- -1 PC CBOC: VISN 22 Las Vegas VA Clinic, Las Vegas, NV (501G2)
- -1 PC CBOC: VISN 22 Silver City VA Clinic, Silver City, NM (501GC)
- -1 PC CBOC: VISN 22 Gallup VA Clinic, Gallup, NM (501GD)
- -1 PC CBOC: VISN 22 Truth or Consequences VA Clinic, Truth or Consequences, NM (501GH)
- -1 PC CBOC: VISN 22 Alamogordo VA Clinic, Alamogordo, NM (501GI)
- -1 PC CBOC: VISN 22 Taos VA Clinic, Taos, NM (501GN)
- -1 PC CBOC: VISN 22 Globe VA Clinic, Globe, AZ (644GF)
- -1 PC CBOC: VISN 22 San Gabriel Valley VA Clinic, Arcadia, CA (691GP)
- -1 PC CBOC: VISN 23 Williston VA Clinic, Williston, ND (437GF)
- -1 PC CBOC: VISN 23 Dickinson VA Clinic, Dickinson, ND (437GJ)
- -1 PC CBOC: VISN 23 Hayward VA Clinic, Hayward, WI (618GH)

Please refer to the section titled "2021 Primary Community Based Outpatient Clinics (PC CBOC)" for the complete list of PC CBOCs in 2021.

PC CBOC changes in 2022

In 2022, PC CBOCs are projected to increase from 523 to 535 (+12 PC CBOC):

- +1 PC CBOC: VISN 12 Oconomowoc PC CBOC, Oconomowoc, WI
- +1 PC CBOC: VISN 12 Urbana PC CBOC, Urbana, IL
- +1 PC CBOC: VISN 15 Madison County PC CBOC, Madison County, IL
- +1 PC CBOC: VISN 17 Paris PC CBOC, Paris, TX
- +1 PC CBOC: VISN 17 Pflugerville PC CBOC, Pflugerville, TX
- +1 PC CBOC: VISN 17 Weatherford PC CBOC, Weatherford, TX

- +1 PC CBOC: VISN 17 Waxahachie PC CBOC, Waxahachie, TX
- +1 PC CBOC: VISN 17 San Marcos PC CBOC, San Marcos, TX
- +1 PC CBOC: VISN 22 Banning PC CBOC, Banning, CA
- +1 PC CBOC: VISN 22 Barstow PC CBOC, Barstow, CA
- +1 PC CBOC: VISN 22 Hemet PC CBOC, Hemet, CA
- +1 PC CBOC: VISN 22 Riverside PC CBOC, Riverside, CA

PC CBOC changes in 2023

In 2023, PC CBOCs are projected to increase from 535 to 536 (+1 PC CBOC):

- +1 PC CBOC: VISN 19 Craig/Rogers County PC CBOC, Craig/Rogers County, OK

### *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 2021

Based on 2020 workload data, 8 OOS sites have been activated, 2 VAMCs, 3 MS CBOCs and 69 PC CBOCs have been reclassified into OOS (+82 OOS), 18 OOS sites have been deactivated, 2 OOS sites have been reclassified into MS CBOCs, 7 OOS sites have been reclassified into PC CBOCs (-27 OOS), resulting in a net increase from 321 to 376 (+55 OOS).

Activations (+8 OOS):

- +1 OOS: VISN 10 Saginaw North VA Clinic, Saginaw, MI (655QC)
- +1 OOS: VISN 17 Christus Santa Rosa VA Clinic, Santa Rosa, CA (671QC)
- +1 OOS: VISN 19 Miles City VA Clinic, Miles City, MT (436QE)
- +1 OOS: VISN 19 Western Colorado VA Mobile Clinic, Grand Junction, CO (575QE)
- +1 OOS: VISN 19 Cache Valley VA Clinic, North Logan, UT (660QD)
- +1 OOS: VISN 20 Renton VA Clinic, Renton, WA (663QA)
- +1 OOS: VISN 20 South Lucile Street VA Clinic, Seattle, WA (663QB)
- +1 OOS: VISN 21 Twenty First Street VA Clinic, Oakland, CA (662QA)

VAMCs reclassified into OOS sites (+2 OOS):

- +1 OOS: VISN 8 Jacksonville Navy VA Medical Center, Jacksonville, FL (573A5)
- +1 OOS: VISN 17 Garland VA Medical Center, Garland, TX (549A5)

MS CBOCs reclassified into OOS sites (+3 OOS):

- +1 OOS: VISN 8 Lakeland VA Clinic, Lakeland, FL (673GB)
- +1 OOS: VISN 10 Terre Haute VA Clinic, Terre Haute, IN (583GA)
- +1 OOS: VISN 22 Gardena VA Clinic, Gardena, CA (600GF)

PC CBOCs reclassified into OOS sites (+69 OOS):

- +1 OOS: VISN 1 Calais VA Clinic, Calais, ME (402GB)
- +1 OOS: VISN 1 Lincoln VA Clinic, Lincoln, ME (402GF)
- +1 OOS: VISN 1 Gloucester VA Clinic, Gloucester, MA (518GE)
- +1 OOS: VISN 1 Framingham VA Clinic, Framingham, MA (523GA)
- +1 OOS: VISN 1 Conway VA Clinic, Conway, NH (608GD)
- +1 OOS: VISN 1 Worcester VA Clinic, Worcester, MA (631GE)
- +1 OOS: VISN 1 Orange VA Clinic, Orange, CT (689GF)
- +1 OOS: VISN 2 Fonda VA Clinic, Fonda, NY (528G6)
- +1 OOS: VISN 2 Catskill VA Clinic, Catskill, NY (528G7)
- +1 OOS: VISN 2 Morristown VA Clinic, Morristown, NJ (561GH)
- +1 OOS: VISN 2 Paterson VA Clinic, Paterson, NJ (561GJ)
- +1 OOS: VISN 2 Sussex VA Clinic, Newton, NJ (561GK)
- +1 OOS: VISN 2 Poughkeepsie VA Clinic, Poughkeepsie, NY (620GG)
- +1 OOS: VISN 6 Hillandale Road VA Clinic, Durham, NC (558GE)
- +1 OOS: VISN 6 Clayton-East Raleigh VA Clinic, Clayton, NC (558GH)
- +1 OOS: VISN 6 Jacksonville 4 VA Clinic, Jacksonville, NC (558GN)
- +1 OOS: VISN 6 Portsmouth VA Clinic, Portsmouth, VA (590GE)
- +1 OOS: VISN 8 Key Largo VA Clinic, Key Largo, FL (546GE)
- +1 OOS: VISN 8 Middleburg VA Clinic, Middleburg, FL (573GO)
- +1 OOS: VISN 9 Morehead VA Clinic, Morehead, KY (596GB)
- +1 OOS: VISN 9 Mountain City VA Clinic, Mountain City, TN (621GO)
- +1 OOS: VISN 9 Dover VA Clinic, Dover, DE (626GA)
- +1 OOS: VISN 9 Tullahoma VA Clinic, Arnold Air Force Base, TN (626GG)
- +1 OOS: VISN 9 Athens VA Clinic, Athens, TN (626GN)
- +1 OOS: VISN 10 Wright-Patterson VA Clinic, Wright-Patterson Air Force Base, OH (552GF)
- +1 OOS: VISN 10 Piquette Street VA Clinic, Detroit, MI (553QA)
- +1 OOS: VISN 12 Baraboo VA Clinic, Baraboo, WI (607GD)
- +1 OOS: VISN 12 Freeport VA Clinic, Freeport, IL (607GF)
- +1 OOS: VISN 15 Dodge City VA Clinic, Dodge City, KS (589G2)
- +1 OOS: VISN 15 Kirksville VA Clinic, Kirksville, MO (589GE)
- +1 OOS: VISN 15 Shawnee VA Clinic, Shawnee, KS (589JC)
- +1 OOS: VISN 15 Franklin County VA Clinic, Washington, MO (657GS)
- +1 OOS: VISN 15 Pocahontas VA Clinic, Pocahontas, AR (657GW)
- +1 OOS: VISN 16 Sugar Land VA Clinic, Sugar Land, TX (580GL)
- +1 OOS: VISN 16 McComb VA Clinic, McComb, MS (586GG)
- +1 OOS: VISN 17 Decatur VA Clinic, Decatur, TX (549GE)
- +1 OOS: VISN 17 Greenville VA Clinic, Greenville, TX (549GH)
- +1 OOS: VISN 17 North Bexar VA Clinic, San Antonio, TX (671GR)
- +1 OOS: VISN 17 El Paso Westside VA Clinic, El Paso, TX (756GC)
- +1 OOS: VISN 17 El Paso Northeast VA Clinic, El Paso, TX (756GC)
- +1 OOS: VISN 19 Denver VA Domiciliary, Denver CO (554A5)
- +1 OOS: VISN 19 Lamar VA Clinic, Lamar, CO (554GH)
- +1 OOS: VISN 19 Clinton VA Clinic, Clinton, OK (635GH)
- +1 OOS: VISN 19 Norman VA Clinic, Norman, OK (635GI)

- +1 OOS: VISN 19 Yukon VA Clinic, Yukon, OK (635GJ)
- +1 OOS: VISN 19 Cody VA Clinic, Cody, WY (666GD)
- +1 OOS: VISN 19 Gillette VA Clinic, Gillette, WY (666GE)
- +1 OOS: VISN 20 Juneau VA Clinic, Juneau, AK (463GE)
- +1 OOS: VISN 20 Mountain Home VA Clinic, Mountain Home, AR (531GI)
- +1 OOS: VISN 20 Salmon VA Clinic, Salmon, ID (531GJ)
- +1 OOS: VISN 20 North Coast VA Clinic, Warrenton, OR (648GD)
- +1 OOS: VISN 20 Newport VA Clinic, Newport, OR (648GH)
- +1 OOS: VISN 20 North Seattle VA Clinic, Seattle, WA (663GG)
- +1 OOS: VISN 20 La Grande VA Clinic, La Grande, OR (687GC)
- +1 OOS: VISN 21 Yreka VA Clinic, Yreka, CA (612GJ)
- +1 OOS: VISN 21 Carson Valley VA Clinic, Gardnerville, NV (654GB)
- +1 OOS: VISN 21 Lahontan Valley VA Clinic, Fallon, NV (654GB)
- +1 OOS: VISN 21 Diamond View VA Clinic, Susanville, CA (654GD)
- +1 OOS: VISN 22 Las Vegas VA Clinic, Las Vegas, NV (501G2)
- +1 OOS: VISN 22 Silver City VA Clinic, Silver City, NM (501GC)
- +1 OOS: VISN 22 Gallup VA Clinic, Gallup, NM (501GD)
- +1 OOS: VISN 22 Truth or Consequences VA Clinic, Truth or Consequences, NM (501GH)
- +1 OOS: VISN 22 Alamogordo VA Clinic, Alamogordo, NM (501GI)
- +1 OOS: VISN 22 Taos VA Clinic, Taos, NM (501GN)
- +1 OOS: VISN 22 Globe VA Clinic, Globe, AZ (644GF)
- +1 OOS: VISN 22 San Gabriel Valley VA Clinic, Arcadia, CA (691GP)
- +1 OOS: VISN 23 Williston VA Clinic, Williston, ND (437GF)
- +1 OOS: VISN 23 Dickinson VA Clinic, Dickinson, ND (437GJ)
- +1 OOS: VISN 23 Hayward VA Clinic, Hayward, WI (618GH)

Deactivations (-18 OOS):

- -1 OOS: VISN 2 Troy VA Clinic, Troy, NY (528GX)
- -1 OOS: VISN 2 Montrose 1 VA Mobile Clinic, Montrose, NY (620QA)
- -1 OOS: VISN 2 Montrose 3 VA Mobile Clinic, Montrose, NY (620QC)
- -1 OOS: VISN 7 East Point VA Clinic, Atlanta, GA (508QB)
- -1 OOS: VISN 7 Fulton County VA Clinic, East Point, GA (508QD)
- -1 OOS: VISN 7 Callahan VA Clinic, Birmingham, AL (521QA)
- -1 OOS: VISN 7 Dothan 1 VA Clinic, Dothan, AL (619GB)
- -1 OOS: VISN 9 Vansant VA Clinic, Vansant, VA (621QC)
- -1 OOS: VISN 10 Lansing North VA Clinic, Lansing, MI (515QA)
- -1 OOS: VISN 10 Cleveland 2 VA Mobile Clinic, Cleveland, OH (541QD)
- -1 OOS: VISN 15 Liberal VA Clinic, Liberal, KS (589G3)
- -1 OOS: VISN 17 Beeville VA Clinic, Beeville, TX (671GH)
- -1 OOS: VISN 19 Denver VA Domiciliary, Denver, CO (554A5)
- -1 OOS: VISN 19 Weber County VA Clinic, South Ogden, UT (660QC)
- -1 OOS: VISN 20 Federal Way VA Clinic, Federal Way, WA (663GF)
- -1 OOS: VISN 20 North Seattle VA Clinic, Seattle, WA (663GG)
- -1 OOS: VISN 23 Mission VA Clinic, Mission, SD (568HJ)
- -1 OOS: VISN 23 St. Cloud VA Mobile Clinic, St. Cloud, MN (656QA)

OOS sites reclassified into MS CBOCs (-2 OOS):

- -1 OOS: VISN 2 Rochester Calkins VA Clinic, Rochester, NY (528QC)
- -1 OOS: VISN 10 Colonel Demas T. Craw VA Clinic, Traverse City, MI (655GB)

OOS sites reclassified into PC CBOCs (-7 OOS):

- -1 OOS: VISN 5 Princeton VA Clinic, Princeton, WV (517QA)
- -1 OOS: VISN 7 Covington VA Clinic, Covington, GA (508GN)
- -1 OOS: VISN 7 Northeast Cobb County VA Clinic, Marietta, GA (508GO)
- -1 OOS: VISN 8 Lecanto VA Clinic, Lecanto, FL (673GH)
- -1 OOS: VISN 16 Little Rock VA Clinic, Little Rock, AR (598QA)
- -1 OOS: VISN 19 Denver VA Clinic, Denver, CO (554GJ)
- -1 OOS: VISN 21 Sierra Foothills VA Clinic, Auburn, CA (612GK)

Please refer to the section titled "2021 Other Outpatient Services (OOS) Sites" for the complete list of OOS sites in 2021.

OOS site changes in 2022

In 2022, OOS sites are projected to increase from 376 to 377 (+1 OOS):

- +1 OOS: VISN 19 Tinker VA Clinic, Tinker Air Force Base, OK

Included among the OOS sites are Dialysis Centers and Community Resource and Referral Centers (CRRC).

Dialysis Centers are highly specialized programs which provide facilities for the treatment of patients with irreversible renal insufficiencies. Treatment procedures require professional supervision by staff experienced in renal pathophysiology. The services may include self-dialysis training for Peritoneal Dialysis, in addition to on-site assisted dialysis (i.e., Hemodialysis). The Dialysis Centers administer both single-patient and multi-patient Hemodialysis systems.

As of September 30, 2021, there were 73 active Dialysis Centers. Please refer to the section titled, "2021 Outpatient Dialysis Centers" for the complete list of Dialysis Centers in 2021.

CRRCs provide Veterans who are homeless and at risk of homelessness with one-stop access to community-based, multiagency services to promote permanent housing, health and mental health care, career development and access to VA and non-VA benefits.

As of September 30, 2021, there were 32 active CRRC facilities. For the complete list, please refer to the section titled "2021 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.

There were 300 Vet Centers, 83 Mobile Vet Centers and 19 Vet Center Outstations in 2021. For the complete list, please refer to the section titled "2021 Vet Centers, Mobile Vet Centers and Vet Center Outstations."

<u>VC Outstation changes in 2022</u>

In 2022, 4 VC Outstation facilities will be activated (+4 VC Outstation) and 1 facility will be closed (-1 VC Outstation), resulting in a net increase from 19 to 22 (+3 VC Outstation):

- +1 VC Outstation: VISN 5 Leesburg Outstation, Leesburg, VA
- +1 VC Outstation: VISN 21 Solano County Outstation, Fairfield, CA
- +1 VC Outstation: VISN 21 Mariana Islands Outstation, Saipan, MP
- +1 VC Outstation: VISN 22 Sierra Vista Outstation, Sierra Vista, AZ
- -1 VC Outstation: VISN 10 McCafferty Outstation, Cleveland, OH (541)

# 2021 VA Medical Centers and Hospitals

| VISN | Station Number | Station Name | Classification | FY 2021 Hospital (Yes / No) |
|---|---|---|---|---|
| 1 | 402 | Togus VA Medical Center | VA Medical Center (VAMC) | Yes |
| 1 | 405 | White River Junction VA Medical Center | VA Medical Center (VAMC) | Yes |
| 1 | 518 | Edith Nourse Rogers Memorial Veterans' Hospital | VA Medical Center (VAMC) | Yes |
| 1 | 523 | Jamaica Plain VA Medical Center | VA Medical Center (VAMC) | No |
| 1 | 523A4 | West Roxbury VA Medical Center | VA Medical Center (VAMC) | Yes |
| 1 | 523A5 | Brockton VA Medical Center | VA Medical Center (VAMC) | Yes |
| 1 | 608 | Manchester VA Medical Center | VA Medical Center (VAMC) | No |
| 1 | 631 | Edward P. Boland Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 1 | 650 | Providence VA Medical Center | VA Medical Center (VAMC) | Yes |
| 1 | 689 | West Haven VA Medical Center | VA Medical Center (VAMC) | Yes |
| 2 | 526 | James J. Peters Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 2 | 528 | Buffalo VA Medical Center | VA Medical Center (VAMC) | Yes |
| 2 | 528A4 | Batavia VA Medical Center | VA Medical Center (VAMC) | No |
| 2 | 528A5 | Canandaigua VA Medical Center | VA Medical Center (VAMC) | No |
| 2 | 528A6 | Bath VA Medical Center | VA Medical Center (VAMC) | Yes |
| 2 | 528A7 | Syracuse VA Medical Center | VA Medical Center (VAMC) | Yes |
| 2 | 528A8 | Samuel S. Stratton Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 2 | 561 | East Orange VA Medical Center | VA Medical Center (VAMC) | Yes |
| 2 | 561A4 | Lyons VA Medical Center | VA Medical Center (VAMC) | Yes |
| 2 | 620 | Franklin Delano Roosevelt Hospital | VA Medical Center (VAMC) | Yes |
| 2 | 620A4 | Castle Point VA Medical Center | VA Medical Center (VAMC) | Yes |
| 2 | 630 | Manhattan VA Medical Center | VA Medical Center (VAMC) | Yes |
| 2 | 630A4 | Brooklyn VA Medical Center | VA Medical Center (VAMC) | Yes |
| 2 | 630A5 | St. Albans VA Medical Center | VA Medical Center (VAMC) | No |
| 2 | 632 | Northport VA Medical Center | VA Medical Center (VAMC) | Yes |
| 4 | 460 | Wilmington VA Medical Center | VA Medical Center (VAMC) | Yes |
| 4 | 503 | James E. Van Zandt Veterans' Administration Medical Center | VA Medical Center (VAMC) | Yes |
| 4 | 529A4 | Butler VA Medical Center | VA Medical Center (VAMC) | No |
| 4 | 542 | Coatesville VA Medical Center | VA Medical Center (VAMC) | Yes |
| 4 | 562 | Erie VA Medical Center | VA Medical Center (VAMC) | No |
| 4 | 595 | Lebanon VA Medical Center | VA Medical Center (VAMC) | Yes |
| 4 | 642 | Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 4 | 646 | Pittsburgh VA Medical Center-University Drive | VA Medical Center (VAMC) | Yes |
| 4 | 646A4 | H. John Heinz III Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | No |
| 4 | 693 | Wilkes-Barre VA Medical Center | VA Medical Center (VAMC) | Yes |
| 5 | 512 | Baltimore VA Medical Center | VA Medical Center (VAMC) | Yes |
| 5 | 512A5 | Perry Point VA Medical Center | VA Medical Center (VAMC) | No |
| 5 | 512GD | Loch Raven VA Medical Center | VA Medical Center (VAMC) | No |
| 5 | 517 | Beckley VA Medical Center | VA Medical Center (VAMC) | Yes |
| 5 | 540 | Louis A. Johnson Veterans' Administration Medical Center | VA Medical Center (VAMC) | Yes |
| 5 | 581 | Huntington / Hershel "Woody" Williams VA Medical Center | VA Medical Center (VAMC) | Yes |
| 5 | 613 | Martinsburg VA Medical Center | VA Medical Center (VAMC) | Yes |
| 5 | 688 | Washington VA Medical Center | VA Medical Center (VAMC) | Yes |

# 2021 VA Medical Centers and Hospitals

| VISN | Station Number | Station Name | Classification | FY 2021 Hospital (Yes / No) |
|---|---|---|---|---|
| 6 | 558 | Durham VA Medical Center | VA Medical Center (VAMC) | Yes |
| 6 | 565 | Fayetteville VA Medical Center | VA Medical Center (VAMC) | Yes |
| 6 | 590 | Hampton VA Medical Center | VA Medical Center (VAMC) | Yes |
| 6 | 637 | Charles George Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 6 | 652 | Hunter Holmes McGuire Hospital | VA Medical Center (VAMC) | Yes |
| 6 | 658 | Salem VA Medical Center | VA Medical Center (VAMC) | Yes |
| 6 | 659 | W.G. (Bill) Hefner Salisbury Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 7 | 508 | Atlanta VA Medical Center | VA Medical Center (VAMC) | Yes |
| 7 | 508GA | Fort McPherson VA Clinic | VA Medical Center (VAMC) | No |
| 7 | 508GK | Trinka Davis Veterans Village | VA Medical Center (VAMC) | No |
| 7 | 509 | Charlie Norwood Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 7 | 509A0 | Augusta VA Medical Center-Uptown | VA Medical Center (VAMC) | Yes |
| 7 | 521 | Birmingham VA Medical Center | VA Medical Center (VAMC) | Yes |
| 7 | 534 | Ralph H. Johnson Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 7 | 544 | Wm. Jennings Bryan Dorn Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 7 | 557 | Carl Vinson Veterans' Administration Medical Center | VA Medical Center (VAMC) | Yes |
| 7 | 619 | Central Alabama VA Medical Center-Montgomery | VA Medical Center (VAMC) | Yes |
| 7 | 619A4 | Central Alabama VA Medical Center-Tuskegee | VA Medical Center (VAMC) | Yes |
| 7 | 679 | Tuscaloosa VA Medical Center | VA Medical Center (VAMC) | Yes |
| 8 | 516 | C.W. Bill Young Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 8 | 546 | Bruce W. Carter Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 8 | 548 | West Palm Beach VA Medical Center | VA Medical Center (VAMC) | Yes |
| 8 | 573 | Malcom Randall Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 8 | 573A4 | Lake City VA Medical Center | VA Medical Center (VAMC) | Yes |
| 8 | 672 | San Juan VA Medical Center | VA Medical Center (VAMC) | Yes |
| 8 | 673 | James A. Haley Veterans' Hospital | VA Medical Center (VAMC) | Yes |
| 8 | 675 | Orlando VA Medical Center | VA Medical Center (VAMC) | Yes |
| 8 | 675GG | Lake Baldwin VA Clinic | VA Medical Center (VAMC) | No |
| 9 | 596 | Lexington VA Medical Center (Franklin R. Sousley Campus) | VA Medical Center (VAMC) | No |
| 9 | 596A4 | Lexington VA Medical Center (Troy Bowling Campus) | VA Medical Center (VAMC) | Yes |
| 9 | 603 | Robley Rex Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 9 | 614 | Memphis VA Medical Center | VA Medical Center (VAMC) | Yes |
| 9 | 621 | James H. Quillen Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 9 | 626 | Nashville VA Medical Center | VA Medical Center (VAMC) | Yes |
| 9 | 626A4 | Alvin C. York Veterans' Administration Medical Center | VA Medical Center (VAMC) | Yes |
| 10 | 506 | Ann Arbor VA Medical Center | VA Medical Center (VAMC) | Yes |
| 10 | 515 | Battle Creek VA Medical Center | VA Medical Center (VAMC) | Yes |
| 10 | 538 | Chillicothe VA Medical Center | VA Medical Center (VAMC) | Yes |
| 10 | 539 | Cincinnati VA Medical Center | VA Medical Center (VAMC) | Yes |
| 10 | 541 | Louis Stokes Cleveland Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 10 | 552 | Dayton VA Medical Center | VA Medical Center (VAMC) | Yes |
| 10 | 553 | John D. Dingell Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 10 | 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 |

# 2021 VA Medical Centers and Hospitals

| VISN | Station Number | Station Name | Classification | FY 2021 Hospital (Yes / No) |
|---|---|---|---|---|
| 12 | 537 | Jesse Brown Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 12 | 550 | Danville VA Medical Center | VA Medical Center (VAMC) | Yes |
| 12 | 556 | Captain James A. Lovell Federal Health Care Center | VA Medical Center (VAMC) | Yes |
| 12 | 578 | Edward Hines Junior Hospital | VA Medical Center (VAMC) | Yes |
| 12 | 585 | Oscar G. Johnson Department of Veterans Affairs Medical Facility | VA Medical Center (VAMC) | Yes |
| 12 | 607 | William S. Middleton Memorial Veterans' Hospital | VA Medical Center (VAMC) | Yes |
| 12 | 676 | Tomah VA Medical Center | VA Medical Center (VAMC) | Yes |
| 12 | 695 | Clement J. Zablocki Veterans' Administration Medical Center | VA Medical Center (VAMC) | Yes |
| 15 | 589 | Kansas City VA Medical Center | VA Medical Center (VAMC) | Yes |
| 15 | 589A4 | Harry S. Truman Memorial Veterans' Hospital | VA Medical Center (VAMC) | Yes |
| 15 | 589A5 | Colmery-O'Neil Veterans' Administration Medical Center | VA Medical Center (VAMC) | Yes |
| 15 | 589A6 | Dwight D. Eisenhower Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 15 | 589A7 | Robert J. Dole Department of Veterans Affairs Medical and Regional Office Center | VA Medical Center (VAMC) | Yes |
| 15 | 657 | John Cochran Veterans Hospital | VA Medical Center (VAMC) | Yes |
| 15 | 657A0 | St. Louis VA Medical Center-Jefferson Barracks | VA Medical Center (VAMC) | Yes |
| 15 | 657A4 | John J. Pershing Veterans' Administration Medical Center | VA Medical Center (VAMC) | Yes |
| 15 | 657A5 | Marion VA Medical Center | VA Medical Center (VAMC) | Yes |
| 16 | 502 | Alexandria VA Medical Center | VA Medical Center (VAMC) | Yes |
| 16 | 520 | Biloxi VA Medical Center | VA Medical Center (VAMC) | Yes |
| 16 | 564 | Fayetteville VA Medical Center | VA Medical Center (VAMC) | Yes |
| 16 | 580 | Michael E. DeBakey Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 16 | 586 | G.V. (Sonny) Montgomery Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 16 | 598 | John L. McClellan Memorial Veterans' Hospital | VA Medical Center (VAMC) | Yes |
| 16 | 598A0 | Eugene J. Towbin Healthcare Center | VA Medical Center (VAMC) | Yes |
| 16 | 629 | New Orleans VA Medical Center | VA Medical Center (VAMC) | Yes |
| 16 | 667 | Overton Brooks Veterans' Administration Medical Center | VA Medical Center (VAMC) | Yes |
| 17 | 504 | Thomas E. Creek Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 17 | 519 | George H. O'Brien, Jr., Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | No |
| 17 | 549 | Dallas VA Medical Center | VA Medical Center (VAMC) | Yes |
| 17 | 549A4 | Sam Rayburn Memorial Veterans Center | VA Medical Center (VAMC) | No |
| 17 | 671 | Audie L. Murphy Memorial Veterans' Hospital | VA Medical Center (VAMC) | Yes |
| 17 | 671A4 | Kerrville VA Medical Center | VA Medical Center (VAMC) | No |
| 17 | 674 | Olin E. Teague Veterans' Center | VA Medical Center (VAMC) | Yes |
| 17 | 674A4 | Doris Miller Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 19 | 436 | Fort Harrison VA Medical Center | VA Medical Center (VAMC) | Yes |
| 19 | 436A4 | Miles City VA Medical Center | VA Medical Center (VAMC) | No |
| 19 | 442 | Cheyenne VA Medical Center | VA Medical Center (VAMC) | Yes |
| 19 | 554 | Rocky Mountain Regional VA Medical Center | VA Medical Center (VAMC) | Yes |
| 19 | 575 | Grand Junction VA Medical Center | VA Medical Center (VAMC) | Yes |
| 19 | 623 | Jack C. Montgomery Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 19 | 635 | Oklahoma City VA Medical Center | VA Medical Center (VAMC) | Yes |
| 19 | 660 | George E. Wahlen Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 19 | 666 | Sheridan VA Medical Center | VA Medical Center (VAMC) | Yes |

# 2021 VA Medical Centers and Hospitals

| VISN | Station Number | Station Name | Classification | FY 2021 Hospital (Yes / No) |
|---|---|---|---|---|
| 20 | 463 | Anchorage VA Medical Center | VA Medical Center (VAMC) | No |
| 20 | 531 | Boise VA Medical Center | VA Medical Center (VAMC) | Yes |
| 20 | 648 | Portland VA Medical Center | VA Medical Center (VAMC) | Yes |
| 20 | 648A4 | Portland VA Medical Center-Vancouver | VA Medical Center (VAMC) | No |
| 20 | 653 | Roseburg VA Medical Center | VA Medical Center (VAMC) | Yes |
| 20 | 663 | Seattle VA Medical Center | VA Medical Center (VAMC) | Yes |
| 20 | 663A4 | American Lake VA Medical Center | VA Medical Center (VAMC) | Yes |
| 20 | 668 | Mann-Grandstaff Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 20 | 687 | Jonathan M. Wainwright Memorial VA Medical Center | VA Medical Center (VAMC) | No |
| 20 | 692 | White City VA Medical Center | VA Medical Center (VAMC) | No |
| 21 | 459 | Spark M. Matsunaga Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 21 | 570 | Fresno VA Medical Center | VA Medical Center (VAMC) | Yes |
| 21 | 593 | North Las Vegas VA Medical Center | VA Medical Center (VAMC) | Yes |
| 21 | 612A4 | Sacramento VA Medical Center | VA Medical Center (VAMC) | Yes |
| 21 | 612GF | Martinez VA Medical Center | VA Medical Center (VAMC) | No |
| 21 | 640 | Palo Alto VA Medical Center | VA Medical Center (VAMC) | Yes |
| 21 | 640A0 | Palo Alto VA Medical Center-Menlo Park | VA Medical Center (VAMC) | Yes |
| 21 | 640A4 | Palo Alto VA Medical Center-Livermore | VA Medical Center (VAMC) | No |
| 21 | 654 | Ioannis A. Lougaris Veterans' Administration Medical Center | VA Medical Center (VAMC) | Yes |
| 21 | 662 | San Francisco VA Medical Center | VA Medical Center (VAMC) | Yes |
| 22 | 501 | Raymond G. Murphy Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 22 | 600 | Long Beach (Tibor Rubin) VA Medical Center | VA Medical Center (VAMC) | Yes |
| 22 | 605 | Jerry L. Pettis Memorial Veterans' Hospital | VA Medical Center (VAMC) | Yes |
| 22 | 644 | Carl T. Hayden Veterans' Administration Medical Center | VA Medical Center (VAMC) | Yes |
| 22 | 649 | Bob Stump Department of Veterans Affairs Medical Center | VA Medical Center (VAMC) | Yes |
| 22 | 664 | San Diego VA Medical Center | VA Medical Center (VAMC) | Yes |
| 22 | 678 | Tucson VA Medical Center | VA Medical Center (VAMC) | Yes |
| 22 | 691 | West Los Angeles VA Medical Center | VA Medical Center (VAMC) | Yes |
| 22 | 691A4 | Sepulveda VA Medical Center | VA Medical Center (VAMC) | No |
| 23 | 437 | Fargo VA Medical Center | VA Medical Center (VAMC) | Yes |
| 23 | 438 | Royal C. Johnson Veterans' Memorial Hospital | VA Medical Center (VAMC) | Yes |
| 23 | 568 | Fort Meade VA Medical Center | VA Medical Center (VAMC) | Yes |
| 23 | 568A4 | Hot Springs VA Medical Center | VA Medical Center (VAMC) | Yes |
| 23 | 618 | Minneapolis VA Medical Center | VA Medical Center (VAMC) | Yes |
| 23 | 636 | Omaha VA Medical Center | VA Medical Center (VAMC) | Yes |
| 23 | 636A4 | Grand Island VA Medical Center | VA Medical Center (VAMC) | No |
| 23 | 636A6 | Des Moines VA Medical Center | VA Medical Center (VAMC) | Yes |
| 23 | 636A8 | Iowa City VA Medical Center | VA Medical Center (VAMC) | Yes |
| 23 | 656 | St. Cloud VA Medical Center | VA Medical Center (VAMC) | Yes |

# 2021 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 |

# 2021 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 |

# 2021 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 |

# 2021 Community Living Centers (CLC)

| CLC Program Count | VISN | Station Number | Official Name |
|---|---|---|---|
| 110 | 21 | 459 | Pacific Islands VA-Spark M. Matsunaga |
| 111 | 21 | 570 | Central California VA-Fresno |
| 112 | 21 | 612 | Northern California VA-East Bay (Martinez) |
| 113 | 21 | 640 | Palo Alto VA |
| 114 | 21 | 640A0 | Palo Alto VA-Menlo Park |
| 115 | 21 | 640A4 | Palo Alto VA-Livermore |
| 116 | 21 | 654 | Sierra Nevada VA-Ioannis A. Lougaris |
| 117 | 21 | 662 | San Francisco VA |
| 118 | 22 | 501 | New Mexico VA-Raymond G. Murphy |
| 119 | 22 | 644 | Carl T. Hayden VA |
| 120 | 22 | 649 | Northern Arizona VA-Prescott |
| 121 | 22 | 678 | Southern Arizona VA-Tucson |
| 122 | 22 | 600 | Long Beach VA |
| 123 | 22 | 605 | Loma Linda VA |
| 124 | 22 | 664 | San Diego VA |
| 125 | 22 | 691 | Greater Los Angeles VA-West Los Angeles |
| 126 | 22 | 691A4 | Sepulveda VA Clinic |
| 127 | 23 | 437 | Fargo VA |
| 128 | 23 | 438 | Sioux Falls VA |
| 129 | 23 | 568 | Black Hills VA-Fort Meade |
| 130 | 23 | 568A4 | Black Hills VA-Hot Springs |
| 131 | 23 | 618 | Minneapolis VA |
| 132 | 23 | 636A4 | Grand Island VA Clinic |
| 133 | 23 | 636A6 | Central Iowa VA-Des Moines |
| 134 | 23 | 656 | St. Cloud VA |

# 2021 Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

| MH RRTP Program Count | VISN | Station # | Official Name | Classification | Type of Service |
|---|---|---|---|---|---|
| 1 | 1 | 405 | White River Junction VA | VA Medical Center (VAMC) | Domiciliary Program |
| 2 | 1 | 518 | Edith Nourse Rogers VA- Bedford | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 3 | 1 | 523 | Boston VA-Jamaica Plain | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 4 | 1 | 523A5 | Boston VA-Brockton | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 5 | 1 | 631 | Central Western Massachusetts VA-Leeds (Northampton) | VA Medical Center (VAMC) | CWT/TR Program |
| 6 | 1 | 689BU | Connecticut VA-West Haven | Residential Care Site (MH RRTP/DRRTP) | Stand Alone Domiciliary Only |
| 7 | 2 | 528 | Western New York VA-Buffalo | VA Medical Center (VAMC) | Domiciliary Program |
| 8 | 2 | 528A4 | Western New York VA-Batavia | VA Medical Center (VAMC) | Domiciliary Program |
| 9 | 2 | 528A5 | Canandaigua VA | VA Medical Center (VAMC) | Domiciliary Program |
| 10 | 2 | 528A6 | Bath VA | VA Medical Center (VAMC) | Domiciliary Program |
| 11 | 2 | 528A8 | Samuel S. Stratton VA- Albany | VA Medical Center (VAMC) | Domiciliary Program |
| 12 | 2 | 561 | New Jersey VA-East Orange | VA Medical Center (VAMC) | Domiciliary Program |
| 13 | 2 | 561A4 | New Jersey VA-Lyons | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 14 | 2 | 620 | Franklin Delano Roosevelt VA (Montrose) | VA Medical Center (VAMC) | Domiciliary Program |
| 15 | 2 | 630A4 | New York Harbor VA-Brooklyn Division | VA Medical Center (VAMC) | Domiciliary Program |
| 16 | 2 | 632 | Northport VA | VA Medical Center (VAMC) | Domiciliary Program |
| 17 | 4 | 529 | Butler VA | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 18 | 4 | 542 | Coatesville VA | VA Medical Center (VAMC) | Domiciliary Program |
| 19 | 4 | 595 | Lebanon VA | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 20 | 4 | 642BU | Philadelphia VA Domiciliary | Residential Care Site (MH RRTP/DRRTP) (Stand-Alone) | Stand Alone Domiciliary Only |
| 21 | 4 | 646A4 | Pittsburgh VA-H.J. Heinz VA | VA Medical Center (VAMC) | Domiciliary Program & CWT/TR |
| 22 | 4 | 562 | Erie VA | VA Medical Center (VAMC) | Domiciliary Program |
| 23 | 4 | 693 | Wilkes-Barre VA | VA Medical Center (VAMC) | Domiciliary Program |
| 24 | 5 | 512A5 | Maryland VA-Perry Point | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 25 | 5 | 540 | Louis A. Johnson VA (Clarksburg) | VA Medical Center (VAMC) | Domiciliary Program |
| 26 | 5 | 581 | Huntington, West VA | VA Medical Center (VAMC) | Domiciliary Program |
| 27 | 5 | 613 | Martinsburg VA | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 28 | 6 | 590 | Hampton VA | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 29 | 6 | 637 | Charles George VA (Asheville) | VA Medical Center (VAMC) | Domiciliary Program |
| 30 | 6 | 652 | Hunter Holmes McGuire VA (Richmond) | VA Medical Center (VAMC) | Domiciliary Program |
| 31 | 6 | 658 | Salem VA | VA Medical Center (VAMC) | Domiciliary Program |
| 32 | 6 | 659 | W.G. (Bill) Hefner VA (Salisbury) | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 33 | 7 | 508 | Atlanta VA - Decatur | VA Medical Center (VAMC) | CWT/TR Program |
| 34 | 7 | 508GA | Atlanta VA - Fort McPherson | Residential Care Site (MH RRTP/DRRTP) (Stand-Alone) | Stand Alone Domiciliary Only |
| 35 | 7 | 509A0 | Augusta VA-Uptown | VA Medical Center (VAMC) | Domiciliary Program |
| 36 | 7 | 521 | Birmingham VA | VA Medical Center (VAMC) | CWT/TR Program |
| 37 | 7 | 557 | Carl Vinson VA (Dublin) | VA Medical Center (VAMC) | Domiciliary Program |
| 38 | 7 | 619A4 | Central Alabama VA-Tuskegee | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 39 | 7 | 679 | Tuscaloosa VA | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 40 | 8 | 516 | C.W. Bill Young VA (Bay Pines) | VA Medical Center (VAMC) | Domiciliary Program |
| 41 | 8 | 546 | Miami VA | VA Medical Center (VAMC) | Domiciliary Program |
| 42 | 8 | 548 | West Palm Beach | VA Medical Center (VAMC) | Domiciliary Program |
| 43 | 8 | 573A4 | North Florida-South Georgia VA-Lake City | VA Medical Center (VAMC) | Domiciliary Program |
| 44 | 8 | 573BU | Gainesville VA Domiciliary | Residential Care Site (MH RRTP/DRRTP) (Stand-Alone) | Stand Alone Domiciliary Only |
| 45 | 8 | 673BV | Tampa VA Domiciliary | Residential Care Site (MH RRTP/DRRTP) (Stand-Alone) | Stand Alone Domiciliary Only |
| 46 | 8 | 675GG | Orlando VA (Lake Baldwin) | VA Medical Center (VAMC) | Domiciliary Program |
| 47 | 8 | 675 | Orlando VA (Lake Nona) | VA Medical Center (VAMC) | Domiciliary Program |
| 48 | 9 | 596 | Lexington VA-Leestown | VA Medical Center (VAMC) | Domiciliary Program |
| 49 | 9 | 603 | Robley Rex VA (Louisville) | VA Medical Center (VAMC) | Domiciliary Program |
| 50 | 9 | 614 | Memphis VA | VA Medical Center (VAMC) | Domiciliary Program |
| 51 | 9 | 621 | James H. Quillen VA (Mountain Home) | VA Medical Center (VAMC) | Domiciliary Program |
| 52 | 9 | 626A4 | Alvin C. York VA (Murfreesboro) | VA Medical Center (VAMC) | Domiciliary Program |
| 53 | 10 | 538 | Chillicothe VA | VA Medical Center (VAMC) | Domiciliary Program |
| 54 | 10 | 539 | Cincinnati VA | VA Medical Center (VAMC) | Domiciliary Program |
| 55 | 10 | 539A4 | Cincinnati VA-Fort Thomas | VA Medical Center (VAMC) | Domiciliary Program |
| 56 | 10 | 541 | Louis Stokes VA (Cleveland - Wade Park Division) | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 57 | 10 | 552 | Dayton VA | VA Medical Center (VAMC) | Domiciliary Program |
| 58 | 10 | 515 | Battle Creek VA | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 59 | 10 | 553BU | Detroit VA Domiciliary | Residential Care Site (MH RRTP/DRRTP) (Stand-Alone) | Stand Alone Domiciliary Only |

# 2021 Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

| MH RRTP Program Count | VISN | Station # | Official Name | Classification | Type of Service |
|---|---|---|---|---|---|
| 60 | 10 | 583BU | Indianapolis VA Domiciliary | Residential Care Site (MH RRTP/DRRTP) (Stand-Alone) | Stand Alone Domiciliary Only |
| 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) | Dom & CWT/TR Program |
| 67 | 12 | 676 | Tomah VA | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 68 | 12 | 695 | Clement J. Zablocki VA (Milwaukee) | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 69 | 15 | 589 | Kansas City VA | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 70 | 15 | 589A4 | Harry S. Truman VA (Columbia MO) | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 71 | 15 | 589A5 | Eastern Kansas VA - Topeka Division | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 72 | 15 | 589A6 | Eastern Kansas VA - Dwight D. Eisenhower (Leavenworth Divisi | VA Medical Center (VAMC) | Domiciliary Program |
| 73 | 15 | 657A0 | St. Louis VA-Jefferson Barracks | VA Medical Center (VAMC) | Domiciliary Program |
| 74 | 15 | 657A5 | Marion IL VA | VA Medical Center (VAMC) | Domiciliary Program |
| 75 | 15 | 589A7 | Wichita VA | VA Medical Center (VAMC) | Domiciliary Program |
| 76 | 16 | 520 | Gulf Coast VA-Biloxi | VA Medical Center (VAMC) | Domiciliary Program |
| 77 | 16 | 564 | Veterans HCS of the Ozarks - Fayetteville | VA Medical Center (VAMC) | Domiciliary Program |
| 78 | 16 | 586BU | Jackson VA Domiciliary | Residential Care Site (MH RRTP/DRRTP) (Stand-Alone) | Stand Alone Domiciliary Only |
| 79 | 16 | 598A0 | Central Arkansas VA-Eugene J. Tobin (N.Little Rock) | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 80 | 17 | 549 | North Texas VA-Dallas | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 81 | 17 | 549A4 | North Texas VA-Sam Rayburn (Bonham) | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 82 | 17 | 671 | South Texas VA-Audie L. Murphy (San Antonio) | VA Medical Center (VAMC) | Domiciliary Program |
| 83 | 17 | 674 | Central Texas VA-Olin E. Teague (Temple) | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 84 | 17 | 674A4 | Central Texas VA-Waco | VA Medical Center (VAMC) | Domiciliary Program |
| 85 | 17 | 519 | West Texas VA-George H. O'Brien, Jr. (Big Spring) | VA Medical Center (VAMC) | Domiciliary Program |
| 86 | 19 | 436 | Montana VA-Fort Harrison | VA Medical Center (VAMC) | Domiciliary Program |
| 87 | 19 | 442 | Cheyenne | VA Medical Center (VAMC) | Domiciliary Program |
| 88 | 19 | 554BU | Valor Point VA Domiciliary | Residential Care Site (MH RRTP/DRRTP) (Stand-Alone) | Stand Alone Domiciliary Only |
| 89 | 19 | 660 | George E. Wahlen VA (Salt Lake) | VA Medical Center (VAMC) | Domiciliary Program |
| 90 | 19 | 635 | Oklahoma City VA | VA Medical Center (VAMC) | CWT/TR Program |
| 91 | 19 | 666 | Sheridan VA | VA Medical Center (VAMC) | Domiciliary Program |
| 92 | 20 | 463 | Alaska VA-Anchorage | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 93 | 20 | 531 | Boise VA | VA Medical Center (VAMC) | Domiciliary Program |
| 94 | 20 | 648A4 | Portland VA-Vancouver | VA Medical Center (VAMC) | Domiciliary Program |
| 95 | 20 | 653 | Roseburg VA | VA Medical Center (VAMC) | Domiciliary Program |
| 96 | 20 | 663A4 | Puget Sound VA-American Lake | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 97 | 20 | 687 | Jonathan M. Wainwright VA (Walla Walla) | VA Medical Center (VAMC) | Domiciliary Program |
| 98 | 20 | 692 | Southern Oregon VA-White City | VA Medical Center (VAMC) | Domiciliary Program |
| 99 | 21 | 459 | Pacific Islands VA-Spark M. Matsunaga | VA Medical Center (VAMC) | Domiciliary Program |
| 100 | 21 | 593 | Southern Nevada (Las Vegas) | VA Medical Center (VAMC) | Domiciliary Program |
| 101 | 21 | 640A0 | Palo Alto VA-Menlo Park | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 102 | 21 | 640BV | Palo Alto VA | VA Medical Center (VAMC) | Domiciliary Program |
| 103 | 21 | 662 | San Francisco VA | VA Medical Center (VAMC) | CWT/TR Program |
| 104 | 22 | 664 | San Diego VA | VA Medical Center (VAMC) | Domiciliary Program |
| 105 | 22 | 664BV | San Diego VA Domiciliary | Residential Care Site (MH RRTP/DRRTP) (Stand-Alone) | Stand Alone Domiciliary Only |
| 106 | 22 | 501 | New Mexico VA-Raymond G. Murphy (Albuquerque) | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 107 | 22 | 644 | Carl T. Hayden VA (Phoenix) | VA Medical Center (VAMC) | Domiciliary Program |
| 108 | 22 | 649 | Northern Arizona VA-Prescott | VA Medical Center (VAMC) | Domiciliary Program |
| 109 | 22 | 678 | Southern Arizona VA-Tucson | VA Medical Center (VAMC) | Domiciliary Program |
| 110 | 22 | 691 | Greater Los Angeles VA-West Los Angeles | VA Medical Center (VAMC) | Domiciliary Program |
| 111 | 23 | 568 | Black Hills VA-Fort Meade | VA Medical Center (VAMC) | CWT/TR Program |
| 112 | 23 | 568A4 | Black Hills VA-Hot Springs | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 113 | 23 | 568A4 | Black Hills VA - Hot Springs (Pine Ridge) | Residential Care Site (CWT/TR) (Stand-Alone) | CWT/TR Program |
| 114 | 23 | 636 | Nebraska-Western Iowa VA-Omaha | VA Medical Center (VAMC) | Domiciliary Program |
| 115 | 23 | 636A4 | Grand Island VA Clinic | VA Medical Center (VAMC) | Dom & CWT/TR Program |
| 116 | 23 | 636A6 | Central Iowa VA-Des Moines | VA Medical Center (VAMC) | Domiciliary Program |
| 117 | 23 | 656 | St. Cloud VA | VA Medical Center (VAMC) | Domiciliary Program |

## 2021 Health Care Centers (HCC)

| HCC Count | VISN | Station Number | Station Name & Location |
|---|---|---|---|
| 1 | 6 | 565GL | Cumberland County VA Clinic, Fayetteville, NC |
| 2 | 6 | 659BY | Kernersville VA Clinic, Kernersville, NC |
| 3 | 6 | 659BZ | South Charlotte VA Clinic, Charlotte, NC |
| 4 | 8 | 516BZ | Lee County VA Clinic, Cape Coral, FL |
| 5 | 8 | 675GA | Viera VA Clinic, 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, IN |
| 9 | 17 | 740 | Harlingen VA Clinic, TX |
| 10 | 17 | 756 | El Paso VA Clinic, TX |
| 11 | 19 | 436GH | Billings VA Clinic, MN |
| 12 | 20 | 653BY | Eugene VA Clinic, OR |

# 2021 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 | 405HA | Burlington Lakeside VA Clinic | Burlington Lakeside |
| 4 | 1 | 523BY | Lowell VA Clinic | Lowell |
| 5 | 1 | 631BY | Springfield VA Clinic | Springfield, Massachusetts |
| 6 | 1 | 689A4 | Newington VA Clinic | Newington |
| 7 | 2 | 528GM | Donald J. Mitchell Department of Veterans Affairs Outpatient Clinic | Rome, New York |
| 8 | 2 | 528GN | Binghamton VA Clinic | Binghamton |
| 9 | 2 | 528QC | Rochester Calkins VA Clinic | Rochester Calkins |
| 10 | 2 | 561BZ | James J. Howard Veterans' Outpatient Clinic | Brick |
| 11 | 2 | 620GA | New City VA Clinic | New City |
| 12 | 4 | 460HG | Cumberland County VA Clinic | Cumberland County New Jersey |
| 13 | 4 | 503GA | Johnstown VA Clinic | Johnstown |
| 14 | 4 | 503GB | DuBois VA Clinic | DuBois |
| 15 | 4 | 503GC | State College VA Clinic | State College |
| 16 | 4 | 529 | Abie Abraham VA Clinic | Butler |
| 17 | 4 | 595GA | Cumberland County VA Clinic | Cumberland County Pennsylvania |
| 18 | 4 | 595GC | Lancaster County VA Clinic | Lancaster County |
| 19 | 4 | 595GE | York VA Clinic | York |
| 20 | 4 | 642GA | Burlington County VA Clinic | Burlington County |
| 21 | 4 | 642GC | Victor J. Saracini Department of Veterans Affairs Outpatient Clinic | Horsham |
| 22 | 4 | 642GD | Gloucester County VA Clinic | Gloucester County |
| 23 | 4 | 646GA | Belmont County VA Clinic | Belmont County |
| 24 | 4 | 646GC | Beaver County VA Clinic | Beaver County |
| 25 | 4 | 646GD | Washington County VA Clinic | Washington County |
| 26 | 4 | 646GE | Fayette County VA Clinic | Fayette County |
| 27 | 4 | 693B4 | Allentown VA Clinic | Allentown |
| 28 | 5 | 512GA | Cambridge VA Clinic | Cambridge, Maryland |
| 29 | 5 | 512GC | Glen Burnie VA Clinic | Glen Burnie |
| 30 | 5 | 512GG | Fort Meade VA Clinic | Fort Meade, Maryland |
| 31 | 5 | 581GB | Charleston VA Clinic | Charleston, West Virginia |
| 32 | 5 | 613GA | Cumberland VA Clinic | Cumberland |
| 33 | 5 | 613GG | Fort Detrick VA Clinic | Fort Detrick |
| 34 | 6 | 558GA | Greenville VA Clinic | Greenville, North Carolina |
| 35 | 6 | 565GC | Wilmington VA Clinic | Wilmington, North Carolina |
| 36 | 6 | 637GC | Hickory VA Clinic | Hickory |
| 37 | 6 | 652GE | Charlottesville VA Clinic | Charlottesville |
| 38 | 6 | 659GA | North Charlotte VA Clinic | North Charlotte |
| 39 | 7 | 508QF | Atlanta VA Clinic | Atlanta North Arcadia Avenue |
| 40 | 7 | 521GA | Huntsville VA Clinic | Huntsville |
| 41 | 7 | 521GJ | Birmingham VA Clinic | Birmingham 7th Avenue South |
| 42 | 7 | 534BY | Savannah VA Clinic | Savannah, Georgia |
| 43 | 7 | 534GD | Goose Creek VA Clinic | Goose Creek |
| 44 | 7 | 534QA | Market Commons VA Clinic | Market Commons |
| 45 | 7 | 544BZ | Greenville VA Clinic | Greenville, South Carolina |
| 46 | 7 | 544GD | Anderson VA Clinic | Anderson |
| 47 | 7 | 557GA | Macon VA Clinic | Macon |
| 48 | 7 | 557GB | Albany VA Clinic | Albany, Georgia |
| 49 | 7 | 557GE | Brunswick VA Clinic | Brunswick |
| 50 | 7 | 619GA | Columbus VA Clinic | Columbus, Georgia |
| 51 | 7 | 619GD | Wiregrass VA Clinic | Wiregrass |

# 2021 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

| MS CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 52 | 7 | 619GF | Central Alabama Montgomery VA Clinic | Central Alabama Montgomery |
| 53 | 8 | 516GD | Bradenton VA Clinic | Bradenton |
| 54 | 8 | 546BZ | William "Bill" Kling Department of Veterans Affairs Outpatient Clinic | Sunrise |
| 55 | 8 | 546GC | Homestead VA Clinic | Homestead |
| 56 | 8 | 573BY | Jacksonville 1 VA Clinic | Jacksonville, Florida |
| 57 | 8 | 573GE | Saint Augustine VA Clinic | Saint Augustine |
| 58 | 8 | 573GF | Sergeant Ernest I. "Boots" Thomas VA Clinic | Tallahassee |
| 59 | 8 | 573GI | The Villages VA Clinic | The Villages |
| 60 | 8 | 573QJ | Jacksonville 2 VA Clinic | Jacksonville 2 |
| 61 | 8 | 672B0 | Eurípides Rubio Department of Veterans Affairs Outpatient Clinic | Ponce |
| 62 | 8 | 672BZ | Mayaguez VA Clinic | Mayaguez |
| 63 | 8 | 673BZ | New Port Richey VA Clinic | New Port Richey |
| 64 | 8 | 673GC | Brooksville VA Clinic | Brooksville |
| 65 | 8 | 673GG | South Hillsborough VA Clinic | South Hillsborough |
| 66 | 8 | 673QJ | Hidden River VA Clinic | Hidden River |
| 67 | 8 | 675GB | William V. Chappell, Jr. Veterans' Outpatient Clinic | Daytona Beach |
| 68 | 9 | 596GA | Somerset VA Clinic | Somerset |
| 69 | 9 | 614GF | Nonconnah Boulevard VA Clinic | Nonconnah Boulevard |
| 70 | 9 | 621BY | William C. Tallent Department of Veterans Affairs Outpatient Clinic | Knoxville, Tennessee |
| 71 | 9 | 626GE | Clarksville VA Clinic | Clarksville |
| 72 | 9 | 626GF | Chattanooga VA Clinic | Chattanooga |
| 73 | 10 | 506GA | Toledo VA Clinic | Toledo |
| 74 | 10 | 515BY | Wyoming VA Clinic | Wyoming |
| 75 | 10 | 539GB | Clermont County VA Clinic | Clermont County |
| 76 | 10 | 539GC | Dearborn VA Clinic | Dearborn |
| 77 | 10 | 539GD | Florence VA Clinic | Florence, Kentucky |
| 78 | 10 | 539GE | Hamilton VA Clinic | Hamilton, Ohio |
| 79 | 10 | 541BY | Canton VA Clinic | Canton, Ohio |
| 80 | 10 | 541BZ | Youngstown VA Clinic | Youngstown |
| 81 | 10 | 541GB | Lorain VA Clinic | Lorain |
| 82 | 10 | 541GD | David F. Winder Department of Veterans Affairs Community Based Outpatient Clinic | Mansfield |
| 83 | 10 | 541GF | Lake County VA Clinic | Lake County |
| 84 | 10 | 541GG | Akron VA Clinic | Akron |
| 85 | 10 | 541GL | Parma VA Clinic | Parma |
| 86 | 10 | 552GA | Middletown VA Clinic | Middletown, Ohio |
| 87 | 10 | 552GB | Lima VA Clinic | Lima |
| 88 | 10 | 552GC | Richmond VA Clinic | Richmond, Indiana |
| 89 | 10 | 552GD | Springfield VA Clinic | Springfield, Ohio |
| 90 | 10 | 583GD | Indianapolis West VA Clinic | Indianapolis West |
| 91 | 10 | 583GF | Wakeman VA Clinic | Wakeman |
| 92 | 10 | 583GG | Shelbyville VA Clinic | Shelbyville |
| 93 | 10 | 610BY | St. Joseph County VA Clinic | St. Joseph County |
| 94 | 10 | 655GA | Gaylord VA Clinic | Gaylord |
| 95 | 10 | 655GB | Colonel Demas T. Craw VA Clinic | Traverse City |
| 96 | 10 | 655GE | Clare VA Clinic | Clare |
| 97 | 10 | 757GD | Daniel L. Kinnard VA Clinic | Newark, Ohio |
| 98 | 12 | 537BY | Adam Benjamin Jr., Veterans' Administration Outpatient Clinic | Crown Point |
| 99 | 12 | 550BY | Bob Michel Department of Veterans Affairs Outpatient Clinic | Peoria |
| 100 | 12 | 550GA | Decatur VA Clinic | Decatur, Illinois |
| 101 | 12 | 578GA | Joliet VA Clinic | Joliet |
| 102 | 12 | 607HA | Rockford VA Clinic | Rockford |

# 2021 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

| MS CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 103 | 12 | 676GD | Wisconsin Rapids VA Clinic | Wisconsin Rapids |
| 104 | 12 | 695BY | John H. Bradley Department of Veterans Affairs Outpatient Clinic | Appleton |
| 105 | 15 | 589G1 | Warrensburg VA Clinic | Warrensburg |
| 106 | 15 | 589G8 | Jefferson City VA Clinic | Jefferson City |
| 107 | 15 | 589JG | Lenexa VA Clinic | Lenexa, Kansas |
| 108 | 16 | 502GB | Lafayette VA Clinic | Lafayette |
| 109 | 16 | 520BZ | Pensacola VA Clinic | Pensacola |
| 110 | 16 | 520GA | Mobile VA Clinic | Mobile |
| 111 | 16 | 564BY | Gene Taylor Veterans' Outpatient Clinic | Springfield, Missouri |
| 112 | 16 | 564GC | Branson VA Clinic | Branson |
| 113 | 16 | 580BY | Beaumont VA Clinic | Beaumont |
| 114 | 16 | 580BZ | Charles Wilson Department of Veterans Affairs Outpatient Clinic | Lufkin |
| 115 | 16 | 580GD | Conroe VA Clinic | Conroe |
| 116 | 16 | 580GE | Katy VA Clinic | Katy |
| 117 | 16 | 580GG | Richmond VA Clinic | Richmond, Texas |
| 118 | 16 | 580GH | Tomball VA Clinic | Tomball |
| 119 | 16 | 580GJ | Texas City VA Clinic | Texas City |
| 120 | 16 | 598GC | Hot Springs VA Clinic | Hot Springs, Arkansas |
| 121 | 16 | 598GG | Conway VA Clinic | Conway, Arkansas |
| 122 | 16 | 629BY | Baton Rouge VA Clinic | Baton Rouge |
| 123 | 16 | 629GB | Hammond VA Clinic | Hammond |
| 124 | 16 | 629GC | Slidell VA Clinic | Slidell |
| 125 | 16 | 667GA | Texarkana VA Clinic | Texarkana |
| 126 | 16 | 667GB | Monroe VA Clinic | Monroe |
| 127 | 16 | 667GC | Longview VA Clinic | Longview |
| 128 | 17 | 504BY | Lubbock VA Clinic | Lubbock |
| 129 | 17 | 519HC | Abilene VA Clinic | Abilene |
| 130 | 17 | 549BY | Fort Worth VA Clinic | Fort Worth |
| 131 | 17 | 549QC | Tyler Broadway VA Clinic | Tyler Broadway |
| 132 | 17 | 671BY | Frank M. Tejeda Department of Veterans Affairs Outpatient Clinic | San Antonio Eckert Road |
| 133 | 17 | 674BY | Austin VA Clinic | Austin |
| 134 | 17 | 740GA | Harlingen VA Clinic-Treasure Hills | Harlingen Treasure Hills |
| 135 | 17 | 740GB | McAllen VA Clinic | McAllen |
| 136 | 17 | 740GH | South Enterprize VA Clinic | South Enterprize |
| 137 | 17 | 756GB | El Paso Eastside VA Clinic | El Paso Eastside |
| 138 | 19 | 436GC | David J. Thatcher VA Clinic | Missoula |
| 139 | 19 | 436GF | Kalispell VA Clinic | Kalispell |
| 140 | 19 | 442GC | Fort Collins VA Clinic | Fort Collins |
| 141 | 19 | 442GD | Loveland VA Clinic | Loveland |
| 142 | 19 | 554GC | Golden VA Clinic | Golden |
| 143 | 19 | 554GD | PFC James Dunn VA Clinic | Pueblo, Colorado |
| 144 | 19 | 554GE | PFC Floyd K. Lindstrom Department of Veterans Affairs Clinic | Colorado Springs |
| 145 | 19 | 623BY | Ernest Childers Department of Veterans Affairs Outpatient Clinic | Tulsa |
| 146 | 19 | 635GA | Lawton VA Clinic | Lawton |
| 147 | 19 | 635QB | South Oklahoma City VA Clinic | South Oklahoma City |
| 148 | 20 | 531GG | Caldwell VA Clinic | Caldwell |
| 149 | 20 | 648GA | Bend VA Clinic | Bend |
| 150 | 20 | 648GB | Salem VA Clinic | Salem, Oregon |
| 151 | 20 | 648GF | Hillsboro VA Clinic | Hillsboro |
| 152 | 20 | 663GC | Mount Vernon VA Clinic | Mount Vernon, Washington |
| 153 | 20 | 668GA | Wenatchee VA Clinic | Wenatchee |

# 2021 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

| MS CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 154 | 20 | 668GB | Coeur d 'Alene VA Clinic | Coeur d 'Alene |
| 155 | 21 | 570GA | Merced VA Clinic | Merced |
| 156 | 21 | 612B4 | Redding VA Clinic | Redding |
| 157 | 21 | 612BY | Oakland VA Clinic | Oakland |
| 158 | 21 | 612GD | Fairfield VA Clinic | Fairfield |
| 159 | 21 | 612GG | Chico VA Clinic | Chico |
| 160 | 21 | 612GH | McClellan VA Clinic | McClellan Park |
| 161 | 21 | 640HA | San Jose VA Clinic | San Jose |
| 162 | 21 | 640BY | Stockton VA Clinic | Stockton |
| 163 | 21 | 640HB | Modesto VA Clinic | Modesto |
| 164 | 21 | 640HC | Major General William H. Gourley VA-DoD Outpatient Clinic | Monterey |
| 165 | 21 | 662GA | Santa Rosa VA Clinic | Santa Rosa |
| 166 | 21 | 662GC | Eureka VA Clinic | Eureka |
| 167 | 21 | 662GD | Ukiah VA Clinic | Ukiah |
| 168 | 21 | 662GE | San Bruno VA Clinic | San Bruno |
| 169 | 21 | 662GG | Clearlake VA Clinic | Clearlake |
| 170 | 21 | 662GH | Oakland VA Clinic | Oakland |
| 171 | 22 | 600GB | Santa Ana VA Clinic | Santa Ana |
| 172 | 22 | 605BZ | Loma Linda VA Clinic | Loma Linda Redlands |
| 173 | 22 | 644BY | Southeast VA Clinic | Southeast Gilbert |
| 174 | 22 | 664BY | Mission Valley VA Clinic | Mission Valley |
| 175 | 22 | 664GB | Oceanside VA Clinic | Oceanside |
| 176 | 22 | 664GC | Chula Vista VA Clinic | Chula Vista |
| 177 | 22 | 664GF | Sorrento Valley VA Clinic | Sorrento Valley |
| 178 | 22 | 678GA | Sierra Vista VA Clinic | Sierra Vista |
| 179 | 22 | 678GB | Yuma VA Clinic | Yuma |
| 180 | 22 | 678GC | Casa Grande VA Clinic | Casa Grande |
| 181 | 22 | 678GF | Northwest Tucson VA Clinic | Northwest Tucson |
| 182 | 22 | 678GG | Southeast Tucson VA Clinic | Southeast Tucson |
| 183 | 22 | 691GD | Bakersfield VA Clinic | Bakersfield |
| 184 | 22 | 691GE | Los Angeles VA Clinic | Los Angeles |
| 185 | 22 | 691GL | Santa Maria VA Clinic | Santa Maria |
| 186 | 22 | 691GM | Oxnard VA Clinic | Oxnard |
| 187 | 23 | 438GD | Aberdeen VA Clinic | Aberdeen |
| 188 | 23 | 568GA | Rapid City VA Clinic | Rapid City |
| 189 | 23 | 618BY | Twin Ports VA Clinic | Twin Ports |
| 190 | 23 | 618GI | Northwest Metro VA Clinic | Northwest Metro Minnesota |
| 191 | 23 | 636A5 | Lincoln VA Clinic | Lincoln, Nebraska |
| 192 | 23 | 636GA | Norfolk VA Clinic | Norfolk |
| 193 | 23 | 636GB | North Platte VA Clinic | North Platte |
| 194 | 23 | 636GC | Mason City VA Clinic | Mason City |
| 195 | 23 | 636GD | Marshalltown VA Clinic | Marshalltown |
| 196 | 23 | 636GF | Quad Cities VA Clinic | Quad Cities |
| 197 | 23 | 636GG | Quincy VA Clinic | Quincy, Illinois |
| 198 | 23 | 636GJ | Dubuque VA Clinic | Dubuque |
| 199 | 23 | 636GM | Carroll VA Clinic | Carroll |
| 200 | 23 | 636GR | Knoxville VA Clinic | Knoxville, Iowa |
| 201 | 23 | 636GS | Ottumwa VA Clinic | Ottumwa |
| 202 | 23 | 636GT | Sterling VA Clinic | Sterling, Illinois |
| 203 | 23 | 636GU | Decorah VA Clinic | Decorah |
| 204 | 23 | 656GA | Brainerd VA Clinic | Brainerd |

# 2021 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 | 402GD | Saco VA Clinic | Saco |
| 4 | 1 | 402HC | Portland VA Clinic | Portland, Maine |
| 5 | 1 | 405GA | Bennington VA Clinic | Bennington |
| 6 | 1 | 405GC | Brattleboro VA Clinic | Brattleboro |
| 7 | 1 | 405HC | Littleton VA Clinic | Littleton |
| 8 | 1 | 405HE | Keene VA Clinic | Keene |
| 9 | 1 | 405HF | Rutland VA Clinic | Rutland |
| 10 | 1 | 405QB | Newport VA Clinic | Newport, Vermont |
| 11 | 1 | 518GA | Lynn VA Clinic | Lynn |
| 12 | 1 | 518GB | Haverhill VA Clinic | Haverhill |
| 13 | 1 | 523BZ | Causeway VA Clinic | Causeway |
| 14 | 1 | 608GA | Portsmouth VA Clinic | Portsmouth, New Hampshire |
| 15 | 1 | 608GC | Somersworth VA Clinic | Somersworth |
| 16 | 1 | 608HA | Tilton VA Clinic | Tilton |
| 17 | 1 | 631GC | Pittsfield VA Clinic | Pittsfield |
| 18 | 1 | 631GD | Greenfield VA Clinic | Greenfield |
| 19 | 1 | 631GF | Fitchburg VA Clinic | Fitchburg |
| 20 | 1 | 650GA | New Bedford VA Clinic | New Bedford |
| 21 | 1 | 650GB | Hyannis VA Clinic | Hyannis |
| 22 | 1 | 650GD | Middletown VA Clinic | Middletown, Rhode Island |
| 23 | 1 | 689GA | Waterbury VA Clinic | Waterbury |
| 24 | 1 | 689GB | Stamford VA Clinic | Stamford |
| 25 | 1 | 689GC | Willimantic VA Clinic | Willimantic |
| 26 | 1 | 689GD | Winsted VA Clinic | Winsted |
| 27 | 1 | 689GE | Danbury VA Clinic | Danbury |
| 28 | 1 | 689HC | John J. McGuirk Department of Veterans Affairs Outpatient Clinic | New London |
| 29 | 1 | 689QA | Errera VA Clinic | Errera |
| 30 | 2 | 526GA | White Plains VA Clinic | White Plains |
| 31 | 2 | 526GB | Yonkers VA Clinic | Yonkers |
| 32 | 2 | 528G3 | Bainbridge VA Clinic | Bainbridge |
| 33 | 2 | 528G4 | Elmira VA Clinic | Elmira |
| 34 | 2 | 528G5 | Auburn VA Clinic | Auburn |
| 35 | 2 | 528G8 | Wellsville VA Clinic | Wellsville |
| 36 | 2 | 528G9 | Tompkins County VA Clinic | Tompkins County |
| 37 | 2 | 528GB | Jamestown VA Clinic | Jamestown, New York |
| 38 | 2 | 528GC | Dunkirk VA Clinic | Dunkirk |
| 39 | 2 | 528GD | Niagara Falls VA Clinic | Niagara Falls |
| 40 | 2 | 528GE | Rochester Clinton Crossings VA Clinic | Rochester Clinton Crossings |

# 2021 Primary Community Based Outpatient Clinics (PC CBOC)

| PC CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 41 | 2 | 528GK | Lockport VA Clinic | Lockport |
| 42 | 2 | 528GL | Massena VA Clinic | Massena |
| 43 | 2 | 528GO | Watertown VA Clinic | Watertown, New York |
| 44 | 2 | 528GP | Oswego VA Clinic | Oswego |
| 45 | 2 | 528GQ | West Seneca VA Clinic | West Seneca |
| 46 | 2 | 528GR | Olean VA Clinic | Olean |
| 47 | 2 | 528GT | Glens Falls VA Clinic | Glens Falls |
| 48 | 2 | 528GV | Plattsburgh VA Clinic | Plattsburgh |
| 49 | 2 | 528GZ | Kingston VA Clinic | Kingston |
| 50 | 2 | 528QK | Saranac Lake VA Clinic | Saranac Lake |
| 51 | 2 | 561GA | Hamilton VA Clinic | Hamilton, New Jersey |
| 52 | 2 | 561GD | Hackensack VA Clinic | Hackensack |
| 53 | 2 | 561GE | Jersey City VA Clinic | Jersey City |
| 54 | 2 | 561GF | Piscataway VA Clinic | Piscataway |
| 55 | 2 | 561GI | Tinton Falls VA Clinic | Tinton Falls |
| 56 | 2 | 620GB | Carmel VA Clinic | Carmel |
| 57 | 2 | 620GD | Goshen VA Clinic | Goshen, New York |
| 58 | 2 | 620GE | Port Jervis VA Clinic | Port Jervis |
| 59 | 2 | 630GA | Harlem VA Clinic | Harlem |
| 60 | 2 | 630GB | Staten Island Community VA Clinic | Staten Island |
| 61 | 2 | 632GA | East Meadow VA Clinic | East Meadow |
| 62 | 2 | 632HA | Valley Stream VA Clinic | Valley Stream |
| 63 | 2 | 632HB | Riverhead VA Clinic | Riverhead |
| 64 | 2 | 632HC | Bay Shore VA Clinic | Bay Shore |
| 65 | 2 | 632HD | Patchogue VA Clinic | Patchogue |
| 66 | 4 | 460GA | Sussex County VA Clinic | Sussex County |
| 67 | 4 | 460GC | Kent County VA Clinic | Kent County |
| 68 | 4 | 460GD | Cape May County VA Clinic | Cape May County |
| 69 | 4 | 460HE | Atlantic County VA Clinic | Atlantic County |
| 70 | 4 | 503GD | Huntingdon County VA Clinic | Huntingdon County |
| 71 | 4 | 503GE | Indiana County VA Clinic | Indiana County |
| 72 | 4 | 529GA | Michael A. Marzano Department of Veterans Affairs Outpatient Clinic | Hermitage |
| 73 | 4 | 529GB | Lawrence County VA Clinic | Lawrence County |
| 74 | 4 | 529GC | Armstrong County VA Clinic | Armstrong County |
| 75 | 4 | 529GF | Cranberry Township VA Clinic | Cranberry Township |
| 76 | 4 | 542GA | Delaware County VA Clinic | Delaware County |
| 77 | 4 | 542GE | West Norriton VA Clinic | West Norriton |
| 78 | 4 | 562GA | Crawford County VA Clinic | Crawford County |
| 79 | 4 | 562GB | Ashtabula County VA Clinic | Ashtabula County |
| 80 | 4 | 562GD | Venango County VA Clinic | Venango County |

# 2021 Primary Community Based Outpatient Clinics (PC CBOC)

| PC CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 81 | 4 | 562GE | Warren County VA Clinic | Warren County |
| 82 | 4 | 595GD | Berks County VA Clinic | Berks County |
| 83 | 4 | 595GF | Schuylkill County VA Clinic | Schuylkill County |
| 84 | 4 | 642GF | Camden VA Clinic | Camden |
| 85 | 4 | 642GH | West Philadelphia VA Clinic | West Philadelphia |
| 86 | 4 | 646GB | Westmoreland County VA Clinic | Westmoreland County |
| 87 | 4 | 693GA | Sayre VA Clinic | Sayre |
| 88 | 4 | 693GB | Williamsport VA Clinic | Williamsport |
| 89 | 5 | 512GE | Pocomoke City VA Clinic | Pocomoke City |
| 90 | 5 | 512GF | Eastern Baltimore County VA Clinic | Eastern Baltimore County |
| 91 | 5 | 517GB | Greenbrier County VA Clinic | Greenbrier County |
| 92 | 5 | 517QA | Princeton VA Clinic | Princeton |
| 93 | 5 | 540GB | Wood County VA Clinic | Wood County |
| 94 | 5 | 540GC | Braxton County VA Clinic | Braxton County |
| 95 | 5 | 540GD | Monongalia County VA Clinic | Monongalia County |
| 96 | 5 | 581GA | Prestonsburg VA Clinic | Prestonsburg |
| 97 | 5 | 613GB | Hagerstown VA Clinic | Hagerstown |
| 98 | 5 | 613GC | Stephens City VA Clinic | Stephens City |
| 99 | 5 | 613GE | Petersburg VA Clinic | Petersburg |
| 100 | 5 | 613GF | Harrisonburg VA Clinic | Harrisonburg |
| 101 | 5 | 688GA | Fort Belvoir VA Clinic | Fort Belvoir |
| 102 | 5 | 688GD | Charlotte Hall VA Clinic | Charlotte Hall |
| 103 | 5 | 688GE | Southern Prince George's County VA Clinic | Southern Prince George's County |
| 104 | 5 | 688GF | Montgomery County VA Clinic | Montgomery County, Maryland |
| 105 | 5 | 688GG | Lexington Park VA Clinic | Lexington Park |
| 106 | 6 | 558GB | Raleigh VA Clinic | Raleigh, North Carolina |
| 107 | 6 | 558GC | Morehead City VA Clinic | Morehead City |
| 108 | 6 | 558GG | Raleigh III VA Clinic | Raleigh III |
| 109 | 6 | 565GA | Jacksonville VA Clinic | Jacksonville, North Carolina |
| 110 | 6 | 565GD | Hamlet VA Clinic | Hamlet |
| 111 | 6 | 565GE | Robeson County VA Clinic | Robeson County |
| 112 | 6 | 565GF | Goldsboro VA Clinic | Goldsboro |
| 113 | 6 | 565GG | Lee County VA Clinic | Lee County, North Carolina |
| 114 | 6 | 565GH | Brunswick County VA Clinic | Brunswick County |
| 115 | 6 | 590GB | Virginia Beach VA Clinic | Virginia Beach |
| 116 | 6 | 590GC | Albemarle VA Clinic | Albemarle |
| 117 | 6 | 590GD | Chesapeake VA Clinic | Chesapeake |
| 118 | 6 | 637GA | Franklin VA Clinic | Franklin, North Carolina |
| 119 | 6 | 637GB | Rutherford County VA Clinic | Rutherford County |
| 120 | 6 | 652GA | Fredericksburg VA Clinic | Fredericksburg |

# 2021 Primary Community Based Outpatient Clinics (PC CBOC)

| PC CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 121 | 6 | 652GB | Fredericksburg 2 VA Clinic | Fredericksburg 2 |
| 122 | 6 | 652GC | Henrico County VA Clinic | Henrico County |
| 123 | 6 | 652GF | Emporia VA Clinic | Emporia |
| 124 | 6 | 652GI | Spotsylvania County VA Clinic | Spotsylvania County |
| 125 | 6 | 658GA | Tazewell VA Clinic | Tazewell |
| 126 | 6 | 658GB | Danville VA Clinic | Danville, Virginia |
| 127 | 6 | 658GC | Lynchburg VA Clinic | Lynchburg |
| 128 | 6 | 658GD | Staunton VA Clinic | Staunton |
| 129 | 6 | 658GE | Wytheville VA Clinic | Wytheville |
| 130 | 7 | 508GE | Oakwood VA Clinic | Oakwood |
| 131 | 7 | 508GF | West Cobb County VA Clinic | West Cobb County |
| 132 | 7 | 508GG | Stockbridge VA Clinic | Stockbridge |
| 133 | 7 | 508GH | Lawrenceville VA Clinic | Lawrenceville |
| 134 | 7 | 508GI | Newnan VA Clinic | Newnan |
| 135 | 7 | 508GJ | Blairsville VA Clinic | Blairsville |
| 136 | 7 | 508GL | Rome VA Clinic | Rome, Georgia |
| 137 | 7 | 508GN | Covington VA Clinic | Covington, Georgia |
| 138 | 7 | 508GO | Northeast Cobb County VA Clinic | Northeast Cobb County |
| 139 | 7 | 508QE | Gwinnett County VA Clinic | Gwinnett County |
| 140 | 7 | 509GA | Athens VA Clinic | Athens, Georgia |
| 141 | 7 | 509GB | Aiken VA Clinic | Aiken |
| 142 | 7 | 509QA | Ray Hendrix Department Of Veterans Affairs Clinic | Statesboro |
| 143 | 7 | 521GC | Florence VA Clinic | Florence, Alabama |
| 144 | 7 | 521GD | Rainbow City VA Clinic | Rainbow City |
| 145 | 7 | 521GE | Oxford VA Clinic | Oxford |
| 146 | 7 | 521GF | Jasper VA Clinic | Jasper |
| 147 | 7 | 521GG | Bessemer VA Clinic | Bessemer |
| 148 | 7 | 521GH | Childersburg VA Clinic | Childersburg |
| 149 | 7 | 521GI | Guntersville VA Clinic | Guntersville |
| 150 | 7 | 534GB | Myrtle Beach VA Clinic | Myrtle Beach |
| 151 | 7 | 534GC | Beaufort VA Clinic | Beaufort |
| 152 | 7 | 534GE | Hinesville VA Clinic | Hinesville |
| 153 | 7 | 544GB | Florence VA Clinic | Florence, South Carolina |
| 154 | 7 | 544GC | Rock Hill VA Clinic | Rock Hill |
| 155 | 7 | 544GE | Orangeburg VA Clinic | Orangeburg |
| 156 | 7 | 544GF | Sumter VA Clinic | Sumter |
| 157 | 7 | 544GG | Spartanburg VA Clinic | Spartanburg |
| 158 | 7 | 557GC | Milledgeville VA Clinic | Milledgeville |
| 159 | 7 | 557GF | Tifton VA Clinic | Tifton |
| 160 | 7 | 557GG | Robins VA Clinic | Robins |

# 2021 Primary Community Based Outpatient Clinics (PC CBOC)

| PC CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 161 | 7 | 557HA | Perry VA Clinic | Perry, Georgia |
| 162 | 7 | 619GE | Monroe County VA Clinic | Monroe County, Alabama |
| 163 | 7 | 619GG | Columbus Downtown VA Clinic | Columbus Downtown |
| 164 | 7 | 619QA | Dothan 2 VA Clinic | Dothan 2 |
| 165 | 7 | 619QB | Fort Benning VA Clinic | Fort Benning |
| 166 | 7 | 679GA | Selma VA Clinic | Selma |
| 167 | 8 | 516GA | Sarasota VA Clinic | Sarasota |
| 168 | 8 | 516GB | St. Petersburg VA Clinic | St. Petersburg |
| 169 | 8 | 516GC | Palm Harbor VA Clinic | Palm Harbor |
| 170 | 8 | 516GE | Port Charlotte VA Clinic | Port Charlotte |
| 171 | 8 | 516GF | Naples VA Clinic | Naples |
| 172 | 8 | 516GH | Sebring VA Clinic | Sebring |
| 173 | 8 | 546GA | Miami Flagler VA Clinic | Miami Flagler |
| 174 | 8 | 546GB | Key West VA Clinic | Key West |
| 175 | 8 | 546GD | Pembroke Pines VA Clinic | Pembroke Pines |
| 176 | 8 | 546GF | Hollywood VA Clinic | Hollywood |
| 177 | 8 | 546GH | Deerfield Beach VA Clinic | Deerfield Beach |
| 178 | 8 | 548GA | Fort Pierce VA Clinic | Fort Pierce |
| 179 | 8 | 548GB | Delray Beach VA Clinic | Delray Beach |
| 180 | 8 | 548GC | Stuart VA Clinic | Stuart |
| 181 | 8 | 548GD | Boca Raton VA Clinic | Boca Raton |
| 182 | 8 | 548GE | Vero Beach VA Clinic | Vero Beach |
| 183 | 8 | 548GF | Okeechobee VA Clinic | Okeechobee |
| 184 | 8 | 573GA | Valdosta VA Clinic | Valdosta |
| 185 | 8 | 573GD | Ocala VA Clinic | Ocala |
| 186 | 8 | 573GJ | St. Marys VA Clinic | St. Marys |
| 187 | 8 | 573GK | Marianna VA Clinic | Marianna |
| 188 | 8 | 573GL | Palatka VA Clinic | Palatka |
| 189 | 8 | 573GM | Waycross VA Clinic | Waycross |
| 190 | 8 | 573QG | Jacksonville Southpoint VA Clinic | Jacksonville Southpoint |
| 191 | 8 | 672GC | Arecibo VA Clinic | Arecibo |
| 192 | 8 | 672GD | Ceiba VA Clinic | Ceiba |
| 193 | 8 | 672GE | Guayama VA Clinic | Guayama |
| 194 | 8 | 673GH | Lecanto VA Clinic | Lecanto |
| 195 | 8 | 675GC | Kissimmee VA Clinic | Kissimmee |
| 196 | 8 | 675GD | Deltona VA Clinic | Deltona |
| 197 | 8 | 675GE | Tavares VA Clinic | Tavares |
| 198 | 8 | 675GF | Clermont VA Clinic | Clermont |
| 199 | 9 | 596GC | Hazard VA Clinic | Hazard |
| 200 | 9 | 596GD | Berea VA Clinic | Berea |

# 2021 Primary Community Based Outpatient Clinics (PC CBOC)

| PC CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 201 | 9 | 603GA | Fort Knox VA Clinic | Fort Knox |
| 202 | 9 | 603GB | New Albany VA Clinic | New Albany |
| 203 | 9 | 603GC | Greenwood VA Clinic | Greenwood |
| 204 | 9 | 603GD | Stonybrook VA Clinic | Stonybrook |
| 205 | 9 | 603GE | Newburg VA Clinic | Newburg |
| 206 | 9 | 603GF | Grayson County VA Clinic | Grayson County |
| 207 | 9 | 603GG | Scott County VA Clinic | Scott County |
| 208 | 9 | 603GH | Carrollton VA Clinic | Carrollton, Kentucky |
| 209 | 9 | 614GA | Tupelo VA Clinic | Tupelo |
| 210 | 9 | 614GB | Jonesboro VA Clinic | Jonesboro |
| 211 | 9 | 614GC | Holly Springs VA Clinic | Holly Springs |
| 212 | 9 | 614GD | Savannah VA Clinic | Savannah, Tennessee |
| 213 | 9 | 614GE | Covington VA Clinic | Covington, Tennessee |
| 214 | 9 | 614GG | Jackson VA Clinic | Jackson, Tennessee |
| 215 | 9 | 614GI | Dyersburg VA Clinic | Dyersburg |
| 216 | 9 | 614GN | Helena VA Clinic | Helena, Arkansas |
| 217 | 9 | 621GC | Norton VA Clinic | Norton |
| 218 | 9 | 621GG | Morristown VA Clinic | Morristown, Tennessee |
| 219 | 9 | 621GI | Dannie A. Carr Veterans Outpatient Clinic | Sevierville |
| 220 | 9 | 621GJ | Bristol VA Clinic | Bristol |
| 221 | 9 | 621GK | Campbell County VA Clinic | Campbell County |
| 222 | 9 | 626GC | Bowling Green VA Clinic | Bowling Green |
| 223 | 9 | 626GH | Cookeville VA Clinic | Cookeville |
| 224 | 9 | 626GJ | Hopkinsville VA Clinic | Hopkinsville |
| 225 | 9 | 626GK | McMinnville VA Clinic | McMinnville |
| 226 | 9 | 626GL | Roane County VA Clinic | Roane County |
| 227 | 9 | 626GM | Maury County VA Clinic | Maury County |
| 228 | 9 | 626GO | International Plaza VA Clinic | International Plaza |
| 229 | 9 | 626GP | Gallatin VA Clinic | Gallatin |
| 230 | 9 | 626QA | Albion Street VA Clinic | Albion Street |
| 231 | 9 | 626QB | Charlotte Avenue VA Clinic | Charlotte Avenue |
| 232 | 10 | 506GB | Flint VA Clinic | Flint |
| 233 | 10 | 506GC | Jackson VA Clinic | Jackson, Michigan |
| 234 | 10 | 506GF | Adrian VA Clinic | Adrian |
| 235 | 10 | 515GA | Muskegon VA Clinic | Muskegon |
| 236 | 10 | 515GB | Lansing VA Clinic | Lansing |
| 237 | 10 | 515GC | Benton Harbor VA Clinic | Benton Harbor |
| 238 | 10 | 538GA | Athens VA Clinic | Athens, Ohio |
| 239 | 10 | 538GB | Portsmouth VA Clinic | Portsmouth, Ohio |
| 240 | 10 | 538GC | Marietta VA Clinic | Marietta |

# 2021 Primary Community Based Outpatient Clinics (PC CBOC)

| PC CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 241 | 10 | 538GD | Lancaster VA Clinic | Lancaster |
| 242 | 10 | 538GE | Cambridge VA Clinic | Cambridge, Ohio |
| 243 | 10 | 538GF | Wilmington VA Clinic | Wilmington, Ohio |
| 244 | 10 | 539GA | Bellevue VA Clinic | Bellevue, Kentucky |
| 245 | 10 | 539GF | Georgetown VA Clinic | Georgetown |
| 246 | 10 | 541GC | Sandusky VA Clinic | Sandusky |
| 247 | 10 | 541GH | East Liverpool VA Clinic | East Liverpool |
| 248 | 10 | 541GI | Warren VA Clinic | Warren |
| 249 | 10 | 541GJ | New Philadelphia VA Clinic | New Philadelphia |
| 250 | 10 | 541GK | Ravenna VA Clinic | Ravenna |
| 251 | 10 | 553GA | Yale VA Clinic | Yale |
| 252 | 10 | 553GB | Pontiac VA Clinic | Pontiac |
| 253 | 10 | 583GC | Martinsville VA Clinic | Martinsville |
| 254 | 10 | 583GE | Lafayette VA Clinic | Lafayette, Indiana |
| 255 | 10 | 610GB | Muncie VA Clinic | Muncie |
| 256 | 10 | 610GC | Goshen VA Clinic | Goshen, Indiana |
| 257 | 10 | 610GD | Peru VA Clinic | Peru |
| 258 | 10 | 610GE | Defiance VA Clinic | Defiance |
| 259 | 10 | 655GC | Oscoda VA Clinic | Oscoda |
| 260 | 10 | 655GD | Lieutenant Colonel Clement C. Van Wagoner VA Clinic | Alpena |
| 261 | 10 | 655GF | Bad Axe VA Clinic | Bad Axe |
| 262 | 10 | 655GG | Cadillac VA Clinic | Cadillac |
| 263 | 10 | 655GH | Cheboygan County VA Clinic | Cheboygan County |
| 264 | 10 | 655GI | Grayling VA Clinic | Grayling |
| 265 | 10 | 757GA | Zanesville VA Clinic | Zanesville |
| 266 | 10 | 757GB | Grove City VA Clinic | Grove City |
| 267 | 10 | 757GC | Marion VA Clinic | Marion, Ohio |
| 268 | 12 | 537GA | Chicago Heights VA Clinic | Chicago Heights |
| 269 | 12 | 537GD | Lakeside VA Clinic | Lakeside |
| 270 | 12 | 537HA | Auburn Gresham VA Clinic | Auburn Gresham |
| 271 | 12 | 550GD | Springfield VA Clinic | Springfield, Illinois |
| 272 | 12 | 550GF | Mattoon VA Clinic | Mattoon |
| 273 | 12 | 550GG | Bloomington VA Clinic | Bloomington, Illinois |
| 274 | 12 | 556GA | Evanston VA Clinic | Evanston, Illinois |
| 275 | 12 | 556GC | McHenry VA Clinic | McHenry |
| 276 | 12 | 556GD | Kenosha VA Clinic | Kenosha |
| 277 | 12 | 578GC | Kankakee County VA Clinic | Kankakee County |
| 278 | 12 | 578GD | Aurora VA Clinic | Aurora, Illinois |
| 279 | 12 | 578GE | Hoffman Estates VA Clinic | Hoffman Estates |
| 280 | 12 | 578GF | LaSalle VA Clinic | LaSalle |

# 2021 Primary Community Based Outpatient Clinics (PC CBOC)

| PC CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 281 | 12 | 578GG | Oak Lawn VA Clinic | Oak Lawn |
| 282 | 12 | 585GA | Hancock VA Clinic | Hancock |
| 283 | 12 | 585GB | Rhinelander VA Clinic | Rhinelander |
| 284 | 12 | 585GC | Menominee VA Clinic | Menominee |
| 285 | 12 | 585GD | Ironwood VA Clinic | Ironwood |
| 286 | 12 | 585GF | Manistique VA Clinic | Manistique |
| 287 | 12 | 585GG | Gladstone VA Clinic | Gladstone |
| 288 | 12 | 585HA | Marquette VA Clinic | Marquette |
| 289 | 12 | 585HB | Sault Saint Marie VA Clinic | Sault Saint Marie |
| 290 | 12 | 607GC | Janesville VA Clinic | Janesville |
| 291 | 12 | 607GE | Beaver Dam VA Clinic | Beaver Dam |
| 292 | 12 | 607GG | Madison West VA Clinic | Madison West |
| 293 | 12 | 676GA | Wausau VA Clinic | Wausau |
| 294 | 12 | 676GC | La Crosse VA Clinic | La Crosse |
| 295 | 12 | 676GE | Clark County VA Clinic | Clark County |
| 296 | 12 | 695GA | Union Grove VA Clinic | Union Grove |
| 297 | 12 | 695GC | Cleveland VA Clinic | Cleveland, Wisconsin |
| 298 | 15 | 589G4 | Hays VA Clinic | Hays |
| 299 | 15 | 589G5 | Parsons VA Clinic | Parsons |
| 300 | 15 | 589G7 | Hutchinson VA Clinic | Hutchinson |
| 301 | 15 | 589GB | Belton VA Clinic | Belton |
| 302 | 15 | 589GD | Nevada VA Clinic | Nevada |
| 303 | 15 | 589GF | Waynesville VA Clinic | Waynesville |
| 304 | 15 | 589GH | Lake of the Ozarks VA Clinic | Lake of the Ozarks |
| 305 | 15 | 589GI | St. Joseph VA Clinic | St. Joseph |
| 306 | 15 | 589GJ | Wyandotte County VA Clinic | Wyandotte County |
| 307 | 15 | 589GR | Lieutenant General Richard J. Seitz Community-Based Outpatient Clinic | Junction City |
| 308 | 15 | 589GU | Lawrence VA Clinic | Lawrence |
| 309 | 15 | 589GV | Fort Scott VA Clinic | Fort Scott |
| 310 | 15 | 589GW | Salina VA Clinic | Salina |
| 311 | 15 | 589GX | Mexico VA Clinic | Mexico |
| 312 | 15 | 589GY | St. James VA Clinic | St. James, Missouri |
| 313 | 15 | 589JA | Sedalia VA Clinic | Sedalia |
| 314 | 15 | 589JB | Excelsior Springs VA Clinic | Excelsior Springs |
| 315 | 15 | 589JD | Marshfield VA Clinic | Marshfield |
| 316 | 15 | 589JE | Platte City VA Clinic | Platte City |
| 317 | 15 | 589JF | Honor VA Clinic | Honor |
| 318 | 15 | 657GA | St. Clair County VA Clinic | St. Clair County |
| 319 | 15 | 657GB | St. Louis County VA Clinic | St. Louis County |
| 320 | 15 | 657GD | St. Charles County VA Clinic | St. Charles County |

# 2021 Primary Community Based Outpatient Clinics (PC CBOC)

| PC CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 321 | 15 | 657GF | West Plains VA Clinic | West Plains |
| 322 | 15 | 657GG | Paragould VA Clinic | Paragould |
| 323 | 15 | 657GH | Cape Girardeau VA Clinic | Cape Girardeau |
| 324 | 15 | 657GI | Farmington VA Clinic | Farmington, Missouri |
| 325 | 15 | 657GK | Mount Vernon VA Clinic | Mount Vernon, Illinois |
| 326 | 15 | 657GL | Paducah VA Clinic | Paducah |
| 327 | 15 | 657GM | Effingham VA Clinic | Effingham |
| 328 | 15 | 657GP | Owensboro VA Clinic | Owensboro |
| 329 | 15 | 657GQ | Vincennes VA Clinic | Vincennes |
| 330 | 15 | 657GR | Mayfield VA Clinic | Mayfield |
| 331 | 15 | 657GT | Carbondale VA Clinic | Carbondale |
| 332 | 15 | 657GU | Harrisburg VA Clinic | Harrisburg |
| 333 | 15 | 657GV | Sikeston VA Clinic | Sikeston |
| 334 | 15 | 657GX | Washington Avenue VA Clinic | Washington Avenue |
| 335 | 15 | 657QA | Olive Street VA Clinic | Olive Street |
| 336 | 15 | 657QD | Heartland Street VA Clinic | Heartland Street |
| 337 | 16 | 502GA | Jennings VA Clinic | Jennings |
| 338 | 16 | 502GE | Douglas Fournet Department of Veterans Affairs Clinic | Lake Charles |
| 339 | 16 | 502GF | Fort Polk VA Clinic | Fort Polk |
| 340 | 16 | 502GG | Natchitoches VA Clinic | Natchitoches |
| 341 | 16 | 520GB | Panama City Beach VA Clinic | Panama City Beach, Florida |
| 342 | 16 | 520GC | Eglin Air Force Base VA Clinic | Eglin Air Force Base |
| 343 | 16 | 564GB | Fort Smith VA Clinic | Fort Smith |
| 344 | 16 | 564GD | Ozark VA Clinic | Ozark |
| 345 | 16 | 564GE | Jay VA Clinic | Jay |
| 346 | 16 | 564GF | Joplin VA Clinic | Joplin |
| 347 | 16 | 580GC | Galveston County VA Clinic | Galveston County |
| 348 | 16 | 580GF | Lake Jackson VA Clinic | Lake Jackson |
| 349 | 16 | 580GK | Kingwood VA Clinic | Kingwood |
| 350 | 16 | 586GA | Kosciusko VA Clinic | Kosciusko |
| 351 | 16 | 586GB | Meridian VA Clinic | Meridian |
| 352 | 16 | 586GC | Greenville VA Clinic | Greenville, Mississippi |
| 353 | 16 | 586GD | Hattiesburg VA Clinic | Hattiesburg |
| 354 | 16 | 586GE | Natchez VA Clinic | Natchez |
| 355 | 16 | 586GF | Columbus VA Clinic | Columbus, Mississippi |
| 356 | 16 | 598GA | Mountain Home VA Clinic | Mountain Home, Arkansas |
| 357 | 16 | 598GB | El Dorado VA Clinic | El Dorado |
| 358 | 16 | 598GD | Mena VA Clinic | Mena |
| 359 | 16 | 598GE | Pine Bluff VA Clinic | Pine Bluff |
| 360 | 16 | 598GF | Searcy VA Clinic | Searcy |

# 2021 Primary Community Based Outpatient Clinics (PC CBOC)

| PC CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 361 | 16 | 598GH | Russellville VA Clinic | Russellville |
| 362 | 16 | 598QA | Little Rock VA Clinic | Little Rock Main Street |
| 363 | 16 | 629GA | Houma VA Clinic | Houma |
| 364 | 16 | 629GD | St. John VA Clinic | St. John |
| 365 | 16 | 629GE | Franklin VA Clinic | Franklin, Louisiana |
| 366 | 16 | 629GF | Bogalusa VA Clinic | Bogalusa |
| 367 | 17 | 504BZ | Clovis VA Clinic | Clovis |
| 368 | 17 | 519GA | Wilson and Young Medal of Honor VA Clinic | Permian Basin |
| 369 | 17 | 519GB | Hobbs VA Clinic | Hobbs |
| 370 | 17 | 519HF | San Angelo VA Clinic | San Angelo |
| 371 | 17 | 549GD | Denton VA Clinic | Denton |
| 372 | 17 | 549GJ | Sherman VA Clinic | Sherman |
| 373 | 17 | 549GL | Plano VA Clinic | Plano |
| 374 | 17 | 549GM | Grand Prairie VA Clinic | Grand Prairie |
| 375 | 17 | 671GB | Victoria VA Clinic | Victoria |
| 376 | 17 | 671GF | South Bexar County VA Clinic | South Bexar County |
| 377 | 17 | 671GK | San Antonio VA Clinic | San Antonio Woodcock Drive |
| 378 | 17 | 671GO | North Central Federal VA Clinic | North Central Federal |
| 379 | 17 | 671GP | Balcones Heights VA Clinic | Balcones Heights |
| 380 | 17 | 671GQ | Shavano Park VA Clinic | Shavano Park |
| 381 | 17 | 674GA | Palestine VA Clinic | Palestine |
| 382 | 17 | 674GB | Brownwood VA Clinic | Brownwood |
| 383 | 17 | 674GC | Bryan VA Clinic | Bryan |
| 384 | 17 | 674GD | Cedar Park VA Clinic | Cedar Park |
| 385 | 17 | 674GF | Temple VA Clinic | Temple South General Bruce Drive |
| 386 | 17 | 674HB | LaGrange VA Clinic | LaGrange |
| 387 | 17 | 740GC | Corpus Christi VA Clinic | Corpus Christi |
| 388 | 17 | 740GD | Laredo VA Clinic | Laredo |
| 389 | 17 | 756GA | Las Cruces VA Clinic | Las Cruces |
| 390 | 19 | 436GA | Anaconda VA Clinic | Anaconda |
| 391 | 19 | 436GB | Great Falls VA Clinic | Great Falls |
| 392 | 19 | 436GD | Travis W. Atkins Department of Veterans Affairs Clinic | Bozeman |
| 393 | 19 | 436GK | Glendive VA Clinic | Glendive |
| 394 | 19 | 436HC | Merril Lundman Department of Veterans Affairs Outpatient Clinic | Havre |
| 395 | 19 | 554GB | Aurora VA Clinic | Aurora, Colorado |
| 396 | 19 | 554GF | Alamosa VA Clinic | Alamosa |
| 397 | 19 | 554GG | La Junta VA Clinic | La Junta |
| 398 | 19 | 554GK | Union Boulevard VA Clinic | Union Boulevard |
| 399 | 19 | 575QA | Glenwood Springs VA Clinic | Glenwood Springs |
| 400 | 19 | 623GA | McAlester VA Clinic | McAlester |

# 2021 Primary Community Based Outpatient Clinics (PC CBOC)

| PC CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 401 | 19 | 623GB | Vinita VA Clinic | Vinita |
| 402 | 19 | 623GC | McCurtain County VA Clinic | McCurtain County |
| 403 | 19 | 635GB | Wichita Falls VA Clinic | Wichita Falls |
| 404 | 19 | 635GD | Ada VA Clinic | Ada |
| 405 | 19 | 635GE | Stillwater VA Clinic | Stillwater |
| 406 | 19 | 635GF | Altus VA Clinic | Altus |
| 407 | 19 | 635HB | Ardmore VA Clinic | Ardmore |
| 408 | 19 | 660GA | Pocatello VA Clinic | Pocatello |
| 409 | 19 | 660GB | Ogden VA Clinic | Ogden |
| 410 | 19 | 660GE | Orem VA Clinic | Orem |
| 411 | 19 | 660GG | St. George VA Clinic | St. George |
| 412 | 19 | 660GJ | South Jordan VA Clinic | South Jordan |
| 413 | 19 | 660QA | Idaho Falls VA Clinic | Idaho Falls |
| 414 | 19 | 666GB | Casper VA Clinic | Casper |
| 415 | 19 | 666GC | Riverton VA Clinic | Riverton |
| 416 | 19 | 666GF | Rock Springs VA Clinic | Rock Springs |
| 417 | 20 | 463GA | Fairbanks VA Clinic | Fairbanks |
| 418 | 20 | 463GB | Kenai VA Clinic | Kenai |
| 419 | 20 | 463GC | Mat-Su VA Clinic | Mat-Su |
| 420 | 20 | 531GE | Twin Falls VA Clinic | Twin Falls |
| 421 | 20 | 648GE | Fairview VA Clinic | Fairview |
| 422 | 20 | 648GG | West Linn VA Clinic | West Linn |
| 423 | 20 | 648GI | Portland VA Clinic | Portland 1st Avenue |
| 424 | 20 | 648GJ | Loren R. Kaufman VA Clinic | The Dalles |
| 425 | 20 | 653GA | North Bend VA Clinic | North Bend |
| 426 | 20 | 653GB | Brookings VA Clinic | Brookings |
| 427 | 20 | 663GB | Silverdale VA Clinic | Silverdale |
| 428 | 20 | 663GD | South Sound VA Clinic | South Sound |
| 429 | 20 | 663GE | North Olympic Peninsula VA Clinic | North Olympic Peninsula |
| 430 | 20 | 663GH | Edmonds VA Clinic | Edmonds |
| 431 | 20 | 663GI | Olympia VA Clinic | Olympia |
| 432 | 20 | 663GJ | Puyallup VA Clinic | Puyallup |
| 433 | 20 | 668GC | East Front Avenue VA Clinic | East Front Avenue |
| 434 | 20 | 687GA | Richland VA Clinic | Richland |
| 435 | 20 | 687GB | Lewiston VA Clinic | Lewiston, Idaho |
| 436 | 20 | 687HA | Yakima VA Clinic | Yakima |
| 437 | 20 | 692GA | Klamath Falls VA Clinic | Klamath Falls |
| 438 | 20 | 692GB | Grants Pass VA Clinic | Grants Pass |
| 439 | 21 | 459GA | Maui VA Clinic | Maui |
| 440 | 21 | 459GB | Hilo VA Clinic | Hilo |

# 2021 Primary Community Based Outpatient Clinics (PC CBOC)

| PC CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 441 | 21 | 459GC | Kailua-Kona VA Clinic | Kailua-Kona |
| 442 | 21 | 459GD | Lihue VA Clinic | Lihue |
| 443 | 21 | 459GE | Guam VA Clinic | Guam |
| 444 | 21 | 459GF | Faleomavaega Eni Fa'aua'a Hunkin VA Clinic | American Samoa |
| 445 | 21 | 459GG | Leeward Oahu VA Clinic | Leeward Oahu |
| 446 | 21 | 459QC | Windward VA Clinic | Windward |
| 447 | 21 | 570GB | Tulare VA Clinic | Tulare |
| 448 | 21 | 570GC | Oakhurst VA Clinic | Oakhurst |
| 449 | 21 | 593GC | Pahrump VA Clinic | Pahrump |
| 450 | 21 | 593GD | Northwest Las Vegas VA Clinic | Northwest Las Vegas |
| 451 | 21 | 593GE | Southeast Las Vegas VA Clinic | Southeast Las Vegas |
| 452 | 21 | 593GF | Southwest Las Vegas VA Clinic | Southwest Las Vegas |
| 453 | 21 | 593GG | Northeast Las Vegas VA Clinic | Northeast Las Vegas |
| 454 | 21 | 593GH | Master Chief Petty Officer Jesse Dean VA Clinic | Laughlin |
| 455 | 21 | 612GE | Mare Island VA Clinic | Mare Island |
| 456 | 21 | 612GI | Yuba City VA Clinic | Yuba City |
| 457 | 21 | 612GK | Sierra Foothills VA Clinic | Sierra Foothills |
| 458 | 21 | 640GA | Capitola VA Clinic | Capitola |
| 459 | 21 | 640GB | Sonora VA Clinic | Sonora |
| 460 | 21 | 640GC | Fremont VA Clinic | Fremont |
| 461 | 21 | 654GE | Reno East VA Clinic | Reno East |
| 462 | 21 | 662GF | San Francisco VA Clinic | San Francisco Downtown |
| 463 | 22 | 501GA | Artesia VA Clinic | Artesia |
| 464 | 22 | 501GB | Farmington VA Clinic | Farmington, New Mexico |
| 465 | 22 | 501GJ | Durango VA Clinic | Durango |
| 466 | 22 | 501GK | Santa Fe VA Clinic | Santa Fe |
| 467 | 22 | 501GM | Northwest Metro VA Clinic | Northwest Metro New Mexico |
| 468 | 22 | 600GA | Anaheim VA Clinic | Anaheim |
| 469 | 22 | 600GC | Cabrillo VA Clinic | Cabrillo |
| 470 | 22 | 600GD | Santa Fe Springs VA Clinic | Santa Fe Springs |
| 471 | 22 | 600GE | Laguna Hills VA Clinic | Laguna Hills |
| 472 | 22 | 605GA | Victorville VA Clinic | Victorville |
| 473 | 22 | 605GB | Murrieta VA Clinic | Murrieta |
| 474 | 22 | 605GC | Palm Desert VA Clinic | Palm Desert |
| 475 | 22 | 605GD | Corona VA Clinic | Corona |
| 476 | 22 | 605GE | Rancho Cucamonga VA Clinic | Rancho Cucamonga |
| 477 | 22 | 644GA | Northwest VA Clinic | Northwest Surprise |
| 478 | 22 | 644GB | Show Low VA Clinic | Show Low |
| 479 | 22 | 644GC | Southwest VA Clinic | Southwest Phoenix |
| 480 | 22 | 644GE | Thunderbird VA Clinic | Thunderbird |

# 2021 Primary Community Based Outpatient Clinics (PC CBOC)

| PC CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 481 | 22 | 644GG | Northeast Phoenix VA Clinic | Northeast Phoenix |
| 482 | 22 | 644GH | Phoenix Midtown VA Clinic | Phoenix Midtown |
| 483 | 22 | 649GA | Kingman VA Clinic | Kingman |
| 484 | 22 | 649GB | Flagstaff VA Clinic | Flagstaff |
| 485 | 22 | 649GC | Lake Havasu City VA Clinic | Lake Havasu City |
| 486 | 22 | 649GD | Anthem VA Clinic | Anthem |
| 487 | 22 | 649GE | Cottonwood VA Clinic | Cottonwood |
| 488 | 22 | 664GA | Imperial Valley VA Clinic | Imperial Valley |
| 489 | 22 | 664GD | Escondido VA Clinic | Escondido |
| 490 | 22 | 678GD | Safford VA Clinic | Safford |
| 491 | 22 | 691GB | Santa Barbara VA Clinic | Santa Barbara |
| 492 | 22 | 691GF | East Los Angeles VA Clinic | East Los Angeles |
| 493 | 22 | 691GG | Antelope Valley VA Clinic | Antelope Valley |
| 494 | 22 | 691GK | San Luis Obispo VA Clinic | San Luis Obispo |
| 495 | 23 | 437GB | Bismarck VA Clinic | Bismarck |
| 496 | 23 | 437GC | Fergus Falls VA Clinic | Fergus Falls |
| 497 | 23 | 437GD | Minot VA Clinic | Minot |
| 498 | 23 | 437GE | Bemidji VA Clinic | Bemidji |
| 499 | 23 | 437GI | Grand Forks VA Clinic | Grand Forks |
| 500 | 23 | 437GK | Jamestown VA Clinic | Jamestown, North Dakota |
| 501 | 23 | 438GA | Spirit Lake VA Clinic | Spirit Lake |
| 502 | 23 | 438GC | Sioux City VA Clinic | Sioux City |

## 2021 Primary Community Based Outpatient Clinics (PC CBOC)

| PC CBOC Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 503 | 23 | 438GF | Watertown VA Clinic | Watertown, South Dakota |
| 504 | 23 | 568HH | Scottsbluff VA Clinic | Scottsbluff |
| 505 | 23 | 618GB | Hibbing VA Clinic | Hibbing |
| 506 | 23 | 618GD | Maplewood VA Clinic | Maplewood |
| 507 | 23 | 618GE | Chippewa Valley VA Clinic | Chippewa Valley |
| 508 | 23 | 618GG | Rochester VA Clinic | Rochester, Minnesota |
| 509 | 23 | 618GJ | Shakopee VA Clinic | Shakopee |
| 510 | 23 | 618GK | Albert Lea VA Clinic | Albert Lea |
| 511 | 23 | 618GL | Minneapolis VA Clinic | Minneapolis Harmon Place |
| 512 | 23 | 618GM | Rice Lake VA Clinic | Rice Lake |
| 513 | 23 | 618GN | Lyle C. Pearson Community Based Outpatient Clinic | Mankato |
| 514 | 23 | 636GH | Waterloo VA Clinic | Waterloo |
| 515 | 23 | 636GI | Lane A. Evans VA Community Based Outpatient Clinic | Galesburg |
| 516 | 23 | 636GL | Bellevue VA Clinic | Bellevue, Nebraska |
| 517 | 23 | 636GN | Cedar Rapids VA Clinic | Cedar Rapids |
| 518 | 23 | 636GP | Shenandoah VA Clinic | Shenandoah |
| 519 | 23 | 636GQ | Holdrege VA Clinic | Holdrege |
| 520 | 23 | 636GW | Coralville VA Clinic | Coralville |
| 521 | 23 | 636GY | Burlington VA Clinic | Burlington |
| 522 | 23 | 656GB | Montevideo VA Clinic | Montevideo |
| 523 | 23 | 656GC | Max J. Beilke Department of Veterans Affairs Outpatient Clinic | Alexandria, Minnesota |

# 2021 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 | 402HL | Bingham VA Mobile Clinic | Bingham Mobile |
| 4 | 1 | 402QA | Fort Kent VA Clinic | Fort Kent |
| 5 | 1 | 402QB | Houlton VA Clinic | Houlton |
| 6 | 1 | 518GE | Gloucester VA Clinic | Gloucester |
| 7 | 1 | 523GA | Framingham VA Clinic | Framingham |
| 8 | 1 | 523GC | Quincy VA Clinic | Quincy, Massachusetts |
| 9 | 1 | 523GD | Plymouth VA Clinic | Plymouth |
| 10 | 1 | 608GD | Conway VA Clinic | Conway, New Hampshire |
| 11 | 1 | 631GE | Worcester VA Clinic | Worcester |
| 12 | 1 | 631QA | Plantation Street VA Clinic | Plantation Street |
| 13 | 1 | 631QB | Lake Avenue VA Clinic | Lake Avenue |
| 14 | 1 | 650QA | Eagle Square VA Clinic | Eagle Square |
| 15 | 1 | 650QB | Eagle Street VA Clinic | Eagle Street |
| 16 | 1 | 689GF | Orange VA Clinic | Orange |
| 17 | 2 | 526GD | Thomas P. Noonan Jr. Department of Veterans Affairs Outpatient Clinic | Sunnyside |
| 18 | 2 | 526QA | Bronx VA Mobile Clinic | Bronx Mobile |
| 19 | 2 | 528G2 | Westport VA Clinic | Westport |
| 20 | 2 | 528G6 | Fonda VA Clinic | Fonda |
| 21 | 2 | 528G7 | Catskill VA Clinic | Catskill |
| 22 | 2 | 528GW | Schenectady VA Clinic | Schenectady |
| 23 | 2 | 528GY | Clifton Park VA Clinic | Clifton Park |
| 24 | 2 | 528QA | Buffalo VA Clinic | Buffalo Main Street |
| 25 | 2 | 528QB | Packard VA Clinic | Packard |
| 26 | 2 | 528QE | Coudersport VA Clinic | Coudersport |
| 27 | 2 | 528QF | Wellsboro VA Clinic | Wellsboro |
| 28 | 2 | 528QG | Erie West VA Clinic | Erie West |
| 29 | 2 | 528QH | South Salina VA Clinic | South Salina |
| 30 | 2 | 528QI | Erie East VA Clinic | Erie East |
| 31 | 2 | 528QN | Watertown 2 VA Clinic | Watertown 2 |
| 32 | 2 | 561BY | Newark VA Clinic | Newark, New Jersey |
| 33 | 2 | 561GH | Morristown VA Clinic | Morristown, New Jersey |
| 34 | 2 | 561GJ | Paterson VA Clinic | Paterson |
| 35 | 2 | 561GK | Sussex VA Clinic | Sussex |
| 36 | 2 | 620GF | Monticello VA Clinic | Monticello |
| 37 | 2 | 620GG | Poughkeepsie VA Clinic | Poughkeepsie |
| 38 | 2 | 620GH | Eastern Dutchess VA Clinic | Eastern Dutchess |
| 39 | 2 | 630QA | New York Harbor 1 VA Mobile Clinic | New York Harbor 1 Mobile |
| 40 | 2 | 630QB | New York Harbor 2 VA Mobile Clinic | New York Harbor 2 Mobile |
| 41 | 2 | 632QA | Northport 1 VA Mobile Clinic | Northport 1 Mobile |
| 42 | 2 | 632QB | Northport 2 VA Mobile Clinic | Northport 2 Mobile |

# 2021 Other Outpatient Services (OOS) Sites

| OOS Site Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 43 | 4 | 460HK | Wilmington VA Mobile Clinic | Wilmington Mobile |
| 44 | 4 | 529GD | Clarion County VA Clinic | Clarion County |
| 45 | 4 | 562GC | McKean County VA Clinic | McKean County |
| 46 | 4 | 595QA | Fort Indiantown Gap VA Clinic | Annville |
| 47 | 4 | 642QA | Chestnut Street VA Clinic | Chestnut Street |
| 48 | 4 | 642QB | Fourth Street VA Clinic | Fourth Street |
| 49 | 4 | 693GC | Tobyhanna VA Clinic | Tobyhanna |
| 50 | 4 | 693GF | Columbia County VA Clinic | Columbia County |
| 51 | 4 | 693GG | Northampton County VA Clinic | Northampton County |
| 52 | 4 | 693QA | Wayne County VA Clinic | Wayne County |
| 53 | 5 | 512QA | Baltimore VA Clinic | Baltimore West Fayette Street |
| 54 | 5 | 517HK | Beckley VA Mobile Clinic | Beckley Mobile |
| 55 | 5 | 540GA | Tucker County VA Clinic | Tucker County |
| 56 | 5 | 540HK | Clarksburg VA Mobile Clinic | Clarksburg Mobile |
| 57 | 5 | 581GG | Gallipolis VA Clinic | Gallipolis |
| 58 | 5 | 581GH | Lenore VA Clinic | Lenore |
| 59 | 5 | 581QA | Huntington Ninth Street VA Clinic | Huntington Ninth Street |
| 60 | 5 | 581QB | Huntington VA Mobile Clinic | Huntington Mobile |
| 61 | 5 | 613GD | Franklin VA Clinic | Franklin, West Virginia |
| 62 | 5 | 688GB | Southeast Washington VA Clinic | Southeast Washington |
| 63 | 5 | 688QA | Franklin Street VA Clinic | Franklin Street |
| 64 | 6 | 558GD | Durham County VA Clinic | Durham County |
| 65 | 6 | 558GE | Hillandale Road VA Clinic | Hillandale Road |
| 66 | 6 | 558GF | Wake County VA Clinic | Wake County |
| 67 | 6 | 558GH | Clayton-East Raleigh VA Clinic | Clayton-East Raleigh |
| 68 | 6 | 558QA | Brier Creek VA Clinic | Brier Creek |
| 69 | 6 | 565GJ | Jacksonville 2 VA Clinic | Jacksonville, North Carolina 2 |
| 70 | 6 | 565GM | Jacksonville 3 VA Clinic | Jacksonville 3 |
| 71 | 6 | 565GN | Jacksonville 4 VA Clinic | Jacksonville 4 |
| 72 | 6 | 565QA | Robeson Street VA Clinic | Robeson Street |
| 73 | 6 | 565QB | Fayetteville VA Mobile Clinic | Fayetteville Mobile |
| 74 | 6 | 565QC | Fayetteville 2 VA Mobile Clinic | Fayetteville 2 Mobile |
| 75 | 6 | 565QD | Raeford Road VA Clinic | Raeford Road |
| 76 | 6 | 565QE | Womack VA Clinic | Womack |
| 77 | 6 | 590GE | Portsmouth VA Clinic | Portsmouth, Virginia |
| 78 | 6 | 590QA | Hampton VA Mobile Clinic | Hampton 1 Mobile |
| 79 | 6 | 590QB | Hampton City County VA Mobile Clinic | Hampton City County Mobile |
| 80 | 6 | 652GG | Richmond 1 VA Mobile Clinic | Richmond 1 Mobile |
| 81 | 6 | 652GH | Hunter Holmes McGuire 2 VA Mobile Clinic | Richmond 2 Mobile |
| 82 | 7 | 508GM | Pickens County VA Clinic | Pickens County |
| 83 | 7 | 508GP | South Cobb County VA Clinic | South Cobb County |
| 84 | 7 | 508QC | Henderson Mill VA Clinic | Henderson Mill |

# 2021 Other Outpatient Services (OOS) Sites

| OOS Site Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 85 | 7 | 508QH | South Fulton County VA Clinic | South Fulton County |
| 86 | 7 | 508QI | North DeKalb County VA Clinic | North DeKalb County |
| 87 | 7 | 508QJ | North Fulton County VA Clinic | North Fulton County |
| 88 | 7 | 534GF | North Charleston VA Clinic | North Charleston |
| 89 | 7 | 534QB | Trident 2 VA Clinic | Trident 2 |
| 90 | 7 | 534QC | Charleston VA Clinic | Charleston City Hall Lane |
| 91 | 7 | 544HK | Columbia VA Mobile Clinic | Columbia Mobile |
| 92 | 7 | 679HK | Tuscaloosa VA Mobile Clinic | Tuscaloosa Mobile |
| 93 | 8 | 546GE | Key Largo VA Clinic | Key Largo |
| 94 | 8 | 548QA | Port Saint Lucie VA Clinic | Port Saint Lucie |
| 95 | 8 | 573A5 | Jacksonville Navy VA Medical Center | Jacksonville Navy |
| 96 | 8 | 573GN | Perry VA Clinic | Perry, Florida |
| 97 | 8 | 573GO | Middleburg VA Clinic | Middleburg |
| 98 | 8 | 573QA | Gainesville Sixteenth Street VA Clinic | Gainesville 1-16th Street |
| 99 | 8 | 573QB | Gainesville Ninety Eighth Street VA Clinic | Gainesville 2-98th Street |
| 100 | 8 | 573QC | Gainesville Sixty Fourth Street 1 VA Clinic | Gainesville 3-64th Street (C) |
| 101 | 8 | 573QD | Gainesville Sixty Fourth Street 2 VA Clinic | Gainesville 4-64th Street (O) |
| 102 | 8 | 573QE | Gainesville Sixty Fourth Street 3 VA Clinic | Gainesville 5-64th Street (D) |
| 103 | 8 | 573QF | Gainesville Twenty Third Avenue VA Clinic | Gainesville 6-23rd Avenue |
| 104 | 8 | 573QH | Ocala West VA Clinic | Ocala West |
| 105 | 8 | 573QK | Lake City VA Clinic | Lake City Commerce Drive |
| 106 | 8 | 672GA | Saint Croix VA Clinic | Saint Croix |
| 107 | 8 | 672GB | Saint Thomas VA Clinic | Saint Thomas |
| 108 | 8 | 672QA | Comerio VA Clinic | Comerio |
| 109 | 8 | 672QB | Utuado VA Clinic | Utuado |
| 110 | 8 | 672QC | Vieques VA Clinic | Vieques |
| 111 | 8 | 673GB | Lakeland VA Clinic | Lakeland |
| 112 | 8 | 673GF | Zephyrhills VA Clinic | Zephyrhills |
| 113 | 8 | 673QA | Forty Sixth Street North VA Clinic | Forty Sixth Street North |
| 114 | 8 | 673QB | Forty Sixth Street South VA Clinic | Forty Sixth Street South |
| 115 | 8 | 673QC | West Lakeland VA Clinic | West Lakeland |
| 116 | 8 | 673QD | Deer Park VA Clinic | Deer Park |
| 117 | 8 | 673QE | New Port Richey South VA Clinic | New Port Richey South |
| 118 | 8 | 673QF | Winners Circle VA Clinic | Winners Circle |
| 119 | 8 | 673QG | Little Road VA Clinic | Little Road |
| 120 | 8 | 673QH | Bruce B. Downs Boulevard VA Clinic | Bruce B. Downs Boulevard |
| 121 | 8 | 673QI | Medical View Lane VA Clinic | Medical View Lane |
| 122 | 8 | 673QK | Tampa 1 VA Mobile Clinic | Tampa 1 Mobile |
| 123 | 8 | 673QL | Tampa 2 VA Mobile Clinic | Tampa 2 Mobile |
| 124 | 8 | 675QB | Port Orange VA Clinic | Port Orange |
| 125 | 8 | 675QC | Westside Pavilion VA Clinic | Westside Pavilion |
| 126 | 8 | 675QD | Crossroads VA Clinic | Crossroads |

# 2021 Other Outpatient Services (OOS) Sites

| OOS Site Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 127 | 8 | 675QE | Orlando 1 VA Mobile Clinic | Orlando 1 Mobile |
| 128 | 8 | 675QG | Palm Bay VA Clinic | Palm Bay |
| 129 | 9 | 596GB | Morehead VA Clinic | Morehead |
| 130 | 9 | 614QA | Union Avenue VA Clinic | Union Avenue |
| 131 | 9 | 621GA | Rogersville VA Clinic | Rogersville |
| 132 | 9 | 621GO | Mountain City VA Clinic | Mountain City |
| 133 | 9 | 621QA | Jonesville VA Clinic | Jonesville |
| 134 | 9 | 621QB | Marion VA Clinic | Marion, Virginia |
| 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 | 626GA | Dover VA Clinic | Dover |
| 139 | 9 | 626GG | Tullahoma VA Clinic | Tullahoma |
| 140 | 9 | 626GN | Athens VA Clinic | Athens, Tennessee |
| 141 | 9 | 626QC | Pointe Centre VA Clinic | Pointe Centre |
| 142 | 9 | 626QD | Glenis Drive VA Clinic | Glenis Drive |
| 143 | 9 | 626QE | Glenis Drive 2 VA Clinic | Glenis Drive 2 |
| 144 | 9 | 626QF | Dalton Drive VA Clinic | Dalton Drive |
| 145 | 10 | 506QA | Packard Road VA Clinic | Ann Arbor Packard Road |
| 146 | 10 | 506QB | Green Road VA Clinic | Green Road |
| 147 | 10 | 515QB | Century Avenue VA Clinic | Century Avenue |
| 148 | 10 | 538QA | Chillicothe VA Mobile Clinic | Chillicothe Mobile |
| 149 | 10 | 539QA | Cincinnati VA Mobile Clinic | Cincinnati Mobile |
| 150 | 10 | 539QB | Highland Avenue VA Clinic | Highland Avenue |
| 151 | 10 | 539QC | Vine Street VA Clinic | Vine Street |
| 152 | 10 | 539QD | Norwood VA Clinic | Norwood |
| 153 | 10 | 541GM | Cleveland VA Clinic-Superior | Cleveland Superior Avenue |
| 154 | 10 | 541QA | Summit County VA Clinic | Summit County |
| 155 | 10 | 541QB | Cleveland VA Clinic-Euclid | Cleveland Euclid Avenue |
| 156 | 10 | 541QC | Cleveland 1 VA Mobile Clinic | Cleveland 1 Mobile |
| 157 | 10 | 541QE | Cleveland East Boulevard 3 VA Mobile Clinic | Cleveland East Boulevard 3 Mobile |
| 158 | 10 | 541QF | Cuyahoga County 4 VA Mobile Clinic | Cuyahoga County 4 Mobile |
| 159 | 10 | 552GF | Wright-Patterson VA Clinic | Wright-Patterson |
| 160 | 10 | 552QC | Montgomery County 3 VA Mobile Clinic | Montgomery County 3 Mobile |
| 161 | 10 | 553QA | Piquette Street VA Clinic | Piquette Street |
| 162 | 10 | 583GA | Terre Haute VA Clinic | Terre Haute |
| 163 | 10 | 583GB | Bloomington VA Clinic | Bloomington, Indiana |
| 164 | 10 | 583QA | Monroe County VA Clinic | Monroe County, Indiana |
| 165 | 10 | 583QB | Indianapolis VA Clinic | Indianapolis Meridian Street |
| 166 | 10 | 583QC | Vigo County VA Clinic | Vigo County |
| 167 | 10 | 583QD | Indianapolis YMCA VA Clinic | Indianapolis YMCA |
| 168 | 10 | 583QE | Cold Spring Road VA Clinic | Cold Spring Road |

# 2021 Other Outpatient Services (OOS) Sites

| OOS Site Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 169 | 10 | 583QF | Crane VA Clinic | Crane |
| 170 | 10 | 610QA | Fort Wayne VA Clinic | Fort Wayne East State Boulevard |
| 171 | 10 | 610QB | Columbia Place VA Clinic | Columbia Place |
| 172 | 10 | 655QA | Saginaw VA Clinic | Saginaw Barnard Road |
| 173 | 10 | 655QC | Saginaw North VA Clinic | Saginaw North |
| 174 | 10 | 757QA | Columbus 1 VA Mobile Clinic | Columbus 1 Mobile |
| 175 | 10 | 757QB | North James Road 2 VA Mobile Clinic | North James Road 2 Mobile |
| 176 | 10 | 757QC | Columbus VA Clinic | Columbus Airport Drive |
| 177 | 12 | 537QA | Chicago VA Clinic | Chicago South California Avenue |
| 178 | 12 | 607GD | Baraboo VA Clinic | Baraboo |
| 179 | 12 | 607GF | Freeport VA Clinic | Freeport |
| 180 | 12 | 676QA | Tomah VA Mobile Clinic | Tomah Mobile |
| 181 | 12 | 695QA | Milwaukee VA Clinic | Milwaukee MLK Drive |
| 182 | 15 | 589G2 | Dodge City VA Clinic | Dodge City |
| 183 | 15 | 589GC | Paola VA Clinic | Paola |
| 184 | 15 | 589GE | Kirksville VA Clinic | Kirksville |
| 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 |
| 190 | 15 | 589QA | Overland Park VA Clinic | Overland Park |
| 191 | 15 | 589QB | Sedgwick County VA Clinic | Sedgwick County |
| 192 | 15 | 589QC | South Parklane VA Clinic | South Parklane |
| 193 | 15 | 589QD | Wichita VA Mobile Clinic | Wichita Mobile |
| 194 | 15 | 657GO | Madisonville VA Clinic | Madisonville |
| 195 | 15 | 657GS | Franklin County VA Clinic | Franklin County |
| 196 | 15 | 657GW | Pocahontas VA Clinic | Pocahontas |
| 197 | 15 | 657GY | Manchester Avenue VA Clinic | Manchester Avenue |
| 198 | 15 | 657QB | Jefferson Avenue VA Clinic | Jefferson Avenue |
| 199 | 15 | 657QE | Scott Air Force Base VA Clinic | Scott Air Force Base |
| 200 | 16 | 502QB | Lafayette Campus B VA Clinic | Lafayette Campus B |
| 201 | 16 | 520QA | Panama City Beach West VA Clinic | Panama City Beach West |
| 202 | 16 | 564GA | Harrison VA Clinic | Harrison |
| 203 | 16 | 564QA | Township VA Clinic | Township |
| 204 | 16 | 564QB | Sunbridge VA Clinic | Sunbridge |
| 205 | 16 | 580GL | Sugar Land VA Clinic | Sugar Land |
| 206 | 16 | 580QB | Houston VA Mobile Clinic | Houston Mobile |
| 207 | 16 | 586GG | McComb VA Clinic | McComb |
| 208 | 16 | 586QA | Jackson VA Mobile Clinic | Jackson Mobile |
| 209 | 16 | 586QB | Dogwood View Parkway VA Clinic | Dogwood View Parkway |
| 210 | 16 | 598QB | Little Rock VA Mobile Clinic | Little Rock Mobile |

# 2021 Other Outpatient Services (OOS) Sites

| OOS Site Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 211 | 16 | 629QA | Baton Rouge South VA Clinic | Baton Rouge South |
| 212 | 16 | 667QA | Knight Street VA Clinic | Knight Street |
| 213 | 17 | 504GA | Childress VA Clinic | Childress |
| 214 | 17 | 504HB | Dalhart VA Clinic | Dalhart |
| 215 | 17 | 519GD | Fort Stockton VA Clinic | Fort Stockton |
| 216 | 17 | 549A5 | Garland VA Medical Center | Garland |
| 217 | 17 | 549GE | Decatur VA Clinic | Decatur, Texas |
| 218 | 17 | 549GF | Granbury VA Clinic | Granbury |
| 219 | 17 | 549GH | Greenville VA Clinic | Greenville, Texas |
| 220 | 17 | 549GK | Polk Street VA Clinic | Polk Street |
| 221 | 17 | 549HK | North Texas VA Mobile Clinic | North Texas Mobile |
| 222 | 17 | 549QA | Dallas VA Clinic | Dallas South Lancaster Road |
| 223 | 17 | 549QB | East Lancaster VA Clinic | East Lancaster |
| 224 | 17 | 671GL | New Braunfels VA Clinic | New Braunfels |
| 225 | 17 | 671GN | Seguin VA Clinic | Seguin |
| 226 | 17 | 671GR | North Bexar VA Clinic | North Bexar |
| 227 | 17 | 671QA | South Texas VA Mobile Clinic | South Texas Mobile |
| 228 | 17 | 671QB | Data Point VA Clinic | Data Point |
| 229 | 17 | 671QC | Christus Santa Rosa VA Clinic | Christus Santa Rosa-San Antonio |
| 230 | 17 | 740GI | Old Brownsville VA Clinic | Old Brownsville |
| 231 | 17 | 740GJ | North Tenth Street VA Clinic | North Tenth Street |
| 232 | 17 | 740QA | Texas Valley Coastal Bend VA Mobile Clinic | Texas Valley Coastal Bend Mobile |
| 233 | 17 | 756GC | El Paso Westside VA Clinic | El Paso Westside |
| 234 | 17 | 756GD | El Paso Northeast VA Clinic | El Paso Northeast |
| 235 | 17 | 756QA | El Paso South Central VA Clinic | El Paso South Central |
| 236 | 17 | 756QB | El Paso Central VA Clinic | El Paso Central |
| 237 | 19 | 436GI | Glasgow VA Clinic | Glasgow |
| 238 | 19 | 436GL | Cut Bank VA Clinic | Cut Bank |
| 239 | 19 | 436GM | Lewistown VA Clinic | Lewistown |
| 240 | 19 | 436GN | Dr. Joseph Medicine Crow VA Clinic | Billings Spring Creek Lane |
| 241 | 19 | 436QA | Hamilton VA Clinic | Hamilton, Montana |
| 242 | 19 | 436QB | Plentywood VA Clinic | Plentywood |
| 243 | 19 | 436QC | Helena VA Clinic | Helena, Montana |
| 244 | 19 | 436QD | Browning VA Clinic | Browning |
| 245 | 19 | 436QE | Miles City VA Clinic | MIles City |
| 246 | 19 | 442GB | Sidney VA Clinic | Sidney |
| 247 | 19 | 442HK | Wheatland VA Mobile Clinic | Wheatland Mobile |
| 248 | 19 | 442QA | Rawlins VA Clinic | Rawlins |
| 249 | 19 | 442QB | Torrington VA Mobile Clinic | Torrington Mobile |
| 250 | 19 | 442QD | Laramie VA Mobile Clinic | Laramie Mobile |
| 251 | 19 | 442QE | Sterling VA Clinic | Sterling, Colorado |
| 252 | 19 | 442QF | Cheyenne VA Mobile Clinic | Cheyenne VA Mobile |

# 2021 Other Outpatient Services (OOS) Sites

| OOS Site Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 253 | 19 | 554GH | Lamar VA Clinic | Lamar |
| 254 | 19 | 554GI | Burlington VA Clinic | Burlington, Colorado |
| 255 | 19 | 554QA | York Street VA Clinic | York Street |
| 256 | 19 | 554QB | Jewell VA Clinic | Jewell |
| 257 | 19 | 554QC | Salida VA Clinic | Salida |
| 258 | 19 | 575GA | Montrose VA Clinic | Montrose, Colorado |
| 259 | 19 | 575GB | Major William Edward Adams VA Clinic | Craig |
| 260 | 19 | 575QB | Moab VA Clinic | Moab |
| 261 | 19 | 575QC | Grand Junction VA Mobile Clinic | Grand Junction Mobile |
| 262 | 19 | 575QD | Grand Junction 28 Road VA Clinic | Grand Junction 28 Road |
| 263 | 19 | 575QE | Western Colorado VA Mobile Clinic | Western Colorado Mobile |
| 264 | 19 | 623QA | Muskogee East VA Clinic | Muskogee East |
| 265 | 19 | 623QB | Tulsa Eleventh Street VA Clinic | Tulsa Eleventh Street |
| 266 | 19 | 623QC | Yale Avenue VA Clinic | Yale Avenue |
| 267 | 19 | 635GC | Blackwell VA Clinic | Blackwell |
| 268 | 19 | 635GG | Enid VA Clinic | Enid |
| 269 | 19 | 635GH | Clinton VA Clinic | Clinton |
| 270 | 19 | 635GI | Norman VA Clinic | Norman |
| 271 | 19 | 635GJ | Yukon VA Clinic | Yukon |
| 272 | 19 | 635QA | North May VA Clinic | North May |
| 273 | 19 | 635QC | Fourteenth Street VA Clinic | Fourteenth Street |
| 274 | 19 | 635QD | Lawton North VA Clinic | Lawton North |
| 275 | 19 | 635QE | Tinker VA Clinic | Tinker |
| 276 | 19 | 660GD | Roosevelt VA Clinic | Roosevelt |
| 277 | 19 | 660GK | Elko VA Clinic | Elko |
| 278 | 19 | 660QB | Price VA Clinic | Price |
| 279 | 19 | 660QD | Cache Valley VA Clinic | Cache Valley |
| 280 | 19 | 666GD | Cody VA Clinic | Cody |
| 281 | 19 | 666GE | Gillette VA Clinic | Gillette |
| 282 | 19 | 666QA | Afton VA Clinic | Afton |
| 283 | 19 | 666QB | Evanston VA Clinic | Evanston, Wyoming |
| 284 | 19 | 666QC | Worland VA Clinic | Worland |
| 285 | 20 | 463GD | Homer VA Clinic | Homer |
| 286 | 20 | 463GE | Juneau VA Clinic | Juneau |
| 287 | 20 | 463QA | Elmendorf-Richardson VA Clinic | Elmendorf-Richardson |
| 288 | 20 | 531GH | Eastern Oregon VA Clinic | Eastern Oregon |
| 289 | 20 | 531GI | Mountain Home VA Clinic | Mountain Home, Idaho |
| 290 | 20 | 531GJ | Salmon VA Clinic | Salmon |
| 291 | 20 | 648GD | North Coast VA Clinic | North Coast |
| 292 | 20 | 648GH | Newport VA Clinic | Newport, Oregon |
| 293 | 20 | 648GK | Lincoln City VA Clinic | Lincoln City |
| 294 | 20 | 653QA | Downtown Eugene VA Clinic | Downtown Eugene |

# 2021 Other Outpatient Services (OOS) Sites

| OOS Site Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 295 | 20 | 663HK | Puget Sound VA Mobile Clinic | Puget Sound Mobile |
| 296 | 20 | 663QA | Renton VA Clinic | Renton |
| 297 | 20 | 663QB | South Lucile Street VA Clinic | South Lucile Street |
| 298 | 20 | 668HK | Spokane VA Mobile Clinic | Spokane Mobile |
| 299 | 20 | 668QB | Libby VA Clinic | Libby |
| 300 | 20 | 668QD | Sandpoint VA Clinic | Sandpoint |
| 301 | 20 | 668QE | Spokane VA Clinic | Spokane 2nd Avenue |
| 302 | 20 | 687GC | La Grande VA Clinic | La Grande |
| 303 | 20 | 687QB | Morrow County VA Clinic | Morrow County |
| 304 | 20 | 687QC | Wallowa County VA Clinic | Wallowa County |
| 305 | 21 | 358 | Manila VA Clinic | Manila |
| 306 | 21 | 459GH | Saipan VA Clinic | Saipan |
| 307 | 21 | 459QA | Lanai VA Clinic | Lanai |
| 308 | 21 | 459QB | Molokai VA Clinic | Molokai |
| 309 | 21 | 593QC | West Cheyenne VA Clinic | West Cheyenne |
| 310 | 21 | 612GJ | Yreka VA Clinic | Yreka |
| 311 | 21 | 612QB | Twenty First Street VA Clinic | Twenty First Street |
| 312 | 21 | 612QC | Cypress Avenue VA Clinic | Cypress Avenue |
| 313 | 21 | 612QD | Howe Road VA Clinic | Howe Road |
| 314 | 21 | 640QA | Palo Alto 1 VA Mobile Clinic | Palo Alto 1 Mobile |
| 315 | 21 | 640QB | Palo Alto 2 VA Mobile Clinic | Palo Alto 2 Mobile |
| 316 | 21 | 654GB | Carson Valley VA Clinic | Carson Valley |
| 317 | 21 | 654GC | Lahontan Valley VA Clinic | Lahontan Valley |
| 318 | 21 | 654GD | Diamond View VA Clinic | Diamond View |
| 319 | 21 | 654GF | North Reno VA Clinic | North Reno |
| 320 | 21 | 654QA | Kietzke VA Clinic | Kietzke |
| 321 | 21 | 654QB | Capitol Hill VA Clinic | Capitol Hill |
| 322 | 21 | 654QC | Winnemucca VA Clinic | Winnemucca |
| 323 | 21 | 654QD | Virginia Street VA Clinic | Virginia Street |
| 324 | 21 | 662QA | Twenty First Street VA Clinic | Twenty First Street |
| 325 | 22 | 501G2 | Las Vegas VA Clinic | Las Vegas |
| 326 | 22 | 501GC | Silver City VA Clinic | Silver City |
| 327 | 22 | 501GD | Gallup VA Clinic | Gallup |
| 328 | 22 | 501GE | Espanola VA Clinic | Espanola |
| 329 | 22 | 501GH | Truth or Consequences VA Clinic | Truth or Consequences |
| 330 | 22 | 501GI | Alamogordo VA Clinic | Alamogordo |
| 331 | 22 | 501GN | Taos VA Clinic | Taos |
| 332 | 22 | 501HB | Raton VA Clinic | Raton |
| 333 | 22 | 600GF | Gardena VA Clinic | Gardena |
| 334 | 22 | 600QA | West Santa Ana VA Clinic | West Santa Ana |
| 335 | 22 | 605QA | Blythe VA Clinic | Blythe |
| 336 | 22 | 644GD | Payson VA Clinic | Payson |

# 2021 Other Outpatient Services (OOS) Sites

| OOS Site Count | VISN | Station Number | Official Station Name | Location (Descriptive Name) |
|---|---|---|---|---|
| 337 | 22 | 644GF | Globe VA Clinic | Globe |
| 338 | 22 | 644QA | Phoenix VA Clinic | Phoenix East Thomas Road |
| 339 | 22 | 644QB | Phoenix VA Mobile Clinic | Phoenix Mobile |
| 340 | 22 | 649QA | Chinle VA Clinic | Chinle |
| 341 | 22 | 649QB | Holbrook VA Clinic | Holbrook |
| 342 | 22 | 649QD | Page VA Clinic | Page |
| 343 | 22 | 649QF | Tuba City VA Clinic | Tuba City |
| 344 | 22 | 649QG | Polacca VA Clinic | Polacca |
| 345 | 22 | 649QH | Kayenta VA Clinic | Kayenta |
| 346 | 22 | 664QA | Rio VA Clinic | Rio |
| 347 | 22 | 678GE | Green Valley VA Clinic | Green Valley |
| 348 | 22 | 678QA | Cochise County VA Clinic | Cochise County |
| 349 | 22 | 678QB | Pinal County VA Clinic | Pinal County |
| 350 | 22 | 691GP | San Gabriel Valley VA Clinic | San Gabriel Valley |
| 351 | 23 | 437GA | Grafton VA Clinic | Grafton |
| 352 | 23 | 437GF | Williston VA Clinic | Williston |
| 353 | 23 | 437GJ | Dickinson VA Clinic | Dickinson |
| 354 | 23 | 437GL | Devils Lake VA Clinic | Devils Lake |
| 355 | 23 | 437QA | North Fargo VA Clinic | North Fargo |
| 356 | 23 | 438GE | Wagner VA Clinic | Wagner |
| 357 | 23 | 568GB | Pierre VA Clinic | Pierre |
| 358 | 23 | 568HA | Newcastle VA Clinic | Newcastle |
| 359 | 23 | 568HB | Gordon VA Clinic | Gordon |
| 360 | 23 | 568HF | Pine Ridge VA Clinic | Pine Ridge |
| 361 | 23 | 568HK | McLaughlin VA Clinic | McLaughlin |
| 362 | 23 | 568HP | Winner VA Clinic | Winner |
| 363 | 23 | 618GA | St. James VA Clinic | St. James, Minnesota |
| 364 | 23 | 618GH | Hayward VA Clinic | Hayward |
| 365 | 23 | 618QA | Fort Snelling VA Clinic | Fort Snelling |
| 366 | 23 | 618QB | Ely VA Clinic | Ely |
| 367 | 23 | 636GK | Fort Dodge VA Clinic | Fort Dodge |
| 368 | 23 | 636GX | Fort Dodge North VA Clinic | Fort Dodge North |
| 369 | 23 | 636QA | Omaha VA Clinic | Omaha Dorcas Street |
| 370 | 23 | 636QB | Des Moines VA Clinic | Des Moines Center Street |
| 371 | 23 | 636QC | Linn County VA Clinic | Linn County |
| 372 | 23 | 636QD | Macomb VA Clinic | Macomb |
| 373 | 23 | 636QG | Iowa City VA Mobile Clinic | Iowa City Mobile |
| 374 | 23 | 636QH | Des Moines VA Mobile Clinic | Des Moines Mobile |
| 375 | 23 | 636QI | Davenport VA Clinic | Davenport |
| 376 | 23 | 636QJ | Iowa City VA Clinic | Iowa City South Clinton Street |

## 2021 Outpatient Dialysis Centers

| Dialysis Center Count | Station Number | Station Name | City | State |
|---|---|---|---|---|
| 1 | 523 | VA Boston HCS | Boston | MA |
| 2 | 650 | Providence VA Medical Center | Providence | RI |
| 3 | 689 | VA Connecticut HCS | West Haven | CT |
| 4 | 526 | James J. Peters VA Medical Center | Bronx | NY |
| 5 | 528 | Albany Stratton VA Medical Center | Albany | NY |
| 6 | 528 | VA Western NY HCS | Buffalo | NY |
| 7 | 561 | VA New Jersey HCS | East Orange | NJ |
| 8 | 630 | VA NY Harbor HCS - Brooklyn | Brooklyn | NY |
| 9 | 630 | VA NY Harbor HCS - Manhattan | New York | NY |
| 10 | 632 | Northport VA Medical Center | Northport | NY |
| 11 | 460 | Wilmington VA Medical Center | Wilmington | DE |
| 12 | 642 | Philadelphia Free Standing Dialysis Center | Philadelphia | PA |
| 13 | 646 | VA Pittsburgh HCS | Pittsburgh | PA |
| 14 | 693 | Wilkes-Barre VA Medical Center | Wilkes-Barre | PA |
| 15 | 688 | Washington DC VA Medical Center | Washington | DC |
| 16 | 558 | Durham VA Medical Center | Durham | NC |
| 17 | 558 | Raleigh Dialysis Center | Raleigh | NC |
| 18 | 565 | Fayetteville VA Medical Center | Fayetteville | NC |
| 19 | 659 | Charlotte Dialysis Center | Charlotte | NC |
| 20 | 659 | Kernersville Dialysis Center | Kernersville | NC |
| 21 | 590 | Hampton VA Medical Center | Hampton | VA |
| 22 | 652 | Hunter Holmes McGuire VA Medical Center | Richmond | VA |
| 23 | 658 | Salem VA Medical Center | Salem | VA |
| 24 | 508 | Atlanta VA Medical Center | Decatur | GA |
| 25 | 521 | Birmingham VA Medical Center | Birmingham | AL |
| 26 | 534 | Ralph H. Johnson VA Medical Center | Charleston | SC |
| 27 | 544 | Wm. Jennings Bryan Dorn VA Medical Center | Columbia | SC |
| 28 | 516 | Bay Pines VA HCS | Bay Pines | FL |
| 29 | 546 | Miami VA HCS | Miami | FL |
| 30 | 548 | West Palm Beach VA Medical Center | West Palm | FL |
| 31 | 573 | North Florida/South Georgia HCS-Gainesville | Gainesville | FL |
| 32 | 672 | VA Caribbean HCS | San Juan | PR |
| 33 | 673 | James A. Haley Veterans' Hospital | Tampa | FL |
| 34 | 675 | Orlando VA Medical Center | Orlando | FL |
| 35 | 596 | Lexington VA Medical Center | Lexington | KY |
| 36 | 614 | Memphis VA Medical Center | Memphis | TN |

## 2021 Outpatient Dialysis Centers

| Dialysis Center Count | Station Number | Station Name | City | State |
|---|---|---|---|---|
| 37 | 626 | Tennessee Valley HCS | Nashville | TN |
| 38 | 506 | VA Ann Arbor HCS | Ann Arbor | MI |
| 39 | 539 | Cincinnati VA Medical Center | Cincinnati | OH |
| 40 | 541 | Cleveland- Freestanding Dialysis Center | Cleveland | OH |
| 41 | 541 | Louis Stokes Cleveland VA Medical Center | Cleveland | OH |
| 42 | 552 | Dayton VA Medical Center | Dayton | OH |
| 43 | 553 | John D. Dingell VA Medical Center | Detroit | MI |
| 44 | 583 | Richard L. Roudebush VA Medical Center | Indianapolis | IN |
| 45 | 537 | Jesse Brown VA Medical Center | Chicago | IL |
| 46 | 578 | Edward Hines, Jr. VA Hospital | Hines | IL |
| 47 | 695 | Milo C. Huempfner Health Care Center | Green Bay | WI |
| 48 | 695 | Milwaukee VA Medical Center | Milwaukee | WI |
| 49 | 589 | Kansas City VA Medical Center | Kansas City | MO |
| 50 | 657 | St. Louis VA Medical Center | St. Louis | MO |
| 51 | 586 | G.V. (Sonny) Montgomery VA Medical Center | Jackson | MS |
| 52 | 598 | Central Arkansas Veterans HCS | Little Rock | AR |
| 53 | 549 | VA North Texas HCS | Dallas | TX |
| 54 | 671 | South Texas Veterans HCS | San Antonio | TX |
| 55 | 501 | New Mexico VA HCS | Albuquerque | NM |
| 56 | 678 | Southern Arizona VA HCS | Tucson | AZ |
| 57 | 554 | VA Eastern Colorado HCS | Denver | CO |
| 58 | 660 | VA Salt Lake City HCS | Salt Lake City | UT |
| 59 | 648 | Portland VA Medical Center | Portland | OR |
| 60 | 663 | VA Puget Sound HCS | Seattle | WA |
| 61 | 459 | VA Pacific Islands HCS | Honolulu | HI |
| 62 | 593 | Southern Nevada HCS | North Las | NV |
| 63 | 612 | David Grant USAF Medical Center | Travis AFB | CA |
| 64 | 640 | VA Palo Alto HCS | Palo Alto | CA |
| 65 | 662 | San Francisco VA Medical Center | San Francisco | CA |
| 66 | 600 | VA Long Beach HCS | Long Beach | CA |
| 67 | 605 | VA Loma Linda HCS | Loma Linda | CA |
| 68 | 664 | VA San Diego HCS | San Diego | CA |
| 69 | 691 | VA Great Los Angeles HCS | Los Angeles | CA |
| 70 | 568 | VA Black Hills HCS | Hot Springs | SD |
| 71 | 618 | Minneapolis VA HCS | Minneapolis | MN |
| 72 | 636 | Iowa City VA HCS | Iowa City | IA |
| 73 | 636 | VA Nebraska-Western Iowa HCS | Omaha | NE |

## 2021 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 |

# 2021 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 |

# 2021 Vet Centers, Mobile Vet Centers and Vet Center Outstations

| VISN | Station Number | Station Name | City | State | VC / MVC / Outstation Number | MVC (Yes / No) | VC Outstation (Yes / No) |
|---|---|---|---|---|---|---|---|
| 4 | 595 | Harrisburg Vet Center | Harrisburg | PA | 0218V | N | N |
| 4 | 642 | Northeast Philadelphia Vet Center | Philadelphia | PA | 0219V | N | N |
| 4 | 646 | White Oak Vet Center | White Oak | PA | 0220V | N | N |
| 4 | 693 | Scranton Mobile Vet Center | Scranton | PA | 0811MVC | Y | N |
| 4 | 562 | Erie Vet Center | Erie | PA | 0222V | N | N |
| 4 | 503 | DuBois Vet Center | DuBois | PA | 0227V | N | N |
| 4 | 693 | Scranton Vet Center | Scranton | PA | 0229V | N | N |
| 4 | 460 | South Jersey Vet Center | Egg Harbor Township | NJ | 0230V | N | N |
| 4 | 646 | Wheeling Vet Center | Wheeling | WV | 0233V | N | N |
| 4 | 642 | Bucks County Vet Center | Bristol | PA | 0238V | N | N |
| 4 | 642 | Norristown Vet Center | Norristown | PA | 0239V | N | N |
| 4 | 595 | Lancaster Vet Center | Lancaster | PA | 0242V | N | N |
| 4 | 460 | Sussex County Vet Center | Georgetown | DE | 0243V | N | N |
| 4 | 460 | Sussex County Mobile Vet Center | Georgetown | DE | 0874MVC | Y | N |
| 4 | 503 | DuBois Mobile Vet Center | DuBois | PA | 0876MVC | Y | N |
| 5 | 512 | Baltimore Vet Center | Baltimore | MD | 0201V | N | N |
| 5 | 581 | Huntington Mobile Vet Center | Huntington | WV | 0807MVC | Y | N |
| 5 | 581 | Huntington Vet Center | Huntington | WV | 0208V | N | N |
| 5 | 512 | Elkton Vet Center | Elkton | MD | 0209V | N | N |
| 5 | 688 | Silver Spring Vet Center | Silver Spring | MD | 0213V | N | N |
| 5 | 688 | Washington, D.C. Vet Center | Washington | DC | 0214V | N | N |
| 5 | 540 | Morgantown Vet Center | Morgantown | WV | 0216V | N | N |
| 5 | 540 | Parkersburg Outstation | Parkersburg | WV | 2081OS | N | Y |
| 5 | 512 | Salisbury Outstation | Salisbury | MD | 2091OS | N | Y |
| 5 | 512 | Aberdeen Outstation | Aberdeen | MD | 2092OS | N | Y |
| 5 | 517 | Beckley Mobile Vet Center | Beckley | WV | 0812MVC | Y | N |
| 5 | 581 | Charleston Vet Center | Charleston | WV | 0223V | N | N |
| 5 | 512 | Logan Outstation | Henlawson | WV | 2231OS | N | Y |
| 5 | 613 | Martinsburg Vet Center | Martinsburg | WV | 0224V | N | N |
| 5 | 688 | Alexandria Vet Center | Alexandria | VA | 0228V | N | N |
| 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 |

# 2021 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 | 534 | Savannah Vet Center | Savannah | GA | 0323V | N | N |
| 7 | 544 | Columbia Vet Center | Columbia | SC | 0324V | N | N |
| 7 | 508 | Lawrenceville Vet Center | Lawrenceville | GA | 0329V | N | N |
| 7 | 557 | Macon Vet Center | Macon | GA | 0333V | N | N |
| 7 | 619 | Montgomery Vet Center | Montgomery | AL | 0334V | N | N |
| 7 | 508 | Marietta Vet Center | Marietta | GA | 0342V | N | N |
| 7 | 557 | Augusta Vet Center | Augusta | GA | 0346V | N | N |
| 7 | 534 | Myrtle Beach Vet Center | Myrtle Beach | SC | 0347V | N | N |
| 7 | 509 | Columbus Vet Center | Columbus | GA | 0349V | N | N |
| 7 | 508 | Atlanta Mobile Vet Center | College Park | GA | 0860MVC | Y | N |
| 7 | 521 | Birmingham Mobile Vet Center | Hoover | AL | 0866MVC | Y | N |
| 7 | 521 | Huntsville Vet Center | Huntsville | AL | 0738V | N | N |
| 7 | 521 | Birmingham Vet Center | Hoover | AL | 0739V | N | N |
| 8 | 672 | Arecibo Vet Center | Arecibo | PR | 0802MVC | Y | N |
| 8 | 573 | Jacksonville Mobile Vet Center | Jacksonville | FL | 0813MVC | Y | N |
| 8 | 672 | St. Croix Outstation | Kingshill | VI | 3121OS | N | Y |
| 8 | 516 | Clearwater Mobile Vet Center | Clearwater | FL | 0816MVC | Y | N |
| 8 | 516 | St. Petersburg Vet Center | St. Petersburg | FL | 0301V | N | N |
| 8 | 573 | Jacksonville Vet Center | Jacksonville | FL | 0305V | N | N |
| 8 | 672 | San Juan Vet Center | Guaynabo | PR | 0307V | N | N |
| 8 | 672 | Arecibo Vet Center | Arecibo | PR | 0309V | N | N |
| 8 | 546 | Miami Vet Center | Miami | FL | 0310V | N | N |
| 8 | 546 | Fort Lauderdale Vet Center | Lauderdale Lakes | FL | 0311V | N | N |
| 8 | 672 | Ponce Vet Center | Ponce | PR | 0312V | N | N |
| 8 | 675 | Orlando Vet Center | Orlando | FL | 0314V | N | N |
| 8 | 673 | Tampa Vet Center | Tampa | FL | 0318V | N | N |
| 8 | 516 | Sarasota Vet Center | Sarasota | FL | 0320V | N | N |
| 8 | 573 | Tallahassee Vet Center | Tallahassee | FL | 0325V | N | N |
| 8 | 548 | Palm Beach Vet Center | Greenacres | FL | 0326V | N | N |
| 8 | 516 | Fort Myers Vet Center | Fort Myers | FL | 0330V | N | N |
| 8 | 573 | Gainesville Vet Center | Gainesville | FL | 0331V | N | N |
| 8 | 675 | Melbourne Vet Center | Melbourne | FL | 0332V | N | N |
| 8 | 672 | St. Thomas Outstation | St Thomas | VI | 3122OS | N | Y |
| 8 | 546 | Pompano Beach Vet Center | Pompano Beach | FL | 0336V | N | N |
| 8 | 548 | Jupiter Vet Center | Jupiter | FL | 0337V | N | N |
| 8 | 673 | Pasco County Vet Center | New Port Richey | FL | 0338V | N | N |
| 8 | 516 | Clearwater Vet Center | Clearwater | FL | 0339V | N | N |
| 8 | 673 | Lakeland Vet Center | Lakeland | FL | 0340V | N | N |
| 8 | 675 | Daytona Beach Vet Center | Daytona Beach | FL | 0341V | N | N |
| 8 | 573 | Ocala Vet Center | Ocala | FL | 0344V | N | N |
| 8 | 675 | Clermont Vet Center | Clermont | FL | 0345V | N | N |
| 8 | 516 | Naples Vet Center | Naples | FL | 0348V | N | N |
| 8 | 672 | Ponce Mobile Vet Center | Ponce | PR | 0861MVC | Y | N |
| 9 | 596 | Lexington Mobile Vet Center | Lexington | KY | 0806MVC | Y | N |
| 9 | 603 | Louisville Vet Center | Louisville | KY | 0202V | N | N |
| 9 | 596 | Lexington Vet Center | Lexington | KY | 0203V | N | N |
| 9 | 621 | Knoxville Mobile Vet Center | Knoxville | TN | 0844MVC | Y | N |
| 9 | 614 | Memphis Mobile Vet Center | Memphis | TN | 0848MVC | Y | N |
| 9 | 675 | Clermont Mobile Vet Center | Clermont | FL | 0864MVC | Y | N |
| 9 | 621 | Johnson City Vet Center | Johnson City | TN | 0701V | N | N |
| 9 | 614 | Memphis Vet Center | Memphis | TN | 0719V | N | N |
| 9 | 621 | Knoxville Vet Center | Knoxville | TN | 0720V | N | N |
| 9 | 626 | Chattanooga Vet Center | Chattanooga | TN | 0722V | N | N |
| 9 | 626 | Nashville Vet Center | Nashville | TN | 0724V | N | N |
| 9 | 626 | Clarksville Outstation | Clarksville | TN | 7241OS | N | Y |

# 2021 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) |
|---|---|---|---|---|---|---|---|
| 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 |
| 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 |

# 2021 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) |
|---|---|---|---|---|---|---|---|
| 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 |
| 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 |

# 2021 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) |
|---|---|---|---|---|---|---|---|
| 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 |
| 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 | 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 |

# 2021 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) |
|---|---|---|---|---|---|---|---|
| 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 |
| 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 | 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 |

## 2021 Vet Centers, Mobile Vet Centers and Vet Center Outstations

| VISN | Station Number | Station Name | City | State | VC / MVC / Outstation Number | MVC (Yes / No) | VC Outstation (Yes / No) |
|---|---|---|---|---|---|---|---|
| 23 | 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 | 568 | Rapid City Vet Center | Rapid City | SD | 0423V | N | N |
| 23 | 636 | Omaha Vet Center | Omaha | NE | 0424V | N | N |
| 23 | 438 | Sioux Falls Vet Center | Sioux Falls | SD | 0425V | N | N |
| 23 | 636 | Lincoln Vet Center | Lincoln | NE | 0427V | N | N |
| 23 | 438 | Sioux City Vet Center | Sioux City | IA | 0428V | N | N |
| 23 | 618 | Duluth Vet Center | Duluth | MN | 0429V | N | N |
| 23 | 636A8 | Quad Cities Vet Center | East Moline | IL | 0430V | N | N |
| 23 | 636A8 | Cedar Rapids Vet Center | Cedar Rapids | IA | 0431V | N | N |
| 23 | 618 | Brooklyn Park Vet Center | Anoka | MN | 0439V | N | N |
| 23 | 437 | Bismarck Vet Center | Bismarck | ND | 0446V | N | N |
| 23 | 636A8 | Cedar Rapids Mobile Vet Center | Cedar Rapids | IA | 0854MVC | Y | N |

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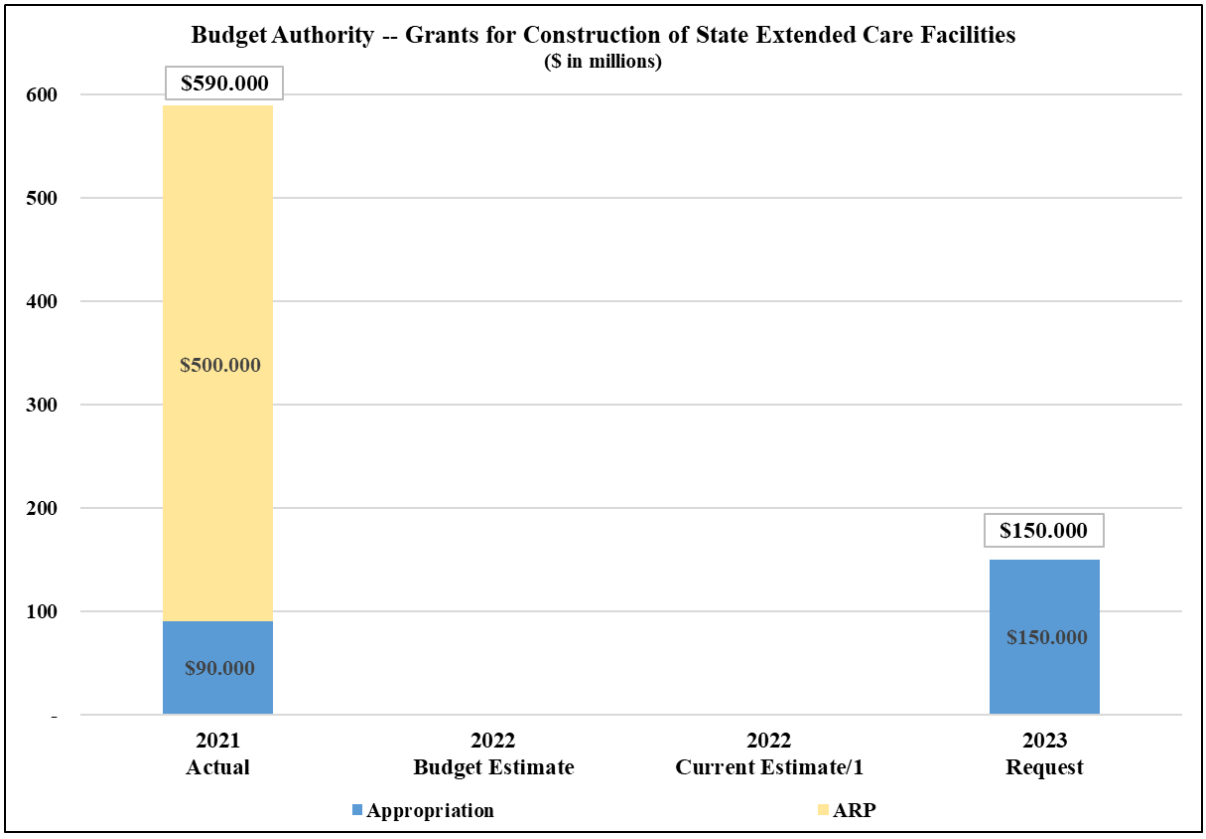
# *Grants for Construction of State Extended Care Facilities*

## Chart: Total Appropriations




1/ The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

## 2023 Budget Discussion

VA is requesting $150 million in 2023 for construction of state home facilities, for furnishing domiciliary or nursing home care to Veterans and to expand, remodel or alter existing buildings for furnishing domiciliary, nursing home care or adult day health care to Veterans in state homes. VA is required by section 8135 of Title 38 to prioritize state grant applications, and its highest priority is to protect Veterans from those conditions that threaten the lives and safety of residents of an existing facility. State homes are owned and operated by the state.

## American Rescue Plan (ARP) Act

The ARP Act (P.L. 117-2) provided an additional $500 million to remain available until expended. Approximately $104 million was obligated in 2021 and the remaing $396 million is projected to be obligated by the end of 2022.

## Table: Total Funding Highlights

**Total Funding Highlights**
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate[1] | 2023 Estimate[2] | 2022 to 2023 Inc/Dec |
|---|---|---|---|---|---|
| Appropriation | $90,000 | $0 | $0 | $150,000 | $150,000 |
| Mandatory Appropriations (ARP Act Sec. 8004) | $500,000 | $0 | $0 | $0 | $0 |
| Adjustments to Obligations: | | | | | |
| Unobligated Balance (SOY) | $266,151 | $596,151 | $566,963 | $168,913 | ($398,050) |
| Unobligated Balance (EOY) | ($566,963) | ($250,000) | ($168,913) | $0 | $168,913 |
| Change in Unobligated Balance | ($300,812) | $346,151 | $398,050 | $168,913 | ($229,137) |
| Prior Year Recoveries | $8,388 | $0 | $0 | $0 | $0 |
| Obligations | $297,576 | $346,151 | $398,050 | $318,913 | ($79,137) |

[1/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

[2/] Obligations in the President's Budget Appendix estimate 2023 obligations at $398 million. The more accurate estimate is the $318 million as shown in this table.

# Table: Annual Discretionary (non-CARES Act) Funding Highlights

**Annual Discretionary (non CARES Act) Funding Highlights**
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate[1] | 2023 Estimate[2] | 2022 to 2023 Inc/Dec |
|---|---|---|---|---|---|
| Appropriation | $90,000 | $0 | $0 | $150,000 | $150,000 |
| Adjustments to Obligations: | | | | | |
| Unobligated Balance (SOY) | $116,151 | $96,151 | $171,367 | $168,913 | ($2,454) |
| Unobligated Balance (EOY) | ($171,367) | $0 | ($168,913) | $0 | $168,913 |
| Change in Unobligated Balance | ($55,216) | $96,151 | $2,454 | $168,913 | $166,459 |
| Prior Year Recoveries | $8,388 | $0 | $0 | $0 | $0 |
| Obligations | $43,171 | $96,151 | $2,454 | $318,913 | $316,459 |

[1/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

[2/] Obligations in the President's Budget Appendix estimate 2023 obligations at $398 million. The more accurate estimate is the $318 million as shown in this table.

# Table: CARES Act Funding Highlights

**CARES Act Funding Highlights**
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Estimate | 2022 to 2023 Inc/Dec |
|---|---|---|---|---|---|
| Appropriation | $0 | $0 | $0 | $0 | $0 |
| Adjustments to Obligations: | | | | | |
| Unobligated Balance (SOY) | $150,000 | $0 | $0 | $0 | $0 |
| Unobligated Balance (EOY) | $0 | $0 | $0 | $0 | $0 |
| Change in Unobligated Balance | $150,000 | $0 | $0 | $0 | $0 |
| Prior Year Recoveries | $0 | $0 | $0 | $0 | $0 |
| Obligations | $150,000 | $0 | $0 | $0 | $0 |

## Table: ARP Act Funding Highlights

**American Rescue Plan (ARP) Act 8004 Highlights**
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Estimate | 2022 to 2023 Inc/Dec |
|---|---|---|---|---|---|
| Mandatory Appropriations (Sec. 8004)..... | $500,000 | $0 | $0 | $0 | $0 |
| Adjustments to Obligations: | | | | | |
| Unobligated Balance (SOY)..... | $0 | $500,000 | $395,596 | $0 | ($395,596) |
| Unobligated Balance (EOY)..... | ($395,596) | ($250,000) | $0 | $0 | $0 |
| Change in Unobligated Balance..... | ($395,596) | $250,000 | $395,596 | $0 | ($395,596) |
| Prior Year Recoveries..... | $0 | $0 | $0 | $0 | $0 |
| Obligations..... | $104,404 | $250,000 | $395,596 | $0 | ($395,596) |

## Program Description

VA conducts inspections, audits and other oversight to ensure the state homes are providing quality care. States are required to fund at least 35% of a project's total estimated cost, and VA may fund up to 65%.

In 2021, the program offered 35 grants to states. Of the 35 grants awarded, 18 were final awards and 17 were conditional awards. States must complete the entire grant application by June 30 of the fiscal year to be considered for a final 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.

In 2022, the value of projects submitted by states is expected to be $814 million at the end of the fiscal year, an increase from $561 million (or roughly 45%) in 2021.

The 2023 budget request, matched with state funding, will support essential life-safety renovation projects to ensure that quality care for Veterans will not be compromised. Remaining funds will be used to support new construction projects and non-life safety renovation projects.

## Legislative History

This program was approved on August 19, 1964 and received appropriations in 1965. On July 5, 1977, P.L. 95-62 authorized the VA to participate in the construction of new domiciliary as well as new nursing homes, and for sums appropriated to remain available until expended. The Veterans' Health Care Act of 1984 (P.L. 98-528, dated October 19, 1984) amended section 8132 to allow states to purchase facilities to be used as state nursing homes and domiciliary. The Veterans' Benefits Improvement and Health Care Authorization Act of 1986 (P.L. 99-576, dated October 28, 1986) amended section 8135 of title 38 to eliminate a limitation that prohibited any state from receiving in any fiscal year more than one-third of the amount appropriated in that fiscal year and required a priority list to be established on July 1 of each year. The Veterans' Benefits and Services Act of 1988 (P.L. 100-322, dated May 20, 1988) further amended section 8135 of title 38 to change the date for compiling a priority list of grantees from July 1 to August 15. Construction grants are to be made from that list for the fiscal year beginning October 1.

The Veterans' Benefits and Services Act of 1988 also permitted VA to approve and award state home grants on a conditional basis and obligate funds for these awards. This law authorized VA to increase a conditionally-approved grant amount if: (1) the estimated cost on which VA based the conditional approval increases; and (2) VA conditionally approved the grant before the state awarded a construction or acquisition contract for the project. The final grant award increase would be limited to 10% of the original obligation.

The Veterans Health Care Act of 1992 (P.L. 102-585, dated November 4, 1992) granted permanent authority for this program and extended – from 90 days to 180 days – the period within which a state must complete the application for a state home grant after receiving a conditional award. The Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262, dated October 9, 1996) added Adult Day Health Care as another type of care that may be provided by state homes.

Under current law, a grant may not exceed 65% of the total cost of the project. The Veteran's Millennium Health Care and Benefits Act of 1999 (P.L. 106-117, dated November 30, 1999) provided greater specificity in directing VA to prescribe regulations for the number of beds for which grant assistance may be furnished. The following changes were enacted:

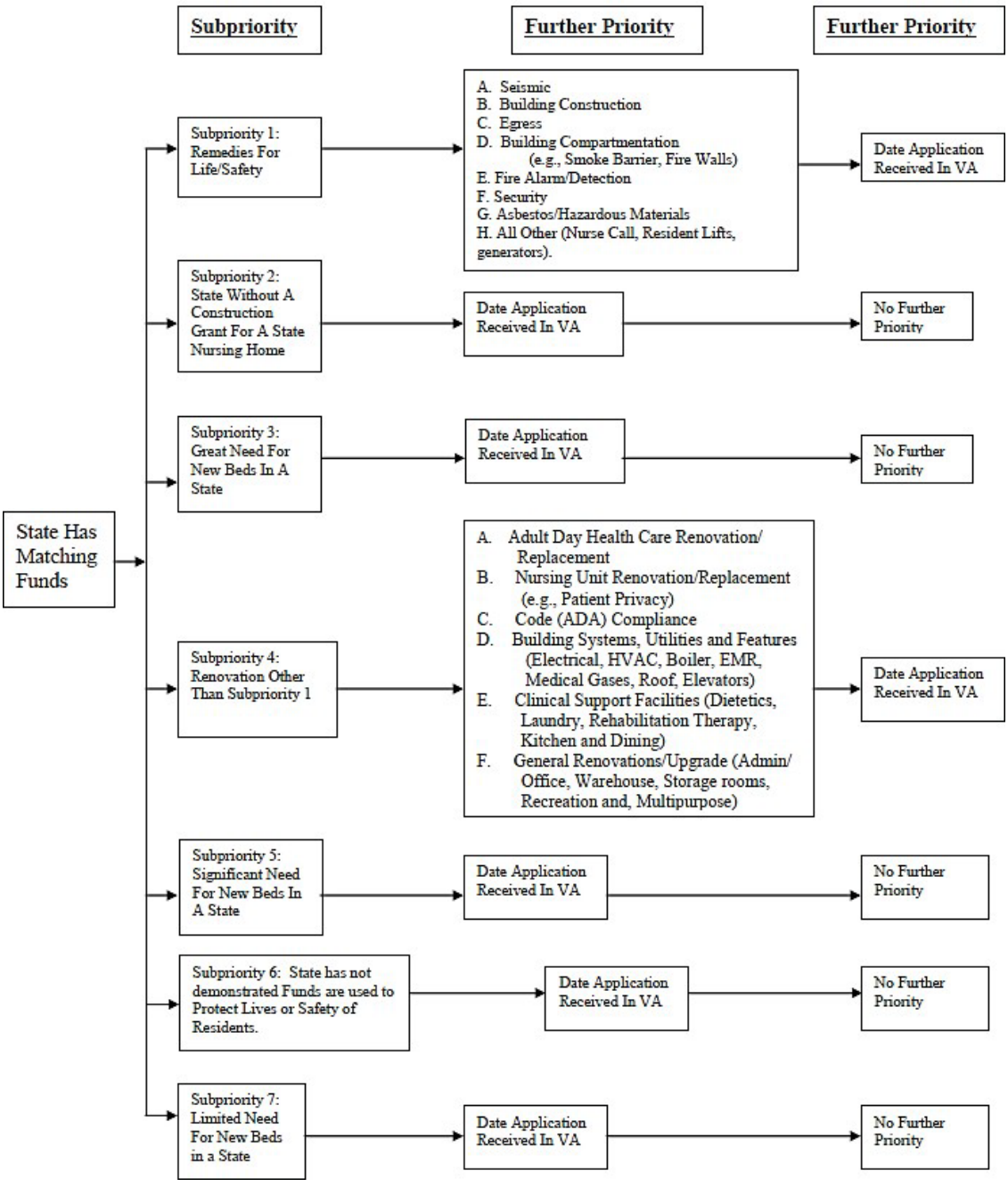
- Requires VA to establish criteria for determining the relative need for additional beds on the part of a state which already has such state home beds;
- Strengthens the requirements governing award of a grant;
- Revises provisions governing the relative priority of each application (among those projects for which states have made their funding available in advance);
- Differentiates among applications for new bed construction by reference to the relative need for such beds, by assigning a higher priority to renovation projects (with a total cost exceeding $400,000), with highest priority to renovations involving patient life or safety and by assigning second highest priority to an application from a state that has not previously applied for award of a VA construction grant or a grant for a state nursing home; and

- Establishes a "transition" rule providing that current regulations and provisions governing applications for state home grants would continue in effect with respect to applications for a limited number of projects. Those "grandfathered" projects are limited to those projects on the list of approved projects, established by the Secretary on October 29, 1998, for which the state had made sufficient funds available and those priority one projects on VA's 2000 list, approved by the Secretary on November 3, 1999, submitted by states which had not received 1999 grant monies and are not included in the October 29 list. All of the "grandfathered" projects received grants and are no longer included in the priority list.

## Project Prioritization

Currently, priority one projects are those with state matching funds set aside for the project. Within priority one, there are seven sub priority classifications. The following diagram illustrates the seven sub priority classifications and provides additional information on the methodology used to prioritize grants for the construction of state home facilities.

**Prioritization for Priority Group 1**



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# *Joint Medical Care Special Programs*

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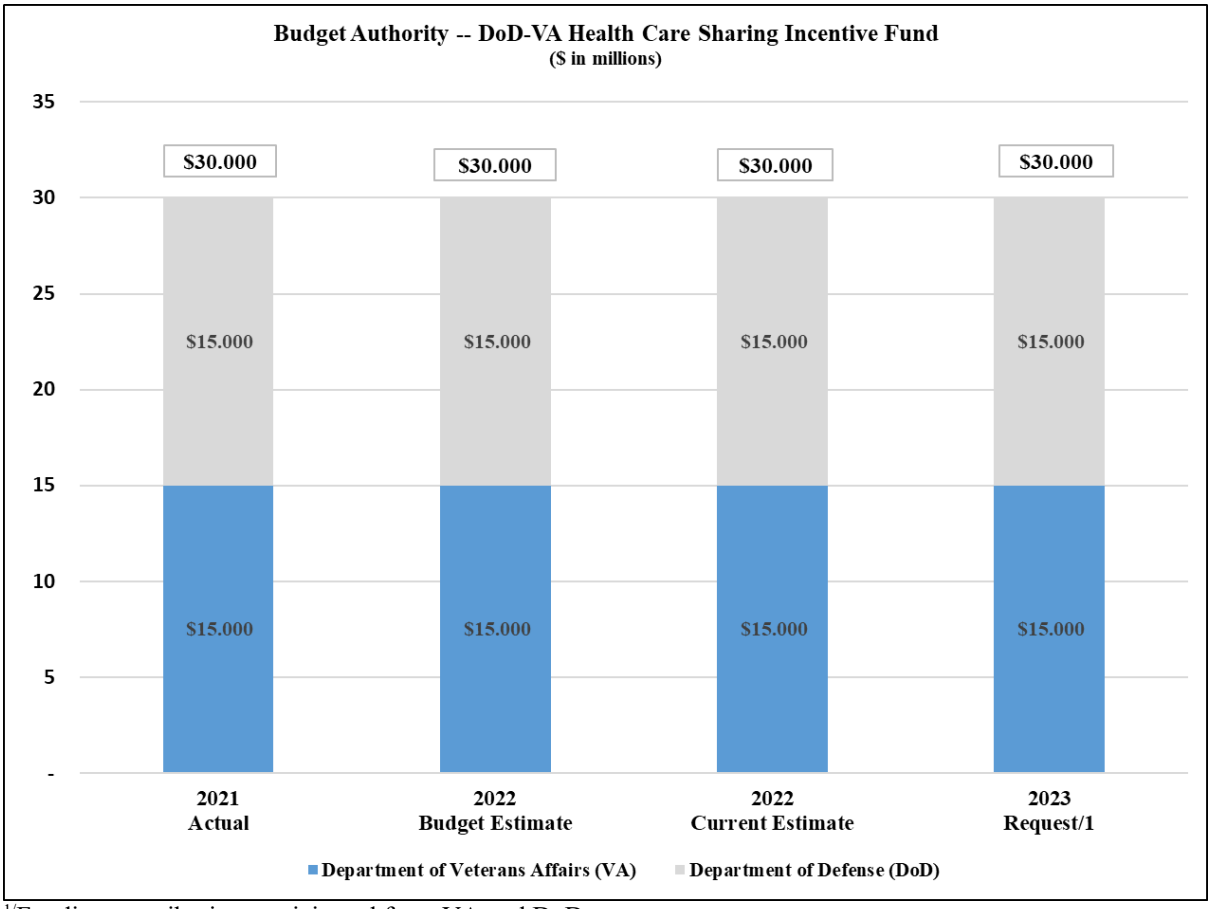
# *DoD-VA Health Care Sharing Incentive Fund*




[1/]Funding contributions anticipated from VA and DoD.

## Program Description

Congress created the DoD-VA Health Care Sharing Incentive Fund, regularly referred to as the Joint Incentive Fund (JIF), between the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to encourage development of sharing initiatives at the facility, intra-regional and nationwide level. The JIF program has been very successful in fostering collaboration and new approaches to problem solving that mutually benefit both VA and DoD.

Through the JIF, there is a minimum of $30 million available annually to enable VA and DoD to identify and provide incentives to implement creative sharing initiatives at the facility, intra-regional and nationwide levels. Section 8111(d) of title 38, United States Code (U.S.C.) requires each Secretary to contribute a minimum of $15 million from the funds appropriated to that

Secretary's Department. The DoD-VA Health Care Sharing Incentive Fund became effective on October 1, 2003. Public Law 116-92, the National Defense Authorization Act for 2020, section 736, amended section 8111(d)(3) of title 38, U.S.C. to extend the program to September 30, 2023. The funds are available until expended.

**Administrative Provision**

An administrative provision related to the JIF will be included in the VA chapter of the President's Budget Appendix:

> SEC. 222. Of the amounts available in this title for ''Medical Services'', "Medical Community Care", ''Medical Support and Compliance'' and ''Medical Facilities'', a minimum of $15,000,000 shall be transferred to the DOD–VA Health Care Sharing Incentive Fund, as authorized by section 8111(d) of title 38, United States Code, to remain available until expended, for any purpose authorized by section 8111 of title 38, United States Code.

**Governance and Accountability**

The VA-DoD Joint Executive Committee delegated the implementation of the fund to the Health Executive Committee (HEC). 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.

**2022 Projects**

JIF funding is considered to be an initial investment in the project to facilitate the mutually beneficial exchanges of health care resources, with the goal of improving the access to high quality and cost-effective health care provided to beneficiaries of both departments. JIF funding is designed and programmed to cover the start-up costs during the initial two-year JIF financial support period, after which time sustainment funding will be provided by the designated Department(s) as appropriate. Implementation of the following list of anticipated projects is subject to availability of funds and may execute over multiple years. Additional projects may be selected at a later date.

- ***DoD/VA National - Boothless Audiometry***

  The Boothless Audiometry Hearing Health Project is an interventional audiology project using boothless audiometry integrated in three DoD Air Force primary care clinics and two VA audiology services at VA health care facilities with tele audiology capabilities. Interventional audiology focuses on preventing and treating hearing loss before it becomes a barrier to other treatments or leads to other comorbidities. Boothless audiometry, a new audiometric testing capability for VA and DoD, is defined as hearing testing outside the audiometric test booth, using a tablet or personal computer. **Funding: $947,866**

- ***DoD/VA National - Unified Health Credentialing***

  The Unified Health Credentialing project makes accessing digital health services faster, easier and more reliable for shared DoD/VA health beneficiaries. The project also reduces the time and effort required for beneficiaries transitioning from DoD to VA to access digital health services, while reducing combined identity proofing costs and the burden on beneficiaries to identity proof multiple times. Under this proposal, beneficiaries will only need to establish and verify a single account to access both DoD and VA health portals, rather than creating and verifying multiple accounts. Finally, the project will work with beneficiaries (through extensive interviews, surveys and usage patterns) to understand their preferences on how they would like to digitally access and experience DoD / VA health services. **Funding: $2.3 million**

Examples of successful JIF projects

- ***DoD/VA National - Individual Longitudinal Exposure Record (ILER)***

  The development of the Individual Longitudinal Exposure Record 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 his/her career. It profoundly changes the way DoD and the VA provide exposure-related medical care and process exposure-related claims and benefits. The ILER will be central to the documentation and tracking of exposures and providing an improved basis for delivering DoD and VA exposure-related health care, medical surveillance, research and development and disability benefits. **Funding: $16.8 million from 2013–2022**

- ***Uniformed Services University of the Health Sciences (USU)/Miami Veterans Affairs Health Care System (MVAHCS) - Mobile Device Rehabilitation*** *(Phase 1 was completed in 2019 & Phase 2 is currently being implemented)*

  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 (ReLOAD), 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 his/her progress from the clinic. This effort assists those with lower limb amputation(s) in the return to their everyday activities while reducing the risk of secondary co-morbidities related to limb loss that would limit activity. **Funding: $8.5 million from 2014 – to date**

- ***DoD/VA National – 3D Printing*** *(Currently being implemented)*

  The project will unify existing field-level DoD and VA 3D printing efforts into a scalable DoD/VA 3D Printing Consortium. It will allow rapid sharing of best practices and organizational knowledge across field sites which will increase the number of patients who

receive 3D printing healthcare 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 – to date**

## VA-DoD Health Care Sharing Incentive Fund Crosswalk

(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Estimate | 2022-2023 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) | $80,620 | $98,120 | $88,770 | $94,959 | $6,189 |
| No-Year Unobligated Balance (EOY) | ($88,770) | ($115,620) | ($94,959) | ($101,148) | ($6,189) |
| Recovery Prior Year Obligations | $1,961 | $0 | $0 | $0 | $0 |
| Obligations | $23,811 | $12,500 | $23,811 | $23,811 | $0 |
| FTE: | | | | | |
| VA Civilian* | 29 | 11 | 29 | 29 | 0 |
| DoD Personnel** | 53 | 4 | 58 | 68 | 10 |
| Total FTE | 82 | 15 | 87 | 97 | 10 |

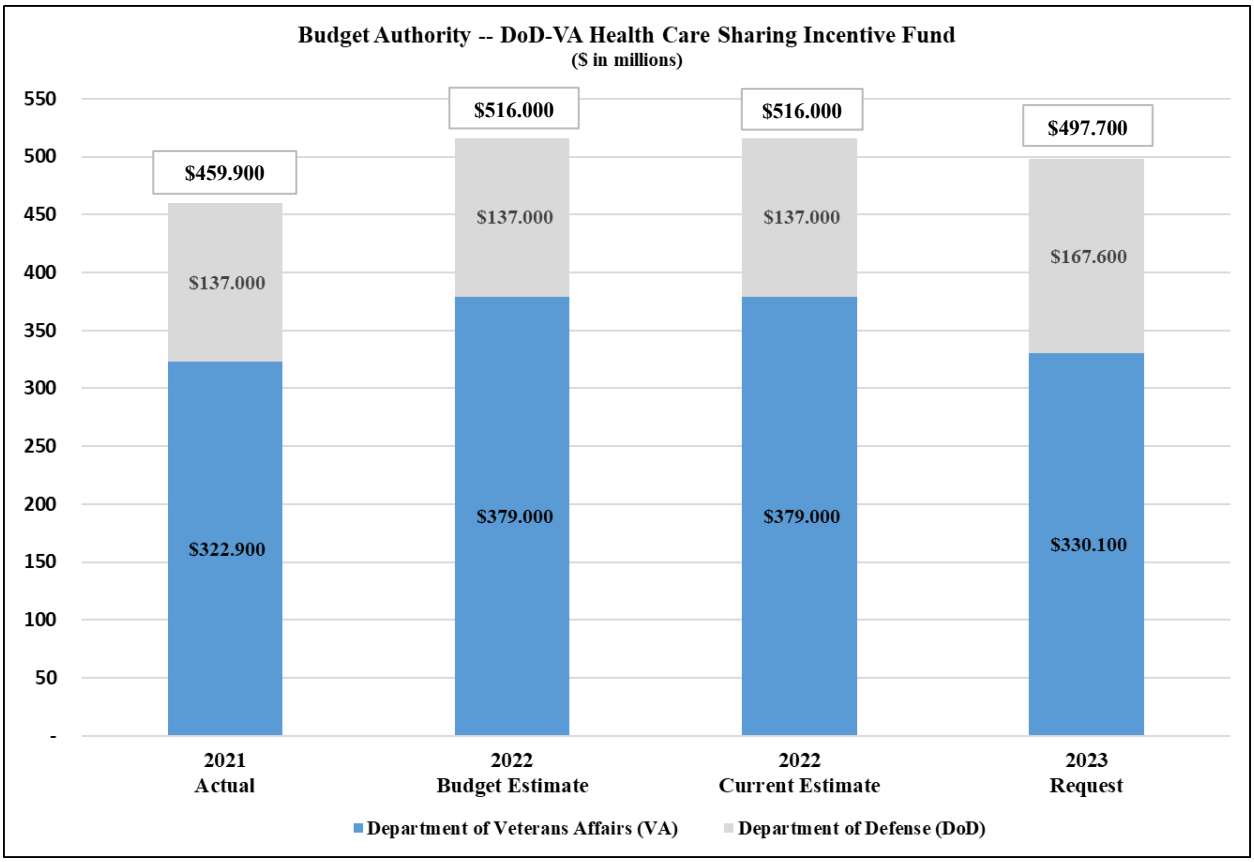
*Data source: VA Financial Management System (FMS). VA assumes a steady-state number of FTEs through the budget years.

**Data source: Defense Health Agency (DHA). Prior to 2021, the reported DoD Personnel data only captured the headquarters' FTEs. Starting in 2021, the counts reflect all FTEs working on active JIF projects across the country.

# *Joint DoD-VA Medical Facility Demonstration Fund*

## *For Captain James A. Lovell Federal Health Care Center, Illinois*

### DoD-VA Medical Facility Demonstration Fund Appropriation Transfers



## Financial Highlights

(dollars in thousands)

| Description | 2021 Actual 1/ | 2022 Budget Estimate | 2022 Current Estimate 2,9/ | 2023 Estimate 2/ | 2022-2023 Increase/ Decrease |
|---|---|---|---|---|---|
| Appropriation, Transfers From: | | | | | |
| Medical Services | $215,945 | $203,805 | $203,805 | $190,377 | ($13,428) |
| Medical Community Care | $28,392 | $43,768 | $43,768 | $50,768 | $7,000 |
| Medical Support & Compliance | $30,213 | $30,613 | $30,613 | $30,613 | $0 |
| Medical Facilities | $40,297 | $92,830 | $92,830 | $50,297 | ($42,533) |
| VA Information Technology | $8,085 | $7,993 | $7,993 | $8,085 | $92 |
| Subtotal, VA Contribution | $322,932 | $379,009 | $379,009 | $330,140 | ($48,869) |
| Department of Defense (DoD) 3/ | $137,000 | $137,000 | $137,000 | $167,610 | $30,610 |
| Total Appropriations 4/ | $459,932 | $516,009 | $516,009 | $497,750 | ($18,259) |
| Collections 5/ | $12,829 | $16,602 | $15,641 | $15,598 | ($43) |
| Reimbursements 6/ | $11,692 | $13,300 | $13,300 | $13,300 | $0 |
| Unob. Bal. (SOY) | $6,943 | $0 | $213 | $0 | ($213) |
| Transfer of CARES Act Unob. Bal. from MS (0160) (P.L. 116-136 §20001) | $10,000 | $0 | $0 | $0 | $0 |
| Unob. Bal. (EOY) | ($213) | $0 | $0 | $0 | $0 |
| Recovery Prior Year Obligations | $0 | $0 | $0 | $0 | $0 |
| Lapse | ($7) | $0 | $0 | $0 | $0 |
| Obligations | $501,176 | $545,911 | $545,163 | $526,648 | ($18,515) |
| *Other DoD Contributions:* | | | | | |
| *MERHCF DoD reimbursement (Included Above)* | *$7,740* | *$7,740* | *$7,740* | *$6,479* | ($1,261) |
| *DoD "Stay Navy" (Excluded from Total Obligations) 7/* | *$14,599* | *$4,100* | *$14,599* | *$4,100* | ($10,499) |
| FTE: | | | | | |
| Civilian | 2,275 | 2,308 | 2,290 | 2,324 | 34 |
| DoD Uniformed Military 8/ | 906 | 906 | 906 | 776 | (130) |
| Total FTE | 3,181 | 3,214 | 3,196 | 3,100 | (96) |

1/ Excludes resources from section 8002 or 8007 of the American Rescue Plan Act. Final allocation of American Rescue Plan Act funding may change in response to workload demand requirements throughout 2022 and 2023.

2/ 2022 and 2023 estimates are based upon the best available information at the time of the development of the budget. These estimates are subject to revision as operational estimates are refined for the Captain James A. Lovell Federal Healthcare Center (JALFHCC). These estimates are in compliance with Public Law 111-84 which established this fund. P.L. 114-223 authorizes contributions from Medical Community Care beginning in 2017.

3/ The actual amount of the Medicare-Eligible Retiree Health Care Fund (MERHCF) reimbursement will impact DoD transfer amount.

4/ Total excludes Stay Navy contribution and MERHCF reimbursement.

5/ Reflects estimated medical care collections, as provided by the VA Office of Community Care.

6/ Reflects estimated MERHCF reimbursement from DoD.

7/ Non-add for Personal Services Contract funded by DoD for the East Campus.

8/ 2022 and 2023 Estimates are from the 2021 Navy Manning Plan. Estimates do not reflect the number of DoD Uniform Military FTE subject to Reconciliation in the JALFHCC Joint Areas.

[9/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements and medical care collections.

## Funding Highlights

The 2023 projected transfers from the Department of Veterans Affairs (VA) and the Department of Defense (DoD) fund the projected financial needs for the Captain James A. Lovell Federal Health Care Center (JALFHCC), as determined by a health care workload analysis and an assessment of the Non-Recurring Maintenance (NRM) requirements for Electronic Health Record Modernization (EHRM). VA will work to achieve the right balance between care provided in the community and care provided through VA throughout the VA health care system, including at JALFHCC.

## Program Description

On May 27, 2005, the VA/ DoD Health Executive Council (HEC) signed an agreement to integrate the North Chicago VA Medical Center (NCVAMC) and the Navy Health Clinic Great Lakes (NHCGL). This landmark agreement created an organization composed of all the medical and dental components on both VA and Department of Navy property under the leadership of a VA Senior Executive Service (SES) Medical Center Director and a Navy Captain (O-6) Deputy Director. The leadership functions in concert with an Interagency Advisory Board and a local Stakeholder Advisory Board. To support the integration of NHCGL and NCVAMC, a $118 million DoD construction project was awarded to construct a new federal ambulatory care clinic and parking facilities co-located with NCVAMC. The project was completed on September 27, 2010, and the first multiple specialty clinic opened on December 20, 2010. The approved Governance Model, with VA as the Lead Partner, relies on an extensive Resource Sharing Agreement (RSA) between the current NCVAMC and NHCGL. This RSA ensures strict adherence to the title 38 requirement that one entity may not endanger the mission of the other entity engaged in a RSA.

The integrated organization – JALFHCC – is comprised of two campuses, West and East Campuses. The West Campus has 48 buildings on 94 acres of land between Green Bay Road and Buckley Road in North Chicago, Illinois. The East Campus has four medical facilities on Naval Station Great Lakes, Illinois. There are two Community Based Outpatient Clinics (CBOCs) in Evanston and McHenry, Illinois and one in Kenosha, Wisconsin. The JALFHCC has 365 available beds and treated 732,919 outpatient encounters and 4,521 inpatient admissions in 2021.[45]

The JALFHCC began using a single unified budget in 2011 to operate the integrated facility and execute funding using the VA Financial Management System (FMS). An account under the Department of Veterans Affairs, "Joint Department of Defense - Department of Veterans Affairs Medical Facility Demonstration Fund" (referred to as the "Fund"), was effective beginning in 2011 (4th Quarter).

[45] Due to the COVID-19 pandemic, the number of elective surgeries completed in 2021 has been reduced, resulting in a decrease in the number of inpatient admissions. The reduced capacity has also resulted in a decrease in outpatient encounters, as compared to 2020.

VA and DoD determine the JALFHCC expenses that can be attributed to VA and DoD, based on cost, workload and the consumption of resources by each Department's beneficiaries. This reconciliation model is used as the basis for preparing future budgets. The reconciliation methodology uses agreed-upon full costing methods and execution data to determine the costs attributable to each Department. The reconciliation methodology uses industry standard measurements such as Relative Value Units (RVUs) and Relative Weighted Products (RWPs) for the determinations of workload values to be compared to VA's Decision Support System (DSS) full costs. Both Departments will continue to work together to improve upon an equitable reconciliation process and ensure respective Department financial controls are implemented.

The authorities to use this Fund shall terminate on September 30, 2023.

**Administrative Provisions**

VA is proposing continuing the following administrative provisions in accordance with Public Law 111-84, NDAA 2010, for 2023, as included in the President's Budget:

> SEC. 219. Of the amounts appropriated to the Department of Veterans Affairs for fiscal year 2023 for "Medical Services", "Medical Community Care", "Medical Support and Compliance", "Medical Facilities", "Construction, Minor Projects", and "Information Technology Systems", up to $330,140,000, 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 116–260 is repealed.
>
> SEC. 220. Of the amounts appropriated to the Department of Veterans Affairs which become available on October 1, 2023, for "Medical Services", "Medical Community Care", "Medical Support and Compliance", and "Medical Facilities", up to $314,825,000, 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. 3571); and (2) for operations of the facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110–417; 122 Stat. 4500): *Provided*, That, notwithstanding section 1704(b)(3) of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111–84; 123 Stat. 2573), amounts transferred to the Joint Department of Defense—Department of Veterans Affairs Medical Facility Demonstration Fund shall remain available until expended.

Also, in accordance with Public Law 111-84, NDAA 2010, DoD is proposing the following general provision, for 2023, as included in the President's Budget:

Section 8051. From within the funds appropriated for operation and maintenance for the Defense Health Program in this Act, up to $168,000,000 shall be available for transfer to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund in accordance with the provisions of section 1704 of the National Defense Authorization Act for Fiscal Year 2010, Public Law 111-84: Provided, That for purposes of section 1704(b), the facility operations funded are operations of the integrated Captain James A. Lovell Federal Health Care Center, consisting of the North Chicago Veterans Affairs Medical Center, the Navy Ambulatory Care Center, and supporting facilities designated as a combined Federal medical facility as described by section 706 of Public Law 110-417: Provided further, That additional funds may be transferred from funds appropriated for operation and maintenance for the Defense Health Program to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund upon written notification by the Secretary of Defense to the Committees on Appropriations of the House of Representatives and the Senate.

**Justification for VA Administrative Provisions:**

The first VA provision (Sec. 219) is required to permit the transfer of funds from specific VA appropriations to the Fund, which was established by Public Law 111-84, section 1704. Section 1704(a)(2)(A) and (B) specify that the Fund will consist of amounts transferred from amounts authorized and appropriated for the DoD and VA specifically for the purpose of providing resources for this Fund. The second provision (Sec. 220) permits the transfer of funds for fiscal year 2024.

The second provision (Sec. 220) in the 2023 budget includes the funding requested to be appropriated and transferred to the Fund within the appropriations request for Medical Services, Medical Support and Compliance, Medical Facilities and Medical Community Care.

The third provision (Sec. 221) authorizes the transfer of funds from the Medical Care Collections Fund to the Fund. Section 1704 of Public Law 111-84 allows VA and DoD to deposit medical care collections to this Fund. Section 1704(b)(2) specifies that the availability of funds transferred to the Fund under subsection (a)(2)(C) shall be subject to the provisions of 1729A of title 38, United States Code (U.S.C). Title 38, U.S.C., section 1729A(e), requires that: (e) amounts recovered or collected under the provisions of law referred to in subsection (b) shall be treated for the purposes of sections 251 and 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901, 902) as offsets to discretionary appropriations to the extent that such amounts are made available for expenditure in appropriations Acts for the purposes specified in subsection (c).

# *Health Care Sharing and VA/DoD Sharing*

**Health Care Sharing**

The Department of Veterans Affairs (VA) procures medical services to strengthen the medical programs at VA Medical Centers (VAMCs) and to improve the quality of health care provided to Veterans under title 38 United States Code (USC). 38 USC 8153 authorizes contracting officers to sole source directly to educational institutions when that institution is affiliated with a VA residency program and the "health-care resource required is a commercial service, the use of medical equipment or space, or research."

As a result, VA purchases medical care services from its academic affiliates, and the obligations associated with this activity are reported on the line, "Services Purchased by VA." The bulk of these contracts are for providing locum tenens physicians, etc., to fill in gaps when there are no VA physicians available, or the internal VA workload is heavy. Services procured through this program are generally performed by academic affiliate providers at VA Medical Centers.

The VA statute also enables the opportunity for VA to collect reimbursements by providing medical care services, equipment or space to its academic affiliate partners. The obligations associated with this activity are reported on the line, "Services Provided by VA."

This authority is a critical component of VA's education and training mission. As one of four statutory missions, VA conducts an education and training program for health professions students and residents to enhance the quality of care provided to veteran patients within the Veterans Health Administration (VHA) system.

Although VA relies on several title 38 authorities for procuring services outside the VA, the following information discusses activities conducted by VA's Office of Acquisition Logistics and Construction (OALC) and VHA Office of Procurement and Logistics pursuant to 38 USC Section 8153 for activity from 2021.

## Health Care Sharing Obligations and Reimbursements

**Health Care Sharing**
(dollars in thousands)

| Description | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Advance Approp. | **2023 Revised Request /2** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|---|
| Services Purchased by VA: | | | | | | | | |
| Medical Service (0160) VHA Contracting Obligations | $841,210 | $1,742,000 | $832,798 | $1,742,000 | **$832,798** | **$832,798** | $0 | $0 |
| Medical Service (0160) National Contracting Obligations /1 | $3,178,369 | | $3,146,585 | | **$3,146,585** | **$3,146,585** | $0 | $0 |
| Medical Service (0160) Obligations Total | $4,019,579 | $1,742,000 | $3,979,383 | $1,742,000 | **$3,979,383** | **$3,979,383** | $0 | $0 |
| Services Provided by VA: | | | | | | | | |
| Medical Service (0160) Reimbursements /2 | $46,294 | $41,900 | $45,599 | $40,900 | **$44,599** | **$43,599** | ($1,000) | ($1,000) |
| Medical Service (0160) Obligations and Reimbursements Total | $4,065,873 | $1,783,900 | $4,024,982 | $1,782,900 | **$4,023,982** | **$4,022,982** | ($1,000) | ($1,000) |

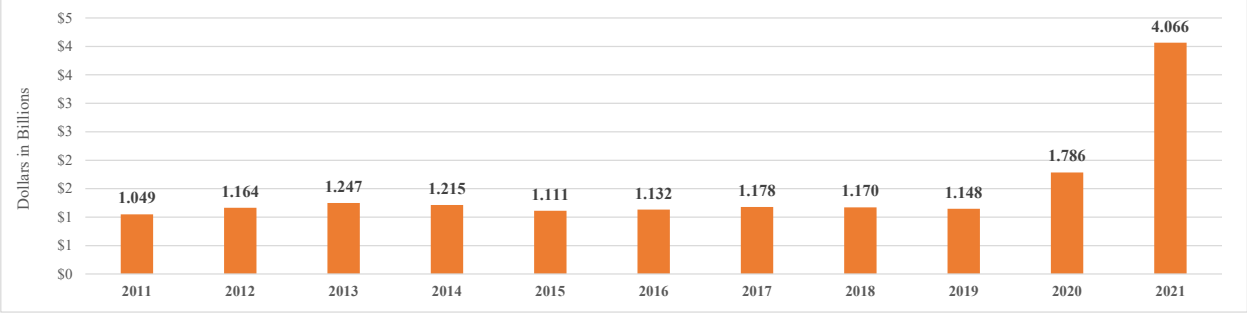
1/ For the first time, this chart includes department-wide National Contracting data.

2/ Estimates are averaging historical reimbursement data over the past five years.

The total amount of health care resource sharing for 2021 was approximately $4.1 billion, an increase of 127.7% above $1.8 billion in 2020.[46] This represents procurement of approximately $4.0 billion and reimbursements totaling approximately $45.6 million.

Chart 1 reflects the growth of the health care resources sharing program since 2011. The bars represent the total health care resource services procured and revenue generated by VA contracting officers during a fiscal year.

### Chart 1. Health Care Resources Sharing Program




Source: Department of Veterans Affairs, Annual Report on Sharing of Health Care Resources, 2021.

## VA Health Care Facilities and Sharing

Traditionally, large VAMCs are more likely to have more extensive sharing arrangements. The referral system of medical practice enhances the size of these sharing programs as patients flow from smaller hospitals and clinics to tertiary care centers. The diversity of sharing arrangements is also influenced by the specialized capability of larger academic medical centers to manage difficult

[46] 2020 and 2021 data are not comparable as 2020 data did not include department-wide National Contracting data.

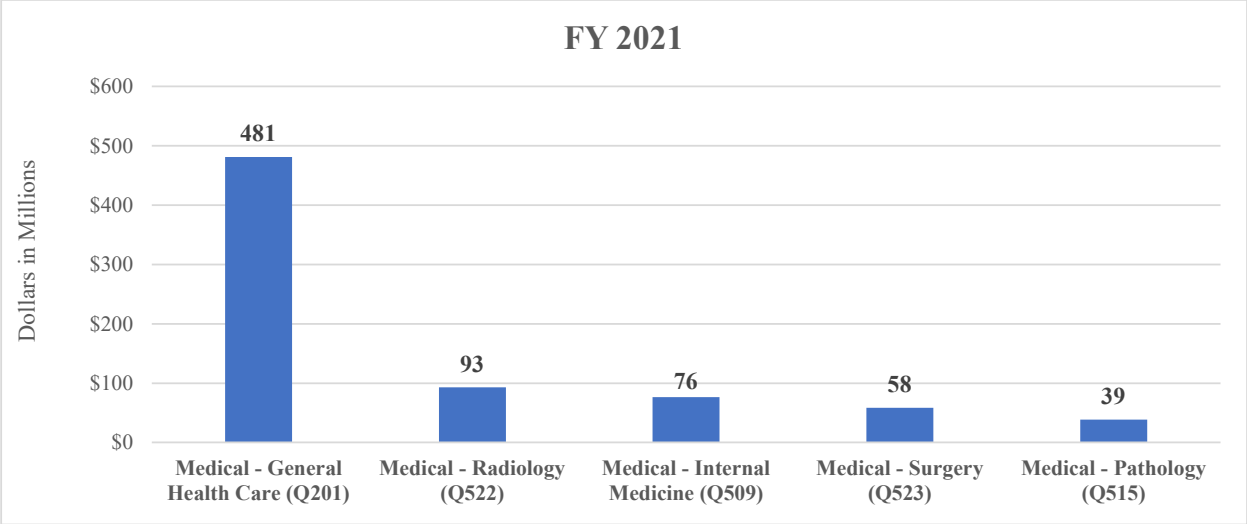
medical care problems. VAMCs in small metropolitan areas rely heavily on sharing agreements to provide health care resources not available at the VA facility.

### Procurements

The procurements are primarily in the following areas: radiation therapy, diagnostic radiology, cardiology, cardio-vascular surgery, anesthesiology and orthopedics. Patients from small hospitals in need of specialty services such as open-heart surgery are often referred to large, affiliated medical centers under this sharing authority.

Chart 2 presents the categories of services purchased by VA with the highest total obligation levels in 2021. These categories account for $747.0 million of total VA purchases of $4.1 billion in obligations that year.

**Chart 2. Common Health Care Resources Procured**



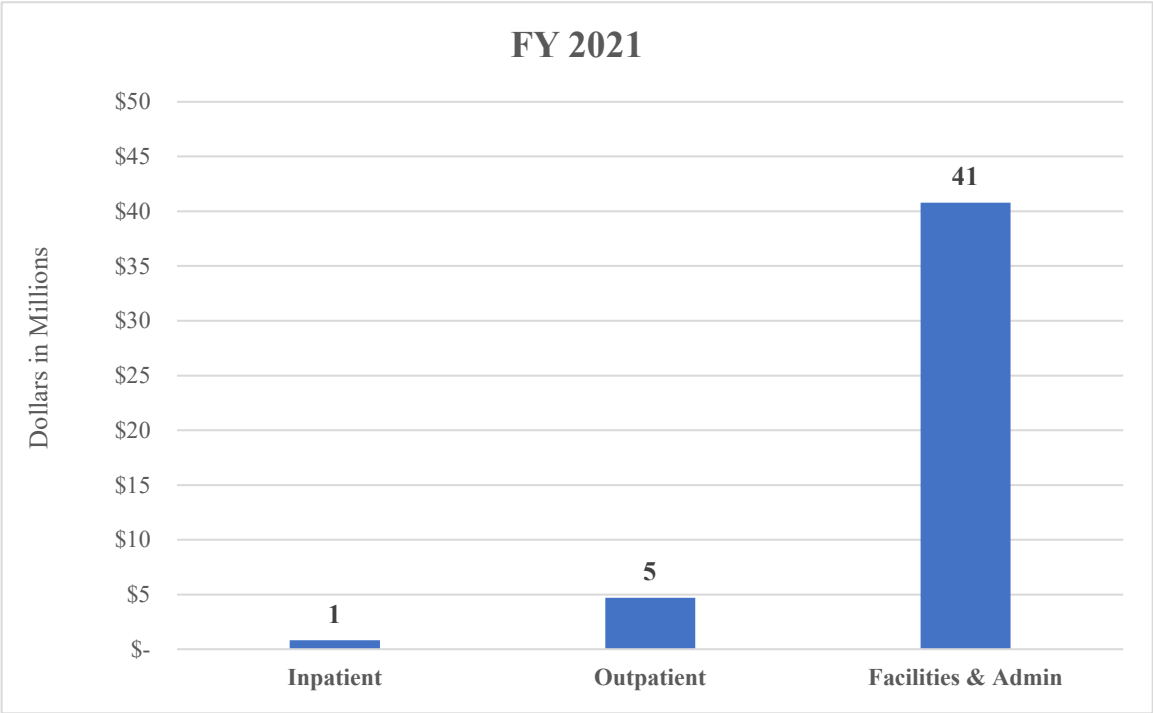

Source: Department of Veterans Affairs, Annual Report on Sharing of Health Care Resources, 2021.

### 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 resources not fully utilized for the care of Veterans may share these resources with other community entities. Such resources are more cost-effective when shared. The reimbursements received from these sharing agreements are retained by the VAMC and are used to enhance services and supports.

Chart 3 presents total reimbursements in 2021 from affiliated medical colleges, community hospitals and other sharing partners.

**Chart 3. Reimbursements from Health Care Resources Sharing**




Source: Department of Veterans Affairs, Annual Report on Sharing of Health Care Resources, 2021.

# VA / DoD Sharing Obligations and Reimbursements

**VA / DoD Sharing**
(dollars in thousands)

| Description | 2021 Actual 1/ | 2022 Budget Estimate | 2022 Current Estimate | 2023 Advance Approp. | **2023 Revised Request** | **2024 Advance Approp.** | +/- 2022-2023 | +/- 2023-2024 |
|---|---|---|---|---|---|---|---|---|
| DoD-Provided Services Purchased by VA | | | | | | | | |
| Medical Community Care (0140) Obligations | $93,572 | $118,155 | $100,122 | $126,426 | **$107,131** | **$114,630** | $7,009 | $7,499 |
| VA-Provided Services Purchased by DoD | | | | | | | | |
| Medical Services (0160) Reimbursements | $73,822 | $61,807 | $72,346 | $60,570 | **$70,899** | **$69,481** | ($1,447) | ($1,418) |

1/ Itemized detail of DoD-Provided Services Purchased by VA in 2021 is as follows:

| Obligations | |
|---|---|
| (8321) Army | $49,450 |
| (8322) Air Force | $33,191 |
| (8323) Navy | $10,392 |
| (8324) Defense Health Agency | $539 |
| Obligations Total | $93,572 |

1/ Itemized detail of VA-Provided Services Purchased by DoD in 2021 is as follows:

| Reimbursements | |
|---|---|
| DoD Sharing - All Other | $24,727 |
| DoD Sharing - Inpatient | $2,991 |
| DoD Sharing - Outpatient | $434 |
| CHAMPUS - Inpatient | $0 |
| CHAMPUS - Outpatient | $0 |
| CHAMPUS - All Other | $6 |
| TRICARE - Inpatient | $9,027 |
| TRICARE - Outpatient | $12,446 |
| TRICARE - All Other | $3,845 |
| TRICARE - Pharmacy | $15 |
| TRICARE - Active Duty Dental | $1 |
| DoD Disability Evaluation - IDES | $20 |
| DoD Spinal Cord Injury - Inpatient | $4,183 |
| DoD Spinal Cord Injury - Outpatient | $4 |
| DoD Spinal Cord Injury - Other | $1,083 |
| DoD Brain Injury - Inpatient | $12,204 |
| DoD Brain Injury - Outpatient | $6 |
| DoD Brain Injury - Other | $2,787 |
| DoD Blind Rehab - Inpatient | $39 |
| DoD Blind Rehab - Outpatient | $5 |
| DoD Blind Rehab - Other | $0 |
| Reimbursements Total | $73,822 |

Title 38 USC. Section 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 the access to, and quality and cost effectiveness of, the health care provided by VHA and the Military Health System to the beneficiaries of both Departments. The obligations and reimbursements shown above[47] are the result of 147 active sharing agreements with 1,107 shared services between 144 facilities (66 VA and 78 DoD) nationwide as of September 2021. This is a 49%[48] increase in the number of shared services included in agreements since September 2020; they do not reflect the funding that the two Departments contribute to the two joint VA-DoD

[47] VA/DoD Sharing Program has been assisting VA/VHA Finance in assessing and improving fiscal data in preparation for US Treasuries mandated implementation of G-Invoicing, VA's transition to its new Integrated Financial and Asset Management System (I-FAMS), as well as VA's and DoD's transition to a new electronic health record (EHR).

[48] VA has been standardizing several VA/DoD resource sharing and fiscal processes to improve data capture and reliability. This has resulted in more comprehensive capture of data on shared healthcare resources between VA and DoD. VA will continue to monitor the factors affecting the quality of data and expects to see fluctuation over the next several years.

accounts, the DoD-VA Health Care Sharing Incentive Fund and the Joint DoD-VA Medical Facility Demonstration Fund.

The following chart represents a summary of the 147 active sharing agreements with 1,107 shared services as of September 30, 2021.

**2021 VA-DoD Health Care Resource Sharing Summary**

| VISN | Shared Service Type | Provider | Number of Shared Services |
|---|---|---|---|
| **VA Central Office** | Administration & Support | DoD/VA | 1 |
| | Ambulatory Care Services | DoD | 1 |
| | Ancillary Services | DoD | 1 |
| | **Total** | | **3** |
| **1** | Clinical Competency / Readiness Training | VA | 1 |
| | **Total** | | **1** |
| **2** | Administration & Support | VA | 1 |
| | Ambulatory Care Services | DoD | 10 |
| | | VA | 1 |
| | Ancillary Services | DoD | 3 |
| | | VA | 3 |
| | Clinical Competency / Readiness Training | VA | 1 |
| | Competency / Readiness Training | DoD | 1 |
| | Inpatient Services | DoD | 2 |
| | **Total** | | **22** |
| **4** | Ambulatory Care Services | DoD | 57 |
| | Ancillary Services | DoD | 8 |
| | Clinical Competency / Readiness Training | DoD/VA | 1 |
| | | VA | 2 |
| | Inpatient Services | DoD | 40 |
| | **Total** | | **108** |
| **5** | Administration & Support | DoD | 7 |
| | | DoD/VA | 2 |
| | Ambulatory Care Services | DoD | 3 |
| | | DoD/VA | 25 |
| | | VA | 6 |
| | Ancillary Services | DoD | 3 |
| | | DoD/VA | 3 |
| | Clinical Competency / Readiness Training | VA | 1 |
| | Dental Services | VA | 1 |
| | Inpatient Services | DoD | 1 |
| | | VA | 1 |
| | **Total** | | **53** |

| VISN | Shared Service Type | Provider | Number of Shared Services |
|---|---|---|---|
| 6 | Administration & Support | DoD | 4 |
| | | DoD/VA | 1 |
| | Ambulatory Care Services | DoD | 90 |
| | | DoD/VA | 3 |
| | Ancillary Services | DoD | 35 |
| | Clinical Competency / Readiness Training | DoD/VA | 1 |
| | | VA | 1 |
| | Dental Services | DoD | 7 |
| | Inpatient Services | DoD | 73 |
| | | DoD/VA | 2 |
| | | VA | 2 |
| | Other & Military Unique | DoD | 1 |
| **Total** | | | **220** |
| 7 | Administration & Support | DoD | 1 |
| | Administration & Support | DoD | 15 |
| | | DoD/VA | 2 |
| | | VA | 2 |
| | Ambulatory Care Services | DoD | 21 |
| | | DoD/VA | 3 |
| | | VA | 12 |
| | Ancillary Services | DoD | 12 |
| | | DoD/VA | 2 |
| | | VA | 4 |
| | Clinical Competency / Readiness Training | DoD/VA | 1 |
| | | VA | 2 |
| | Competency / Readiness Training | DoD/VA | 1 |
| | Dental Services | VA | 1 |
| | Inpatient Services | DoD | 14 |
| | | DoD/VA | 1 |
| | | VA | 2 |
| | Other & Military Unique | DoD | 2 |
| **Total** | | | **98** |

| VISN | Shared Service Type | Provider | Number of Shared Services |
|---|---|---|---|
| 8 | Administration & Support | DoD | 2 |
| | | VA | 3 |
| | Ambulatory Care Services | DoD | 2 |
| | | VA | 1 |
| | Ancillary Services | DoD | 2 |
| | Clinical Competency / Readiness Training | VA | 3 |
| | Competency / Readiness Training | VA | 1 |
| **Total** | | | **14** |
| 9 | Administration & Support | DoD | 2 |
| | Ambulatory Care Services | DoD/VA | 4 |
| | | VA | 1 |
| | Ancillary Services | DoD | 1 |
| | | DoD/VA | 3 |
| | Inpatient Services | DoD/VA | 1 |
| **Total** | | | **12** |
| 10 | Administration & Support | DoD | 3 |
| | Ambulatory Care Services | DoD | 10 |
| | Ancillary Services | DoD | 3 |
| | Inpatient Services | DoD | 19 |
| | Administration & Support | DoD | 2 |
| | Ambulatory Care Services | VA | 1 |
| | Clinical Competency / Readiness Training | DoD/VA | 1 |
| | | VA | 1 |
| | Competency / Readiness Training | DoD/VA | 1 |
| | Inpatient Services | DoD | 39 |
| **Total** | | | **80** |
| 12 | Ambulatory Care Services | VA | 1 |
| | Ancillary Services | VA | 1 |
| **Total** | | | **2** |
| 15 | Ambulatory Care Services | DoD | 11 |
| | Ancillary Services | DoD | 3 |
| | Inpatient Services | DoD | 7 |
| | Administration & Support | DoD | 2 |
| | | VA | 1 |
| | Ambulatory Care Services | DoD | 14 |
| | | VA | 9 |
| | Ancillary Services | DoD | 7 |
| | | VA | 1 |
| | Clinical Competency / Readiness Training | VA | 1 |
| | Dental Services | VA | 1 |
| | Inpatient Services | DoD | 17 |
| | Other & Military Unique | VA | 1 |
| **Total** | | | **75** |

| VISN | Shared Service Type | Provider | Number of Shared Services |
|---|---|---|---|
| 16 | Administration & Support | DoD/VA | 1 |
| | | VA | 11 |
| | Ambulatory Care Services | DoD | 56 |
| | | DoD/VA | 1 |
| | | VA | 5 |
| | Ancillary Services | DoD | 10 |
| | Clinical Competency / Readiness Training | VA | 3 |
| | Competency / Readiness Training | VA | 1 |
| | Competency / Readiness Training | DoD/VA | 2 |
| | Dental Services | DoD | 2 |
| | Inpatient Services | DoD | 14 |
| | Other & Military Unique | DoD/VA | 1 |
| **Total** | | | **107** |
| 17 | Administration & Support | DoD | 2 |
| | | VA | 1 |
| | Ambulatory Care Services | DoD | 16 |
| | | VA | 1 |
| | Ancillary Services | DoD | 4 |
| | | VA | 1 |
| | Clinical Competency / Readiness Training | DoD/VA | 4 |
| | Dental Services | DoD | 1 |
| | Inpatient Services | DoD | 5 |
| | Other & Military Unique | DoD | 2 |
| **Total** | | | **37** |
| 19 | Administration & Support | DoD | 1 |
| | | VA | 5 |
| | Ambulatory Care Services | DoD | 9 |
| | | DoD/VA | 1 |
| | | VA | 2 |
| | Ancillary Services | DoD | 5 |
| | | VA | 2 |
| | Clinical Competency / Readiness Training | DoD/VA | 1 |
| | Competency / Readiness Training | VA | 1 |
| **Total** | | | **27** |

| VISN | Shared Service Type | Provider | Number of Shared Services |
|---|---|---|---|
| 20 | Ancillary Services | VA | 1 |
| | Administration & Support | DoD | 9 |
| | | DoD/VA | 1 |
| | | VA | 3 |
| | Ambulatory Care Services | DoD | 14 |
| | | DoD/VA | 4 |
| | | VA | 3 |
| | Ancillary Services | DoD | 7 |
| | | DoD/VA | 1 |
| | | VA | 2 |
| | Clinical Competency / Readiness Training | VA | 3 |
| | Competency / Readiness Training | DoD | 1 |
| | | DoD/VA | 1 |
| | Dental Services | DoD | 1 |
| | Inpatient Services | DoD | 8 |
| | | DoD/VA | 2 |
| | | VA | 2 |
| | Other & Military Unique | DoD/VA | 1 |
| **Total** | | | **64** |
| 21 | Ambulatory Care Services | DoD | 2 |
| | Inpatient Services | DoD/VA | 2 |
| | | VA | 2 |
| | Administration & Support | DoD | 2 |
| | | DoD/VA | 1 |
| | | VA | 6 |
| | Ambulatory Care Services | DoD | 37 |
| | | DoD/VA | 1 |
| | | VA | 13 |
| | Ancillary Services | DoD | 9 |
| | | VA | 10 |
| | Clinical Competency / Readiness Training | DoD/VA | 1 |
| | | VA | 4 |
| | Dental Services | DoD | 3 |
| | Inpatient Services | DoD | 27 |
| | | VA | 2 |
| **Total** | | | **122** |

| VISN | Shared Service Type | Provider | Number of Shared Services |
|---|---|---|---|
| 22 | Administration & Support | DoD | 2 |
| | | DoD/VA | 4 |
| | | VA | 12 |
| | Ambulatory Care Services | DoD | 2 |
| | | VA | 3 |
| | Ancillary Services | DoD/VA | 2 |
| | | VA | 6 |
| | Clinical Competency / Readiness Training | DoD/VA | 3 |
| | | VA | 3 |
| | Competency / Readiness Training | VA | 1 |
| | Dental Services | DoD/VA | 1 |
| | Inpatient Services | DoD | 4 |
| | | DoD/VA | 2 |
| | | VA | 1 |
| | Other & Military Unique | DoD/VA | 3 |
| **Total** | | | **49** |
| 23 | Ancillary Services | VA | 1 |
| | Administration & Support | DoD | 1 |
| | | VA | 1 |
| | Ambulatory Care Services | DoD/VA | 1 |
| | Ancillary Services | VA | 1 |
| | Clinical Competency / Readiness Training | DoD/VA | 1 |
| | | VA | 3 |
| | Competency / Readiness Training | DoD/VA | 1 |
| | | VA | 1 |
| | Competency / Readiness Training | VA | 1 |
| | Inpatient Services | VA | 1 |
| **Total** | | | **13** |
| **Total Shared Services** | | | **1,107** |

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# *Medical and Prosthetic Research*

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# *Medical and Prosthetic Research*

## Table: Appropriations and Other Federal Resources

(dollars in thousands)

| | 2021 Actual | 2022 Request | 2022 Current Estimate | 2023 Request | % Change 2023 Req-2022 Est. |
|---|---|---|---|---|---|
| Medical and Prosthetic Research Appropiation[1] | $795,000 | $882,000 | $882,000 | $916,000 | 4% |
| American Rescue Plan Appropiation/Reallocation (P.L. 117-2, Section 8002)[2] | $9,000 | $0 | $30,000 | $0 | 0% |
| Medical Care Support[3] | $668,115 | $749,700 | $749,700 | $778,600 | 4% |
| Other Federal and Non-Federal Resources | $531,535 | $540,000 | $540,000 | $540,000 | 0% |
| Reimbursements | $42,888 | $61,000 | $61,000 | $61,000 | 0% |
| **Total Budgetary Resources[4]** | **$2,046,537** | **$2,232,700** | **$2,262,700** | **$2,295,600** | 1% |
| **Total FTE** | **4,175** | **3,585** | **4,292** | **4,523** | 5% |
| *Medical and Prosthetic Research Appropriation (Discretionary)5* | *4,135* | *3,585* | *4,284* | *4,410* | 3% |
| *American Recovery Plan (P.L. 117-2, Section 8002) (Mandatory)* | *40* | *0* | *8* | *113* | |

1. The appropriation amounts for 2021 is net of a rescission $20 Million from P.L. 116-260 align with Congressional scoring. (Public Law 117-2, Section 8002). The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements, and medical care collections.
2. In 2022, VA plans to reallocate $30 Million of the funding provided in section 8002 of the American Rescue Plan Act for Research (pursuant to Section 254 of P.L 117-
3. Medical Care Support includes funding from the Medical Services, Medical Support and Compliance, and Medical Facilities Appropriations to support Research.
4. The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements, and medical care collections.
5. Includes Direct and Reimbursable FTE.

## Medical and Prosthetic Research and Development Appropriation Language

*For necessary expenses in carrying out programs of medical and prosthetic research and development as authorized by chapter 73 of title 38, United States Code, $916,000,000, plus reimbursements, shall remain available until September 30, 2024: Provided, That the Secretary of Veterans Affairs shall ensure that sufficient amounts appropriated under this heading are available for prosthetic research specifically for female veterans and for toxic exposure research.*

## Medical and Prosthetic Research and Development Appropriation Request

To fulfill the commitment of the Department of Veterans Affairs (VA) to provide superior health care to Veterans, the Medical and Prosthetic Research and Development Program, through the Veterans Health Administration (VHA) Office of Research and Development (ORD), requests $916.0 million in direct appropriations in 2023.

The 2023 request supports our six-cross cutting clinical priorities: suicide prevention; pain management and opioid use; traumatic brain injury (TBI), posttraumatic stress disorder (PTSD); Gulf War illness and military environmental exposures; and cancer, with a focus on precision oncology and builds upon the historic investment from the 2022 request to continue to increase funding for those areas and advance the Department's research missions in mental health.

The 2023 request increases investment in the following high priority areas of Veteran's Health:

- **Military Environmental Exposures (+$20.9 million above 2022 Request includes $20.0 million increase and $0.9 million in pay/non pay inflation):** Military environmental exposures can lead to short-term acute health outcomes, or long-term chronic multi-symptom illnesses, making additional investments critical. An estimated one in three Veterans who deploy reports an exposure to environmental hazards, and one in four believes that a major health concern has occurred because of the exposure.

- **Traumatic Brain Injury (TBI)/ Brain Health (+$11.8 million above 2022 Request includes $10.0 million increase and $1.8 million in pay/non pay inflation):** TBI is a signature injury of post-9/11 Veterans of the wars in Iraq and Afghanistan. The injury can lead to lifelong disabilities that can vary by TBI severity, the characteristics of the event or events that caused the injury and the number of exposures to insults such as blasts. 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. Symptoms can include headaches, irritability, visual and balance deficits, sleep disorders, memory lapses, slower thinking and depression. Further research investments in TBI and in overall brain health can lead to new approaches to ease or manage these symptoms and thereby improve quality of life for affected Veterans and their families and caregivers.

- **Cancer and Precision Oncology (+$12.0 million above 2022 Request includes $10.0 million increase and $2.0 million in pay/non pay inflation):** In 2023, ORD will continue to invest in cancer and precision oncology research in order to build a more robust cancer knowledge base that integrates genetic and clinical data to identify better treatments, guide care decisions and identify opportunities for further investigation.

  Research will compliment the Cancer Moonshot 2.0 initiative by continuing by leveraging its strong clinical care and research expertise to advance precision oncology care for Veterans while fostering system-wide adoption of best oncology practices.

  While the focus of efforts will initially benefit more prevalent cancers among Veterans including ones affecting the prostate and lung, they provide an opportunity to leverage a national infrastructure for areas in rare cancers and ones possibly linked to environmental exposures. Fully realizing the promise of genomic-driven cancer care will require adequate resources and innovative partnerships.

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investigation. While the focus of efforts will initially benefit more prevalent cancers among Veterans including ones affecting the prostate and lung, they provide an opportunity to leverage a national infrastructure for areas in rare cancers and ones possibly linked to environmental exposures. Fully realizing the promise of genomic-driven cancer care will require adequate resources and innovative partnerships that increase the sharing of data and knowledge so advances can be realized more quickly to benefit both Veterans and the general patient population.

- **Implementation of the Commander John Scott Hannon Mental Health Care Improvement (+$5.4 million above 2022 Request includes $5.0 million increase and $0.4 million in pay/non pay inflation):** The request supports suicide prevention research, including supporting the Commander John Scott Hannon Mental Health Care Improvement Act (Hannon Act). This includes clinical trials and epidemiological studies on risk and prevention factors. The Hannon Act is advancing efforts to prevent suicide and promote mental health and general well-being among Veterans.

The 2023 request is formulated in accordance with VA Research's five overarching strategic priorities:

- Increasing Veterans' access to high-quality clinical trials
- Increasing the real-world impact of VA research
- Putting VA data to work for Veterans
- Actively promoting inclusion, diversity, equity and access
- Building community through VA research

As an intramural research program, ORD utilizes funding from multiple sources as detailed in the Appropriations and Other Federal Resources table above to operate the VA Research Program. More detail about the various resources are included below:

- The Medical and Prosthetic Research Appropriation and the American Rescue Plan (P.L. 117-2, Section 8002) to intramurally fund medical research studies. This funding supports approximately 2,697 total projects (an increase of 134 projects over the 2022 estimate) and 4,523 FTE. We will partner with more than 200 medical schools and other academic institutions in 2023.
- Funding from the VA Medical Care appropriation supports the additional expenses required of VA facilities supporting the research mission. This includes clinician allowable effort, equipment maintenance contracts, biomedical maintenance support and other general and direct administrative support.
- VA's research program also receives extramural funding from private and federal grants. This funding is not managed centrally by ORD, but on a local level at individual VA medical centers (VAMCs), largely through 78 VA Affiliated Non-Profit Research Corporations (NPCs). In 2023, grants from other federal organizations, such as the National Institutes of Health (NIH), Department of Defense (DoD) and Centers for Disease Control

(CDC), are estimated to total $370.0 million. Funding from other non-federal sources in 2023 is estimated at $170.0 million, for a total estimated amount of $540.0 million.

## Medical and Prosthetic Research and Development Program Overview

### Table: Appropriation Highlights

| | (dollars in thousands) | | | | |
|---|---|---|---|---|---|
| | **2021 Estimate** | **2022 Request** | **2022 Estimate** | **2023 Request** | **2022-2023 Est.-Req.** |
| **Appropriations…..** | **$804,000** | **$882,000** | **$912,000** | **$916,000** | **$4,000** |
| *Discretionary* [1] | $795,000 | $882,000 | $882,000 | $916,000 | **$34,000** |
| *Mandatory (ARP, Section 8002)* [2] | $9,000 | $0 | $30,000 | $0 | **($30,000)** |
| **Obligations.....** | **$941,101** | **$971,100** | **$975,010** | **$1,003,250** | **$28,240** |
| *Discretionary* | $933,873 | $971,100 | $973,238 | $973,250 | **$12** |
| *Mandatory (ARP, Section 8002)* [2] | $7,228 | $0 | $1,772 | $30,000 | **$28,228** |
| **Total Projects.....** | 2,443 | 2,563 | 2,563 | 2,697 | 134 |
| **Employment Distribution** | | | | | |
| Discretionary FTE[3] | 4,135 | 4,095 | 4,284 | 4,410 | 126 |
| Mandatory (ARP, Section 8002)[2] | 40 | 0 | 8 | 113 | 105 |
| **Total.....** | **4,175** | **4,095** | **4,292** | **4,523** | 231 |

1. The discretionary appropriation amounts for 2021 are net of a rescission of $20 Million from P.L. 116-260 (2021) to align with Congressional scoring. The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, updated for estimated transfers, reimbursements, and medical care collections.
2. In 2022, VA plans to reallocate $30 Million of the funding provided in section 8002 of the American Rescue Plan Act for Research (pursuant to Section 254 of P.L 117-103), which will be executed out of the Veterans Medical Care and Health Fund. Final 2022 funding allocations among categories may change in response to workload demand requirements throughout 2022 and 2023.

**Table: Net Change and 2023 Summary of Resource Requirements (Medical and Prosthetic Research Appropriation and Section 8002 of the ARP)**

| *(dollars in thousands)* | | |
|---|---|---|
| | | ***BA*** |
| ***2022 Request-Direct (Medical and Prosthetic Research Appropriation)*** | | ***$882,000*** |
| ***2023 Current Services Increases*** | | |
| *Pay Raise (4.6%)* | | *$13,997* |
| *Biomedical Research and Dev Price Index (2.4%)* | | *$11,431* |
| | ***Subtotal*** | ***$25,428*** |
| ***2023 Total Current Services*** | | ***$907,428*** |
| ***Offsets*** | | |
| *Reduce Starts of New Projects (estimated 47 projects)* | | *($11,414)* |
| *Defer Contracts to Outyears* | | *($25,000)* |
| | ***Subtotal*** | ***($36,414)*** |
| ***Funding Increases for 2023 Initiatives:*** | | |
| *Military Environmental Exposures* | | *$20,000* |
| *Traumatic Brain Injury (TBI)/Brain Health* | | *$10,000* |
| *Cancer and Precision Oncology* | | *$10,000* |
| *Implementation of the Commander John Scott Hannon Mental Health Care Improvement Act* | | *$4,986* |
| | ***Subtotal*** | ***$44,986*** |
| ***2023 Total Budget Request-Discretionary (Medical and Prosthetic Research Appropriation)*** | | ***$916,000*** |
| ***Section 8002 of the American Rescue Plan Resources (ARP)*** | | |
| *Additional COVID-19 Funding Requirements* | | *$5,000* |
| *Scientific Computing* | | *$15,000* |
| *Diversity, Equity & Inclusion in Research* | | *$8,000* |
| *Additional funding for Fund Hannon Act Implementation* | | *$2,000* |
| | ***Subtotal*** | ***$30,000*** |
| ***Total Medical and Research Appropriation and Section 8002 of ARP*** | | ***$946,000*** |

**New Initiatives for 2023**

VA Research is uniquely positioned to address Veterans', the VA's and the nation's biomedical and health ecosystem research needs by leveraging its capabilities and resources as part of the largest integrated healthcare system in the country. The requested funding increases below are selected based on VA Research's unique role where scientific discovery can improve Veterans' health and well-being; partnering to solve specific, real-world problems that Veterans, clinicians and the healthcare system face.

In 2023, VA Research will increase funding in the following areas:

- Military Environmental Exposures
- Traumatic Brain Injury (TBI)/Brain Health
- Cancer and Precision Oncology
- Implementation of the Commander John Scott Hannon Mental Health Care Improvement Act

In addition, VA Research will leverage $30.0 million in resources from the Section 8002 of the American Rescue Plan Act for Research (executed from the Veterans Medical Care and Health Fund) to further invest in critical areas such as:

- COVID-19 ($5.0 million)
- Scientific Computing ($15.0 million)
- Diversity, Equity & Inclusion in Research ($8.0 million)
- Additional funding for Hannon Act Implementation ($2.0 million)

Additional information about the new initiatives is listed in the subsequent sections.

***Military Environmental Exposures***
***(+$20.0 million above 2022 Discretionary Request excluding pay/non-pay inflation)***

An estimated one in three Veterans have reported a military environmental exposure of some kind while serving in the military. Military environmental exposures can lead not only to short-term acute health outcomes, but also long-term chronic multi-symptom illnesses such as those seen in the Southwest Asia area of operations: pre-9/11 Gulf War Veterans of Operation Desert Shield/Desert Storm and post-9/11 Veterans of the wars in Iraq and Afghanistan.

Moreover, rare cancers and other illnesses have been reported by Veterans deployed to Karshi-Khanabad Air Base (K2), and respiratory, cardiopulmonary and other disorders have been reported from burn pit exposures while in Iraq and Afghanistan. Defining adverse health outcomes from military exposures including fuels, radiofrequency, explosive ordnance disposal and per- and polyfluoroalkyl substances (PFAS) remains an ORD priority.

ORD will build on this investment in 2023 by continuing to apply a proactive and systematic approach, which includes coordinating with environmental exposure focused programs within VHA, VBA and federal partners to ensure gaps in research are identified and emerging scientific findings are communicated and incorporated into VA programs.

**New Military Exposure Research Program (MERP) with emphasis on exposure assessment:** One of the major challenges in the field of military environmental exposures is a lack of exposure assessment at the individual level. The mission of the MERP is to advance military exposure assessments and understand the effects of military exposures on Veterans' health outcomes. The program's objective is to improve exposure assessments that will lead to more precise determination of the types and amounts of specific exposures incurred by Service members to inform care and policy, a key gap in the field. The MERP will work closely with Federal and academic subject matter experts in developing and refining exposure methodologies and applying emerging technologies to fill this gap. Validation and implementation of promising qualitative and quantitative methodologies will be applied by leveraging internal and external VA partnerships including the War Related Illness and Injury Study Center (WRIISC).

These are the activities we expect to undertake:

- **Stand-up two strategic committees to inform MERP and provide scientific guidance.** These committees will include an Executive Committee and a Scientific Steering Committee. A non-FACA (Federal Advisory Committee Act) Executive Committee will include leaders from key VA partnerships. The executive group will receive and review annual reports from the MERP and will provide the MERP with guidance on programmatic goals and targeted objectives. The Scientific Steering Committee will include subject matter experts (SMEs) on exposure assessment and health outcomes from military environmental exposures. The SMEs will use their knowledge in cutting-edge scientific technologies and methodologies to provide advice, prioritization and direction to the MERP's scientific directors, staff and collaborators.
- **Develop a gap-analysis portfolio.** Identifying gaps in needs, capabilities, technologies and resources is the key to a successful program. Working with VBA and VHA, among other stakeholders, MERP will develop a strategic gap-analysis portfolio with two principal categories: military environmental exposure assessment and health outcomes from dose-induced military environmental exposures.
- **Develop key partnerships.** The MERP will develop key partnerships with federal agencies and academic institutions to leverage expertise, tools and resources. Initial key partnerships will be developed with organizations including the DoD, the Army Public Health risk mitigation team, the National Institutes of Environmental Health Sciences (NIEHS), toxicologists and SMEs with appropriate state-of-the-science technologies and data and biospecimen resources. These key partnerships will provide additional value to the MERP. ORD's own infrastructure will also be leveraged, including cross-cutting service support, multi-omic platforms from the Million Veteran Program (MVP) and informatics for data analysis. Within VHA's Health Outcomes Military Exposures (HOME) programs, resources can be utilized such as the Burn Pit Centers of Excellence, clinical exposure registries and individual longitudinal exposure record (ILER). Additional resources that collect environmental information through imaging and data collecting

sources, such as wearable technologies, will be leveraged. In addition, strategic collaborations with other federal agencies outside VA with expertise in environmental research, occupational hazard research, toxicology and risk assessment will provide unique resources, skills and databases so that military exposures research can build on, rather than duplicate, existing knowledge. Data Use and Memorandum of Understanding agreements will be established.

- **Activate a MERP Exposure Assessment core.** MERP will establish a core of toxicologists with a nucleus of collaborators and resources to develop, test and validate exposure assessment assays. Members of this core will determine the best specimen surrogates for analysis with high rigor and reproducibility. They will also identify state-of-the-art technology and establish standard operating protocols.
- **Fund exposure assessment projects.** MERP will leverage feedback from its Executive and Scientific Steering committees and analytics to focus on gap-filling, evidence-based knowledge for Veterans with military environmental exposure. ORD will continue to support studies on the health outcomes of military exposures through its traditional mechanisms of investigator-initiated research, including epidemiologic studies; clinical trials; basic research; and collaborations with other VHA program offices, including the Health Outcomes Military Exposures (HOME) patient care services policy team and the Veterans Benefits Administration.

  MERP will leverage SME, technologies and infrastructure via a whole of government and academic approach. MERP leadership will work closely with diverse investigative teams in project development, execution and accountability. Scientific rationale is the foundation of policy decisions. This prospective approach is expected to inform policy and clinical care.
- **Expand the workforce in military exposures research and training**. An emphasis will be placed 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. Expanding MERP's outreach through key partnerships will open new career opportunities.

**Recent accomplishments in military exposures research:**

- Demonstrated, in a scientific survey of Vietnam Veterans, differences in exposures among those who served in the ground war theater, those who served in offshore waters (Blue Water Navy sailors), those who served outside the war theater at the time and civilians with a number of chronic health conditions.
- Developed a research dataset of all individuals who served in the Vietnam era by merging several large DoD, VA and CDC databases. Key variables in the dataset include whether these individuals served in the war theater and their vital status.
- Partnered with NIH to launch a deep phenotyping of Gulf War Illness, called "In-Depth."
- Analyzed the feasibility of conducting VA-sponsored research on the intergenerational effects of toxic military exposures.

- Conducted outreach engagement sessions with Gulf War Veterans to better understand their health concerns as they age and on the value of participating in research.

**Activities to be continued or undertaken:**

- 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 the "In-Depth" phenotyping project on Gulf War Veterans.
- Analyze differences in mortality between Vietnam-era Veterans and civilians.
- Test the research usability of the Individual Longitudinal Exposure Record, a VA-DoD collaboration to track in-service exposures.
- Fund the continuation of longitudinal studies in service members who have embedded fragments from blasts and projectiles in their bodies.
- Conduct an observational study assessing the association of previous land-based deployments to Iraq, Afghanistan and neighboring regions and burn pit exposure with current measures of pulmonary health among a study cohort. We are seeking to enroll 4,500 Veterans for this study.
- Issue requests for applications (RFAs) and funding studies on genomics and on the phenotyping of military exposures.
- Issue RFAs and fund studies addressing the National Academies of Science, Engineering and Medicine (NASEM) recommendations, including their recommendations on burn pits and airborne hazards, anti-malarial drugs and the intergenerational effects of toxic exposures.

***Traumatic Brain Injury (TBI)/Brain Health***
***(+$10.0 million above 2022 Discretionary Request excluding pay/non-pay inflation)***

TBI is a signature injury of the wars in Iraq and Afghanistan. The injury can lead to lifelong disabilities that can vary by TBI severity, the characteristics of the event or events that caused the injury and the number of exposures to insults such as blasts. Due to the nature of combat and previously unknown injuries that may have occurred from training, TBIs are frequently not recognized at the time of injury. This culminates in a diagnosis occurring in VA medical facilities sometimes years after the patient's most recent TBI, a situation that has been termed "remote" TBI. This delay in diagnosis and associated care can magnify neurobehavioral conditions that negatively impact Veterans' quality of life.

Each year VA sees some 100,000 patients who have a TBI diagnosis. TBI symptoms include headaches, irritability, sleep disorders, visual and balance deficits, memory lapses, slower thinking and depression. TBI manifests not only in cognitive deficits, but also with problems in behavioral health; sensory perception; and motor, endocrine and autonomic nervous system function. Potential consequences of TBI include neurodegenerative disease, prolonged sensory processing

deficits, substance misuse and mental health issues. The majority of TBI cases are mild and difficult to diagnose. VA investigators are examining various approaches to detect, monitor and treat Veterans with TBI.

ORD will continue to focus on developing objective tools and resources to improve the diagnosis and monitoring of brain health in Veterans who have sustained TBI. Highlights of these efforts include the following:

The VA TBI Biorepository Brain Bank Network consists of a registry and a network of human tissue banking sites that collects, processes, stores and provides research specimens for scientific studies. The VA TBI Brain Bank provides central nervous system (CNS) tissue and associated de-identified health information to both VA and non-VA scientists studying the lifetime effects of TBI in Veterans and enhances discovery research for therapeutic development.

- Research funding to study the impact of TBI on multiple sensory systems will be increased. These efforts will focus on how the brain integrates, processes and perceives information from the environment. Veterans with a central nervous system injury after military training and combat exposures are at risk for deficits in sensory perception, some of which are very apparent, while others can be subtle and difficult to detect. These can include impairments of vision, hearing, balance and sense of smell. Such impairments can also increase the risk of substance misuse, psychological health conditions and loss of employment and may also lower quality of life. The end goal of the research is to effectively diagnose and treat Veterans with service-connected TBI to improve the effectiveness of their rehabilitation and increase their quality of life.
- Brain stimulation (magnetic, electrical and electromagnetic modalities) standards for clinical trials in TBI treatment will be developed. Brain stimulation is both a promising and controversial mode of therapy for brain and psychological health conditions. Results from small trials have been inconsistent and this inconsistency has contributed to the lack of larger clinical trials. This initiative involves engaging investigators and other stakeholders to develop common standards and protocols for brain stimulation modalities.
- TBI-specific laboratory animal major equipment (LAM) and the Shared Equipment Evaluation Program (ShEEP) will be used to increase research capacity and infrastructure, especially in locations in which TBI research is currently in need of resources. These investments will increase VA's TBI research capacity and have the potential to increase the diversity of those who conduct research in VA facilities. All funding will go to capital-level equipment to build capacity and infrastructure, with a focus of providing support to VAMCs with TBI investigators that have limited resources.

Major activities in ORD's TBI research include the continuation of two studies exploring the longitudinal effects of one or more TBIs in Veterans and a preclinical research center to study the effects of blasts:

- TRACTS is promoting multidisciplinary research aimed at improving our understanding of the complex cognitive and emotional problems faced by Iraq and Afghanistan Veterans.
- LIMBIC-CENC's overarching goal is to improve understanding of the impact of TBI on Service members and Veterans. The program will fund a longitudinal study and associated

TBI research to include collecting relevant imaging and tissue samples to inform acute and chronic TBI care.

- The VA Open Field Blast Core facility in Columbia, Missouri, will enable preclinical studies that will provide key insights into the disease processes associated with primary blast exposure and may provide links to neuronal degeneration, cognitive and neurobehavioral decline.

**Recent accomplishments in TBI / brain health research:**

- The Long-term Impact of Military-relevant Brain Injury Consortium-Chronic Effects of Neurotrauma Consortium (LIMBIC-CENC) made valuable research and clinical contributions to the VA/DoD 2021 mild TBI (mTBI) Clinical Practice Guidelines. There were 4 published research studies by LIMBIC-CENC investigators that were used to inform the CPG authos on sleep apnea, biomarkers and repeated mTBI effects on neuropsychological functioning.
- LIMBIC-CENC confirmed that taking a symptom-based approach to care after Mild Traumatic Brain Injury (mTBI), from primary to secondary prevention through recovery, is paramount to care management, regardless of any co-morbid or co-existing disorders.
- LIMBIC-CENC will continue to follow the Prospective Longitudinal Study Participants in order to track Long-COVID symptoms and potential changes in biomarkers.
- Completed planning process of the VA Brain Bank Biorepository and Registry, with sites selected, including investment in standardization of processes and equpment.
    - This included demonstrating that many symptoms and concurrent disorders associated with mTBI are risk factors for Alzheimer's disease (AD), dementia and neurodegeneration; and that providers must optimize the symptomatic treatment and underlying cause of these risk factors to meaningful reduce the risk of AD, dementia and other neurodegenerative conditions.
- In 2021, LIMBIC-CENC unveiled web-based and portable clinical support tools through its Knowledge Translation Center to aid clinicians in managing their mTBI patients and those suspected of having greater susceptibility to acquire mild cognitive impairment, dementia, or other neurodegenerative diseases.
- The Translational Research Center for TBI and Stress Disorders (TRACTS) developed the Virtual Assessment of Deployment Trauma and Rehabilitation (V-TRACTS). As a result of the global pandemic, in-person TRACTS longitudinal cohort assessments were put on hold in March 2020. TRACTS has reached its longstanding clinical innovation goal of creating a Deployment Trauma Assessment and Rehabilitation Center, which is now being tested in an online telehealth platform. The purpose of this clinical demonstration research study is to test the feasibility and acceptability of a holistic, research-informed targeted assessment and treatment program for post-9/11 Veterans. V-TRACTS will use online assessment and feedback to tailor intervention options and offer precision treatment to each individual.

**Activities to be continued or undertaken:**

- Launch a Cooperative Studies Program study examining growth hormone replacement therapy in Veterans with mild TBI and adult growth hormone deficiency.
- Initiate Clinical Health Imaging Portability Standards (CHIPS). Currently, magnetic resonance imaging (MRI) clinical scans performed in the United States are not calibrated to a shared standard. There are no established quantitative norms in MRI diagnosis. Quantitative metrics are necessary to assess brain health over time (longitudinally). The absence of calibration standards impedes the ability to do cross-site or instrument quantitative comparisons, a critical need for VA health care.

  CHIPS will allow MRI to become a reliable noninvasive assessment to monitor brain health not only for Veterans, but for all people who have sustained one or more TBIs. A VA-based team is collaborating with industry and academia partners to create and implement these standards.
- Develop a program announcement for a collaborative network to develop Total Brain Diagnostics (TBD). TBD will be a collaborative network to develop and integrate fluid biomarkers, imaging and physiological measures to enable objective diagnoses and the ability to better monitor previously acquired TBI. This ORD-wide initiative will leverage VA's National Artificial Intelligence Institute (NAII) to integrate diagnostics in order to provide a complete view of brain health that personalizes diagnosis, prognosis and treatment. The VA-based team is collaborating with NIH, DoD and several not-for-profit organizations.
- Make infrastructure investments in the Open-field Blast Core Site. VA continues to support a core facility to study the long-term effects of blast exposure in preclinical (animal) models, in order to advance the translation of findings in animals to Veterans. The Department's goal is to identify and treat consequences of blasts that occurred during training or deployment. A contract to create a second site has been awarded so that operations can continue year-round, as the current site is limited by weather conditions and lacks the infrastructure to operate throughout the year. Improving infrastructure and adding a second site will provide VA investigators with a year-round testing resource.
- Provide additional funds to support scientifically meritorious TBI research studies. This will include a joint funding announcement with the National Institute on Aging (NIA) to investigate the impacts of TBI on aging and dementia.
- Make new investments in the implementation of virtual care across the VHA Polytrauma System of Care. The aim is to validate virtual care programs and identify opportunities to enhance and standardize the services VA provides. Investments include a three-year study designed to evaluate the impact of virtual care programming on completing the Comprehensive TBI Evaluation (CTBIE) and on providing care to Veterans with TBI. Additional funding will improve TBI screening and the processes for completing the comprehensive TBI evaluations that Veterans returning from deployment receive. Currently, more than a third of Veterans who screen positive for TBI do not return for a follow-up appointment to undergo a comprehensive evaluation. Improving completion rate of the CTBIE by Veterans with suspected TBI could improve access to care, benefits and overall quality of life.

- Increase investment in TBI-related health services research. In particular, we will invest in initiatives to increase access to supported employment for Veterans with TBI. TBI is known to increase unemployment risk, which increases marital, relationship and housing instability. Maintaining employment has long-term positive implications on quality of life for Veterans and their families as well as helps to prevent homelessness.
- Invest in longitudinal TBI research for moderate to severe TBI including Veterans with disorders of consciousness (an understudied VA population). We will develop Veteran-based scientific literature on longitudinal outcomes, comorbidity and rehabilitation needs. This mechanism will support a clinical trial infrastructure that can be leveraged in future clinical trials to advance the treatment of moderate to severe TBI. Research in this critical TBI population would benefit both quality of life for Veterans and for family members who are often their caregivers.

***Cancer/Precision Oncology***
***(+$10.0 million above 2022 Request excluding pay/non-pay inflation)***

In 2023, VA Research will complement the Cancer Moonshot 2.0 initiative by continuing to leverage its strong clinical care and research expertise to advance precision oncology care for Veterans while fostering system-wide adoption of best oncology practices.

Precision oncology care is about matching the appropriate treatment to the right patient at the right time based on an understanding of the molecular characteristics of the patient and their cancer. The multidisciplinary collaborative efforts in precision oncology and the use of new technologies have helped to accelerate characterization of mutations in patient's tumors to develop new clinical trials aimed at providing a stronger evidence base to care, increase access to precision-oncology treatments, Veteran-focused research to identify new biomarkers to stratify patients for care, inform diagnosis, prognosis and prediction of treatment responses.

VA Research is supporting work using artificial intelligence and machine learning to validate genomic data and information from patient electronic records to predict risk for cancer and developing clinical decision support tools to aid in clinical management. Some of these activities are being done in partnership with other federal agencies or entirely within the VA healthcare system.

VA research is at the leading edge of cancer research and is poised to support activities in the Cancer Moonshot 2.0 initiative including research in molecular diagnostics accessing our diverse patient population; identifying genomic signatures that may be associated with carcinogens from environmental/military exposures; identifying druggable targets and pathways in rare and common cancers based on understanding of their unique characteristics and applying precision oncology approaches to cancer screening and early detection. VA's use of research also aims to close the knowledge gap in genetic and molecular understanding of cancers thereby reducing disparities in disproportionately affected populations and inform clinical management to reduce inequities in access to care.

Cancers arise from a complex set of interactions that involve genetic, molecular, biochemical, lifestyle and environmental factors, through a multistep process where normal cells undergo

changes that result in tumors over time. Cancer increases with age and given the aging Veteran population there is an increased number of Veterans who present with cancer from early disease to advanced stages including metastatic and disease that recur after treatment with definitive curative therapies.

Identifying genetic and molecular alterations that drive cancer development, understanding the cellular and molecular mechanisms involve in cancer development and developing potential therapies that target alterations in genes and the associated cellular pathways is a major focus of VA research. VA Research encompasses the full spectrum of preclinical, translational, clinical and health-related quality of life studies. These studies address chemoprevention, early detection, diagnosis, treatment and survival for Veterans suffering from cancer including lung, colorectal, prostate, bladder, kidney, skin, pancreatic, esophageal, brain and female-specific cancers (such as breast, cervical and ovarian cancer), as well as lymphomas, melanomas and other rare cancers.

Cancer takes a significant toll on Veterans creating physical burdens as well as affecting their quality of life. VA Research approach is to support innovative, high impact investigations using novel techniques, cutting edge technologies, bioinformatics tools and team science to accelerate our understanding of the pathobiology, molecular mechanisms, genetic and risk factors that contribute to cancer while developing and testing novel therapeutics against cancer to improve clinical management. This work is reflected in our investment in discovery/preclinical, translational, clinical/trials and epidemiological studies, as well as our focused efforts in precision oncology which aims to provide the right treatment for the right patient at the right time based on the molecular characteristics of their individual tumor.

In 2023, funding increases will focus on VA's Precision Oncology efforts. These efforts will build on previous support to facilitate a partnership between the National Cancer Institute (NCI) and VA (see below -NAVIGATE) to enable NCI-supported clinical trials to be conducted within VA. The success of the program has shown the ability to enroll increased number of Veterans in NCI-supported clinical trials providing Veterans with additional therapeutic options for their cancer. Additionally, a more robust cancer knowledge base that integrates genetic and clinical data is needed to identify better treatments, guide care decisions and identify opportunities for further investigation. The usefulness of any knowledge base depends on three things: the data, mechanisms for sharing knowledge and the ability to translate findings into care.

Fully realizing the promise of genomic-driven cancer care will require adequate resources and innovative partnerships that increase the sharing of data and knowledge so advances can be realized more quickly to benefit both Veterans and the general patient population.

VA Research also features a number of partnerships with VHA's National Oncology Office, such as:

- Expansion of the precision oncology footprint through 18 lung cancer and eight new genitourinary cancer clinical and research centers (also referred to as "hub sites") across Veteran Integrated Service Networks (VISNs). This expansion in clinical trial infrastructure will create even more demand for novel clinical trials in 2023. Potentially, it will also create significantly more therapeutic options for Veterans across the VA Research enterprise. An increase in clinical trial funding support will help to meet this rapidly

growing demand and will create opportunities for Veterans, VA investigators and VA facilities to contribute to state-of-the-art research on novel therapies and approaches to care.

This will require the use of technologies such as machine learning, natural language processing and advanced analytics 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 is "big data" which represents unique needs due to its size and scale. Therefore, the VA will, either through partnerships or by building the capability within the system, use a portion of these funds to fulfill these data needs. Along with the overall Scientific Computing efforts identified later in this chapter.

An increasing number of Veterans with advanced lung, genitourinary and other cancers are being provided with genetic sequencing to identify actionable mutations for potential matches to novel therapies. The data derived from genetic sequencing provide opportunities for designing innovative biomarker-driven precision oncology clinical trials using new and repurposed Food and Drug Administration (FDA) drugs. In addition to precision clinical trials, VA investigators are working to enhance traditional therapeutic trial opportunities. For example, immunotherapy has shown durable benefit in approximately 20% of lung cancer patients, but most of the lung cancer population shows either resistance or no benefit from immunotherapy due to immune checkpoint blockades.

Clinical trials that combine chemotherapy drugs with checkpoint inhibitors (immunotherapy) can reduce cancer progression while increasing anti-tumor immune response. This combined approach is one area that is available for clinical trial investigation by VA researchers using traditional therapeutic approaches within our clinical trial network. Another example is the VA STARPORT which is being conducted in the VA's Cooperative Studies Program across 16 VA medical centers. The study is examining a treatment approach using targeted surgery or radiation for men whose prostate cancer has spread within the body after initial curative therapy (i.e., surgery or radiation).

ORD launched the Research for the Precision Oncology Program (RePOP) and the Precision Oncology Data Repository (PODR) in 2016 to acquire knowledge and establish the capabilities necessary to improve the care of Veterans with cancer. RePOP provides a mechanism to recruit patients for broader sharing of data and to reuse tumor tissue, while PODR serves as a repository for patients' data and supports research activities such as creating predictive models, developing advanced analytic techniques and building clinical applications.

These efforts are designed to share data with the larger research community and to help put that data to work on behalf of Veterans. PODR will meet its goals through a partnership with the University of Chicago. The university will host a hybrid cloud infrastructure to provide greater access to both VA data and robust computing resources for the larger research community. These efforts complement and integrate with VA's partnerships with DoD and NCI.

VA Research is investing in a nationwide lung cancer network to diagnose lung cancer at earlier stages, when survival rates are higher and to increase opportunities for Veterans with lung cancer to participate in clinical trials. The network will use a hub-and-spoke model to facilitate the

participation of Veterans in rural and less urban centers while leveraging the use of telehealth and teleoncology to reach all Veterans.

Another area of progress in precision oncology concerns prostate cancer, a common condition in VA's patient population. To date, clinicians have been unable to target molecular changes in advanced prostate cancer that may improve survival and quality of life. Consequently, ORD has facilitated and coordinated a partnership with the Prostate Cancer Foundation to establish the Precision Oncology Program for Cancer of the Prostate (POPCaP) in VA. This partnership launched in 2016 with the aim of using precision medicine to provide prostate cancer treatment to Veterans equal to, or better than, that provided by the best private and academic cancer centers. As an important part of VA's transformation into a System of Excellence for Precision Oncology, POPCaP provides Veterans access to genetic testing and genetic counseling, biomarker-driven clinical trials and on- and off-label FDA-approved drugs paired with specific mutations identified in metastatic prostate cancer. One example of a clinical trial that came from this partnership is the comparison of Carboplatin versus Olaparib in Veterans with Brca deficient metastatic prostate cancer. The study makes use of a repurposed and a new FDA approved drug and will enroll close to 100 Veterans in this study.

To leverage the sequencing efforts of the National Precision Oncology Program (NPOP) and offer a broad scope of treatment options to Veterans, VA will launch the Prostate Cancer Analysis for Therapy Choice (PATCH). This effort will increase the number of VHA facilities involved in precision prostate cancer clinical trials, improve access for Veterans to those trials and increase the number of Veterans enrolled in targeted therapeutic and immunotherapy studies while increasing the number of physician-scientists providing care and working in prostate cancer research. Adding new prostate cancer network hubs to the existing 10 sites will increase Veterans' access to cutting-edge therapies, particularly for those living in rural and remote areas of the country. PATCH brings together the power of the VA Research enterprise with integrated clinical care to provide access to the most advanced therapies in cancer care.

PATCH is well-positioned to leverage data gathered from clinical trials and electronic medical records, access to high-quality biospecimens and a VA patient population that includes high numbers of African Americans, who traditionally have had poorer prostate cancer outcomes. These assets are fueling new discoveries and enhanced translation of those discoveries into clinical practice, geared to improve the health and well-being of Veterans.
Expanding the number of patients who received molecular testing not only provide information to guide treatments but also provide information that facilitate the development of new clinical trials. In the case of rare cancers and/or were the number of female Veterans are not in adequate numbers to feasibly conduct a clinical trial and/or other studies in VA, it makes sense to partner with the NCI, DoD or other agency to provide Veterans access to novel therapeutic options or to participate in research that provide molecular understanding of disease. Examples of these include NAVIGATE (access to NCI cutting edge trials), APOLLO (studying protein-based cancer biomarkers identified in tumors, alterations and mutations and applying this knowledge to guide treatment for Veterans).

Finally, as part of VA's commitment to women Veterans, ORD will establish mechanisms to give Veterans with breast cancer greater access to clinical trials. VA Research is building networks to advance research and initiate new rare cancer activities with partner agencies including NCI and

the National Institute of Dental and Craniofacial Research. This effort will help remove potential barriers that might exclude certain subsets of patients from precision oncology and from the potential genomic insights that could be obtained by studying the biology of cancer in these patients. Both breast cancer and rare cancers will involve offering virtual trials across the system because of the comparatively smaller number of both conditions in VA. Together, these efforts will create a larger precision oncology ecosystem to enable advancements in research and care.

VA Research recognizes the value and importance of sharing information across VHA to facilitate the fluid transfer of knowledge from bedside to bench and back to bedside. This sharing of information across the research enterprise has the potential to accelerate translation of new findings into clinically relevant improvements in care. Therefore, VA Research will be harmonizing data systems to enhance data-sharing across the VHA system. This effort will support the growing development of new biomarkers and targeted and immunotherapy strategies and further enhance the use of technologies to refine data that informs precision oncology and facilitates discoveries that can be translated.

**Recent accomplishments in Precision Oncology:**

- Initiated two new multisite precision oncology trials in PATCH supported by ORD and industry partners.
- Used the POPCaP network to conduct clinical trial of a therapeutic invention for COVID-19.
- Expanded the POPCaP network to 13 sites across the VA Research enterprise.
- Established seven genitourinary (GU) sites to expand access to genetic testing and clinical trials to Veterans with genitourinary cancers (prostate, bladder, others) going forward in 2022-2023.
- Hired and onboarded POPCaP and PATCH Program Managers to facilitate network standardization, collaboration and support the development and initiation of new clinical trials.
- Launched the Lung Precision Oncology Program (LPOP) in 17 VISNs, which brings together nearly 76 VA medical centers to conduct lung cancer screening and lead precision clinical trials, as part of a larger lung cancer precision oncology plan.
- Developed three novel combination therapeutic clinical trials to address advanced non-small cell lung cancer.
- Initiated standardized germline sequencing for metastatic prostate cancer at 65 sites across the nation.
- Initiated a mentoring program to foster the development of early-career physician scientists in clinical research and to support precision oncology initiatives.

**Activities to be continued or undertaken**:

- VA Research will also collaborate with the VHA's National Oncology Office as part of the Cancer Moonshot to support data efforts for support molecular diagnostics ($5.0 million investment). These efforts are fundamental to the success of any molecular testing initiative is the role of patient data, allowing for health information from patient electronic health records to come together with "omics" information to provide timely clinical decision support at the intersection of research and clinical practice within a healthcare system. It is also 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.
- Expand precision oncology to genitourinary cancers (such as those in the bladder and kidney). We anticipate these efforts will generate robust research activities to continually inform the development of new clinical trials, therapeutics and predictive markers for cancer detection, diagnosis and therapeutic response.
- Further expand LPOP to VISN 17 to enhance nationwide access to early lung cancer screening, clinical trials and research. This expansion will expand the LPOP network to 85 VA sites.
- Work to establish additional GU sites to form a distributed network of POPCaP and GU sites nationwide with at least one site in every VISN.
- Provide infrastructure support for the POPCaP/GU and LPOP networks and enterprise-wide clinical trial coordination and management and for collaborative research that advances translation of discoveries into clinical practice.
- Support the development of a new computer vision and machine learning (CVML) hub focused on creating tools to address cancer diagnosis, prognosis, risk stratification and prediction of treatment response in the VA population.
- Support the development of a deeply annotated multimodal imaging and pathology-based repository that can serve as a resource for cancer researchers in VA for hypothesis generation and testing and additional radiogenomic studies.
- Support demonstration projects to clinically validate the development and application of companion diagnostic approaches in the context of lung and prostate cancer by using computer vision and machine learning.
- Support studies aimed at finding precision oncology approaches to stratify lung and oropharyngeal cancer patients into alternative therapeutic strategies to improve treatment outcomes and overall survival. These validation studies will use imaging-based tools and machine learning to demonstrate the clinical utility of radiomic and pathomic prognostic and predictive biomarkers in personalized treatment.
- Support multisite lung cancer clinical trials that combine chemotherapy with checkpoint inhibitors (immunotherapy) to improve the anti-tumor immune response and efficacy of checkpoint inhibitors.
- Support planning for multisite clinical trials focused on de-escalation or adaptive therapy in Veterans with advanced prostate and lung cancer to reduce physical and financial

toxicities and side effects, while enhancing the potential for greater durability of response, slower time to drug resistance and improved outcomes and quality of life.

- Expand collaborative investigations by VA investigators into strategies for improving diagnostic and molecular therapies targeted at the preinvasive stage of bladder cancer, known as carcinoma in situ (CIS). CIS lesions develop from carcinogens in tobacco smoke and occupational exposure to chemicals, leading to recurrence, invasion and metastasis.
- Continue support for the development of a virtual clinical trial infrastructure to facilitate rapid startup and accrual to clinical studies for malignancies with rare biomarkers. These studies are expected to help Veterans in less urban and more remote geographic areas.
- Continue support for a centralized process for requesting next generation sequencing of prostate tissue specimens to speed the identification of novel molecular targets, prognostics and predictive biomarkers that precisely phenotype metastatic prostate cancer and inform development of biomarker-driven clinical trials. Special emphasis is placed on sequencing specimens from underrepresented populations including rural Veterans.
- Establish a new network of VA investigators focused on rare cancers, with the goal of initiating translational research to address ongoing clinical needs including the identification of novel therapeutic targets for testing in clinical trials. VA hopes to explore opportunities for collaboration in this area with other federal partners. Examples of areas of interest include Merkle cell carcinoma; B-cell hematologic malignancies; ovarian cancers; and head and neck cancers.
- Support research on high-risk localized prostate cancer, with a focus on addressing biochemical failure and disease recurrence. The goal is to advance opportunities for precision guided therapy in patients with recurrent disease.
- Expand the uptake of institutional review board (IRB) and clinical trials software to increase efficiency in clinical trial protocol review and execution.

***Implementation of the Commander John Scott Hannon Mental Health Care Improvement Act (+$5.0 million above 2022 Request excluding pay/non-pay inflation)***

The request supports suicide prevention research (including supporting the Commander John Scott Hannon Mental Health Care Improvement Act [Hannon Act]), clinical trials and epidemiological studies on risk and prevention factors. The Hannon Act is advancing efforts to prevent suicide and promote mental health and general well-being among Veterans. This includes a study of all-cause mortality of Veterans including by suicide, with particular focus on the effects of opioids and benzodiazepines.

The Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Hannon Act) was signed into law October 17, 2020. The law enhances VA programs for mental health care, suicide prevention, care for women Veterans and telehealth care for Veterans and transitioning Service members. The Hannon Act will also accelerate VA's research into causes of mental health issues to identify, improve and expand mental health treatment protocols and health professional training. It will examine how VA manages mental health and suicide prevention

resources and how it provides care in these areas. Overall, it will advance efforts by VA, other federal partners and local communities in preventing suicide and promoting mental health and well-being among Veterans. The Hannon Act is comprised of 34 sections, five of which ORD is the designated lead and three in which ORD serves in a key support role:

**ORD is the designated lead for:**

- Section 204(a). *Department of Veterans Affairs study of all-cause mortality of veterans including by suicide*. [This section specifically concerns the effects of opioids and benzodiazepines.]
- Section 301. *Study on connection between living at high altitude and suicide risk factors among veterans*.
- Section 305. *Precision medicine mental health initiative.*
- Section 306. *Statistical analysis and data evaluation by Department of Veterans Affairs.*
- Section 704. *Use by the Department of Veterans Affairs of commercial institutional review boards in sponsored research trials*.

**ORD is in a supporting role for:**

- Section 405. *Joint mental health programs by 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*.

**Recent accomplishments:**

- Funded and carried out a VA study on all-cause mortality among Veterans prescribed both opioids and benzodiazepines that will inform planning for the independent study by National Academies (NASEM) to be carried out under Section 204.
- Launched a study on the association between suicide risk and living at high altitude (Section 301). The study is leveraging existing VA data and the use of supercomputers and is the most comprehensive study of this question ever undertaken. The approach will combine a broad array of rich data sources, including individual-level demographic and VA clinical data (e.g., oxygenation levels, depression) for approximately 14 million Veterans, along with a variety of social and geospatial information including altitude, rurality, social determinants of health and firearm ownership characteristics.
- Launched two pilot sites for the Measures Investigating Neuropsychiatric Disorders (MVP-MIND) precision medicine study (Section 305). MVP-MIND will leverage the infrastructure, policy and standardized processes established for MVP.

- Affirmed VA's ability to enter into contracts to support statistical analyses and data evaluation (Section 306).
- Completed a report to Congress on approvals of institutional review boards (IRBs) (Section 704).
- Issued a national policy revision for VHA Directive 1200.05, Requirements for the Protection of Human Subjects in Research, permitting VA facilities to use commercial IRBs approved by ORD in studies involving multiple study sites. (Section 704).
- Completed an updated evidence synthesis review of hyperbaric oxygen treatment (HBOT) for PTSD to inform the efforts of the VHA National Center for Healthcare Advancement & Partnerships (HAP) to fulfill the requirements of Section 702.
- Provided data on VA research programs for a joint VA/DoD report on mental health programs (Section 405).
- Actively participated in the planning efforts to establish the Office of Research Reviews within the Research Security Division of the VA Office of Information and Technology (Section 705). This new office will be responsible for performing centralized information security reviews and developing complete information security processes for approved research sponsored outside VA, with a focus on multisite clinical trials; developing and maintaining a list of commercially available software preferred for use in sponsored clinical trials by VA and ensuring the list is maintained as part of the officially approved software products list of VA; and developing benchmarks for appropriate timelines for information security reviews.

**Activities Funded from Section 8002 of the American Rescue Plan (ARP)**

In 2023, VA Research anticipates obligating $30.0 million from Section 8002 of the American Rescue Plan Act of 2021 (ARP) (P.L. 117-2) to support the priorities below.

***Additional COVID-19 Funding Requirements (+$5.0 million)***

As part of the nation's largest integrated health care system, VA Research has been uniquely positioned to provide its expertise in COVID-19 research. For the duration of the pandemic ORD has collected and study biospecimens connected with VA electronic health records to learn more about the virus and its variants from the VHA patient population.

Currently a funding shortfall exists (of approximately $3.0 million in 2023) with ORD COVID-19 Biorepository/VA SHIELD. This repository of biospecimens and associated data in emerging diseases is now available for research studies. It will help advance scientific understanding of infectious and other diseases; support clinical research; and further diagnostic, therapeutic and preventative strategies for immediate deployment in VA clinics.

An additional, $2.0 million is also required to support the Coordinated enterprise-wide research on variant sequencing program. This project, known as VA SeqCURE (**Seq**uencing **C**ollaborations

**U**nited for **R**esearch and **E**pidemiology), supports a network of VA research labs established to conduct variant sequencing to monitor the evolution of the SARS-CoV-2 genome. This effort is critical due to concerns that emerging variants may escape immunity generated by COVID-19 vaccines or prior infection.

***Scientific Computing (+$15.0 million)***

ORD is aggressively working to modernize systems for a robust research and development capability in order to aggressively pursue advances in medicine and technology through Research. On-premises infrastructure and supercomputing can only scale to so many projects.

The additional funding will support contract awards for the purchase of "cloud credits" for the research community to use for various analyses and/or storage of data from research projects. Additional funding will help clear a backlog of big data analyses (i.e., genomic data) for large national studies.

***Diversity, Equity and Inclusion (+$8.0 million)***

Additional funding will allow VA Research to continue to invest in programs that support Diversity, Equity and Inclusion (DEI).

This includes the following:

- ***New RFA, Research Supplements to Promote Diversity, Equity and Inclusion:*** This will attract and support early-career investigators from underrepresented groups to VA research. through a mentored VA research opportunity.
- ***Support for the Career Development/Minority Serving Institution Research Training Program:*** This program will support the increase of diversity supplements for Career Development Awards (CDA) to support diversity and the Minority Service Institution Research Training Program. These candidates will enter the VA Career Development program pipeline to become the next generation of clinician scientists and healthcare leaders for the VA and better serve a diverse population of Veterans.
- ***Research Supplements to Promote Collaborations to Enhance Diversity, Equity and Inclusion:*** The purpose of opportunity is to engage and recruit researchers from underrepresented groups by leveraging existing ORD-funded research to establish strong collaborative partnerships between VA Merit Award investigators and investigators at non-VA institutions (such as Minority Serving Institutions).
- ***Establish a new Summer Research Pilot Program:*** This program will enhances the diversity of the biomedical, behavioral, clinical, health services and the rehabilitative research workforce by providing research experiences and related opportunities that can enrich the pool of college students from diverse backgrounds, including nationally underrepresented groups, Veterans and individuals with disabilities who will be available to compete for future research opportunities to conduct research to improve the health, healthcare and independence of Veterans.

- ***Minority Health Initiative:*** This program seeks to increase ORD studies focused on Veterans from minority health populations. ORD will provide supplemental funds to investigators proposing to recruit Veterans who are underrepresented in VA.

***Additional funding for the Hannon Act Implementation (+$2.0 million)***

Implementation of the Hannon Act is funded with $5.0 million, but additional requirements remain. This includes implementing Section 204 (a). *Department of Veterans Affairs study of all-cause mortality of veterans including by suicide*. The additional $2 million will fund a required National Academies of Sciences, Engineering and Medicine (NASEM) to study mortality related to opioids. This will include work with NASEM to initiate an independent study on all-cause mortality among Veterans prescribed both opioids and benzodiazepines. The study will use VA data, be performed by NASEM investigators and be reviewed by a NASEM panel. VA subject matter experts will orient NASEM staff to VA data and allow them to make any necessary revisions to their protocols to ensure they can adhere to the language of the legislation.

**2023 Priorities and Updates**

ORD's 2023 priorities correlate to the overall ORD mission of improving Veterans' health and well-being via basic, translational, clinical, health services and rehabilitative research; applying scientific knowledge to develop effective individualized care solutions for Veterans; attracting, training and retaining the highest-caliber investigators and nurturing their development as leaders in their fields; and assuring a culture of professionalism, collaboration, accountability and the highest regard for research volunteers' safety and privacy.

To set these priorities ORD follows an iterative, multi-stakeholder process, outlined in the Government Accountability Office (GAO) report "Efforts to Prioritize and Translate Research into Clinical Practice," completed in January 2020. ORD leadership sets VA's national research priorities based on input from internal and external stakeholders and other factors. These priorities factor into funding decisions and underpin enhanced central coordination of research on these priorities. In addition, ORD responds to timely priorities identified by Congress, Veterans Service Organizations and other key stakeholders.

In 2023, these priorities support new research approaches and additional capacity in high-priority areas of Veterans' health including coronavirus-related research and impacts, suicide prevention, pain management and opioid use, PTSD and the prosthetic needs of women Veterans with limb loss. In addition, we continue to work to reduce, refine and replace the use of sensitive animal species in VA research and invest in research in artificial intelligence (AI) related to medical research.

Details about each of these efforts can be found below:

**Suicide Prevention**

Preventing suicide is critical for Veterans and is a national public health priority. This request will result in new tools to identify and manage risk factors, identify more effective prevention strategies and better ensure effective strategies are implemented to prevent Veteran suicide. A key research focus continues to be on the risks present in the period of transition from active-duty military service to civilian life, as well as research directed toward reducing access to lethal means of

suicide among individuals with identified suicide risk. A recent focus on the impacts of COVID-19 on suicide ideation over time will continue in hopes of reducing pandemic-related suicides.

A number of other coordinated efforts are focused on reducing suicide by developing and implementing a scientifically sound evidence base. These efforts include supporting clinical trials as well as epidemiological studies on risk and prevention factors. Other specific highlights include the use of MVP data to identify Veterans who have died by suicide for the discovery of genetic risk factors and clinical trials for continued examination of the value of behavioral interventions for reducing suicidality.

**Recent accomplishments:**

- Supported a program of suicide prevention research with a focus on prevention, lethal means safety, risk factors and broader mental health impacts related to the COVID-19 pandemic. We will continue to fund meritorious projects integrated with research related to impacts of COVID-19.
- Documented that a medical records flag for suicide risk increased VA health care visits among Veterans with substance use disorders.
- Worked closely with the Office of Mental Health and Suicide Protection (OMHSP) to develop a program to promote messaging about firearms safety in primary care. The program includes staff training, a patient brochure and a pocket card to assist primary care teams to discuss firearm safety with Veterans. The pocket card is available on the OMHSP website and its content is included in the 2019 VA/DoD Clinical Practice Guidelines for Suicide Prevention. ORD supports an evaluation of this effort through the Suicide Prevention Research Integrated Network (SPRINT).
- Released an updated RFA for a targeted solicitation inviting research proposals on specific suicide prevention research questions identified as high priority by ORD.
- Conducted an analysis that allows ORD to track suicide prevention research contributions over the last decade.
- Organized a national VA meeting in September 2021 with OMHSP, MIRECCs and ORD-funded investigators to review the current state of evidence, operations and research priorities; to learn about active suicide prevention intervention research spanning a continuum from clinical care to community; and to evaluate research findings within the context of the COVID-19 pandemic on patients with mental health disorders.
- Launched a project to develop a Suicide Prevention Trials Database that will establish a publicly available resource.
- Completed, through the Evidence Synthesis Program, two new suicide-related literature reviews:
    - *Systematic Review - Population and Community-based Interventions to Prevent Suicide.*
    - *Risk and Protective Factors Across Socioecological Levels of Risk for Suicide.*

**Activities to be continued or undertaken:**

- Create and update research roadmaps related to specific focus areas identified as high-risk targets, such as military-to-Veteran transition and lethal means safety.
- Organize and expand a community of researchers to increase awareness of and attention to suicide prevention research, to encourage networking and to help develop the next generation of suicide prevention researchers.
- Develop coordinated data science research activities throughout the research program as well as with other VA program offices.
- In partnership with the Quality Enhancement Research Initiative (QUERI), continue evaluations of three national initiatives focused on suicide risk assessment using the electronic health record; suicide prevention among transitioning Service members; and the implementation of Caring Contacts to reduce the risk of suicide among Veterans.
- Continue to fund SPRINT to support networking within and outside the VA through cyberseminars and meetings that promote interactions between VA investigators and federal partners engaged in suicide prevention. SPRINT also works closely with OMHSP to speed the sharing of reaching findings with the field, thereby hastening improvements in care and reducing Veteran deaths by suicide.
- In response to the Commander John Scott Hannon Veterans Mental Health Care Improvement Act (2020), conduct large-scale data analyses, using computing resources from the Department of Energy, to assess the impact of altitude on suicidal thinking and behaviors among Veterans.
- Partner with DoD, the Department of the Army and NIMH in the third phase of the Study To Assess Risk and Resilience in Service members – Longitudinal Study (STARRS-LS). VA investigators are working with STARRS-LS investigators in developing analyses and papers to inform issues of critical importance to Veterans, such as homelessness and transition from military status. Efforts are underway to facilitate the sharing of VA health data with DoD to further analyses looking at the impact of the military experience on suicidality among Veterans.
- Provide data on VA research programs for a joint VA/DoD report on mental health programs (Section 405).
- Use findings from a current study on altitude and suicide risk to inform VA policy and help ORD determine which types of follow-up studies are most appropriate to further our understanding of the biological mechanisms underlying the relationship between altitude and suicide. These findings will also be used to inform the development of effective interventions for suicidality and depression among Veterans living in high-altitude areas.
- Enhance the availability and incentivizing the analysis of longitudinal data, including imaging and EEG data, from Veterans with mental health conditions or traumatic brain injury while ensuring data security and Veterans' privacy. (Section 305).
- Launch prospective data collection through a network of clinical research sites for the precision medicine for mental health initiative (Section 305).

**Scientific Computing to Personalize Veteran Care**

VA is the largest integrated health care system in the country. As such, VA's electronic health record (EHR), genetic data and imaging data put the Department in a unique position to drive scientific discovery to better personalize care for Veterans to drive scientific discovery towards the goals of precision medicine. ORD will invest in the following tools to modernize data infrastructure:

- Expanding the available data types and number of analyses within the VA Data Commons, a system that expands the number of qualified researchers who are able to analyze de-identified EHR and genetic data from over 848,0000 Veterans enrolled in MVP (as of August 31, 2021).
- Enhancing cloud-based analytic tools in the EHR to better support VA research.
- Supporting implementation and data feeds to cloud-based dashboards and decision support tools used by senior VA leadership.
- Using artificial intelligence (AI) and other advanced methods to bring together research and clinical teams to meet the needs of Veterans.

***Recent Accomplishments:***

- VA Research can now purchase scientific computing with software and storage of research data hosted in a cloud environment because they constitute a "service". The purchase of "cloud credits" for the research community to use for various analyses and/or storage of data from research projects allows ORD to clear a backlog of big data analyses (i.e., genomic data) for large national studies resulting from the prior constraints. This has allowed ORD to work with VA's Office of Information and Technology to create a pathway to provision data into the VA-owned Amazon Web Services and Azure cloud environments.
- The first analytic pilot project under the newly established process will be a genome-wide association study of MVP data. As the scientific computing program matures, more data analytic software is added to the cloud environments and more genome-phenome based studies are performed. This budget item will likely grow accordingly.
- Completed the Brain Injury Data Sharing (BIDS) project linking VA and DoD health records for Veterans and Service members with private sector systems affiliated with the national Patient-Centered Clinical Research Network (PCORNet). BIDS uses privacy-preserving records linkage technology that protects individual privacy but allows data linkage between federal agencies and between federal agencies and state or non-governmental entities.

**Activities to be continued or undertaken**:

- Continue to build on models of centralized data cores that coordinate across research and operations groups to curate and validate electronic health record and genetic test data such as the Prostate Cancer data core, the Genetic and Molecular Diagnostic Test (GDx) data core and the Pharmacogenomics Action for Cancer Survivorship (PHASeR) data core in the VA Informatics and Computing Infrastructure (VINCI).

- Survey all available options for the use of scientific computing platforms in order to establish the best value venues for researchers to execute analyses and store data. ORD is establishing processes to intake and track requests for use of scientific computing both on premises and in cloud environments.
- Establish a system for tracking projects and analyses to occur in a more efficient manner.

**Pain Management/Opioid Use**

Chronic pain is more prevalent and of greater intensity in the Veteran population than in the general population. It is often accompanied by coexisting mental health and overlapping painful conditions. This places Veterans at risk for harms from opioid medication, especially opioid use disorder (OUD). VA Research supports the generation of new knowledge to improve the prevention, diagnosis and treatment of OUD, as well as the development and testing of innovative approaches for chronic pain management for Veterans. 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 and VHA's Opioid Safety Initiative.

**Recent accomplishments:**

- Funded studies using regenerative medicine approaches to repair painful musculoskeletal injury, including the use of cells and/or biomaterials. Research using cell or biomaterials-based approaches to target pain in musculoskeletal conditions is still in the preclinical stage. Historically, research focused on joint biomechanics and inflammation as outcomes. The idea of alleviating pain is novel as the animal or person will likely not use the affected limb regardless of how well the regenerative construct increases joint range of motion, etc. Combining regenerative medicine technology with rehabilitation makes the approach even more significant.Cartilage Repair Strategies to Alleviate Arthritic Pain (CaRe-AP) is a consortium of VA investigators using cell and rehabilitative approaches to repair damage to the knee resulting in pain and osteoarthritis. The consortium consists of basic, rehabilitative and clinician investigators with the goal of translating cell therapies to the clinic.
- Cell-based therapies for intervertebral disc degeneration (back and neck pain). Use of innovative methods to repair and replace the entire intervertebral disc and comparing it with existing disc replacement strategies.
- Funded "Pain in a Dish" model using induced pluripotent stem cells from patients to screen novel non-opioid drugs and to identify genes that modulate pain (e.g., worsen or decrease pain) as new targets for future "personalized" pharmacologic therapy.
- Funded activity-dependent interventions for chronic low back pain. This study will determine whether short-term and overall activity is beneficial or deleterious (pain flare-ups) in a cohort of Veterans living with low back pain.
- Funded patient-centered care for older Veterans uses patient-reported outcomes and contextual patient generated data to provide primary care providers with insight on the specific needs and abilities of the Veteran.

- Funded the implementation of "Tele-Pain" to deliver an interdisciplinary, multimodal pain management program to smaller VA facilities. This program seeks to broaden the reach of services to Veterans living with chronic painful conditions in rural communities by using telehealth to fill gaps in delivering effective pain management care to the community setting.
- Funded the Perioperative Pain Self-Management Program to prevent chronic perioperative pain and prolonged opioid use. The program incorporates the fundamentals of cognitive behavioral therapy to help Veterans think differently about pain, improve their pain coping skills and reduce reliance on medication following total knee arthroplasty.
- Completed a State-of-the-Art (SOTA) Conference on Effective Management of Pain and Addiction: Strategies to Improve Completed a State-of-the-Art (SOTA) Conference on Effective Management of Pain and Addiction: Strategies to Improve Opioid Safety.
- Funded a multicenter, multidisciplinary Consortium of Research on Pain and Opioids to coordinate health services research on these areas. The overall goal of this initiative, jointly supported by NIH, DoD and VA, is to develop the capacity to implement cost-effective large-scale clinical research in military and Veteran health care delivery organizations focusing on nonpharmacological approaches to pain management and other comorbid conditions.
- Funded the APPROACH (Assessing Pain, Patient Reported Outcomes and Complementary and Integrative Health) trial. The trial's main objective is to learn whether adding self-care strategies to practitioner-delivered complementary and integrative care increases the effectiveness of pain management.
- Released an RFA for research on priorities identified by the HSRD SOTA conference. The RFA was released on September 22, 2021, "HSR&D Targeted Solicitation for Service Directed Research on Opioids Safety and Opioid Use Disorder." Four applications were submitted and reviewed.
- In response to the National Academy of Science's report titled "An Approach to Evaluate the Effects of Concomitant Prescribing of Opioids and Benzodiazepines on Veteran Deaths and Suicides," expanded a current national study to examine outcomes of opioid tapering in more than 9,000 Veterans taking long-term opioids.
- Funded two partnered evaluations, with primary funding from VA clinical operations partners, on facilitating and evaluating a Stepped-Care Model and Medication Treatment for Opioid Use Disorder, and three partnered implementation initiatives on improving access to medications for OUD in primary care settings, facilitating practice re-design of opioids care, and delivering effective hospital practices to improve pain outcomes while preventing and delaying opioid adverse events.
- Funded development of novel endomorphin analogs with antinociceptive activity (blocking pain signals), reduced abuse potential and potential for opioid dependence therapy.

**Activities to be continued or undertaken:**

- Build upon a collaboration with the Arthritis Foundation (HAP Partnership Impact - National Center for Healthcare Advancement and Partnerships) to continue to develop novel interventions for the treatment of osteoarthritis.
- Continue to focus on non-opioid approaches for chronic painful conditions, including increasing the number of clinical trials and using team-based models to develop novel non-pharmacological therapeutics.
- Develop RFAs across all ORD services for new studies on opioid addiction, including a targeted solicitation for research on strategies to improve opioid safety based on strategic prioritization by partners and researchers at the SOTA Conference described above.
- Develop safe strategies for reducing opioid use, improving use of medication therapy for OUD and improving the co-management of OUD and pain.
- Continue the Pain Management Collaboratory with NIH and DoD. The Collaboratory is comprised of trials of non-drug approaches for the management of pain and common co-occurring conditions.
- Launch a phase 2 clinical trial of transcranial direct current stimulation combined with a brief cognitive intervention to reduce perioperative pain and opioid requirements in Veterans, following the encouraging results of a pilot study.
- Launch a proof-of-concept trial of cannabis derivatives in neuropathic pain.
- Develop a program that would support clinical trials aimed at evaluating novel chemical entities, devices and promising interventions to accelerate translational research on non-opioid pain management.

**Posttraumatic Stress Disorder (PTSD)**

VA Research has led the way in developing and testing effective psychotherapies for PTSD and in exploring other approaches to treat the disorder such as medications, behavioral interventions and therapeutic devices. Research is directed at understanding the underlying biology and etiology of PTSD to identify potential treatment targets. We also support treatment related research which is focused on expanding the evidence base consisting of psychotherapy, medications and other approaches. VA has a strong track record of facilitating the implementation of research findings in this area directly into clinical practice. This research investment is important because Veterans with PTSD may respond differentially to treatment than non-Veterans. There are recommended treatments for PTSD, including counseling and medications, but we know these treatments may not work for everyone. VA Research is developing and testing new treatments for Veterans with military-related PTSD, so that every affected Veteran has the opportunity to get relief from their symptoms.

VA researchers demonstrated the effectiveness of prolonged exposure therapy for treating PTSD and depression in male and female Veterans of all eras. Prolonged exposure therapy is now one of two main forms of psychotherapy VA offers as evidence-based treatment for the disorder. We continue to work to better understand the underlying biology of PTSD, advance new treatments and refine diagnostic approaches. In our portfolio of psychotherapy research, scientists are

working to define which approach works best for which individuals and what improvements can be made to evidenced-based therapy to increase effectiveness.

On the medication front, ORD has developed a strategic plan to examine the efficacy and effectiveness of new medications for PTSD under our PTSD Psychopharmacology Initiative. This initiative is focused specifically on increasing the number and type of available evidence-based treatments over the two currently approved medications. We started with two clinical trials in 2016 and the Initiative now funds 12 ongoing trials. Through these trials, we hope to identify one or more compounds that improve PTSD symptoms. This ambitious program continues to grow through our support of mentoring and training for new clinical trialists and our active outreach to identify suitable drug candidates, including the possibility to identify molecular targets from analyses conducted on MVP samples. A major clinical trial has been launched in VA, CSP 2016, to determine which medications commonly used for sleep disorders will be most effective for sleep disorders in PTSD. This is one of the largest trials to examine insomnia, targeting enrollment of over 1200 Veterans with PTSD. Three medications will be evaluated, providing key clinical information regarding which is most effective for decreasing insomnia related to PTSD.

Altogether, the research focused on biological understanding that will lead to improved treatments. Our research on medications, therapies and other treatments will improve Veterans' quality of life by increasing the number and type of evidence-based treatments and identifying personalized approaches for treatment.

**Recent accomplishments:**

- Launched a telehealth program to serve Veterans living in rural areas who have PTSD. Researchers at the Puget Sound VA helped deploy Telemedicine Outreach for PTSD, a program based on research conducted in VA that demonstrated the effectiveness of virtual team-based care for rural Veterans with PTSD.
- Identified eight novel genetic variants associated with re-experiencing symptoms, a major symptom of PTSD, in more than 165,000 Veterans—one of the largest genome-wide association studies to date on PTSD.
- Provided a PTSD Repository that is used by VA's PTSD Consultation Program. The repository provides an evidence base for questions program staff receives from national clinicians and other stakeholders. The repository has also been used by the National Center for PTSD to address urgent "hot topic" requests and media inquiries.
- Funded a large multi-site clinical trial to investigate the feasibility and efficacy of stellate ganglion block as a treatment for PTSD in Veterans to begin enrolling in 2022.
- Funded rapid turnaround studies to understand the challenges faced by Veterans with PTSD during the COVID 19 pandemic and to test new strategies to meet these challenges.
- Demonstrated the efficacy of a brief couples-based therapy delivered via telehealth for Veterans with PTSD. The study found treatment effects similar to those seen with individual therapies for PTSD and higher retention than in previous trials.

**Activities to be continued or undertaken:**

- Recruit, under the MVP-MIND effort, Veterans with a variety of mental health conditions to participate in MVP, including PTSD. MVP-MIND is designed to increase the representation of Veterans with PTSD and other mental health conditions that commonly affect Veterans in MVP.
- Enrolling into CSP2016, adaptative multi-site clinical trial of multiple medications to treat insomnia in Veterans with PTSD.
- Continue to launch new meritorious clinical trials addressing medication, therapy and other approaches.
- Support studies to explore the impact of support from peers, family members and caregivers on the treatment outcomes of Veterans with PTSD and that test the effectiveness of complementary, integrative interventions such as yoga.

**Coronavirus-Related Research and Impacts**

Since the start of the COVID-19 pandemic, as part of the nation's largest integrated health care system, VA Research has been uniquely positioned to provide its expertise in COVID-19 research. COVID-19 research funding supports efforts began during the pandemic and accomplished in coordination with other federal agencies. VA is fortunate to have nationally recognized experts in infectious diseases. We have leveraged both our expertise and unique capabilities to conduct and participate in major national research studies. We will build on this work in collaboration with our clinical partners and other agencies to inform care in VA and across the country.

For instance, VA researchers are generating real-world evidence of COVID-19 vaccines' effectiveness over time across the country. Through collaborations with FDA, CDC and NIH, this knowledge helps to inform decisions on significant issues such as the need for boosters and new vaccine targets. In addition, we are working with DoD on a project to closely follow several thousand people from the time of diagnosis, including detailed biosample collection. This will help us to understand the mechanisms of different clinical trajectories following COVID-19.

VA will continue to build coordination through curation, dissemination and documentation of relevant data resources in the VA COVID-19 Shared Data Resource as well as through core methodological and technical coordination among central working groups. VA is also collaborating with national and international health care systems on the analysis of real-world data on COVID-19 through the Observational Health Data Sciences and Informatics collaborative and other networks. Some of these activities will involve a collaborative effort between ORD and the VA Office of Information Technology (OIT), with support from the Department of Health and Human Services (HHS) Biomedical Advanced Research and Development Authority (BARDA). This partnership will allow VA to provide access and support to the Department's research and analysis, supported by the Veterans Informatics and Computing Infrastructure (VINCI). The goal is to leverage VA Corporate Data Warehouse data to better understand the effectiveness of vaccines or therapeutics that Veterans receive.

**Recent accomplishments:**

- **Established the ORD COVID-19 Biorepository/VA SHIELD.** This repository of biospecimens and associated data in emerging diseases is now available for research studies. It will help advance scientific understanding of infectious and other diseases; support clinical research; and further diagnostic, therapeutic and preventative strategies for immediate deployment in VA clinics.
- **Coordinated enterprise-wide research on variant sequencing.** This project, known as VA SeqCURE (**Seq**uencing **C**ollaborations **U**nited for **R**esearch and **E**pidemiology), supports a network of VA research labs established to conduct variant sequencing to monitor the evolution of the SARS-CoV-2 genome. This effort is critical due to concerns that emerging variants may escape immunity generated by COVID-19 vaccines or prior infection.
- **Launched Epidemiology, Immunology and Clinical Characteristics of COVID-19 (EPIC$^3$).** This observational study, done in collaboration with the EPIC$^2$ study at DoD, collects Veterans' data and biospecimens to gain a detailed understanding of COVID-19's impact in different people. Among other contributions, the study will shed light on why certain people have more severe disease and why some develop post-acute sequelae SARS-CoV-2 infection (PASC, or "long COVID").
- **Established a program on COVID-19 Pandemic-Related Disrupted and Deferred Care.** The COVID19 pandemic has been marked worldwide by increases in all-cause mortality that track with pandemic severity but exceed the number of deaths attributed directly to COVID. An especially concerning national statistic is the marked increase in overdose deaths.

  It is not yet known to what extent these deaths are related to disruptions in care caused by overcrowded hospitals, delayed elective procedures and a dramatic drop in medical encounters. or conversely due to undiagnosed or delayed effects of COVID-19 infection.

  - **National Study of All-Cause Mortality:** VA has launched a national study of all-cause mortality among its patients during the pandemic to assess which populations were most affected, which causes of death increased the most, the relationship to local conditions and local policies and the possible contribution undiagnosed COVID may have had to excess mortality.
  - **Impact of COVID-19 on Mental Health Care, Acute Care and Chronic Disease Outcomes:** We will also carry out a minimum of three studies conducting detailed analyses of COVID's effects on mental health care and outcomes (including overdoses and suicide), acute care such as treatment of stroke and myocardial infarction and preventive care including immunizations and cancer screening. These results will help inform VA programs and facilities as they confront a backlog of deferred care and will help all health systems better prepare for future pandemics or other events that disrupt care.
- **Created the COVID-19 Observational Research Collaboratory (CORC).** The CORC is a multi-site Coordinating Center that coordinates ongoing research related to long-term

COVID outcomes and facilitates new studies by promoting common data and methods. The Center is:

  - Examining electronic record data and conduct surveys with thousands of patients at least 6 months post-infection to assess the effect of COVID on clinical diagnoses, health care utilization, costs, symptoms and other patient-reported outcomes (compared to matched patients without COVID).
  - Establishing a data infrastructure of 250,000 COVID-infected Veterans, developing matched comparison populations and curating data to facilitate additional studies.
  - Establishing a methods group to review methods of ongoing studies, review manuscripts and produce methods guidance (white papers). The goal is to ensure coordinated and consistent approaches across these projects.

- **Launched a study of vaccine hesitancy**. Although vaccine administration has been very effective among the VA population, there remains an important subset of the Veteran population who have not yet been fully vaccinated. Unvaccinated patients remain at high risk of infection and poor outcomes, and reasons for their hesitancy vary. Surveys of Veterans and other unvaccinated patients indicate that a patient's health care provider is the person they trust most for advice about the vaccine. VA has initiated an important study that will test whether a specific training program for frontline clinicians (motivational interviewing) can improve their ability to persuade hesitant Veterans about the value of COVID-19 vaccination. Given the likelihood that COVID-19 will become an endemic disease, improving the ways we talk with patients about the value of immunizations is a critical need.

**Activities to be continued or undertaken:**

Many of the activities described previously will continue into 2023. Additionally, ORD will continue to fund new investigator-initiated COVID-19 projects. Of particular note are the following:

- **Long COVID:** ORD will pursue additional studies into particular priority questions related to long COVID in Veterans, some of which were identified through an expert meeting in August 2021. They will be led by individual research programs within VA, clinical program office partners and other federal funders. Funding will support collaborative teams that will address questions such as functional impairment in long COVID, its effects on cognition and mental health and the effects of different viral variants on the severity of long COVID.
- **Vaccine and therapeutic effectiveness:** Given VA's large patient population and sophisticated electronic health record system, VA Research is uniquely positioned to track and analyze patient outcomes. VA investigators can contribute toward a better understanding of the effectiveness over time of vaccines and various treatments. They can also help us learn about the role of comorbidities such as diabetes or heart disease in COVID disease severity and treatment outcomes.
- **Variant Sequencing:** Through the VA SeqCURE effort mentioned above, VA Research is partnering with VA clinical operations and outside federal partners to study emerging variants that may escape immunity generated by vaccines or prior infection

and to understand the risk factors and clinical progression associated with different variants.

**Investment in the VA Research Enterprise**

The goal of the VA Research enterprise initiative is to efficiently support research that will advance the health and well-being of Veterans by creating a streamlined and collaborative organization with standardized infrastructure and processes. This will enable operational and resource efficiencies; facilitate coordination of efforts across the VA system; and support a shared approach toward larger goals.

***The VA Research enterprise is the entire set of people, tools and processes committed to a whole-of-VA approach for supporting researchers, clinicians and Veterans.*** Enterprise activities aim to coordinate and leverage current and future investments to produce a more comprehensive "value added" impact while creating efficiencies across a broader range of activities. The VA Research Enterprise aspires to embody five key qualities:

- **A Unique Value Proposition:** The VA Research enterprise addresses VA's and the nation's biomedical and health ecosystem research needs as well as Veterans' needs by leveraging its capabilities and resources as part of the largest integrated health care system in the country.
- **Real-world Outcomes:** The VA Research enterprise improves Veterans' well-being by efficiently solving specific, real-world problems.
- **Engaged People:** The VA Research enterprise involves and relies upon a diverse staff, researchers and communities who feel a sense of belonging, empowerment and who share the purpose to improve Veterans' well-being.
- **Integration:** The VA Research enterprise is an integral part of the VA enterprise and the nation's biomedical and health ecosystem, strategically leveraging its relationships and partnerships.
- **Operational Excellence:** The VA Research enterprise is efficient and flexible in its operations. It offers streamlined processes, effective communication and collaboration, high-quality customer service and the right tools and resources to support staff, researchers and communities as they work to improve Veterans' well-being.

**Recent accomplishments:**

- Adopted a Software as a Service an enterprise-wide research committee management tool (VA Innovation and Research Review System – VAIRRS) to promote standardization and harmonization and allow for the creation of dashboards to enable decision makers to visualize performance and use those metrics for performance improvement and evidence-based decision making. This tool has been established at all 106 active research programs at VA medical centers and within the VA Central Institutional Review Board (IRB).
- Developed an enterprise-wide clinical trials capacity, including initiating an acquisition for a clinical trials management system to be integrated into both the current and the new electronic health records systems.

- Developed and launched an innovative electronic determinations decision support tool (VA Electronic Determination Aid – VAEDA) to harmonize and standardize the over 10,000 research/not research decisions that are made each year to better administer the review workload on VAMC research offices.
- Expanded the Partnered Research Program to promote a "front door" model to industry, non-profits and federal research partners to promote streamlined study implementation. The program augments the national clinical trials enterprise to better enable VA's ability to stand up externally sponsored research to enhance Veterans' access to potential new therapies.
- Established enterprise-wide contracts to eliminate delays in study implementation and support study conduct.
- Centralized and streamlined human resources (HR) functions to allow for more efficient hiring and onboarding, which will improve customer satisfaction.
- Established initial models of partnership with clinical and operational stakeholders within VHA to focus on a more integrated approach to cancer and COVID-19 research.

**Activities to be continued or undertaken:**

- **ORD Governance and Success Measures**: A robust ORD governance system is the foundation of all of the initiatives listed below. By establishing an ORD governance plan with defined processes and owners (including program and change management roles), ORD will ensure effective coordination, prioritization and implementation of enterprise efforts. The governance structure will also allow ORD to measure progress towards reaching its enterprise goals and periodically re-evaluate its enterprise priorities.
- **IT and Data Governance:** While ORD has been investing in research IT resources over the years, there are still opportunities to improve coordination and limit redundancies and duplication of research IT efforts. The IT and Data Governance initiative aims to rationalize research IT and data efforts, improve ORD's ability to use data for decision-making and provide staff and researchers with the right IT tools to enhance their productivity. Under this initiative, ORD will establish IT and data ownership, implement improvements to research IT tools and processes, deploy new tools to support enterprise functions and establish data policies.
- **Actively Managed Portfolios:** This initiative aims to develop and pilot a new research portfolio management model for selected high priority research areas to address the need for greater real-life impact and alignment of VA research with Veterans' needs. Establishing strategy, processes, funding mechanisms and metrics for actively managed portfolios will enable ORD to effectively and systematically solve concrete problems faced by Veterans and VA.
- **Central Research HR Function:** This effort aims to establish dedicated research HR roles, processes and communications to further streamline the recruitment of staff for ORD-funded research projects.
- **Rationalization of ORD's Organization**: This effort aims to ensure alignment of ORD's organizational structure and roles with enterprise functions. As part of this initiative, ORD

will define its functions to better support enterprise-level activity, evaluate its current organizational structure and design a new structure to implement ORD's enterprise priorities, improving decision-making and accountability.

- **Leadership Mentoring Program:** This initiative aims to provide ORD employees with growth and development opportunities and implement effective leadership practices across ORD. By establishing a standardized mentoring and training program, ORD hopes to improve employee experience and drive accountability and leadership across the organization.
- **Finance Processes:** This initiative aims to increase ORD's visibility into the execution of research funds distributed to the field and enable optimal fund allocation by developing and improving research funding execution tracking progress and tools.
- **Enhanced Partnered Research Program (PRP):** This initiative aims to further improve VA's ability to effectively cooperate with the industry and enhance Veterans' access to high-quality clinical trials by further building out the PRP. The PRP build-out will likely include expansion of the PRP team, new tools and processes and enhanced communications and training efforts.
- **Field Contract Support:** This initiative aims to expand ORD-funded researchers' access to necessary research resources by providing them with centralized contract resources including contract management, relevant access tools and processes.

**Research Support of VA's Electronic Health Record Modernization (EHRM)**
The ORD Strategic Initiative for Research and EHR Synergy (OSIRES) team addresses the requirements for VA Research continuity, success and growth throughout the 10-year Electronic Health Record Modernization (EHRM) process.

**Key Aims/Workstreams:**

- **Identify Research functional requirements** for using the new EHR and its data and advocate for those requirements with the Office of Electronic Health Record Modernization (OEHRM) and the Cerner Electronic Health Records System management team.
- **Facilitate VA Research aspects of the Cerner/OEHRM deployment**, including functional integration; research roles and permissions; training needs; workflow design; data access; governance; and provisioning.
- **Support VA R&D at transitioning VA medical centers** beginning at the time of their Cerner-led Current State Review (approximately 18 months prior to deployment):
    - Identify affected projects and risks.
    - Facilitate onboarding of current projects into Millennium PowerTrials.
    - Communicate with local sites regarding deployment activities and deployment preparation.
    - Develop toolkits to guide local R&D leadership in creating a transition team and supporting successful deployment.

- **Identify Research Subject Matter Experts/Points of Contact (SME/POC)**), to continue a Research Management and Transition Plan to address needs, impacts and opportunities throughout the EHRM, focusing on Research as an EHR user, Research as an EHR data user and Research EHR Innovation. The plan will include:
    - Deployment assessment and planning (immediate and short-term).
    - Planning for executable TO activities for mitigation and growth across Cerner (short- and medium-term).
    - Recommendations for forward-looking opportunities to maximize the capabilities of the Cerner system for the ongoing growth of VA Research (medium- and long-term).
- **Develop and implement national communication, education and resources** for the research field regarding transition activities, impacts and the use of Millennium and its data.
- **Communicate and escalate impacts, risks and policy issues to ORD** to facilitate enterprise standardization, organizational decision-making and higher-level advocacy.
- **Develop a centralized Research Application Analyst (RAA) program** for the ongoing sustainability of PowerTrials and other research integrations within the EHR.

**Activities to be continued or undertaken**:

- Continue to support local site preparation, national configuration and decision-making and Cerner/OEHRM communication and development. As we accrue experience with site deployment and go live, we will harden strategic approaches and activity cadence and create and refine playbooks and toolkits to address Research transition needs.
- Hire at least five additional staff members to support national change management for Research, including enterprise standardization, communication and education and training related to the transition. Data translation, regulatory and access needs will sharply increase.
- Pilot the creation of central Research Application Analyst (RAA) positions to provide technical support and new study onboarding and to initiate back-end production changes for the PowerTrials application. We anticipate the RAA position to be a critical element in the long-term sustainability of PowerTrials and other Research integrations with the EHR. Fledgling pilot results will support the development of resources, strategies and RAA staffing plans during 2023.

**Reducing the Need for VA Research with Sensitive Species**
The numbers of animals of each of the sensitive species (canines, felines and non-human primates) that have been needed in VA research have decreased over the past two decades by more than 90%. This reflects both changes in the nature of the research questions being addressed and unique research opportunities that have opened up with the many new strains of genetically modified mice and rats that have been bred.

There have also been new techniques developed that now make it possible to conduct some of the research that in the past could only be done with sensitive species. At the same time, understanding

of the optimal ways to care for animals involved in research continues to grow. VA is committed to continuing to meet or exceed all applicable animal welfare standards as they evolve.

At the same time, VA maintains an unwavering commitment to conducting research that is needed to improve Veterans' lives. An external review of VA research with animals by the NIH Office of Laboratory Animal Welfare concluded that the VA programs are effectively supporting the humane programs of animal care and use at their institutions and are conducting research with canines and other vertebrate species in compliance with the PHS (Public Health Service) Policy and all applicable rules and regulations.

A report by NASEM focused specifically on VA's research with canines was released in July 2020. It affirmed the continuing scientific necessity of work with canines in some areas of research, including all of the currently active VA research with canines. The report further concluded that VA animal research programs were complying with and exceeding federal regulations and guidelines on humane animal care and use.

Since 2018, Congress has placed limits on canine research. In 2020, Congress introduced additional constraints and expanded the species subject to those constraints to include felines and non-human primates. Processes have been set up to comply with all congressional mandates. Collectively, VA's monitoring and evaluation processes for studies with sensitive species of animals are by far the most stringent of any in the nation.

**Recent accomplishments:**

- Invested $3 million in applications submitted by investigators who seek to develop and evaluate alternatives to canines in cardiology work. We will continue to look for additional opportunities to fund other such studies.
- Applied for and received membership to the Interagency Coordinating Committee on the Validation of Alternative Methods.
- Began work to modify the instrumentation, develop the new techniques required and learn about the detailed anatomical and physiological similarities and difference between a

models for studying arrhythmia-induced heart failure, to evaluate the suitability of new models.

- Formalized a Standard Operating Procedure for securing the written approval of the VA Secretary for research protocols involving sensitive species of animals before work begins.
- Established an Executive Committee and Working Group to carry our implementation of the five-year plan to Congress and held initial meetings of both to finalize the implementation plan.
- Executive committee representative presented the implementation plan to the National Research Advisory Council on December 8, 2021.
- Established a Memorandum of Understanding with the National Center to Advance Translational Research.
- Completed a joint program with the National Center to Advance Translational Science on replacing current VA research involving animals with research based on microphysiological systems in November 2021.
- A new ORD RFA on "Developing and Validating Alternatives to the Use of Canines, Felines and Non-Human Primates in VA Research' to be posted in calendar year 2022 was submitted for final approvals.

**Activities to be continued or undertaken:**

- Continue support for and participation in the NASEM Roundtable working group on best practices for the reduction, replacement and refinement of canine research in VA.
- Participate as a full member on the Interagency Coordinating Committee on the Validation of Alternative Methods (ICCVAM).
- Participate in an ICCVAM workgroup on increasing the incentives for investigators to develop and validate alternatives to animal testing.
- Look for additional opportunities to fund research on alternatives to dogs, cats and non-human primates.
- Develop a targeted funding program to foster collaborations with veterinary schools to conduct more clinical trials with client-owned pets, for work that can benefit both Veterans and pets.
- Provide support to NASEM for their update of the *Guide for the Care and Use of Laboratory Animals*, a key compliance document for all VA animal care and use programs.
- Continue a collaboration with the National Center to Advance Translational Science to promote the use of microphysiological systems to replace animal models.

**Addressing the Prosthetic Needs of Women Veterans with Amputations**

In conjunction with the priority to ensure disabled Veterans who require a prosthesis are able to 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 women Veterans is growing and VA must be able to meet their prosthetic needs as well.

ORD has added a statement to our RFAs that "Prosthetic and other assistive technology needs of women Veterans" are an area of special emphasis for us. This request has increased the number of VA researchers proposing studies that consider the needs of women Veterans in the design of prosthetic devices. The most meritorious applications we receive are selected for funding based on the results of rigorous scientific peer review.

**Recent accomplishments:**

- Funded a supplement to increase the number of women Veterans and allow comparisons by gender in an existing DoD-funded project, "Needs, Preferences and Functional Abilities of Veterans and Service Members with Upper Limb Amputation." The project's findings confirm that women with upper-limb amputation are less likely than men to have ever used or to currently use prostheses, to have received prosthetic training, or to use devices controlled with body movement. They are more likely to use devices that serve exclusively a cosmetic purpose. Its results highlighted a need to develop prostheses for women that are cosmetically acceptable, yet lightweight and functional.
- Produced redesigned 3D-printed metal prosthetic fingers in smaller sizes more appropriate for women Veterans, which were licensed to an industry partner (Point Designs) that can rapidly make these smaller sizes available to Veterans. Refining and testing design changes will continue to improve function of the smallest finger sizes.
- Developed a novel prosthetic ankle/foot attachment system that can be quickly adapted for use with different footwear, such as high heels. With the assistance of the ORD Technology Transfer Program (TTP). The Investigators signed a licensing agreement in January 2021 with an industry partner (UNYQ) who plans to release the device on the market at the International Orthopedic Technology Trade Show and World Congress in Leipzig, Germany in May 2022.
- Funded a study to evaluate and refine outcome measures of upper-limb prosthetic use in women Veterans to ensure test items and scores reflect issues important to them in research and clinical care.
- Funded a study in women Veterans with major lower-limb amputation to characterize prosthetic prescription, use and satisfaction, and to identify barriers and facilitators to successful functional mobility and health-related quality of life in order to promote gender-sensitive prosthetic care and equitable outcomes.

**Activities to be continued or undertaken:**

- Start a definitive evaluation to seek FDA approval of an osseointegrated prosthetic device for both women and men with lower-limb amputation.
- Determine if women with lower-limb loss are at greater risk of developing secondary musculoskeletal conditions.

- Study the effects of carrying loads, specifically infants and toddlers, on Veterans with lower-limb amputation and applying the results to generate guidance for prosthetic prescribing.
- Characterize the healthcare needs of Women based on the following criteria: access to care, needs, priorities, preferences and experiences of women Veterans related to mobility devices and identifying potential solutions to any challenges discovered.

**Investing in Artificial Intelligence (AI)**

VA is the largest integrated health care system in the country. It has established several big data repositories, including the largest genomic knowledge base in the world linked to health care information. It also trains the largest number of nurses and doctors in the United States. Given these factors, VA is uniquely positioned to advance AI research, development and implementation at the frontiers of science and health for our nation's Veterans and the population at large.

The National Artificial Intelligence Institute (NAII) seeks to develop AI research and development capabilities in VA to support Veterans and their families, survivors and caregivers. The NAII designs and collaborates on large-scale AI R&D initiatives, national AI policy and partnerships across agencies, industries and academia. The NAII is dedicated to advancing AI research and development for real-world impact and outcomes to ensure Veteran health and well-being.

**Recent accomplishments:**

- Released a VA AI Strategy, making VA one of the first five federal agencies with an explicit AI strategy.
- Developed VA AI guidance (in response to Executive Order and OMB guidance request) for industry partnerships on AI use cases for the NAII.
- Contributed language and subject matter expertise to policymakers in support of the Executive Order Promoting the Trustworthy Use of Artificial Intelligence in Government (EO 13960).
- Led the development and operationalization of a COVID-19 morbidity/mortality model in coordination with the Washington DC VAMC.
- Led VA participation in a government-wide hiring sprint to recruit data scientists and helped sites across VA diffuse the position descriptions and other documents to aid in their own recruitment efforts.
- Kicked off, in January 2021, NAII's second VA Tech Sprint. Participation from industry was up more than 300%, due in-large part to leveraging GSA's Challenge.gov platform to publicize the invent and provide incentives. More than 30 teams completed the Tech Sprint in May, providing unique opportunities for pilots and refinement of future AI use cases.
- 2021 Tech Sprint pilots, including: solutions for medication adherence, detection of suicidal ideation and Veterans in crisis and physical therapy monitoring.
- Contributed reviews to the Scientific Merit Review Board for the RRD Committee on Sensory Systems & Communication Disorders (RRD3).

- Established the AI@VA Community, an AI community of practice providing training, networking and collaboration opportunities to VA employees. The AI@VA Community has a SharePoint hub and Teams group. AI@VA also connects with academia and industry, highlighting VA's AI accomplishments through a newsletter. Over 500 VA employee members and over 300 external (academia, industry) members.
- Participated in the writing of an EO on AI Workforce Development and S.2551 - AI Training Act, in cooperation with WH Office of Science and Technology Policy (OSTP). S.2551 - 117th Congress (2021-2022): AI Training Act | Congress.gov | Library of Congress
- Began development of an extensive AI internship program in partnership with leading universities.
- Drafted the NAII Strategic Plan through 2026.
- Drafted the VA AI Strategy Implementation Charter.
- Some examples include via coordinating AI@ VA Community on various research topics, reviewing technical strategy and trustworthy AI metrics with services/offices and researchers and running AI tech sprints with SMEs on specific AI-empowered topics.

**Activities to be continued or undertaken:**

- Implement Executive Order 13960, "Promoting the Trustworthy Use of Artificial Intelligence in Government," including a VA-wide data call for use cases and the cataloging of operational AI.
- Design an AI-To-Go environment in which models from AI researchers can be tested against VA data to ensure human-centered design principles are built into every step of our translational AI processes.
- Work to establish a standard for AI knowledge certification and execute a pilot to evaluate that knowledge.
- Plan the BRAIN Summit (formerly AI and the Brain) to bring researchers and private industry together in this field.
- Plan educational partnerships and an AI Tech Sprint focused on quantum computing for privacy-preserving AI and AI for imaging. NAII has reviewed a number of use cases around privacy-preserving AI in which quantum computing has a unique potential to enable AI to be applied for Veterans' benefit while ensuring their privacy.
- Launch additional AI Tech Sprints. The Sprint seeks to build collaborations and potential partnerships by designing AI-enabled research and development tools that leverage federal research and development data to address Veterans' needs.
- Conduct pilots of AI based systems identified in the 2022 tech sprint and continue 2021 tech sprint pilots as needed.
- Expand pilots of the Digital Command Center (DCC).
- Pilot and assess technologies to improve the operational effectiveness of the VHA.

- Work with the National Science Foundation to design and co-launch a cross-federal National AI Research Institutes program.
- Implement VA wide training on AI, to include a comprehensive library of resources, lunch and learn sessions and original materials.
- Coordinate the AI@VA Community to pursue collaborative research projects.
- Review technical strategy and trustworthy AI metrics with services, offices and researchers across VA.
- Continue leading cooperative data research and analytics regarding PPI/PHI/Classified among agencies.
- Develop an extensive AI internship program in partnership with leading universities and implement AI based processes to streamline and expedite administrative operations VA-wide
- Convene an AI Task Force to lead implementation of the VA AI Strategy.

## Table: Medical and Prosthetic Research Crosswalks

**Medical and Prosthetic Research Summary (Discretionary)**
(dollars in thousands)

| | 2021 Actual | 2022 Request | 2022 Estimate | 2023 Request | 2023 Req-2022 Est |
|---|---|---|---|---|---|
| **APPROPRIATION** | | | | | |
| Medical and Prosthetic Research Annual Appropriation | $815,000 | $882,000 | $882,000 | $916,000 | $34,000 |
| Rescission | ($20,000) | $0 | $0 | $0 | $0 |
| **APPRROPIATION [Subtotal]** | $795,000 | $882,000 | $882,000 | $916,000 | $34,000 |
| **REIMBURSEMENTS** | $42,888 | $61,000 | $61,000 | $61,000 | $0 |
| **BUDGET AUTHORITY** | **$795,000** | **$882,000** | **$882,000** | **$916,000** | **$34,000** |
| **UNOBLIGATED BALANCE (SOY)** | | | | | |
| No-year | $4,199 | $4,500 | $4,500 | $4,500 | $0 |
| 2-year | $131,502 | $65,600 | $98,988 | $75,000 | ($23,988) |
| 5-year | $23,000 | $12,500 | $12,500 | $6,250 | ($6,250) |
| **Unobligated Balance (SOY) [Subtotal]** | $158,701 | $82,600 | $115,988 | $85,750 | ($30,238) |
| **UNOBLIGATED BALANCE (EOY)** | | | | | |
| No-year | ($3,642) | ($4,500) | ($4,500) | ($4,500) | $0 |
| 2-year (Annual Appropriation) | ($98,988) | ($50,000) | ($75,000) | ($85,000) | ($10,000) |
| 5-year | ($12,500) | $0 | ($6,250) | $0 | $6,250 |
| Lapse (Two Year) | ($389) | | | | |
| **Unobligated Balance (EOY) [Subtotal]** | ($115,519) | ($54,500) | ($85,750) | ($89,500) | ($3,750) |
| **PRIOR YEAR RECOVERIES** | $52,803 | | $0 | $0 | $0 |
| **OBLIGATIONS** | **$933,873** | **$971,100** | **$973,238** | **$973,250** | **$12** |
| | | | | | |
| Full-Time Equivalents (FTE): | | | | | |
| Direct FTE | 3,997 | 3,447 | 4,146 | 4,272 | 126 |
| Reimbursable FTE | 138 | 138 | 138 | 138 | 0 |
| Total FTE | 4,135 | 3,585 | 4,284 | 4,410 | 126 |

**American Rescue Plan (Mandatory)**
(dollars in thousands)

| | 2021 Actual | 2022 Request | 2022 Estimate | 2023 Estimate | 2023 Req-2022 Est |
|---|---|---|---|---|---|
| **MANDATORY** | $9,000 | $0 | $0 | $0 | $0 |
| ARP Act § 8002 | | | | | |
| **UNOBLIGATED BALANCE (SOY)** | | | | | |
| ARP section 8002 - 3 year | $0 | $0 | $1,772 | $30,000 | $28,228 |
| **UNOBLIGATED BALANCE (EOY)** | | | | | |
| ARP section 8002 - 3 year | ($1,772) | $0 | ($30,000) | $0 | $30,000 |
| **OBLIGATIONS** | $7,228 | $0 | $1,772 | $30,000 | $28,228 |
| | | | | | |
| Full-Time Equivalents (FTE): | 40 | 0 | 8 | 113 | 105 |

In FY 2022, VA plans to reallocate $30 Million of the funding provided in section 8002 of the American Rescue Plan Act for Research (persuant to Section 254 of P.L 117-103), which will be executed out of the Veterans Medical Care and Health Fund. Final 2022 funding allocations among categories may change in response to workload demand requirements throughout 2022 and 2023.

[1/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, together with updated estimates for transfers, reimbursements and medical care collections.

## Table: Distribution of Program Resources

**Office of Research and Development Program Distribution**

**(Dollars in Thousands)**

| Program | 2021 Actual | 2022 Estimate | 2023 Request |
|---|---|---|---|
| Research Administration (820) | $123,190 | $133,317 | $138,456 |
| Biomedical Laboratory R&D (821) | $194,422 | $210,405 | $218,516 |
| Rehabilitation R&D (822) | $103,514 | $112,024 | $116,342 |
| Health Services R&D (824) | $123,107 | $133,227 | $138,363 |
| Cooperative Studies Program (825) | $99,210 | $107,366 | $111,505 |
| Clinical Science R&D (829) | $78,374 | $84,817 | $88,087 |
| Million Veteran Program (826) | $93,183 | $100,843 | $104,731 |
| **Discretionary Appropriation Total[1]** | **$815,000** | **$882,000** | **$916,000** |
| **Mandatory, American Rescue Plan (Public Law 117-2, Section 8002)[2]** | $9,000 | $0 | $30,000 |
| **TOTAL** | **$824,000** | **$882,000** | **$946,000** |

1. The total amounts above reflect the total annual appropriation allocated to the programs above during the year of enactment. Rescissions are executed out of prior year funding.
2. In FY 2022, VA plans to reallocate $30 Million of the funding provided in section 8002 of the American Rescue Plan Act for Research (pursuant to Section 254 of P.L 117-103), which will be executed out of the Veterans Medical Care and Health Fund. Final 2022 funding allocations among categories may change in response to workload demand requirements throughout 2022 and 2023.

**Specifically tracked programs executed in Services Above:**

| | | | |
|---|---|---|---|
| Long-Term Impact of Military-Relevant Brain Injury Consortium (LIMBIC) | $5,000 | $5,000 | $5,000 |
| Military Exposures Research from the Gulf War | $16,000 | $16,000 | $16,000 |
| Diversity Action Program | $2,500 | $2,500 | $2,500 |
| **TOTAL** | **$23,500** | **$23,500** | **$23,500** |

[1/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, together with updated estimates for transfers, reimbursements and medical care collections.

## ORD Operational Units

ORD supports its priorities through the funding distribution shown in the table above. These areas are described below.

### Research Administration

Research Administration leads the development of the VA research enterprise and supports centralized functions within ORD such as the Technology Transfer Program (TTP); ORD Fiscal Management; the National Artificial Intelligence Institute (NAII) the Office for Research Protection, Policy and Education (ORPP&E); Communications; and Operations. Salary support for all of ORD is also captured in the Research Administration category, along with administrative support distributed to each research program in the field that is not linked to specific projects.

This also includes continued development of a coordinated VA Research enterprise in which we act as a cohesive whole rather than individual medical centers as detailed earlier.

**Biomedical Laboratory Research and Development Service**

Biomedical Laboratory Research and Development (BLR&D) supports and conducts preclinical research to understand life processes from the molecular, genomic and physiological levels, with the goal of gaining new insight and knowledge regarding diseases that affect Veterans and ultimately contribute to new and better preventive measures and medical treatments.

**Rehabilitation Research and Development Service**

Rehabilitation Research and Development (RR&D) advances scientific knowledge and fosters innovations to maximize Veterans' functional independence, quality of life and participation in their lives and community. RR&D also invests in building rehabilitation research capacity and developing the next generation of VA rehabilitation researchers. RR&D integrates clinical, preclinical and applied rehabilitation research to enable translation of research results into clinical practice to improve the health and well-being of Veterans and the nation.

**Health Services Research and Development Service**

Health Services Research and Development (HSR&D) pursues research that addresses all aspects of VA health care. This includes patient care practices; models of care delivery (including telehealth); access to care; quality, safety and costs of care; health equity; patient and provider experience; and implementation of evidence-based clinical interventions into real-world practice. HSR&D also addresses critical issues for Veterans who have returned home from Iraq and Afghanistan with conditions that may require care over their lifetimes, most notably PTSD, pain and risk of suicide.

HSR&D oversees and facilitates VA's QUERI program, which leverages scientifically supported quality improvement methods, paired with a deep understanding of Veterans' preferences and needs, to implement evidence-based practices rapidly into routine care and improve the quality and safety of care delivered to Veterans. QUERI's national network of programs and partnered evaluation initiatives includes more than 200 clinicians and experts in health services research who collaborate with VA leaders, administrators and frontline providers to ensure VA's transformation to a learning healthcare system.

HSR&D's Evidence-based 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.

**Cooperative Studies Program**

The Cooperative Studies Program is responsible for planning and conducting large multicenter clinical trials and epidemiological studies. It serves as a foundational part of the VA national clinical research enterprise and seeks to advance the health and health care of Veterans through

cooperative research studies that produce innovative, definitive and effective solutions to Veteran and national health care problems.

**Clinical Science Research and Development Service**

Clinical Science Research and Development (CSR&D) is focused on advancing Veterans' health care by developing the evidence base for new and improved treatments through clinical trials and moving ideas along the translational pathway from scientific discovery to clinical application. CSR&D research encompasses interventional and effectiveness studies, clinical trials, clinical methodology and epidemiology, as well as related infrastructure needs.

**Million Veteran Program**

The Million Veteran Program (MVP) is a national voluntary research program that partners with Veterans receiving their care in the VA health care system to study how genes affect health. To do this, MVP is building one of the world's largest databases of genes and health by safely collecting blood samples and health information from 1 million Veteran volunteers. As of August 31, 2021, MVP had enrolled nearly 848,000 Veterans. Data collected from MVP is stored in a secure manner and is coded for researchers so that Veterans cannot be directly identified. Researchers are using MVP data to study diseases like diabetes and cancer and military-related conditions such as PTSD, risk of suicide and Gulf War illness. Three patent applications and more than 65 peer-reviewed publications have resulted from the program thus far, with many of those publications appearing in prominent, high-impact journals.

These efforts also include a partnership funded through an interagency agreement (IAA) between VA and the Department of Energy (DOE) to combine health and genomic data from MVP with DOE's expertise in AI and machine learning. Through the IAA, a secure computing enclave for personal health information has been established at the Oak Ridge National Laboratory. Copies of the VA Corporate Data Warehouse (CDW) data and MVP data have been moved. Three joint exemplar projects were initiated in 2019 on using AI to predict risk for death by suicide and to better understand metastatic prostate cancer and cardiovascular disease in Veterans. Efforts in 2023 will include:

- The development of decision-support tools for VA clinicians for predicting risk for suicide, metastatic prostate cancer and cardiovascular disease.
- The solicitation of new projects through request for concept proposals in the topic areas of polypharmacy, pain, opioid use disorder, pharmacogenomics, PTSD and TBI.

**Specifically Tracked Programs**

To honor internal commitments within VA and commitments ORD has made to Congress and DoD, ORD specifically tracks the following programs to ensure appropriate funding levels are maintained:

**Long-term Impact of Military-relevant Brain Injury Consortium (LIMBIC)** is a coordinated multicenter collaboration linking basic science, translational and clinical neuroscience researchers

from VA, the military and academia to effectively address the long-term effects of mild TBI and its diagnosis and treatment.

**Military Exposures Research from the Gulf War** aims to better understand and treat health problems experienced by some Veterans following exposures to toxic substances and environmental hazards during the Gulf War. These efforts are guided by a strategic plan by the Research Advisory Committee on Gulf War Veterans' Illnesses, a committee that was created by Congress in 1998 (Public Law 105-368) and first appointed by the VA Secretary in January 2002. The committee directs VA in committing at least $15 million to Gulf War research annually.

**The Diversity Action Program** was created to increase the number of underrepresented minority scientists in VA Research. The centerpiece of this program is a Historically Black Colleges and Universities (HBCU)-focused Career Development Award to support early-career scientists affiliated with HBCUs in collaboration with their local VA medical centers. More recently, VA has established a new system of Core Recruitment Sites (CRS) at HBCUs with medical schools, with plans to expand the system further to other underrepresented institutions. The goal of the program is to provide early exposure and training to develop future scientists from underrepresented populations.

**Collaboration with Federal Agencies and Other Organizations**

To expand the scope and impact of VA research, ORD collaborates whenever possible with others in the research community who share our mission of improving health care. Partnering with others with common research interests allows VA to leverage resources and expand the impact of our nation's investment in research. Collaboration supports the swift transition of medical findings into real-life strategies to improve life for Veterans and all Americans.

**VA and DoD** share a commitment to honor those who have served our nation by providing them with the best health care available. Our collaborative research projects cover a wide range of topics, including the long-term health effects of military service on Service members, Veterans and family; military environmental exposure; TBI, polytrauma, prosthetics and amputation care; PTSD and other mental health issues; suicide prevention; and pain management. VA and DoD have agreements allowing for the transfer of medical record data to support research, among other activities, that is stored in a joint database maintained by ORD as the DoD/VA Infrastructure for Clinical Intelligence (DaVINCI). VA and DoD are partnering in several development tasks to support research using Cerner tools.

VA also is a formal partner with DoD, the Department of the Army and the National Institute of Mental Health (NIMH) in the third phase of the Study To Assess Risk and Resilience in Servicemembers – Longitudinal Study (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. Additional projects on polypharmacy, pharmacogenomics and TBI are being planned.

**VA and the Department of Health and Human Services (HHS)** are collaborating on diabetes management; patient safety; the use of health information data; the identification of strategies and designs for military environmental exposures research; characterization of Gulf War illness; cancer clinical trials; and research on COVID-19 preventives, diagnostics and therapeutics.

VA Research also collaborates with the Indian Health Service, part of HHS, to improve access to care for American Indian Veterans. VA collaborates with other components of HHS such as the National Cancer Institute (NCI) and the National Institute on Aging (NIA), as described below. Through the Pain Management Collaboratory, VA collaborates with the NIH and DoD on a series of trials of non-opioid treatments for chronic pain in Veterans and active-duty military members.

**VA and NCI** have been collaborating through a joint network focused on improving and increasing Veteran participation in cancer clinical trials through a partnered called the NCI and VA Interagency Group to Accelerate Trials Enrollment (NAVIGATE). This effort combines the scientific, operational and regulatory expertise of both agencies to enable more Veterans to participate in cancer treatment and prevention trials, which often are considered a standard of care for those affected. The network has 12 dedicated cancer trial enrollment sites that share best practices and provide a coordinated approach to working with NCI, oncology groups and other stakeholders to provide more opportunities for Veterans and cancer researchers to contribute to the knowledge of effective cancer therapies. Recruitment and enrollment are further enhanced through data-driven electronic medical record pre-screening to find the most likely sites and patients that could qualify for trials.

NAVIGATE sites have enrolled more Veterans into NCI trials than other VA sites that have not received dedicated funding for local clinical trials infrastructure, highlighting the success of the program.

ORD, through QUERI, actively collaborates with the National Institutes of Health to provide national training in implementation research and health system science methods to promote translation of research findings into real-world health care settings through the Implementation Research Institutes sponsored by NIMH and NCI.

**VA and NIA** are collaborating on the VA-NIA Alzheimer's Disease Veteran-Centric Alliance Network for Health Care Excellence (AD-VANCE) Initiative, a partnership to fast-track the development of new treatments and cures for Alzheimer's disease and related dementias (AD/ADRD) and to improve the care of Veterans with AD/ADRD and the well-being of their caregivers.

**VA also fosters dynamic collaborations with its university affiliates, with nonprofit organizations and private industry.**

Examples of accomplishments in this area include the following:

- Partnered with the Prostate Cancer Foundation to speed the development of new treatments and cures for prostate cancer. This partnership has resulted in new clinical trials that are already producing state-of-the-art results for individualized care. One example is a trial titled "Carboplatin or Olaparib for BrcA Deficient Prostate Cancer," or COBRA, which is recruiting up to 100 Veterans with an aggressive form of prostate cancer.
- Established a new Core Recruitment Site to attract applicants from HBCUs. This represents an enhanced partnership with Morehouse School of Medicine to increase diversity in the scientific workforce.
- Collaborated with the nonprofit organization PINK Concussions to encourage women to donate their brains upon death for research into the effects of TBI and PTSD.
- Licensed production of 3D-printed metal prosthetic fingers in smaller sizes for women Veterans and others, developed by VA researchers, to a commercial partner (PointDesigns).
- Initiated a clinical trial in lower-limb osseointegration across multiple VA sites in collaboration with industry partner DJO Global. If successful, this will lead to FDA approval of an osseointegrated limb prosthesis, providing an alternative to the standard socket used to attach a prosthetic limb.
- Translated three inventions by the Minneapolis Adaptive Design and Engineering Program at the Minneapolis VA Health Care System into the commercial phase so they can be available for wide use by Veterans and others. The licensing agreements were facilitated by demonstrating the research technology at a Paralyzed Veterans of America (PVA) annual convention. They include:
    - An arm cycle exercise device that can be used by patients while they lie in bed. The Multi-Purpose Arm Cycle Ergometer for Rehabilitation (M-PACE) allows patients with conditions such as spinal cord injury to participate in a wider range of exercise and rehabilitation activities. This ergometer is now licensed to Action Manufacturing.
    - A standing mobile wheelchair that allows the user physiological benefits by being in an upright position and psychological benefits by interacting with others at eye-level. LEVO now holds the license.
    - The SKINSYTE camera system, which allows self-examination for early detection and monitoring of skin breakdown, wounds and other conditions in hard-to-see body locations. VA has a license agreement with Derek Herrera.
- Collaborated with the University of Chicago and the Open Commons Consortium, organizations already supporting similar NIH initiatives, to help ORD create a VA Data Commons to jump start its research infrastructure modernization. This effort is setting up and measuring the cost of performing large genomic analyses in a secure cloud environment.

- Served as a contributing member of the OHDSI community along with hundreds of collaborators in 30 countries across six continents.
- Established, under the Access to Clinical Trials (ACT) for Veterans initiative, capabilities and policies to facilitate partnerships to start high-quality, multisite clinical trials more quickly with the pharmaceutical industry. Several of these efforts have resulted in access to new therapeutics and vaccines for the COVID-19 pandemic and have also helped with oncology trials.
- Developed a partnership between ORD's HSR&D program and the Elizabeth Dole Foundation to support a landmark RAND Corporation research blueprint for Veterans and their caregivers. This expands VA's ability to deliver integrated, Veteran- and caregiver-partnered, data-driven approaches to care. It serves as a model for excellence in peer-reviewed research on innovation, training, implementation, evaluation, adoption and dissemination of best practices in supporting Veterans' caregivers across VA and in private and non-profit sectors.

**Overview of Ongoing Strategic Priorities**

ORD's five strategic priorities are aligned with VHA's strategic goal of promoting a learning health system. They are also aligned with VHA's modernization objective to promote a "clinically-integrated, community-supported, highly reliable system of care focused on providing the highest-quality and safest outcomes" for Veterans.

The five strategic priorities include:

**Strategic priority #1: Increase Veterans' access to high-quality clinical trials:**

VA is to become a leader in and the epicenter for a range of groundbreaking clinical trials. Clinical trials are the gold standard for evidence-based medicine and practice. They enable clinicians, patients and policymakers to know whether new treatments are effective and safe and which options among existing therapies may be better in different situations. VA Research has a robust program of clinical trials, including a quality-certified clinical research program embedded within VA's health care system and partnerships with industry, other federal agencies and foundations. These partnered trials provide additional opportunities for Veterans and VA clinicians to participate in important studies that advance health outcomes for Veterans and the nation.

Besides influencing medical care in VA and throughout the United States and the world, VA clinical trials offer Veterans hope when their conditions are beyond the help routine clinical care can offer, by increasing their access to potentially life-enhancing and life-lengthening treatments. Veterans gain access to promising new treatments in a highly regulated environment, while also finding opportunities to serve the nation once again through their voluntary participation in research.

Activities in this priority capitalize on key strengths of the VA clinical research enterprise, such as our unparalleled nationwide network of clinician-investigators and study sites. One example of a critical trial now underway is VA STARPORT, supported by VA's Cooperative Studies Program and enrolling more than 460 Veterans with prostate cancer at 16 VA sites. The study is examining

an innovative treatment approach using targeted surgery or radiation for men whose prostate cancer has spread within the body despite initial surgery or radiation.

**Strategic priority #2: Increase the substantial real-world impact of VA Research:**

VA makes a significant investment in basic science, rehabilitation, clinical and health services research. These investments advance the development of new discoveries. It is the Department's responsibility to ensure that these discoveries get translated into real-world clinical applications and implemented more rapidly into routine clinical practice. This goal is also a core component of VA Research's response to the Foundations for Evidence-based Policymaking Act (Evidence Act, Public Law 115-435), notably through the development of a learning agenda and through technical assistance to other VHA program offices on evidence-building activities and evaluation plans.

Before research can be effectively translated into real-world practice, innovations generated by researchers require additional development, validation and implementation. This ensures that all Veterans can benefit from the outcomes of research discoveries. Notably, advances in genomics and other areas of basic science have accelerated the rate of development of new therapies in animal models. These advances, in turn, will inform new clinical treatments for Veterans.

Advances in technology can lead to the development of new devices that improve Veterans' ability to function and their quality of life. VA is also at the forefront of creating new models of care to help frontline providers enhance access to effective innovations and treatments, notably through telemedicine, mobile technology and electronic health record innovations that promote Veteran-centered care.

**Strategic priority #3: Put VA data to work for Veterans:**

VA has some of the richest health datasets in the world, including those associated with MVP. These datasets hold information that will benefit both Veterans and the nation. To accelerate the rate of these discoveries, VA is taking the steps necessary to ensure that research with a translational trajectory will be conducted at larger scale.

VA aims to accelerate scientific discovery by reducing the time and effort needed to appropriately access, properly understand and effectively use Veteran data for improving Veterans' well-being. VA's investment in health information technology and scientific discovery is coupled with its status as the largest integrated provider of health care and mental health services in the nation. This enables the Department to develop medical datasets that are among the most comprehensive and richly detailed in the world, covering diagnoses, medication information, procedures and test results. Much of this information has been linked to the MVP mega-biobank and to other clinical projects that include both genomic and patient-reported information.

In addition, ORD is involved in VA's IT and EHR modernization process by embedding opportunities for clinical trials in the Cerner PowerTrials platform; updating research infrastructures in VA Informatics and Computing Infrastructure (VINCI) and Genomic Information System for Integrated Science (GenISIS); and piloting scalable research platforms using VA Enterprise GovCloud, VA Data Commons and the Cerner HealtheDataLab. It is critical to meet the needs related to research infrastructure, including but not limited to IT resources, in order to accomplish cutting-edge scientific work.

**Strategic priority #4: Actively promote diversity, equity and inclusion (DEI) within our sphere of influence.**

VA Research is committed to fostering and leveraging DEI as part of our commitment to improving all Veterans' well-being through research. ORD has established a working group to facilitate and further develop these ideals. An array of programs designed and implemented by the working group aim to develop a diverse pipeline of VA investigators, thereby enhancing the VA research workforce with talented and trained individuals from underrepresented backgrounds in medical science; stimulate research on minority health and health disparities; promote inclusion within ORD and across the enterprise; and promote equity in all scientific activities. ORD also created a Diversity Action Program to increase the participation of underrepresented minority scientists in VA Research by partnering with Historically Black Colleges and Universities.

**Strategic priority #5: Build community through VA research**.

It is critical for VA to partner with Veterans to ensure we conduct research that is meaningful and impactful for them. Previously, ORD has supported activities to understand perspectives and strategies for including various communities as part of the research is supports. For example, through the CSP Network of Dedicated Enrollment Sites, local communities of investigators and patients were established at 10 VA medical centers to facilitate participation, compliance and understanding of clinical trials. This group has further extended efforts to rural communities and lower-complexity VA facilities, ones that have not had an extensive history in participation in such research.

**Supplemental Tables**

Designated Research Areas (DRA) represent areas of importance to our Veteran patient population. The amounts shown for these research areas are not mutually exclusive and detail projects tracked in the Research Analysis and Forecasting Tool (RAFT). Research projects that span multiple areas may be counted in several categories. Thus, amounts depicted within this table total more than the VA research appropriation. This method of reporting is consistent with that of other federal agencies.

# Table: Appropriations and Projects by Designated Research Area (DRA)[1]

| Dollars in Thousands | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Description | 2021 Enacted | | 2022 Request | | 2022 Current Estimate | | FY 2023 Request | | FY 2023 Request- FY 2022 Request | |
| | Dollars | Projects | $ | Projects | Dollars | Projects | Dollars | Projects | Dollars | Projects |
| Acute & Traumatic Injury | $ 21,510 | 108 | $ 25,893 | 110 | $ 25,893 | 110 | $ 26,155 | 108 | 262 | -2 |
| Aging (e.g. Alzheimer's) | $ 137,665 | 710 | $ 147,704 | 719 | $ 147,704 | 719 | $ 151,328 | 716 | 3,624 | -3 |
| Autoimmune, Allergic & Hematopoietic Disorders | $ 37,863 | 200 | $ 38,912 | 185 | $ 38,912 | 185 | $ 39,601 | 183 | 689 | -2 |
| Cancer (e.g. Precision Oncology) | $ 71,512 | 317 | $ 69,285 | 299 | $ 69,285 | 299 | $ 81,295 | 341 | 12,010 | 42 |
| CNS Injury & Associated Disorders (e.g. TBI) | $ 104,958 | 418 | $ 127,111 | 490 | $ 127,111 | 490 | $ 140,776 | 527 | 13,665 | 37 |
| Degenerative Diseases of Bones & Joints | $ 34,448 | 162 | $ 41,136 | 176 | $ 41,136 | 176 | $ 41,601 | 173 | 465 | -3 |
| Dementia & Neuronal Degeneration | $ 37,850 | 162 | $ 41,633 | 175 | $ 41,633 | 175 | $ 42,344 | 173 | 711 | -2 |
| Diabetes & Major Complications | $ 41,608 | 174 | $ 47,144 | 188 | $ 47,144 | 188 | $ 47,729 | 185 | 585 | -3 |
| Digestive Diseases | $ 25,502 | 132 | $ 26,071 | 142 | $ 26,071 | 142 | $ 26,256 | 139 | 185 | -3 |
| Emerging Pathogens/Bio-Terrorism | $ 6,084 | 24 | $ 3,043 | 21 | $ 3,043 | 21 | $ 2,833 | 19 | (210) | -2 |
| Gulf War Veterans Illness | $ 12,691 | 35 | $ 15,539 | 42 | $ 15,539 | 42 | $ 15,226 | 40 | (313) | -2 |
| Health Systems | $ 84,085 | 285 | $ 69,915 | 258 | $ 69,915 | 258 | $ 71,094 | 255 | 1,179 | -3 |
| Heart Disease/Cardiovascular Health | $ 64,944 | 296 | $ 71,637 | 299 | $ 71,637 | 299 | $ 72,963 | 296 | 1,326 | -3 |
| Infectious Diseases | $ 52,207 | 206 | $ 57,079 | 224 | $ 57,079 | 224 | $ 58,200 | 222 | 1,121 | -2 |
| Kidney Disorders | $ 18,860 | 102 | $ 18,225 | 108 | $ 18,225 | 108 | $ 18,230 | 105 | 5 | -3 |
| Lung Disorders | $ 27,019 | 136 | $ 27,877 | 124 | $ 27,877 | 124 | $ 28,218 | 122 | 341 | -2 |
| Mental Illness (e.g. Suicide Prevention) | $ 123,685 | 498 | $ 121,644 | 500 | $ 121,644 | 500 | $ 130,137 | 519 | 8,493 | 19 |
| Military Occupations & Environ. Exposures (e.g. Burn Pits and Agent Orange) | $ 23,918 | 100 | $ 30,534 | 121 | $ 30,534 | 121 | $ 51,414 | 198 | 20,880 | 77 |
| Other Chronic Diseases | $ 6,423 | 34 | $ 7,610 | 44 | $ 7,610 | 44 | $ 7,474 | 42 | (136) | -2 |
| Prosthetics | $ 20,275 | 89 | $ 25,451 | 85 | $ 25,451 | 85 | $ 25,569 | 83 | 118 | -2 |
| Sensory Loss | $ 20,992 | 99 | $ 23,171 | 101 | $ 23,171 | 101 | $ 23,367 | 99 | 196 | -2 |
| Special Populations | $ 41,887 | 174 | $ 42,823 | 170 | $ 42,823 | 170 | $ 43,280 | 167 | 457 | -3 |
| Substance Abuse | $ 30,459 | 119 | $ 29,937 | 127 | $ 29,937 | 127 | $ 30,073 | 124 | 136 | -3 |

1. Research projects that span multiple areas may be counted in several categories. Thus, amounts depicted within this table total to more than the VA research appropriation. This method of reporting is consistent with that of other federal agencies.
2. Funding increases reflect a pay raise (4.6%), biomedical inflation (2.4%), and funding for new initiatives in 2023 (within the Medical and Prosthetics Research Appropriation).

## Table: Select Appropriations and Projects by Research Project Area (RPA)[1]

The selected research areas by Research Project Area (RPA) are a subcategory of Designated Research Areas (DRA) that also represent areas of importance to our Veteran patient population. RPA allow more granularity for reporting on research project areas. The selected RPAs below reflect increase levels within the 2023 Request.

| Description | 2021 Enacted | | 2022 Request | | 2022 Estimate | | FY 2023 Request[2] | | FY 2023 Request-FY 2022 Request | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Dollars in Thousands | | | | | | | | | |
| | Dollars | Projects | Dollars | Projects | Dollars | Projects | Dollars | Projects | Dollars | Projects |
| Traumatic Brain Injury (part of CNS & Associated | $ 45,125 | 197 | $ 65,125 | 267 | $ 65,125 | 267 | $ 76,935 | 304 | 11,810 | 37 |
| Precision Oncology (part of Cancer DRA) | $ 11,025 | 32 | $ 17,058 | 50 | $ 17,058 | 50 | $ 22,550 | 66 | 5,492 | 17 |
| Suicide Prevention (part of Mental Health DRA) | $ 15,377 | 73 | $ 15,377 | 73 | $ 15,377 | 73 | $ 20,806 | 92 | 5,429 | 19 |

1. Research projects that span multiple areas may be counted in several categories. Thus, amounts depicted within this table total to more than the VA research appropriation. This method of reporting is consistent with that of other federal agencies.
2. Funding increases reflect a pay raise (4.6%), biomedical inflation (2.4%), and funding for new initiatives in 2023 (within the Medical and Prosthetics Research Appropriation).

## Table: Obligations by Object (Medical and Prosthetic Research Summary (Discretionary)

| (Dollars in Thousands) | 2021 Actual | 2022 Request | 2022 Estimate | 2023 Request | 2023 Req-2022 Est |
|---|---|---|---|---|---|
| **10 Personal Compensation** | **349,987** | **307,000** | **362,189** | **362,194** | **5** |
| *Other Personal Compensation* | 200 | - | 207 | 207 | 0 |
| *Personal Benefits* | 139,619 | 141,000 | 144,487 | 144,489 | 2 |
| **21 Travel & Transportation of Persons:** | **262** | **3,100** | **268** | **268** | **0** |
| **22 Transportation of Things** | **111** | **300** | **113** | **113** | **0** |
| **23 Communication, Utilities & Misc** | **10,059** | **1,000** | **10,269** | **10,269** | **0** |
| **24 Printing & Reproduction** | **728** | **400** | **743** | **1** | **(742)** |
| **25 Other Services:** | **348,633** | **427,300** | **368,710** | **372,559** | **3,849** |
| *25.1 Advisory and Assistance Services:* | 8,534 | 10,459 | 9,025 | 9,120 | 94 |
| *25.2 Other services from non-Federal Sources:* | 1,611 | 1,975 | 1,704 | 1,722 | 18 |
| *25.4 Operation and Maintenance of Facilities:* | 987 | 1,209 | 1,043 | 1,054 | 11 |
| *25.6 Medical Care Contracts:* | 111,423 | 136,565 | 117,840 | 119,070 | 1,230 |
| *25.8 Adminstrative Contractual Services* | 226,079 | 277,092 | 239,098 | 241,594 | 2,496 |
| **26 Supplies & Materials** | **56,416** | **46,000** | **57,763** | **$54,661** | **(3,101)** |
| **31 Equipment** | **27,856** | **45,000** | **28,488** | **$28,488** | **0** |
| **Total** | **933,873** | **971,100** | **973,238** | **973,250** | **12** |

[1/] The 2022 Current Estimate differs from the President's Budget Appendix and reflects the 2022 Budget request for discretionary appropriations and use of ARP resources, together with updated estimates for transfers, reimbursements and medical care collections.

# Table: Obligations by Object (American Rescue Plan)

| (Dollars in Thousands) | 2021 Actual | 2022 Request | 2022 Estimate | 2023 Estimate | 2023 Req-2022 Est |
|---|---|---|---|---|---|
| **10 Personal Compensation** | **1,989** | **-** | **488** | **8,560** | **8,072** |
| *Other Personal Compensation* | - | | | | - |
| *Personal Benefits* | 1,005 | - | 246 | 3,834 | **3,588** |
| **21 Travel & Transportation of Persons:** | **-** | **-** | **-** | **-** | **-** |
| **22 Transportation of Things** | **-** | **-** | **-** | **-** | **-** |
| **23 Communication, Utilities & Misc** | **-** | **-** | **-** | **-** | **-** |
| **24 Printing & Reproduction** | **-** | **-** | **-** | **-** | **-** |
| **25 Other Services:** | **2,933** | **-** | **719** | 8,917 | **8,198** |
| *25.1 Advisory and Assistance Services:* | | | | | - |
| *25.2 Other services from non-Federal Sources:* | - | - | - | - | - |
| *25.4 Operation and Maintenance of Facilities:* | - | - | - | | - |
| *25.6 Medical Care Contracts:* | 1,108 | - | 272 | 3,369 | **3,097** |
| *25.8 Adminstrative Contractual Services* | 1,825 | - | 447 | 5,548 | **5,101** |
| **26 Supplies & Materials** | **1,301** | **-** | **319** | **4,145** | **3,826** |
| **31 Equipment** | **-** | **-** | **-** | **4,544** | **4,544** |
| **Total** | **7,228** | **-** | **1,772** | **30,000** | **28,228** |

# *Revolving and Trust Activities*

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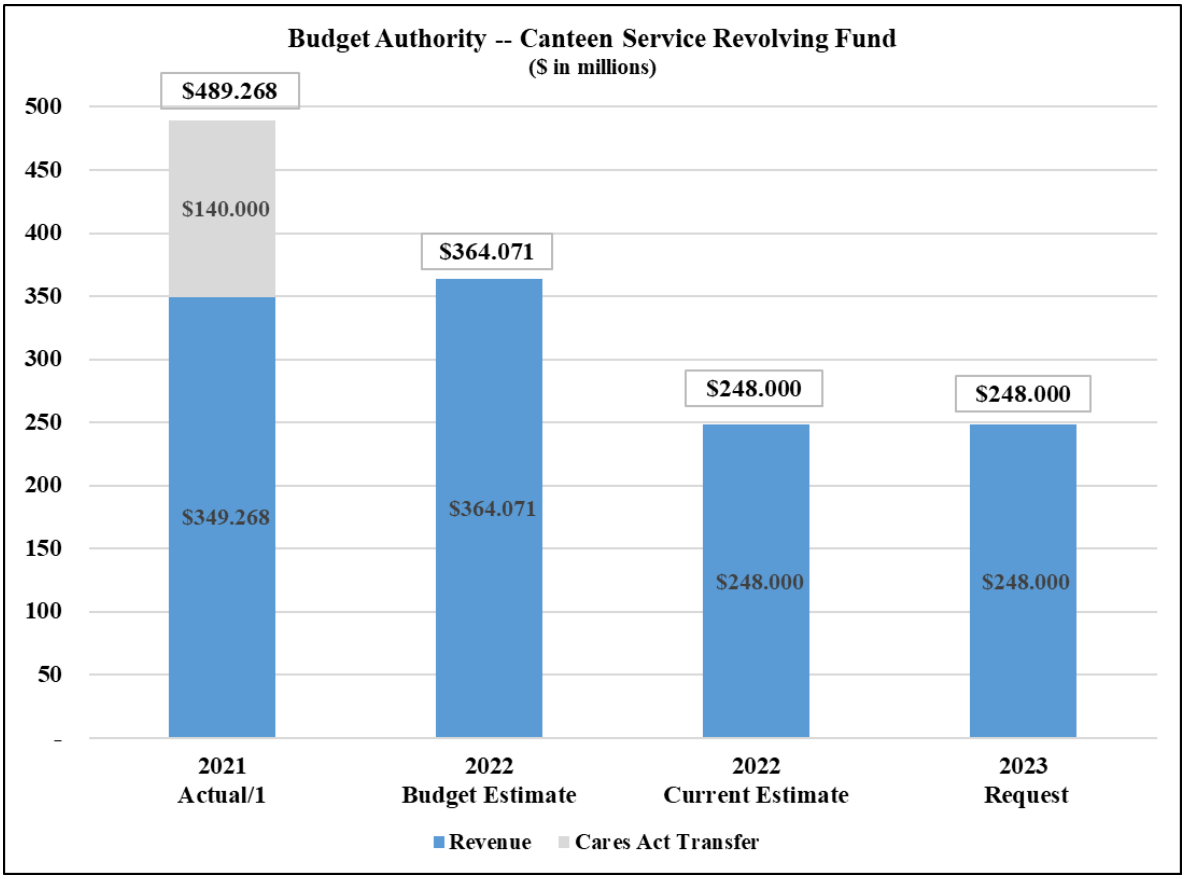
# *Veterans Canteen Service Revolving Fund*




[1/] To account for lost revenue, the Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. 116-159) provided authority to transfer $140 million in unobligated balances appropriated to Medical Services in the CARES Act to VCS, without which the revolving fund would have been depleted and service to our Veterans adversely impacted.

**Program Description**

The Veterans Canteen Service (VCS) was established by Congress in 1946 to furnish, at reasonable prices, meals, merchandise and services necessary for the comfort and well-being of Veterans in hospitals and domiciliaries operated by the VA (Title 38 U.S.C. 7801-10). It has since expanded to provide reasonably priced merchandise and services to America's Veterans enrolled in VA's health care system, their families, caregivers, VA employees, volunteers and visitors.

Congress originally appropriated a total of $5.0 million for the operation of the VCS and no additional appropriations have been required. Funds in excess of the needs of the Service totaling $12.1 million have been returned to the U.S. Treasury. However, provisions of the Veterans'

Benefits Act of 1988 (Public Law 100-322) eliminated the requirement that excess funds be returned to the Treasury and authorized such funds to be invested in interest-bearing accounts, specifically Treasury Bills and Notes. Gains realized from these accounts are used to fund business operations. Currently, VCS has no interest-bearing investments.

Creating an environment where patrons can truly enjoy their shopping or dining experience has become a necessity for modern businesses. Providing VA customers the same high-quality service found in private industry has been, and will continue to be, necessary for VCS. This philosophy will take VCS into 2022 and beyond.

**Fund Highlights /1**
(dollars in thousands)

| Description | 2021 Actual * | 2022 Budget Estimate | 2022 Current Estimate | 2023 Estimate | +/- 2022-2023 |
|---|---|---|---|---|---|
| Total revenue..... | $349,268 | $364,071 | $248,000 | $248,000 | $0 |
| Obligations..... | $377,706 | $356,790 | $254,000 | $262,000 | $8,000 |
| FTE..... | 2,267 | 3,500 | 2,250 | 2,318 | 68 |

[1/] The numbers in the chart above reflect an estimate of the activity during the Federal Government Fiscal Year (October – September), as the Veterans Canteen Service uses a retail industry fiscal year (February – January) used by similar private sector retailers to enhance their ability to compare their operations to their private sector peers.

[2/]To account for lost revenue, the Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. 116-159) provided authority to transfer $140 million in unobligated balances appropriated to Medical Services in the CARES Act to VCS, without which the revolving fund would have been depleted and service to our Veterans adversely impacted.

The retail-calendar-fiscal-year reporting cycle has been adopted to better align VCS operations with the financial reporting structure of the retail industry. The calendar uses a (4-5-4) weekly cycle for the monthly reporting schedule. The 4-5-4 retail accounting calendar divides the year, beginning with the month of February, into quarters with the first and last month of each quarter consisting of four weeks each and the middle month of each quarter consisting of five weeks. Although the retail accounting calendar is used for management purposes, VCS will continue to report to VA on a Federal fiscal year basis.

## Summary of Budget Request

No appropriation by Congress will be required for VCS to operate during 2023. The VCS is a self-sustaining, revolving fund activity that obtains its revenues from non-Federal sources; therefore, no Congressional action is required. Within VA, VCS functions independently and has primary control over its major activities, including sales, procurement, supply, finance and personnel management.

**Changes From 2022 Budget Request**
(dollars in thousands)

| Description | 2022 Budget Estimate | 2022 Current Estimate * | Increase/ Decrease |
|---|---|---|---|
| Total revenue..... | $364,071 | $248,000 | ($116,071) |
| Obligations..... | $356,790 | $254,000 | ($102,790) |
| FTE..... | 3,500 | 2,250 | (1,250) |

As a result of the COVID-19 Pandemic in early 2020, the VA medical centers in which VCS canteens are located reduced patient visits and allowed non-essential employees to telework. These changes greatly reduced the foot traffic in VCS canteens, resulting in a corresponding decrease in gross sales. Average customers per day, excluding weekends, dropped 38.3% from 237,000 pre-pandemic to 146,000 in 2020. While operational activity began to improve, the customer counts only increased slightly to 147,000 per day in 2021.

**Summary of Employment**

For personnel management, VCS uses techniques generally applied in commercial retail chain store, food and vending operations. Primary consideration is given to salary expenses in relation to sales. Salary expense data are provided to management personnel for each department in each Canteen, as well as VCS in total. These data are compared to the corresponding period from the previous year and to personnel cost thresholds and standards prior to making decisions regarding employment increases or decreases. Personnel cost as a percent of sales is the standard by which VCS measures personnel cost management.

The following chart reflects the full-time equivalent employment (FTE) for 2021 through 2023:

**Summary of Employment**

| | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Estimate | +/- 2022-2023 |
|---|---|---|---|---|---|
| FTE..... | 2,267 | 3,500 | 2,250 | 2,318 | 68 |

## Revenues and Expenses
**(dollars in thousands)**

| | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Estimate | +/- 2022-2023 |
|---|---|---|---|---|---|
| Sales Program: | | | | | |
| Revenue | $349,268 | $364,071 | $248,000 | $248,000 | $0 |
| Less operating expenses | ($305,966) | ($374,640) | ($346,889) | ($374,640) | ($27,751) |
| Net operating income-sales | $43,302 | ($10,569) | ($98,889) | ($126,640) | ($27,751) |
| Net non-operating income | ($839) | ($9,328) | ($840) | ($924) | ($84) |
| Net income for the year | $42,463 | ($19,897) | ($99,729) | ($127,564) | ($27,835) |

## Financial Condition

The schedule below reflects the anticipated financial condition of the VCS through 2023. Changes from year to year are the result of anticipated changes in revenues, obligations and outlays previously portrayed.

As a result of the COVID 19 pandemic, VCS began to slowly recover in 2021 and is expected to have a gradual increase in revenue as the number of visitors slowly return to pre-pandemic levels.

**Financial Condition**
**(dollars in thousands)**

| | 2021 Actual * | 2022 Budget Estimate | 2022 Current Estimate * | 2023 Estimate * | +/- 2022-2023 |
|---|---|---|---|---|---|
| **Assets:** | | | | | |
| Cash with Treasury, in banks, in transit | $150,775 | $32,422 | $125,775 | $114,283 | ($11,492) |
| Accounts receivable (net) | $23,107 | $60,638 | $24,263 | $25,476 | $1,213 |
| Inventories | $12,884 | $25,739 | $13,529 | $14,205 | $676 |
| Real property and equipment (net) | $35,400 | $27,563 | $37,170 | $39,028 | $1,858 |
| Other assets | $194 | $551 | $204 | $214 | $10 |
| Total assets | $222,360 | $146,912 | $200,939 | $193,205 | ($7,734) |
| **Liabilities:** | | | | | |
| Accounts payable including funded accrued liabilities | $28,319 | $51,280 | $28,847 | $29,444 | $597 |
| Unfunded annual leave and coupons books | $10,890 | $14,102 | $11,434 | $12,006 | $572 |
| Total liabilities | $39,208 | $65,382 | $40,281 | $41,450 | $1,169 |
| **VHA equity:** | | | | | |
| Unexpended balance: | | | | | |
| Unobligated balance | $13,779 | $36,764 | $14,468 | $15,191 | $723 |
| Undelivered orders | $0 | $0 | $0 | $0 | $0 |
| Invested capital | $169,373 | $44,766 | $165,986 | $162,666 | ($3,320) |
| Total Government equity (end-of-year) | $183,152 | $81,530 | $180,454 | $177,857 | ($2,597) |

**Retained Income**
**(dollars in thousands)**

| | 2021 Actual * | 2022 Budget Estimate | 2022 Current Estimate * | 2023 Estimate * | +/- 2022-2023 |
|---|---|---|---|---|---|
| Retained Income: | | | | | |
| Opening Balance | $73,263 | $26,224 | $66,773 | $50,018 | ($16,755) |
| Transactions: | | | | | |
| Net Operating Income | ($6,490) | ($19,897) | ($16,755) | ($11,492) | $5,263 |
| Net Non-Operating Gain | $0 | $52 | $0 | $0 | $0 |
| Closing Balance | $66,773 | $6,379 | $50,018 | $38,526 | ($11,492) |

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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, 80 are active. Most of the corporations have indefinite, ongoing operations. However, recent changes in the law permit NPC mergers. This may result in a decrease in the number of NPCs overall.

All 80 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 2021 to 2023.

**Table: Contribution Highlights**

**Contribution Highlights**
**(dollars in thousands)**

| | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Estimate | +/- 2022-2023 |
|---|---|---|---|---|---|
| Contributions..... | $274,901 | $261,574 | $282,977 | $289,374 | $6,397 |
| Expenses..... | $269,392 | $248,256 | $272,541 | $276,570 | $4,029 |

The following table is a list of research corporations that have received approval for formation along with their actual 2021 contribution from the non-VA Federal and private sources. In addition, NPCs with no contributions have been approved for operation. Some have received contributions in the past, others have not received any contributions to date:

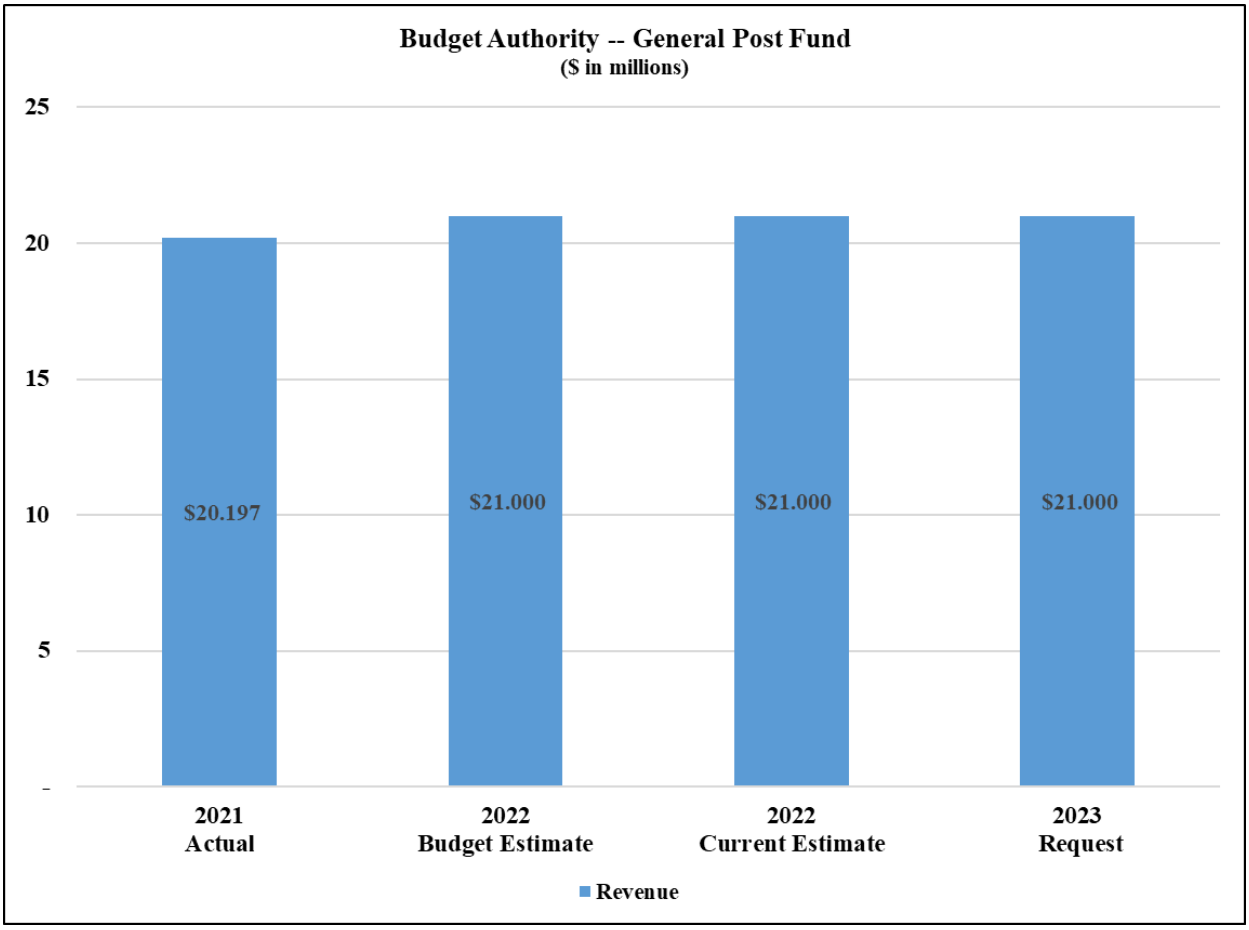
**Table: Nonprofit Corporations**

| Nonprofit Corporations | City | State | Actual Revenues (Contributions) 2021 | Estimated Revenues (Contributions) 2022 | Estimated Revenues (Contributions) 2023 |
|---|---|---|---|---|---|
| 1. Albany Research Institute, Inc | Albany | NY | 2,565,000 | 1,910,000 | 1,876,000 |
| 2. Arizona Veterans Research and Education Foundation | Phoenix | AZ | 2,037,000 | 2,300,000 | 2,600,000 |
| 3. Asheville Medical Research and Education Corporation | Asheville | NC | 110,000 | 140,000 | 160,000 |
| 4. Augusta Biomedical Research Corporation | Augusta | GA | 50,000 | 50,000 | 20,000 |
| 5. Baltimore Research and Education Foundation | Baltimore | MD | 3,000,000 | 3,150,000 | 3,308,000 |
| 6. Bedford VA Research Corporation, Inc | Bedford | MA | 121,000 | 121,000 | 121,000 |
| 7. Biomedical Research and Education Foundation of Southern Arizona | Tucson | AZ | 395,000 | 1,300,000 | 1,400,000 |
| 8. Biomedical Research Foundation | Little Rock | AR | 1,000,000 | 1,300,000 | 1,400,000 |
| 9. Biomedical Research Institute of New Mexico | Albuquerque | NM | 7,300,000 | 8,000,000 | 9,000,000 |
| 10. Boston VA Research Institute, Inc | Boston | MA | 11,800,000 | 11,700,000 | 11,600,000 |
| 11. Bronx Veterans Medical Research Foundation, Inc | Bronx | NY | 5,000,000 | 5,000,000 | 4,500,000 |
| 12. Buffalo Institute for Medical Research, Inc | Buffalo | NY | 1,170,000 | 950,000 | 800,000 |
| 13. Center for Veterans Research and Education | Minneapolis | MN | 5,594,000 | 5,874,000 | 6,167,000 |
| 14. Chicago Association for Research and Education in Science | Hines | IL | 5,500,000 | 5,500,000 | 5,500,000 |
| 15. Cincinnati Education & Research for Veterans Foundation | Cincinnati | OH | 2,239,000 | 2,462,000 | 2,000,000 |
| 16. Clinical Research Foundation, Inc | Louisville | KY | 250,000 | 290,000 | 300,000 |
| 17. Dallas VA Research Corporation | Dallas | TX | 1,600,000 | 1,650,000 | 1,720,000 |
| 18. Dayton VA Research and Education Foundation | Dayton | OH | 144,000 | 150,000 | 175,000 |
| 19. Denver Research Institute, Inc | Denver | CO | 8,210,000 | 8,000,000 | 7,000,000 |
| 20. Dorn Research Institute, Inc | Columbia | SC | 482,000 | 554,000 | 638,000 |
| 21. East Bay Institute for Research and Education | Sacramento | CA | 1,585,000 | 1,600,000 | 2,200,000 |
| 22. Foundation for Advancing Veterans' Health Research, Inc | San Antonio | TX | 3,422,000 | 3,809,000 | 4,162,000 |
| 23. Foundation for Atlanta Veterans Education and Research, Inc | Atlanta | GA | 10,500,000 | 10,605,000 | 10,711,000 |
| 24. Great Plains Veterans Research Foundation | Sioux Falls | SD | 50,000 | 50,000 | 100,000 |
| 25. Greater Los Angeles Research and Education Foundation | Los Angeles | CA | 7,230,000 | 7,284,000 | 7,392,000 |
| 26. Houston VA Research and Education Foundation | Houston | TX | 800,000 | 800,000 | 800,000 |
| 27. Idaho Veterans Research and Education Foundation, Inc | Boise | ID | 1,700,000 | 800,000 | 400,000 |
| 28. Indiana Institute for Medical Research, Inc | Indianapolis | IN | 884,000 | 910,000 | 965,000 |

| Nonprofit Corporations | City | State | Actual Revenues (Contributions) 2021 | Estimated Revenues (Contributions) 2022 | Estimated Revenues (Contributions) 2023 |
|---|---|---|---|---|---|
| 29. Institute for Clinical Research, Inc. | Washington | DC | 8,500,000 | 9,000,000 | 7,500,000 |
| 30. Institute for Medical Research, Inc. | Durham | NC | 9,239,000 | 10,902,000 | 12,855,000 |
| 31. Iowa City VA Medical Research Foundation. | Iowa City | IA | 225,000 | 300,000 | 400,000 |
| 32. Lexington Biomedical Research Institute, Inc. | Lexington | KY | 400,000 | 300,000 | 300,000 |
| 33. Loma Linda Veterans Association for Research and Education, Inc. | Loma Linda | CA | 850,000 | 900,000 | 950,000 |
| 34. Louisiana Veterans Research and Education Corporation. | New Orleans | LA | 200,000 | 230,000 | 265,000 |
| 35. Lowcountry Center for Veterans Research. | Charleston | SC | 1,350,000 | 2,732,000 | 3,137,000 |
| 36. McGuire Research Institute, Inc. | Richmond | VA | 3,350,000 | 4,000,000 | 4,100,000 |
| 37. Middle Tennessee Research Institute, Inc. | Nashville | TN | 500,000 | 600,000 | 600,000 |
| 38. Midwest Veterans' Biomedical Research Foundation. | Kansas City | MO | 1,200,000 | 1,500,000 | 1,500,000 |
| 39. Missouri Foundation for Medical Research. | Columbia | MO | 285,000 | 342,000 | 410,000 |
| 40. Mountain Home Research and Education Corporation. | Mountain Home | TN | 600,000 | 500,000 | 500,000 |
| 41. Narrows Institute for Biomedical Research, Inc. | Brooklyn | NY | 275,000 | 275,000 | 275,000 |
| 42. Nebraska Educational Biomedical Research Association. | Omaha | NE | 450,000 | 500,000 | 510,000 |
| 43. North Florida Foundation for Research and Education, Inc. | Gainesville | FL | 1,382,000 | 1,400,000 | 1,500,000 |
| 44. Northern California Institute for Research and Education, Inc. | San Francisco | CA | 49,250,000 | 49,000,000 | 49,000,000 |
| 45. Ocean State Research Institute, Inc. | Providence | RI | 880,000 | 906,000 | 934,000 |
| 46. Overton Brooks Research Corporation. | Shreveport | LA | 30,000 | 30,000 | 30,000 |
| 47. Pacific Health Research and Education Institute. | Honolulu | HI | 1,500,000 | 1,000,000 | 1,500,000 |
| 48. Palo Alto Veterans Institute for Research | Palo Alto | CA | 30,862,000 | 31,788,000 | 32,742,000 |
| 49. Philadelphia Research and Education Foundation. | Philadelphia | PA | 391,000 | 444,000 | 467,000 |
| 50. Portland VA Research Foundation, Inc. | Portland | OR | 8,000,000 | 8,500,000 | 9,000,000 |
| 51. Research! Mississippi, Inc. | Jackson | MS | 189,000 | 250,000 | 275,000 |
| 52. Research, Incorporated. | Memphis | TN | 810,000 | 850,000 | 865,000 |
| 53. Salem Research Institute, Inc. | Salem | VA | 1,350,000 | 1,500,000 | 1,500,000 |
| 54. Salisbury Foundation for Research and Education, Inc. | Salisbury | NC | 621,000 | 845,000 | 834,000 |
| 55. Seattle Institute for Biomedical and Clinical Research. | Seattle | WA | 17,400,000 | 17,200,000 | 17,200,000 |

| Nonprofit Corporations | City | State | Actual Revenues (Contributions) 2021 | Estimated Revenues (Contributions) 2022 | Estimated Revenues (Contributions) 2023 |
|---|---|---|---|---|---|
| 56. Sierra Veterans Research and Education Foundation | Reno | NV | 315,000 | 559,000 | 313,000 |
| 57. Sociedad de Investigacion Cientificas, Inc | San Juan | PR | 505,000 | 510,000 | 525,000 |
| 58. South Florida Veterans Affairs Foundation for Research and Education, Inc | Miami | FL | 275,000 | 275,000 | 300,000 |
| 59. Southern California Institute for Research and Education | Long Beach | CA | 3,000,000 | 3,000,000 | 3,000,000 |
| 60. Tampa VA Research and Education Foundation, Inc | Tampa | FL | 3,000,000 | 3,000,000 | 4,000,000 |
| 61. TempVA Research Group, Inc | Temple | TX | 1,350,000 | 1,075,000 | 1,006,000 |
| 62. The Bay Pines Foundation, Inc | Bay Pines | FL | 725,000 | 798,000 | 878,000 |
| 63. The Cleveland VA Medical Research and Education Foundation | Cleveland | OH | 4,654,000 | 4,794,000 | 4,937,000 |
| 64. The Research Corporation of Long Island, Inc | Northport | NY | 110,000 | 200,000 | 250,000 |
| 65. Tuscaloosa Research and Education Advancement Corporation | Tuscaloosa | AL | 1,519,000 | 570,000 | 760,000 |
| 66. VA Black Hills Research and Education Foundation | Fort Meade | SD | 2,000 | 4,000 | 5,000 |
| 67. VA Connecticut Research and Education Foundation | West Haven | CT | 1,700,000 | 1,900,000 | 2,000,000 |
| 68. Veterans Bio-Medical Research Institute, Inc | East Orange | NJ | 1,965,000 | 1,965,000 | 1,965,000 |
| 69. Veterans Education and Research Ass'n. of Northern New England, Inc | White River Junction | CT | 3,464,000 | 3,568,000 | 3,654,000 |
| 70. Veterans Education and Research Association of Michigan | Ann Arbor | MI | 1,400,000 | 1,500,000 | 1,600,000 |
| 71. Veterans Education and Research Institute | Detroit | MI | 150,000 | 200,000 | 250,000 |
| 72. Veterans Health Foundation | Pittsburgh | PA | 2,118,000 | 2,224,000 | 2,335,000 |
| 73. Veterans Health Research Institute of Central New York, Inc | Syracuse | NY | 1,289,000 | 1,290,000 | 1,300,000 |
| 74. Veterans Medical Research Foundation of San Diego | San Diego | CA | 14,000,000 | 14,000,000 | 14,000,000 |
| 75. Veterans Research and Education Foundation | Oklahoma City | OK | 300,000 | 350,000 | 400,000 |
| 76. Veterans Research and Education Foundation of St. Louis | St Louis | MO | 3,097,000 | 3,407,000 | 3,748,000 |
| 77. VISTAR, Inc | Birmingham | AL | 400,000 | 550,000 | 550,000 |
| 78. Western Institute for Veterans Research | Salt Lake City | UT | 4,465,000 | 4,911,000 | 5,157,000 |
| 79. Westside Institute for Science and Education | Chicago | IL | 0 | 0 | 0 |
| 80. Wisconsin Corporation for Biomedical Research | Milwaukee | WI | 267,000 | 270,000 | 273,000 |
| **Total** | | | **274,901,042** | **282,977,044** | **289,374,046** |

## General Post Fund




**Program Description**

This trust fund consists of gifts, bequests and proceeds from the sale of property left in the care of VA facilities by former beneficiaries who die leaving no heirs or without having otherwise disposed of their estate. Such funds are used to promote the comfort and welfare of Veterans at hospitals and other facilities for which no general appropriation is available. Also, donations from pharmaceutical companies, non-profit corporations and individuals to support VA medical research can be deposited into this fund (title 38 U.S.C., Chapters 83, Acceptance of Gifts and Bequests and 85, Disposition of Deceased Veterans' Personal Property). The resources from this trust fund are utilized for the direct benefit of the patients.

Expenditures from this fund are for recreational activities and religious needs; specific equipment purchases; national recreational events; the vehicle transportation network; television projects; and other items as outlined in Veteran Health Administration Directive 4721, General Post Fund. In addition, Public Law 105-114 authorizes the receipts from the sale of a property acquired for transitional housing to be deposited in the General Post Fund and used for the acquisition, management and maintenance of other transitional housing properties.

## Summary of Budget Request

Operations of this trust fund are financed from fund receipts. Congress has provided permanent, indefinite budget authority for this fund and no appropriation is requested.

### Table 1: Fund Highlights

| Description (dollars in thousands) | 2021 Actual | 2022 Budget Estimate | 2022 Current Estimate | 2023 Estimate | +/- 2022-2023 |
|---|---|---|---|---|---|
| Budget Authority (permanent, indefinite) | $20,197 | $21,000 | $21,000 | $21,000 | $0 |
| Projected Receipts : | | | | | |
| Trust Fund and Donation | $14,120 | $23,700 | $14,700 | $15,300 | $600 |
| Therapeutic Residences | $887 | $1,700 | $900 | $900 | $0 |
| Total Projected Receipts | $15,007 | $25,400 | $15,600 | $16,200 | $600 |

### Table 2: Changes from Original 2022 Budget Estimate

| Description (dollars in thousands) | 2022 Budget Estimate | 2022 Current Estimate | Increase/ Decrease |
|---|---|---|---|
| Budget Authority (permanent, indefinite) | $21,000 | $21,000 | $0 |
| Projected Receipts: | | | |
| Trust Fund and Donation | $23,700 | $14,700 | ($9,000) |
| Therapeutic Residences | $1,700 | $900 | ($800) |
| Total Projected Receipts | $25,400 | $15,600 | ($9,800) |

## Program Activity

### Trust Fund and Donations

Estimates of trust fund obligations for 2022 and 2023 are $21 million and $21 million respectively. The obligations are consistent with the purposes for which proceeds from this fund may legally be expended (Comptroller General's Decision B 125715, November 10, 1955) and the intent of the donors. Donors usually specify that their donations be used for designated recreational or religious purposes, research projects, or equipment purchases (e.g., televisions, medical equipment and physical therapy equipment).

## Compensated Work Therapy - Therapeutic Residences (CWT-TR)

Per title 38 U.S.C. 2032, funds received through the operation of the Therapeutic Housing Program are to be deposited in the General Post Fund. The Secretary has the discretionary authority to expend up to an additional $500,000 from the fund above the amount credited to the fund in a fiscal year from proceeds of this program.

## Table 3: Financial Actions and Conditions

| Description (dollars in thousands) | 2021 Actual |
|---|---|
| **Balance beginning of year:** | |
| Cash | $26,629 |
| Investments | $98,975 |
| Property, Plant, Equipment & Other Assets | $50,511 |
| Total | $176,115 |
| **Increase during period:** | |
| Cash | $98,001 |
| Investments | $25,143 |
| Property, Plant, Equipment & Other Assets | $4 |
| Total | $123,148 |
| **Decrease during period:** | |
| Cash | $69,908 |
| Investments | $46,425 |
| Property, Plant, Equipment & Other Assets | $2,505 |
| Total | $118,838 |
| **Balance at end of year:** | |
| Cash | $54,722 |
| Investments | $77,693 |
| Property, Plant, Equipment & Other Assets | $48,010 |
| Total | $180,425 |

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# *Electronic Health Record Modernization*

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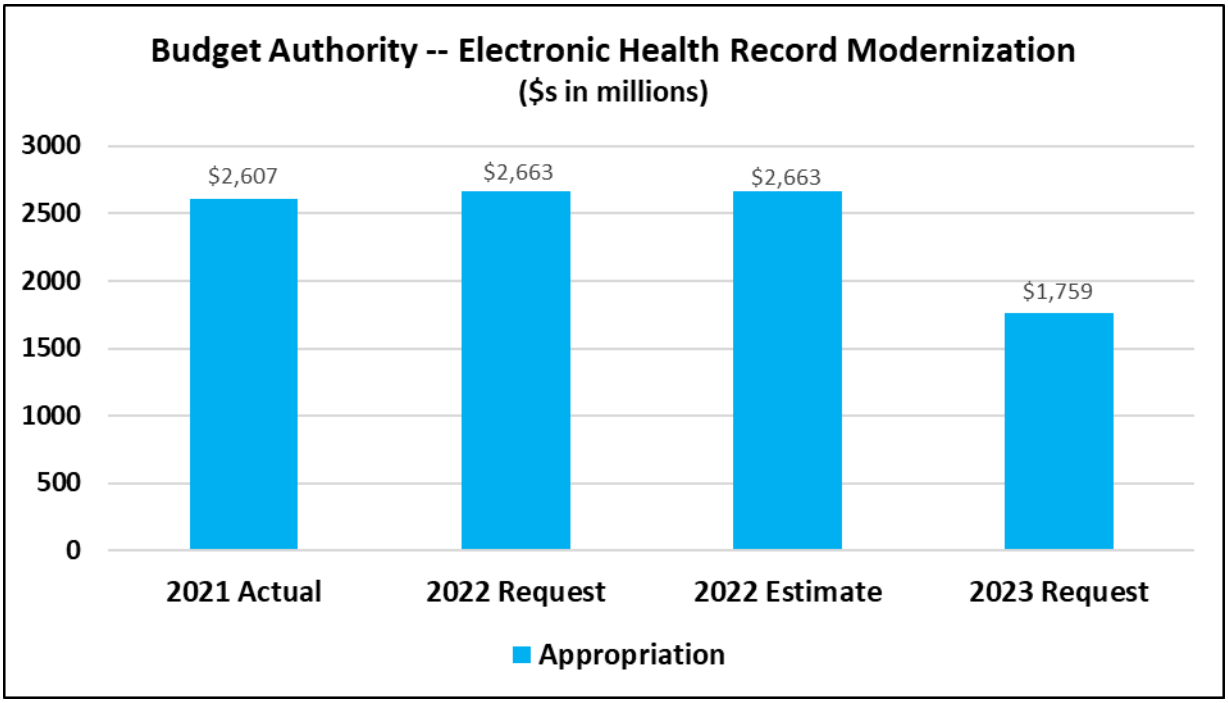
# *Electronic Health Record Modernization*

## Budget Authority and Appropriation Language




Note: 2021 reflects a rescission of $20 million from unobligated balances required by P.L. 116-260, Consolidated Appropriations Act, 2021, Division J, Title II, section 254.

### Appropriation Language

*For activities related to implementation, preparation, development, interface, management, rollout, and maintenance of a Veterans Electronic Health Record system, including contractual costs associated with operations authorized by section 3109 of title 5, United States Code, and salaries and expenses of employees hired under titles 5 and 38, United States Code, $1,759,000,000, to remain available until September 30, 2025: Provided, That the Secretary of Veterans Affairs shall submit to the Committees on Appropriations of both Houses of Congress quarterly reports detailing obligations, expenditures, and deployment implementation by facility, including any changes from the deployment plan or schedule: Provided further, That the funds provided in this account shall only be available to the Office of the Deputy Secretary, to be administered by that Office.*

## Appropriation Highlights

**Electronic Health Record Modernization Integration Office**
**Appropriation Highlights**
**($ thousands)**

| | 2021 Enacted | 2022 Request | 2022 Current Estimate | 2023 Request | 23 Request vs 22 Estimate | |
|---|---|---|---|---|---|---|
| | | | | | $ | % |
| **Budgetary Resources:** | | | | | | |
| Electronic Health Record (EHR) | $1,191,000 | $1,425,498 | $1,425,498 | $1,119,145 | ($306,353) | -21.5% |
| Infrastructure Readiness (IR) | $1,181,000 | $951,797 | $951,797 | $440,739 | ($511,058) | -53.7% |
| Program Management Office (PMO) | $255,000 | $285,705 | $285,705 | $199,116 | ($86,589) | -30.3% |
| **Subtotal, Appropriation** | $2,627,000 | $2,663,000 | $2,663,000 | $1,759,000 | ($904,000) | |
| Electronic Health Record (EHR) | $4,172 | | $551,491 | | ($551,491) | -100.0% |
| Infrastructure Readiness (IR) | $277 | | $124,163 | | ($124,163) | -100.0% |
| Program Management Office (PMO) | $19,981 | | $44,811 | | ($44,811) | -100.0% |
| **Subtotal, Unobligated balance brought forward, Oct 1** | $24,430 | $0 | $720,465 | $0 | ($720,465) | -100.0% |
| Recoveries, 2nd year of funds | $16,206 | | | | | |
| Recoveries, 3rd year of funds | $33,660 | | | | | |
| **Subtotal, Recoveries** | $49,866 | $0 | $0 | $0 | $0 | |
| Rescission of Prior Year Funds - EHR | ($4,172) | | | | | |
| Rescission of Prior Year Funds - IR | ($277) | | | | | |
| Rescission of Prior Year Funds - PMO | ($15,551) | | | | | |
| **Subtotal, Rescission of Prior Year Funds** | ($20,000) | $0 | $0 | $0 | $0 | |
| **Subtotal, Budgetary Resources** | **$2,681,296** | **$2,663,000** | **$3,383,465** | **$1,759,000** | **($1,624,465)** | -48.0% |
| Program Management Office (PMO) | ($131) | | | | | |
| **Subtotal, Unobligated Balance Expiring** | **($131)** | **$0** | **$0** | **$0** | $0 | |
| Electronic Health Record (EHR) | ($551,491) | | | | | |
| Infrastructure Readiness (IR) | ($124,163) | | | | | |
| Program Management Office (PMO) | ($44,811) | | | | | |
| **Subtotal, Unexpired Unobligated Balance** | **($720,465)** | **$0** | **$0** | **$0** | $0 | |
| **Total, Obligations** | **$1,960,700** | **$2,663,000** | **$3,383,465** | **$1,759,000** | **($1,624,465)** | **-48.0%** |
| **Direct Obligations by Program Activity** | | | | | | |
| Electronic Health Record (EHR) | $672,526 | $1,425,498 | $1,976,989 | $1,119,145 | ($857,844) | -43.4% |
| Infrastructure Readiness (IR) | $1,070,904 | $951,797 | $1,075,960 | $440,739 | ($635,221) | -59.0% |
| Program Management Office (PMO) | $217,270 | $285,705 | $330,516 | $199,116 | ($131,400) | -39.8% |
| **Total, Obligations** | **$1,960,700** | **$2,663,000** | **$3,383,465** | **$1,759,000** | **($1,624,465)** | -48.0% |
| **Full Time Equivalent (FTE):** | | | | | | |
| Direct FTE | 175 | 337 | 222 | 227 | - | 2.3% |
| **Total, FTE** | **175** | **337** | **222** | **227** | - | 2.3% |

## Budget Overview

### 2023 Budget Request at a Glance

($ in thousands)

| | |
|---|---|
| 2022 President's Budget Request Level | $2,663,000 |
| Program Changes | $ -904,000 |
| 2023 Budget Request | $1,759,000 |
| Change from 2022 Request Level | -34% |

VA is requesting $1.759 billion for the Veterans Electronic Health Record. This will provide for the purchase of licenses and activities for additional future medical center deployments, site assessments, training of staff, purchase and installation of computer hardware and interface development. Lessons learned from deployments of the new electronic health record (EHR) solution at the initial operating capability (IOC) sites in 2020 and future deployments will inform future budgetary requirements and an implementation path moving forward. VA's request for 2023 reflects a strategic revision to the original Electronic Health Record Modernization (EHRM) deployment schedule, determining a way forward after the initial phase of the realignment thru early 2024.

**VA's $1.759 billion request includes:**

- **$1.119 billion for EHR Contract** – This request aligns with VA's revised EHRM deployment plan, and is based on the unpredictable COVID-19 environment while optimizing resources, providing flexibility, preserving momentum, and supporting the continued alignment and interoperability with the Department of Defense (DoD). The funding will support contracts for site assessments, site transitions, enterprise integration and site implementation support for the post go-live activities and deployment efforts at future VISNs. The 2023 funding request is reduced due to fewer scheduled deployments, going from 25 VAMC in 2022 to 16 VAMC in 2023 (Waves S-Y). This will ensure completion of current deployments and aligns with the new schedule.
- **$440.7 million for Infrastructure Readiness** – Funds will aid in supplying deployment sites with updated computers and network infrastructure capable of supporting the EHR solution six to eighteen months in advance of scheduled deployment. The funding will also support system interfaces and cybersecurity efforts. The funding request is decreased due to VHA taking over the responsibility to fund medical devices in 2023 and a reduction in interfaces due to fewer specialized enterprise systems.

- **$199.1 million for Project Management Office (PMO)** – The funding will support 227 FTE supporting effective change management as the EHR solution is implemented throughout the nation. The goal is to retain qualified experts who understand VA's legacy systems, computer programming languages and interfaces. The request supports reimbursement of 37 VHA experts that are critical to change management and effective deployment. EHRM will support the FEHRM program office for $18 million; part of this request includes federal staff pay, contract support staff, funding for travel, training, equipment, and supplies. As federal staff increase, the contract support and VHA reimbursable field support staff will decrease to a more focused level.

**Electronic Health Record Implementation and the COVID-19 Environment**

VA's priority remains the health and safety of Veterans and its staff. The COVID-19 pandemic has increased demand for VA health care services. VA's health care providers and facility staff have also been directly affected by COVID-19, reducing the workforce available to provide patient care in those areas experiencing a surge in cases. In response to the pandemic and its effect on VA health care operations, VA has revised its EHR deployment strategy to be more agile and is continuing to closely coordinate with VA facilities to not only ensure EHR deployment is based on site readiness, but VA is also considering the ongoing impact of COVID-19.

**Mission**

The health and safety of Veterans is one of VA's highest priorities. VA is committed to providing a seamless network of care for all Veterans, which includes access to a comprehensive EHR. VA's current electronic health information system, Veterans Health Information Systems and Technology Architecture (VistA), is not sustainable and cannot deliver critical capabilities, such as supporting interoperability within VA and with DoD and community care providers.

VA's new EHR solution will create a longitudinal health record of a Veteran. This system is the same that DoD uses to store service member records, from enlistment to discharge, and migration from service member to Veteran. VA's new EHR solution is critical to the delivery of health care in the modern era, allowing information sharing among providers, such as timely reminders to clinicians about Veterans' medical conditions, adverse drug interactions, physician notes and referrals, pharmacy notes and lab results. The complete medical history can be shared among the medical community. This will enhance the delivery of quality health care to our nation's Veterans. Designed to accommodate health care delivery priorities that are unique to VA and bring industry best practices to Veteran health care, the EHR solution will integrate modern functionality and infrastructure into a simple experience, allowing the system to operate seamlessly with community care providers. This will eliminate dependencies on legacy systems and the risks associated with using multiple products to share Veteran medical records.

VA's new EHR solution provides administrative services to VA health care providers, such as the scheduling and cancellation of appointments, allowing medical providers to interact with Veterans via smartphone and web-based technologies and providing the ability to update and validate Veteran data on a real-time basis. It will also provide a more efficient and effective way of collecting, managing and tracking Veteran medical information, while reducing medical information intake time, thus improving the ease of sharing among authorized medical users and the storing of Veteran medical information.

**Program Update**

VA continues to work closely with DoD to capture lessons learned and ensure the deployment of an EHR that is fully interoperable between the departments. VA continues to host critical national and local workshops designed to educate diverse clinical end-users and validate workflows to ensure VA's new EHR solution meets the department's needs. VA will execute 4 local workshops at each facility in VISN 20 and 10 during their deployment timeline. These workshops are intended for VISN and local site design teams subject matter experts to collaborate on the design, configuration, and review of localized data and future-state within the context of the national build. The first two workshops focus on integrated and solution specific demos of key nationally approved workflows and content. Third and fourth workshops focused on continued workflow reviews, additional data collection and demonstrations of localized build. VA works collaboratively with each facility to map roles across all workshops pulling forward participants from workshop to workshop. This ensures alignment, reducing rework and challenges with having the correct participants at workshop sessions.

The program's success relies on effective user adoption. VA deployed a change management strategy that includes working with end-users, beginning with VA Medical Center (VAMC) leadership, managers/supervisors and clinicians to provide the necessary ongoing trainings. Additionally, VA established 18 Electronic Health Record Councils (EHRC) that represent each of the functional areas of the new EHR solution, including VHA clinicians. Each council is responsible for reviewing and finalizing the design of standardized clinical requirements and business processes to be implemented across the enterprise at all VISNs. The EHRCs serve as change agents at the local level and are composed of 60% practicing VHA clinicians and 40% VA Central Office subject matter expert staff.

In October 2020, VA launched the new EHR solution at Mann-Grandstaff VAMC in Spokane, Washington, its four associated community-based outpatient clinics (CBOCs) and the West Consolidated Patient Account Center (WCPAC), located in Las Vegas. The EHR implementation at Mann-Grandstaff VAMC presented challenges, as well as opportunities for VA to learn and adapt its deployment strategy. In March 2021, Secretary Denis McDonough announced a comprehensive strategic review to fully assess the EHRM program and ensure the success of future EHR deployments. Some of the lessons learned from the strategic review included the need to refine the program's governance and management structures and to enhance collaboration and partnerships enterprise-wide within VA, as well as with the DoD and the FEHRM.

Based on the findings of the strategic review, on December 1, 2021, VA announced its updated plan to move forward with the EHRM program, and the newly formed Electronic Health Record Modernization Integration Office (EHRM IO). The EHRM IO will lead efforts in mitigating the challenges documented during strategic review, lead implementation of a revised schedule for rollout of the EHR solution through early 2024 and ensure new EHR governance and management structures include the establishment of a Program Executive Director (PED) for EHR Integration, a significantly strengthened Office of the Functional Champion (OFC) and a Deputy Chief Information Officer (DCIO) for EHR, as well as a new EHR Integration Council. (See Implementing Organizational & Program Improvements below for further details.)

To date, progress has been made in the areas of ensuring patient safety; evaluating all patient safety issues raised during Mann-Grandstaff implementation and identifying mitigations to apply in future sites. This included drafting a strategy for national VISN, and local level clinical and informatics team collaboration on safety incident engagement. Progress was made building confidence at VA sites, with VA and Cerner working together to establish engagement activities with leadership that provide awareness for the complexities of transitioning to a new EHR and improving staff guidance. Progress improvements to operational efficiencies were made by conducting current state end-to-end process and workflow assessments for a comprehensive set of clinical and business domains at sites in VISNs 10, 12 and 20. A process is in place to receive, categorize, analyze root causes, implement sustainable solutions, and prioritize with clinical inputs.

In addition, to increase fidelity of the full EHRM IO spend plan and life cycle costs across the VA enterprise, in December 2021, VA completed a review of the physical and information technology infrastructure costs incurred in support of the EHRM deployment from fiscal year 2018 through 2021. VA included these historical costs in its most recent congressionally mandated report (CMR) on the program. Additionally, VA has contracted with the Institute of Defense Analyses (IDA) to complete an independent cost estimate (ICE) of all EHRM IO program costs. VA anticipates that the ICE will be completed by October 2022. After completion of the ICE, VA will include the full cost view of EHRM IO, with the historical costs.

The EHRM IO effort will continue to be an evolving process as technological advancements are made. VA's approach involves deploying the EHR solution at VA's IOC sites to identify challenges, hone governance, identify efficient strategies and reduce risk to the portfolio by solidifying workflows and detecting course correction opportunities prior to deployment at additional sites. As part of the deployment process, VA and Cerner will continue to conduct current state reviews (CSR). CSRs are collaborative current functional and technical assessments, which start with a one- to seven-day site visit. CSRs result in identification of necessary remediation unique to the facility. The time period between CSR and kickoff allows VA and Cerner to review the findings and refine the site-specific deployment plan.

CSR visits have been completed for VISNs 20, 10, and 12 and are pending for all other locations. Technical CSRs have largely been unaffected by COVID, although considerations are needed when assessing technical devices and infrastructure in clinical spaces. Due to COVID, the functional CSRs have shifted to a predominantly virtual formatting, with sessions being completed by Teams, phone, or similar modalities. Pre-COVID, the functional CSRs were primarily in-person. The virtual functional CSRs contain the same sessions and interviews that they would in-person. When COVID case counts and restrictions ease, the eventual goal would be to shift back to a more in-person model. COVID has also had impact on site/VISN order and timing of CSRs due to stand-downs with health care systems during surges in COVID cases that impacted ability of clinicians to participate in engagement activities.

**Implementing Organizational & Program Improvements**

After deploying the new EHR at Mann-Grandstaff VAMC, VA restructured its approach to management and governance of the program. This new direction introduced a new EHRM IO management structure to address previously identified organizational challenges with limited

stakeholder inputs in decision making, accountability, and information sharing. In addition, lessons learned from the EHR system implementation at the Mann-Grandstaff VAMC indicate that cross-organizational and cross-functional coordination across technical, clinical, and program management activities is required. Furthermore, the need to foster communication, clarify roles and responsibilities for all stakeholders, and integrate dependent tasks is critical to achieving this program's outcomes for Veterans and their families.

The new EHRM IO management structure is streamlined and supported by a revised program management approach that incorporates industry best practices in communication, risk management, business process, system development lifecycle management and customer experience. In addition, VA is maturing integrated plans, strategies and tools to ensure the inclusion of all stakeholders in EHRM IO execution. The new management structure is also ensuring active participation in the decision-making process by all stakeholders. It has controls in place to prevent silos that occurred in the past. When disagreements occur, the governance bodies— EHRM IO Integration Council, VA Operations Board (VAOB) and VA Executive Board (VAEB) — provide requisite oversight and enable collaborative decision-making. These changes enable the successful development of VA's capabilities to achieve the full promise of a joint record between VA and DoD that enhances care and services for service members and Veterans.

Consistent with Congressional requirements and expectations, this new management structure retains the accountability and oversight of the EHRM IO program with the Deputy Secretary of VA. VA brought in the highly experienced leader from DoD's Military Health System to serve as PED and to lead the EHRM IO, which replaces the former Office of Electronic Health Record Modernization (OEHRM). The PED reports directly to the VA Deputy Secretary and is responsible for cross organizational and cross functional coordination of communication and implementation strategies, to include functional, technical and program management. The EHRM IO has operational control over the OFC, the Office of the EHRM IO DCIO and the Program Management Office (PMO), all dedicated to the success of VA's EHRM IO effort. The EHR Integration Council, chaired by the PED, will ensure decisions are fully coordinated and timely by receiving input from stakeholders across VA (e.g., VHA, OIT, Office of Enterprise Integration (OEI), Veterans Benefits Administration (VBA), Office of the Chief Acquisition Officer and the Office of the Chief Financial Officer).

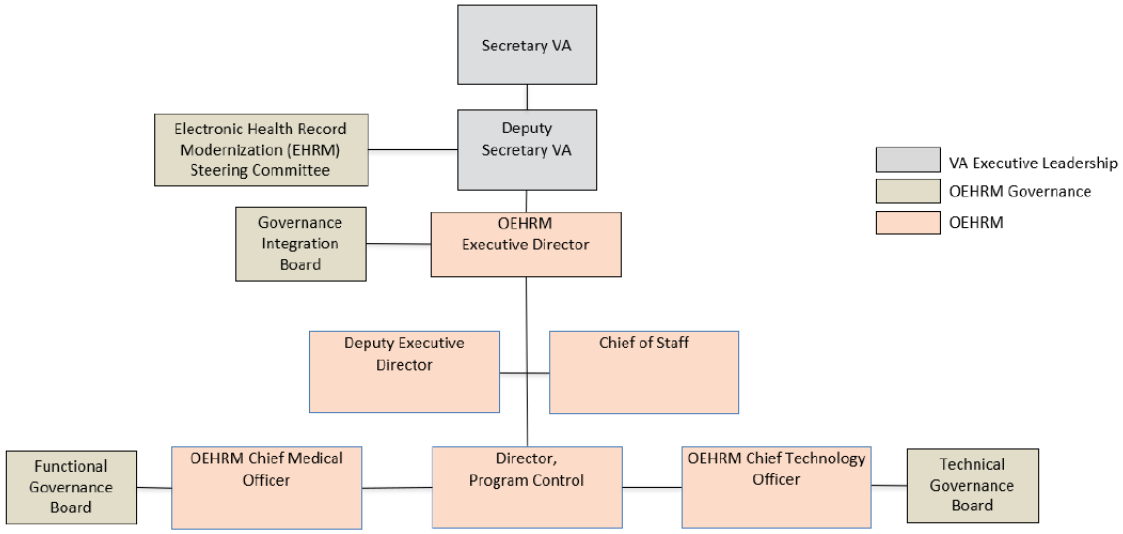
The OFC, led by an Executive Director, consolidates functions from the former EHRM Chief Medical Officer and the functions of the VHA Functional Champion. The OFC is responsible for coordination, integration, and oversight of all functional components of re-engineering clinical and business processes, interoperability, clinical informatics, quality and patient safety, user testing, training, change management, and deployment to VA medical centers. The establishment of the OFC is a significant structural change for this new approach, significantly increasing VHA's engagement and expanding the Functional Champion role and its associated team. Additionally, the OFC ensures appropriate clinical involvement and helps bridge any divides between IT, the EHR vendor and the care delivery teams to ensure that the needs of the practicing clinicians and support staff are met.

The EHRM IO DCIO assumes all technology integration functions in the former OEHRM. The DCIO ensures that there is close bidirectional communication with technical staff at local sites.

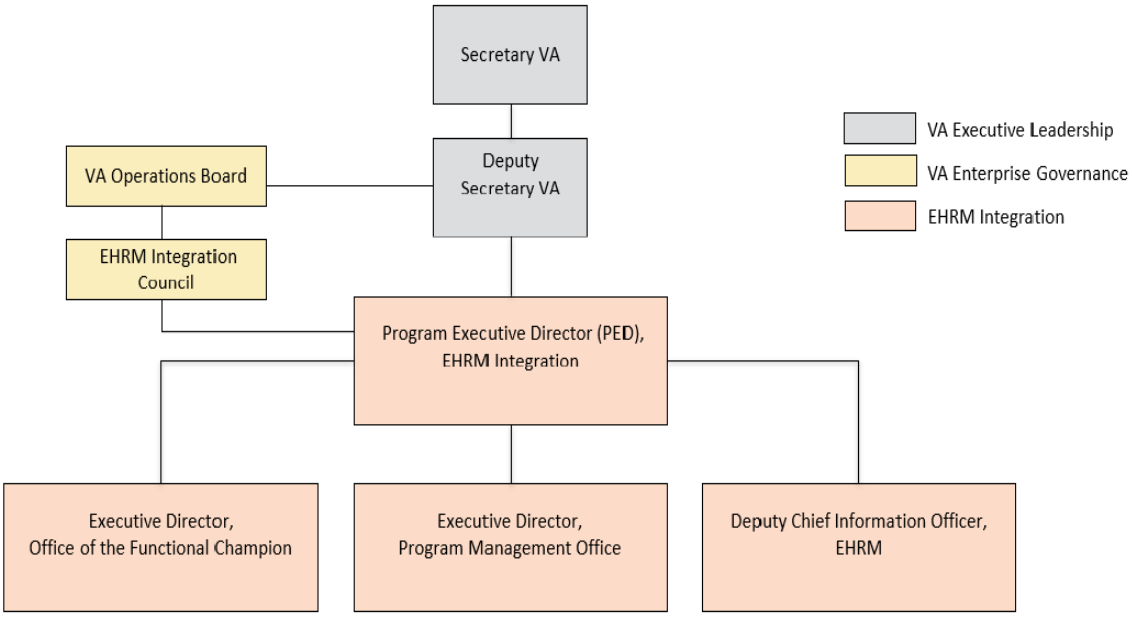
The PMO, led by an Executive Director (ED), is responsible for program management activities, including integrated scheduling, cost estimates, contract management and risk management.

While the OFC, DCIO and PMO ED reports to the PED, they seek guidance and expertise from the Under Secretary for Health and the Chief Information Officer to adhere to VHA and OIT policies. In addition, to ensure adherence to the "need for the best industry standards" in management, VA policies and processes, the PMO ED seek concurrence and expertise on matters related to program management and contract management through the Office of Acquisition, Logistics, and Construction and with the Office of Management on budget formulation and execution, cost estimates and audits.

**Former Management Structure**



**Current Management Structure**

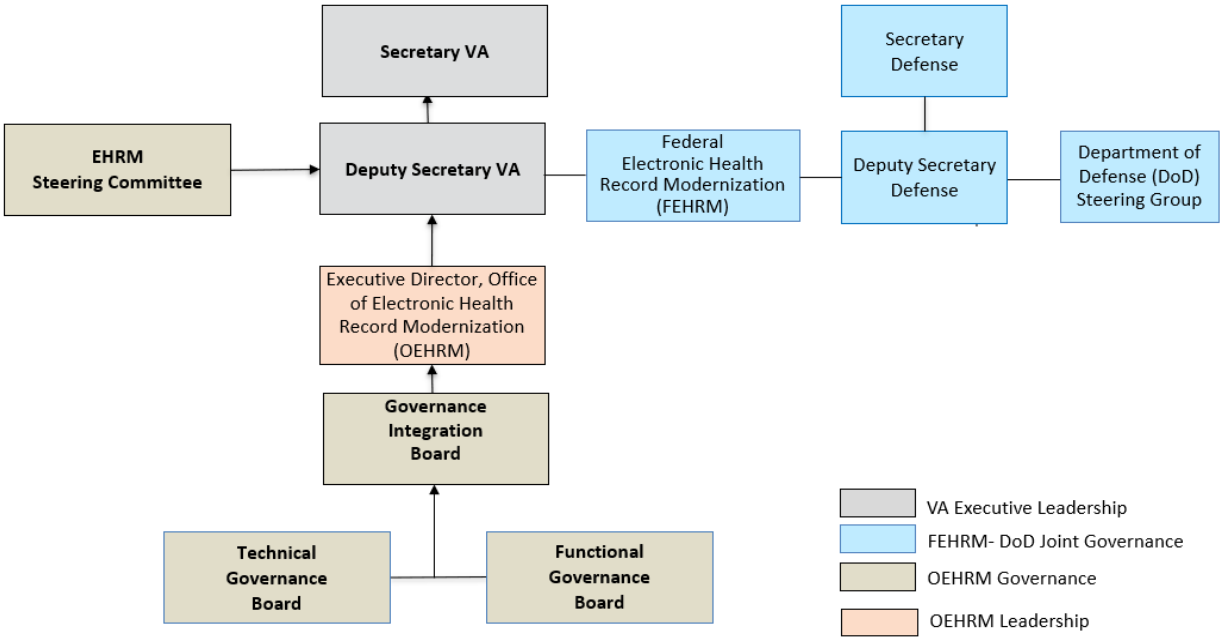



## Making Governance Effective

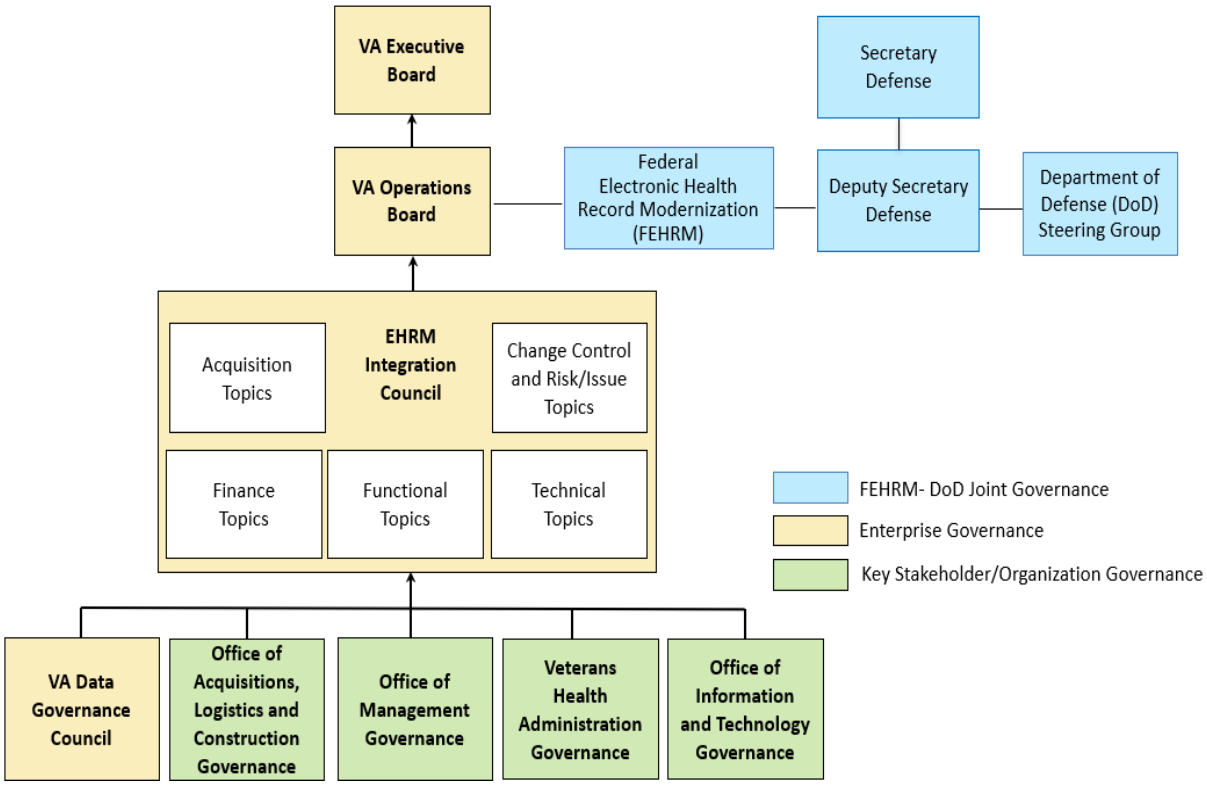
The 2021 strategic review enforced the requirement for effective and streamlined governance processes for a successful EHR deployment. Findings from the strategic review identified a need for greater clarity of responsibilities and empowerment through a governance structure that ensures stakeholder input and enables timely decision making. As a result, VA has prioritized resolving these issues to make EHRM IO's governance more effective and has established a new EHRM IO Integration Council. This Council will report to the VA Operations Board (VAOB), the Deputy Secretary and the VA Executive Board (VAEB) chaired by the Secretary and will ensure that all technical, health care policy, operational and business stakeholders are included in decision-making process.

The Integration Council (the Council), chaired by the PED, will ensure that decisions are fully coordinated and made timely while addressing the need for operational decisions at the enterprise level. The Council will also holistically address acquisition, finance, functional, technical and change control issues, capturing all key stakeholder views. Additionally, the Council will subsume other documented and undocumented EHRM IO governance structures, unifying governance and increasing transparent data-driven decision-making to ensure that decisions are communicated to end user stakeholders with a single voice. Lastly, the Council shall support synchronization and integration with other priority initiatives, such as Financial Management Business Transformation, and Veteran/Employee experience.

## Former Governance Structure



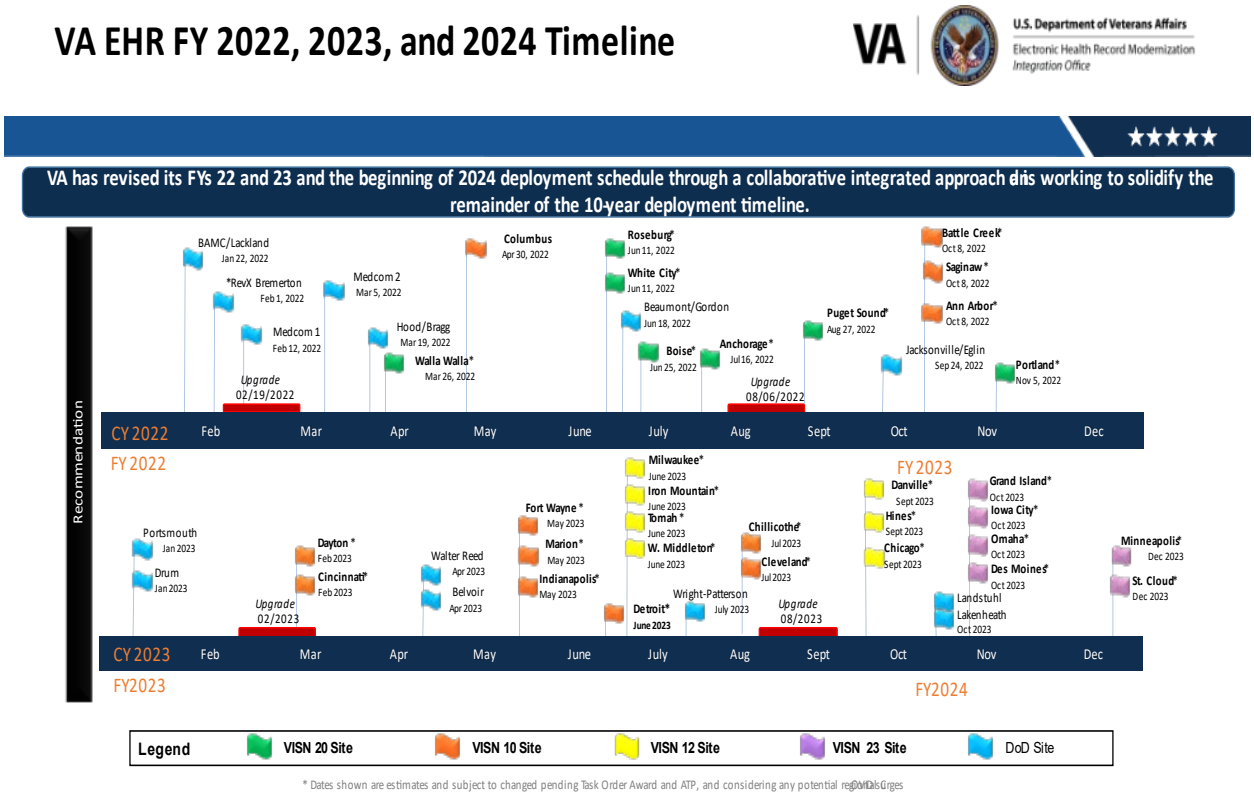

## Current Governance Structure



## Updated Deployment Activities

The updated deployment schedule was developed based on current information. Adjustments and modifications to the schedule will be made based on any additional clinical and technical findings. The dates shown are estimates and subject to change pending task order award, authority to proceed, and potential COVID-19 surges.

The schedule leverages the lessons learned from VA's IOC sites and incorporates feedback from facility end-users, VISN leadership and VHA program offices. Pre-deployment activities are underway in VISNs 10 (Ohio, Michigan, Indiana) and 20 (Washington, Oregon, Idaho, Alaska) while preparing for future fiscal year site deployments in VISNs 12 (Wisconsin, Illinois) and 23 (North Dakota, South Dakota, Nebraska, Minnesota, Iowa).



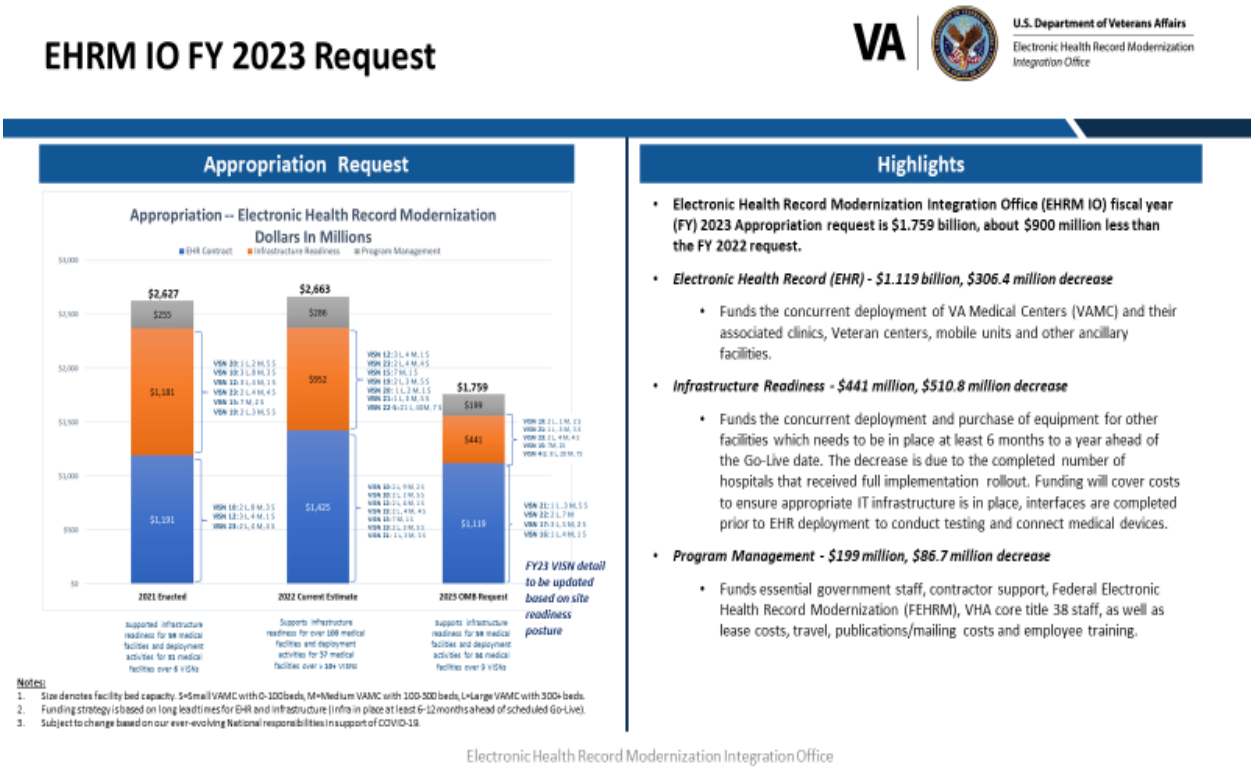

VA will undertake multiple CSRs at VA medical centers in 2022 and 2023 (see CSR's update in Program Update section). These reviews are the first step in preparing the VA medical center and related clinics for implementation of the new EHR solution. The functional portion identifies clinical capabilities that must be configured for the services that the medical facility provides. CSRs include a comprehensive review of 1) each facility's clinical processes for patient care (known as workflows) in the VistA/Computerized Patient Record System (CPRS) legacy EHR; 2) a site-specific analysis of each facility's patient documentation requirements; and 3) a review of existing technical infrastructure, including network closets, server rooms, end-user devices, medical devices, printers and scanners. Cerner conducts CSRs at each facility in close collaboration with the EHRM IO, local VHA clinical staff and OIT staff. They utilize the VA pre-assessments of site infrastructure, contracted VHA physical plant construction and installed or in-process IT hardware to inform their CSR. The technical portion of the CSR identifies deficiencies

in the existing computer hardware networks, equipment, electrical power, air conditioning capacity and space requirements that must be improved before installation of the new EHR solution. During technical CSR activities, Cerner inventories current state end-user and medical devices, peripherals, wired local area networks (LAN) and wireless local area networks (WLAN). Functional CSR events may include either focus groups or departmental walkthroughs, during which Cerner compares a facility's unique process flows to recommended practices. All facility local service lines and subject matter experts assist with identifying project risks and opportunities for improvement. Both inform subsequent data collection and design planning; assist with further understanding business practices; and ensure that Cerner Millennium solution's configuration accomplishes VA's goals. Cerner details their CSR findings in functional and technical reports, which also include technical upgrades and improvements needed to support implementation and potential areas of improvement in the future state.

During the multi-year transition effort, VA will continue to use VistA and related clinical systems until all legacy VA electronic health record modules are replaced by the new EHR solution. For the purposes of ensuring uninterrupted health care delivery, existing systems will run concurrently with the deployment of VA's EHR solution while facilities are transitioning. VA's approach involves deploying the new EHR solution at the initial sites to identify potential problems and correct them before deploying to additional sites. VA will continue to assess each deployment for best practices and lessons learned to become more proficient at deploying the new EHR solution.

VA has acquired and configured network protection suites and routers for the facilities and purchased additional bandwidth for the IOC sites. On average, expanding wireless capability mitigates the need for 25% or more of the cabling requirement identified during the CSRs. Also, VA has installed data storage capability in Austin, Texas that allows for health data migration and synchronization with the Kansas City Data Center. Additionally, VA has built an enclave at the Cerner Data Center, the new EHR's secondary and backup data center, which improves the availability of patient data during transition and deployment. VA has established, with DoD, a Joint Cybersecurity service provider agreement to efficiently and effectively secure medical data and readily accommodates changes to the environment as new medical devices are added. Also, the centralization of data allows clinicians across the DoD and VA enterprise have access to data that was previously isolated to local facility staff only.

## Budget Request

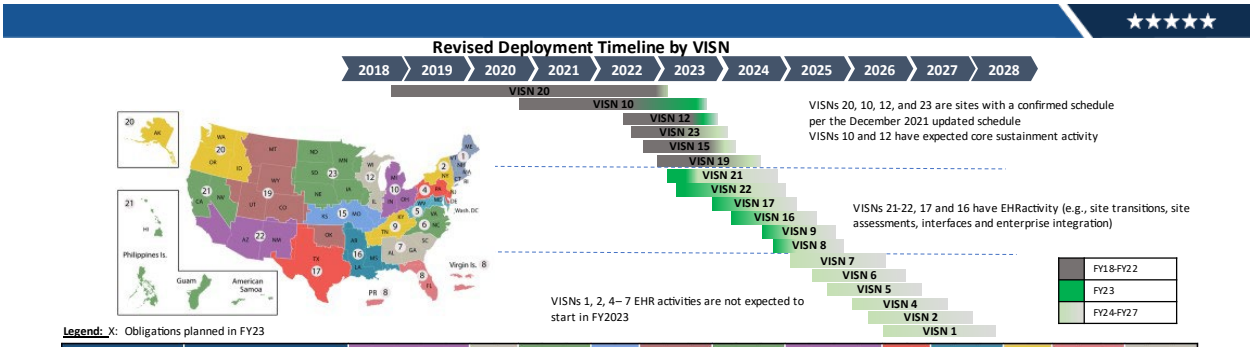



VA has established the EHRM IO to ensure successful preparation, deployment, and continued operation of the new EHR solution and the health information technology tools dependent upon it. VA's main priority for 2023 is to ensure that the EHRM IO effort judiciously balances speed of implementation with no risk to cost, schedule and performance objectives to ensure optimal care of our Veterans and their families. For 2023, VA requests $1.759 billion, which is a decrease of $904 million (-34%) relative to the 2022 Budget request. The 2023 Budget request is separated into three subaccounts detailed below:

## Electronic Health Record Modernization - $1.119 billion

### EHR Cost and Deployment Schedule for FY 2023

U.S. Department of Veterans Affairs
Electronic Health Record Modernization
Integration Office




**Legend:** X: Obligations planned in FY23

| Area | Estimated Costs for FY23 ($M) | VISN 10 | | | | | VISN 12 | VISN 23 | | | VISN 15 | | VISN 19 | | | VISN 21 | | | VISN 22 | | | | VISN 17 | | VISN 16 | | | VISN 9 | | VISN 8 | | | VISN 7 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Wave: | A | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z | AA | BB | CC | DD | EE | FF | GG | HH | II | JJ | KK | LL |
| Site Transitions | $598.4 | | | | | | | | | | | | | | | | x | x | x | x | x | x | x | | | | | | | | | | | | | |
| Site Assessments | $37.0 | | | | | | | | | | | | | | | | | | | | | | x | x | x | x | x | | | | | | | | | |
| Core Sustainment | $48.0 | | x | x | x | x | x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Interfaces | $60.0 | | | | | | | | | | | | | | | | | | x | x | x | x | x | x | x | x | x | x | x | x | x | x | | | |
| Enterprise Integration | $375.7 | <<Continuous activities throughout the program not tied to specific sites, includes Vendor Site Implementation Support, Cerner Operations, Enterprise Integration>> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total Estimated Costs | $1,119.1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

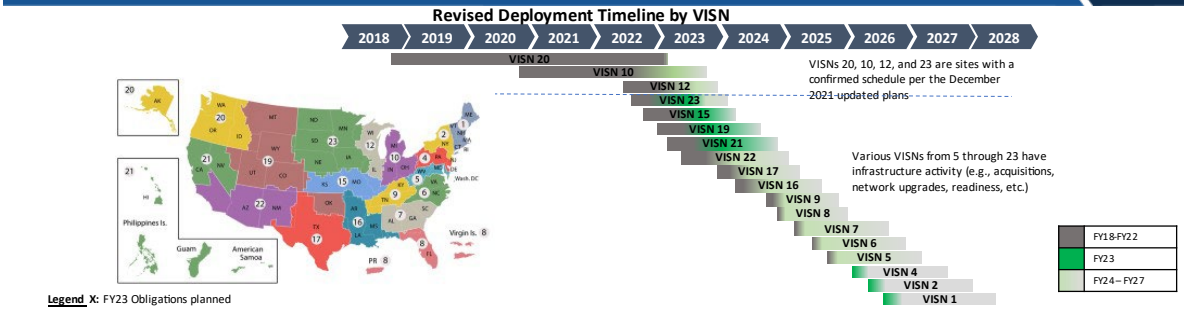
Electronic Health Record Modernization Integration Office

The request includes estimated cost for activities required to plan for and deploy the new EHR solution such as site activation, change management, training, data migration, data normalization, data hosting, interoperability, workflow development, testing, sustainment, help desk support, licenses, data analytics, and innovations. 2023 funds will be used to deploy the new EHR in multiple locations, as shown in chart above, dependent upon site readiness. The new EHR solution will help simplify health care delivery for both patients and clinical providers. Medical providers will have instant and seamless access to a Veteran's full health records and history. VA will compile data from servicemembers' records to guarantee it is available to be accessed years later by DoD, VA, and private sector doctors. This centralization of data will provide clinicians with a full picture of a Veteran's medical history. Through national and local workflow design processes, VA partnered with DoD and commercial vendors and is working to strengthen and improve health care for all Veterans and active duty servicemembers and to improve the productivity and user experience for VA system users.

## Infrastructure Readiness - $440.7 million

### Infrastructure Readiness Cost and Deployment Schedule for FY 2023

U.S. Department of Veterans Affairs
Electronic Health Record Modernization
Integration Office




**Legend X:** FY23 Obligations planned

| Area | Estimated Costs for FY23 ($M) | VISN 20 | VISN 10 | VISN 12 | VISN 23 | VISN 15 | VISN 19 | VISN 21 | VISN 22 | VISN 17 | VISN 16 | VISN 9 | VISN 8 | VISN 7 | VISN 6 | VISN 5 | VISN 4 | VISN 2 | VISN 1 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Joint Security Architecture (JSA) and Forward Deployed Server Stack (FDSS) | $31.4 | | | | | | | | | | | | | | | | x | x | x |
| Local Area Network (LAN) | $3.3 | | | | | | | | | | | | | | | | x | x | x |
| End User Device (EUD) | $40.9 | | | | | | | x | | | | | | | | | | | |
| Medical Systems and Interfaces | $41.4 | | | | x | x | x | | | | | | | | | | | | |
| Enterprise Costs | $323.7 | <<Continuous activities throughout the program not tied to specific sites>> | | | | | | | | | | | | | | | | | |
| Total Estimated Costs | $440.7 | | | | | | | | | | | | | | | | | | |

Electronic Health Record Modernization Integration Office

The request includes estimated infrastructure support costs, such as modifications to legacy systems, interfaces and wired and wireless networks at VA medical centers and their associated sites. Infrastructure readiness is a critical component of the success of the EHRM IO effort, and VA's strategy includes ensuring upgrades are in place six to eighteen months in advance of go-live. Components of VA, namely OIT, VHA and EHRM IO, collaborate to improve current IT infrastructure to a point of efficiency that supports the new EHR solution and positions VA to effectively deploy the solution across the enterprise.

## Program Management Office - $199.1 million

The request includes estimated cost of program management, including government and contract personnel, administrative and overhead expenses. EHRM IO will ensure successful execution, oversight, active coordination, and proactive management of the program. Specifically, it ensures contractors perform to the cost, schedule and performance objectives and the corresponding management of associated project risks while guaranteeing that VA infrastructure is ready for the system's deployment. EHRM IO employs highly trained government and contractor personnel to provide this expert oversight in a myriad of professional disciplines.

## Accomplishments

The VA continues to build on previous milestones to achieve the mission objectives set for the EHRM IO initiative. Despite continuing uncertainties due to the global pandemic, EHRM IO achieved many notable accomplishments on the road towards deploying a new EHR system that will connect VA medical centers and clinics with providers from the DoD, the Department of Homeland Security's U.S. Coast Guard and the community. Achievements include the EHR go-live at Mann-Grandstaff VAMC, its four CBOCs, and the WCPAC, which was executed during a pandemic, an electrical outage, and regional wildfires. Data and lessons learned from the Mann-Grandstaff Go-Live, as well as the Centralized Scheduling Solution implementation at VA Central Ohio Healthcare System in Columbus, Ohio, informed the refinement of the new EHR solution and engagement with future sites for pre-deployment activities. Achievements also included the successful implementation of additional capabilities and functionalities within the EHR, including access to immunization and prescription drug monitoring information; enhanced collaboration across VA and with DoD to support joint decision making and implement lessons learned; significant infrastructure readiness and testing efforts; improvements in training and expansion of the joint Health Information Exchange (joint HIE).

1. **Mann-Grandstaff VAMC Go-Live**: On Oct. 24, 2020, VA launched the new EHR solution at Mann-Grandstaff Veterans VAMC, its four associated CBOCs and the WCPAC. The new system benefits 35,000 Veterans and 2,200 staff. The implementation was a significant technological accomplishment that required complex integration of 73 IT system interfaces and over 900 VA-validated workflows, in addition to significant upgrades to facility infrastructure, network cabling, medical devices and computers accomplished over the previous two years. In preparation for go-live, over 1,450 Mann-Grandstaff and WCPAC participants engaged in workflow adoption activities, and EHRM IO personnel completed 850 change impact analyses, held 48 awareness briefings, and established a spotlight series on integrated workflow topics that reached 800 attendees.

   Additionally, EHRM IO implemented 10 functional areas and solutions for the Revenue Cycle component of the EHR at Mann-Grandstaff and WCPAC. Examples of these areas are scheduling, registration, medical coding and billing and collections. These included 49 capabilities, 4 of which were delivered earlier than planned. The new capabilities improved efficiency by automating 90% of third-party insurance claims, which were previously all manually reviewed. In all, the new Revenue cycle capabilities were utilized by 242 end users at Mann-Grandstaff, 118 at WCPAC and an additional 237 at various out-based sites. The new clinically driven revenue cycle supports VA's legislative and congressional requirements.

   Soon after go-live, VA held 23 listening sessions to gather end-user issues and track them to resolution. Of the 148 issues recorded, 146 (98.6%) were resolved through training, configuration changes, policy changes or through an enhancement request. The two outstanding issues are enhancements for user roles and templates that are being worked by the national EHRC's and DoD subject matter experts.

2. **Enhanced Collaboration with VA Sites and Offices and DoD:** EHRM IO's Chief Medical Office (CMO), now part of the OFC, completed over 4,310 unique interactions with over 225 stakeholders and over 450 workflow adoption activities with over 1,450 participants to support EHR configuration and implementation. Work continued with DoD to better align the two

functional communities on joint decision making. This effort included collaboration on functional input for the Joint Sustainment and Adoption Board (JSaAB), facilitated by the FEHRM program office, which resulted in over 2,900 joint decisions made for the EHR in 2021. The ongoing close coordination with DoD and FEHRM on joint decisions ensured interoperability objectives continued to be met to create a seamless care experience for service members, Veterans, and their providers. Additionally, in May 2021, EHRM IO launched an account management structure to support 19 solution experts to manage change requests routed to the JSaAB, coordinate with DoD counterparts and support end-user communications. These communications included 104 EHR system alerts and 250 EHRM IO flash communications on EHR updates distributed to sites and shared via VHA's Office of the Functional Champion weekly User Impact Series, which supports super users, provider champions, informaticists and end users in adopting updates to the EHR.

3. **Testing:** All critical and high category test findings from integration validation test events at Mann-Grandstaff VAMC were closed prior to go-live. The 28 integration validation test events held across all VISN 20 sites and Columbus, Ohio, resulted in 500 critical and high category test findings. 95% of test findings at sites other than Mann-Grandstaff were fixed or closed.

   In addition to integration validation for all IOC sites, EHRM IO's extensive testing program for the new EHR solution focused on new capabilities, system integration testing and data migration for the new and enhanced capabilities and system integrations. The testing and evaluation team successfully conducted 682 tests of functional workflows, system interfaces, data migration and integration validation in support of the Mann-Grandstaff Capability Set (CS) 2.0 release. Of the 360 test findings documented, all critical and high category test findings were closed before go-live to ensure that the new and enhanced capabilities were functional, and that additional migration of blood bank data was transitioned from legacy systems into the new EHR solution. The remaining test findings were closed before or during the go-live period.

4. **Capability Set 2.0 Implementation:** EHRM IO continued to address additional capability needs through design and build activities for the CS 2.0 implementation in collaboration with the Cerner deployment team and VA's EHR National Councils. Twenty-seven additional capabilities were deployed at Mann-Grandstaff VAMC as part of CS 2.0 on July 24, 2021, and Sept. 17, 2021. These capabilities added to the existing 216 capabilities included at go-live and provided enhancements and additional functionality to better support Mann-Grandstaff in the areas of ambulatory care, diagnostic testing, sleep and vascular laboratory and radiology functions, sepsis advisory management, oncology, referral management, telehealth, first party billing, reporting and contract management. EHRM IO also leveraged CS 2.0 to improve data sharing of immunizations and prescription drug monitoring. Connection to the Washington, Idaho and Montana state immunization information systems enabled providers to query the state databases and import relevant historical immunization data directly into patients' charts. The enhanced Prescription Drug Monitoring Program (PDMP) solution (required by the MISSION Act) enabled providers to access the national PDMP solution to query patients' prescribed controlled substance medications and prescription fulfillments and orders. This enhancement expanded the PDMP query beyond a single state to the PDMP's national solution of 46 participating states and 4 jurisdictions (Guam, Washington D.C., DoD Military Health System and Puerto Rico), improving real-time clinical management for Veterans.

5. **Infrastructure Readiness:** EHRM IO's Technology and Integration Office (TIO) infrastructure readiness teams upgraded aging infrastructure and increased network bandwidth at VA sites to improve network and system performance to meet the requirements of the new EHR solution. EHRM IO has deployed approximately 28,488 new workstations and laptops in VISN 10 and 12 facilities, upgraded 13,258 in VISN 20 facilities and deployed 26,000 end-user devices such as computers, voice over internet protocol phones and printers at VISN 10 and 12 facilities. Upgrades were also made to multi-VISN biomedical devices to improve clinical workflows and enhance patient experience. The improvements made to the telecommunications network and end user equipment reduced login times, improved scheduling application performance, training efforts, and call center support for Veterans.

   Additionally, EHRM IO implemented the Forward Deployed Solution Set (FDSS) and Joint Security Architecture (JSA) at all 10 sites in VISN 20 (Washington, Oregon, Idaho, Alaska) and 10 of 12 sites in VISN 10 (Ohio, Michigan, Indiana) and initiated JSA installations in VISNs 12 (Wisconsin, Illinois) and 23 (North Dakota, South Dakota, Nebraska, Minnesota, Iowa) in support of the EHR deployment at ambulatory care centers in those regions. FDSS provides managed components and services that are foundational for the EHR implementation, including hardware, software, support, storage requirements, remote operational management and monitoring. JSA provides greater cyber security for connectivity to the Joint Federal EHR Enclave and is required for interface testing and evaluation and medical device isolation. It allows secure communication across the VA enterprise to the same cyber posture as DoD and allows secure access for interface testing, evaluation, special medical device isolation and production use. Both FDSS and JSA will be deployed to each VAMC in advance of future EHR implementations.

   Finally, during 2021 EHRM IO continued to develop and improve overall requirements and plans for the new platform. Subject matter experts addressed topics such as LAN, wide area network, wireless LAN, end-user devices (e.g., computers, monitors, printers), JSA and technical requirements for training spaces. New standards were incorporated into OIT and VHA enterprise standards, which complemented the 12 CSRs conducted at VISN 10 sites and 7 CSRs initiated at VISN 12 sites. The CSRs provided the TIO infrastructure readiness teams with details regarding the condition of the existing network and equipment at upcoming deployment sites to determine upgrades required to support the new EHR solution.

6. **Training Efforts**: EHRM IO made over 1,600 content changes to improve and enhance training materials and courses since the conclusion of training at Mann-Grandstaff in October 2020. These improvements were driven by planned recurring maintenance, finalized solution builds and associated implementations and lessons learned from the deployment. Virtual instructor-led training courses were developed to mirror all instructor-led training options, enabling the entire training catalog to be delivered virtually and provide increased accessibility. Feedback was leveraged to create focused courses for outpatient-only facilities, separating cross-venue content and streamlining delivery for relevant material. Based on lessons learned, multiple courses were redesigned in collaboration with the EHR National Councils to incorporate additional workflows and adjust course length to better address learner needs.

   Super-user and end-user training was delivered across five sites at Mann-Grandstaff, WCPAC, North Central CPAC, VA Central Ohio Healthcare System and Jonathan M. Wainwright

Memorial VAMC (Walla Walla, Washington), as well as super-user training at Southern Oregon Rehabilitation Center & Clinics in White City, Oregon. Additionally, EHRM IO delivered training for several enhancement efforts, including the Mann-Grandstaff advancement initiative, CS 2.0 and block releases.

The Phase 1 Sandbox was launched in March 2021, which is a copy of the existing EHR training domain that provides end users additional hands-on practice with skills, workflows and scenarios in the EHR that they learn during training. One-thousand users at VA Central Ohio Healthcare System were given access to the sandbox to become more familiar with the EHR system.

7. **Joint Health Information Exchange (joint HIE) Expansion:** EHRM IO coordinated with DoD, U.S. Coast Guard and the FEHRM program office to expand the joint HIE network to include CommonWell Health Alliance on Oct. 9, 2020, with an auto-enrollment feature for patient matching, which increased bi-directional data sharing with community partners. The departments further enhanced the capabilities with a manual-enrollment feature on Aug. 18, 2021. With these combined features implemented, 10,767,254 patients have been successfully enrolled in CommonWell to increase interoperability of data with community partners. With this expansion, joint HIE's nationwide network added more than 24,000 hospitals and clinics to the 46,000 existing community partners, which include hospitals, pharmacies, clinics, labs, federally qualified health centers and nursing homes. The joint HIE also onboarded 22 additional health care partners to eHealth Exchange, bringing the total number of partners connected to 246. The joint HIE allows providers within the VA and DoD to quickly and securely access EHR data for patients who have been seen by a participating community partner, Tri-Care or other HIE-participating health care systems. These participating community providers also have a single point of entry to request and access both the VA and DoD EHRs for use in providing patient care to VA's Veterans, DoD's service members and other beneficiaries. Currently, the joint HIE connects VA to nearly 70% of the U.S. market share, either through eHealth Exchange, CommonWell or point-to-point connections.

8. **EHRM IO Workforce:** EHRM IO strengthened its organizational foundation by onboarding 54 permanent government staff, including internal transfers, growing the permanent workforce to a peak of 210 staff. Mission requirements were further supported by a 38% increase in non-permanent staff (detailed and temporary). Like many other organizations during the COVID-19 pandemic, EHRM also embraced a movement to greater workplace flexibility due to the increasingly nationwide scope of its mission and to attract top talent and address hard to fill positions while also managing costs. As part of these greater workplace flexibilities, ERHM IO expanded telework options for staff. EHRM IO closed 2021 with nearly 58% of its workforce (including non-permanent staff) remote, compared to 46% at the end of 2020.

9. **Budget Execution:** In 2021, EHRM IO obligated $1.961 billion to fund activities throughout each of its budget categories: EHR contract, infrastructure readiness and program management. For the EHR budget category, VA obligated $672.5 million to fund enterprise integration activities required to support the integration, installation, and design for the implementation of the new EHR solution across VA's enterprise. For the infrastructure readiness cost category, VA obligated $1.075 billion to fund end-user EHR devices, identity and access management, interfaces, interoperability, Medical Community of Interest (MedCOI) and VA LAN. For the

program management cost category, VA obligated $212.7 million to fund pay and benefits for government staff, program management contracts, travel, equipment, leases, and supplies. Of the remaining funds from 2021 we plan to execute by the third quarter. We have planned requirements for the remaining balances and should see the vast majority of those depleted.

10. **Support for VA EHRM IO Initiatives:** EHRM IO supported the 12-week strategic review of the EHRM program directed by VA Secretary Denis McDonough, which began in March 2021, providing enhanced reporting and analysis of the program's performance and progress and incorporating the recommendations in the resulting Comprehensive Lessons Learned (CLL) Report into the program. EHRM IO continues to support the closeout of actions from the CLL and implementation of its recommendations. Additionally, EHRM IO supported VA's effort to provide greater clarity on the program's life cycle costs through a more synchronized, enterprise-level approach that includes IT infrastructure requirements, VHA physical infrastructure modernization requirements and management of identified and emerging project needs.

## DoD/VA Electronic Health Record Collaboration

Modernizing the EHR has been and continues to be one of our highest national priorities, along with ensuring the health and safety of our Veterans. VA remains committed to this effort and is working diligently to ensure its success through direct engagement with the FEHRM program office, as authorized by the 2020 National Defense Authorization Act.

**FEHRM Resource Support:** EHRM IO's budget request includes $18.9 million to fund joint responsibilities between DoD and VA for support of the FEHRM joint activities

**FEHRM Support**
**($ thousands)**

| | 2021 Enacted | 2022 Request | 2022 Current Estimate | 2023 Request | 23 Request vs 22 Estimate | |
|---|---|---|---|---|---|---|
| | | | | | $ / Staff | % |
| **Program Element:** | | | | | | |
| Pay & Benefits | $495 | $1,298 | $1,033 | $1,147 | $114 | 11.0% |
| Contract Support | $14,100 | $16,500 | $17,726 | $17,726 | $0 | 0.0% |
| Equipment | $0 | $12 | $12 | $12 | $0 | 0.0% |
| Travel | $3 | $75 | $75 | $75 | $0 | 0.0% |
| **Total Obligations** | **$14,598** | **$17,885** | **$18,846** | **$18,960** | **$114** | **0.6%** |
| **Federal Staffing** | **2** | **6** | **6** | **7** | **1** | **16.7%** |
| **Contractor Support Staffing** | **65** | **55** | **65** | **65** | **0** | **0.0%** |

### Federal Electronic Health Record Modernization

DoD and VA share a common mission to support a lifetime of high-quality health care for service members, Veterans, and their families. In support of this mission, the FEHRM, chartered in December 2019, leads DoD, VA, and other partners in implementing a single, common EHR that enhances patient care and provider effectiveness, wherever care is provided.

With experts in analytics, clinical care, information technology and training, the FEHRM is driving federal solutions for more efficient, safer care and a better health care experience for all by working toward the following joint objectives with DoD and VA:

- Actively manage risks and the operation of the Kansas City Data Center, where all VA and DoD health data resides.
- Minimize risk to EHR solution deployment/implementation.
- Identify opportunities for efficiency, standardization and system and process optimization.
- Advance interoperability across the federal and private sectors.

### 2021 FEHRM Accomplishments

In 2021, the FEHRM delivered common capabilities in support of the DoD, VA, USCG and other partner missions to deploy a single, common federal EHR. These common capabilities included the oversight of configuration and content changes to the EHR and the management of the Federal Enclave and joint Health Information Exchange. Through the FEHRM's value added contributions

and mission focus, there are now over 57,000 DoD, VA and USCG users of the federal EHR in multiple facilities across 18 states.

Employing a strategy of convergence and operationalization, the FEHRM executed the Enterprise Operations Center during DoD Waves SAN DIEGO and CARSON; developed the Interoperability Modernization Strategy Supporting Plan; supported the USCG Pacific EHR deployment; implemented a new interface between the Joint Longitudinal Viewer and the Individual Longitudinal Exposure Record; and helped the DoD and VA build a path forward for joint sharing sites by completing discovery assessment engagements with 14 prioritized sites. Lastly, the FEHRM successfully hosted the first-ever congressionally mandated Federal EHR Annual Summit. This three-day event was attended by over 500 EHR users and provided valuable feedback the FEHRM will use to optimize the EHR and drive better health care outcomes.

## Total Obligations by Subaccount

**Electronic Health Record Modernization Integration Office**
**Obligation by Subactivity Highlight**
**($ thousands)**

| | 2021 Enacted | 2022 Request | 2022 Current Estimate | 2023 Request | 23 Request vs 22 Estimate | |
|---|---|---|---|---|---|---|
| | | | | | $ | % |
| **Grand Total** | **$1,960,700** | **$2,663,000** | **$2,663,000** | **$1,759,000** | **-$904,000** | -33.9% |
| | | | | | | |
| **EHR** | **$672,526** | **$1,425,498** | **$1,425,498** | **$1,119,145** | **-$306,353** | -21.5% |
| Site Transitions | $164,856 | $852,000 | $852,000 | $598,385 | -$253,615 | -29.8% |
| EHR Operations | $184,493 | $286,020 | $286,020 | $235,000 | -$51,020 | -17.8% |
| Enterprise Integration | $118,384 | $192,478 | $192,478 | $209,000 | $16,522 | 8.6% |
| VA Current Site Assessments | $82,358 | $60,000 | $60,000 | $36,960 | -$23,040 | -38.4% |
| Vendor Site Implementation Support | $122,435 | $35,000 | $35,000 | $39,800 | $4,800 | 13.7% |
| | | | | | | |
| **Infrastructure** | **$1,075,453** | **$951,797** | **$951,797** | **$440,739** | **-$511,058** | -53.7% |
| **Site Specific:** | **$133,672** | **$16,000** | **$62,906** | **$57,969** | **-$4,937** | -7.8% |
| End User Devices | $133,672 | $16,000 | $62,909 | $57,969 | -$4,940 | -7.9% |
| **Enterprise:** | **$232,175** | **$219,732** | **$294,417** | **$192,797** | **-$101,620** | -34.5% |
| Data Migration & Syndication | $34,403 | $18,988 | $34,071 | $24,283 | -$9,788 | -28.7% |
| Identity & Access Management | $25,198 | $43,472 | $44,061 | $39,124 | -$4,937 | -11.2% |
| Security | $36,705 | $77,146 | $67,031 | $47,277 | -$19,754 | -29.5% |
| Testing Activities | $60,508 | $57,807 | $70,476 | $52,026 | -$18,450 | -26.2% |
| Interoperability | $75,361 | $22,319 | $78,778 | $30,087 | -$48,691 | -61.8% |
| **Hybrid:** | **$709,606** | **$716,065** | **$594,474** | **$189,973** | **-$404,501** | -68.0% |
| VA LAN | $150,639 | $130,375 | $45,435 | $15,980 | -$29,455 | -64.8% |
| Joint Security Architecture & WAN | $102,377 | $99,631 | $79,219 | $46,197 | -$33,022 | -41.7% |
| Legacy System Mods & Interfaces | $319,234 | $193,603 | $250,431 | $124,796 | -$125,635 | -50.2% |
| Medical Devices | $137,356 | $292,455 | $219,389 | $3,000 | -$216,389 | -98.6% |
| | | | | | | |
| **PMO** | **$212,721** | **$285,705** | **$285,705** | **$199,116** | **-$86,589** | -30.3% |
| PMO Support Contracts | $170,440 | $186,017 | $208,811 | $142,069 | -$66,742 | -32.0% |
| Pay & Benefits (including reimbursements) | $37,476 | $83,471 | $66,094 | $48,750 | -$17,344 | -26.2% |
| Travel | $598 | $5,342 | $1,898 | $1,461 | -$437 | -23.0% |
| Equipment, Supplies, Leases & Other | $4,207 | $10,875 | $8,902 | $6,836 | -$2,066 | -23.2% |
| | | | | | | |
| **Carryover 2021:** | | | **$720,465** | | | |
| EHR | | | $551,491 | | | |
| Infrastructure | | | $124,163 | | | |
| PMO | | | $44,811 | | | |

## Electronic Health Record - Request $1.119 billion (-$ 306.4 million, -21.5%)

| | 2021 Enacted | 2022 Request | 2022 Current Estimate | 2023 Request | 23 Request vs 22 Estimate | |
|---|---|---|---|---|---|---|
| | | | | | $ | % |
| | ($ thousands) | | | | | |
| **EHR** | **$672,526** | **$1,425,498** | **$1,425,498** | **$1,119,145** | **-$306,353** | -21.5% |
| Site Transitions | $164,856 | $852,000 | $852,000 | $598,385 | -$253,615 | -29.8% |
| EHR Operations | $184,493 | $286,020 | $286,020 | $235,000 | -$51,020 | -17.8% |
| Enterprise Integration | $118,384 | $192,478 | $192,478 | $209,000 | $16,522 | 8.6% |
| VA Current Site Assessments | $82,358 | $60,000 | $60,000 | $36,960 | -$23,040 | -38.4% |
| Vendor Site Implementation Support | $122,435 | $35,000 | $35,000 | $39,800 | $4,800 | 13.7% |

The 2023 request includes $1.119 billion for the new EHR solution and all activities required to plan for and deploy the solution, which is a $306.4 million (21.5%) decrease relative to the 2022 President's Budget request. This 2023 decrease is expected and aligned with the original 10-year Life Cycle Cost Estimate (LCCE) which planned for 2022 being a surge year, followed by a decrease in 2023 and slight increases over the next 4 budget years. VA has contracted for an independent LCCE which is expected to be completed by the end of the fiscal year. EHR's operational cost for 2023 is lower than the operational cost for 2022, given that there are fewer deployments planned to be funded in 2023. The change from the 2022 request also addresses the number of VAMCs operating the new EHR solution in 2023 relative to 2022. This request aligns with VA's revised deployment plan, which provides flexibility and preserves deployment momentum, while supporting alignment with DoD's priorities. There are fewer and more focused deployments in 2023 due to the combined impacts of COVID-19 and the strategic pause.. Funding will support the concurrent deployment of VAMCs and their associated clinics, Veteran centers, mobile units, and ancillary facilities in VISNs.

**Site Transitions - Request $598.4 million** ***(-$253.6 million, -29.8%)***

Site transitions consist of all site-specific deployment-related activities required to fully transition each VAMC and associated sites to the new EHR solution, more specifically including:

- Change management
- Training
- Localized workflow design
- Local communications
- Local implementations
- Final testing
- User testing
- Site go-live activities
- Post go-live support

This list is the full range of site-specific activities that are required to implement the new EHR solution at the local facilities, which includes training and transitioning of staff at those sites.

The 2023 request will fund deployment activities at 16 sites verses the 25 sites that were funded with the 2022 President's Budget request, which accounts for the decreased funding request of $253.6 million.

**EHR Operations – Request $235.0 million *(-$51.0 million, -17.8%)***
EHR operations are sustainment activities required to operate and maintain the new EHR solution as VA approaches site transitions. Activities include data hosting, help desk, software license maintenance, end user operations, forward deployed solution set (FDSS) and ongoing national and local level sustainment support to ensure proper maintenance and performance of the new solution.

The 2023 request will fund EHR Operations and sustainment activities at 15 sites verse the 24 sites that were funded with the 2022 President's Budget request, which accounts for the decreased funding request of $51.0 million.

**Enterprise Integration - Request $209.0 million *(+$16.5 million, +8.6%)***
Enterprise integration activities are enterprise-level activities required to support the integration, installation, and design for the implementation of the new EHR solution software across the enterprise. Enterprise integration tasks include data migration, design and implementation of enterprise level technical capabilities, national workflow design, national change management and training and enterprise communications. These are cross-cutting activities that must be conducted at an enterprise level to ensure VA systems, organizations and staff are ready for site-level transitions to occur.

The 2023 request will fund Enterprise Integration activities plus additional software development needed to address major functionality and capability gaps, which accounts for the $16.5 million funding request increase over the 2022 President's Budget request.

**VA Current Site Assessments - Request $37.0 million *(-$23.0 million, -38.4%)***
Site assessments are pre-site transition activities that occur at each VAMC and associated facilities prior to a site's EHR transition. The purpose of these activities is two-fold: 1) a functional assessment allows VA to properly assess the current state of the site, to understand the services delivered at that site, and to properly estimate the level of effort required for site transition; and 2) a technical assessment that informs VA's site infrastructure modernization plans by providing VA with a gap analysis of current site infrastructure and upgrades required to support the new system. These upgrades must then be separately procured under non-Cerner contracts; some of which may have long lead times for actual delivery and installation, to support the capacity, security, and/or interoperability of the new EHR solution with site end-user devices. In 2022, VA aims to conduct approximately twenty-two site assessments. The 2023 budget request will fund Current Site Review activities at 12 sites verses the 28 sites that were funded in the 2022 President's Budget request which accounts for the $23.0 million decrease in funding.

**Vendor Site Implementation Support - Request $39.8 million *(+$4.8 million, +13.7%)***

Cerner will support VA with project management functions to accomplish coordination of information technology to include execution of individual task orders. This support includes cross site coordination, reporting, quality assurance, quality management, project planning, and risk management.

**Infrastructure Readiness - Request $440.7 million (-$511.1 million, -53.7%)**

| | 2021 Enacted | 2022 Request | 2022 Current Estimate | 2023 Request | 23 Request vs 22 Estimate | |
|---|---|---|---|---|---|---|
| | | | | | $ | % |
| ($ thousands) | | | | | | |
| **Infrastructure** | **$1,075,453** | **$951,797** | **$951,797** | **$440,739** | **-$511,058** | -53.7% |
| **Site Specific:** | **$133,672** | **$16,000** | **$62,906** | **$57,969** | **-$4,937** | -7.8% |
| End User Devices | $133,672 | $16,000 | $62,906 | $57,969 | -$4,937 | -7.8% |
| **Enterprise:** | **$232,175** | **$219,732** | **$294,417** | **$192,797** | **-$101,620** | -34.5% |
| Data Migration & Syndication | $34,403 | $18,988 | $34,071 | $24,283 | -$9,788 | -28.7% |
| Identity & Access Management | $25,198 | $43,472 | $44,061 | $39,124 | -$4,937 | -11.2% |
| Security | $36,705 | $77,146 | $67,031 | $47,277 | -$19,754 | -29.5% |
| Testing Activities | $60,508 | $57,807 | $70,476 | $52,026 | -$18,450 | -26.2% |
| Interoperability | $75,361 | $22,319 | $78,778 | $30,087 | -$48,691 | -61.8% |
| **Hybrid:** | **$709,606** | **$716,065** | **$594,474** | **$189,973** | **-$404,501** | -68.0% |
| VA LAN | $150,639 | $130,375 | $45,435 | $15,980 | -$29,455 | -64.8% |
| Joint Security Architecture & WAN | $102,377 | $99,631 | $79,219 | $46,197 | -$33,022 | -41.7% |
| Legacy System Mods & Interfaces | $319,234 | $193,603 | $250,431 | $124,796 | -$125,635 | -50.2% |
| Medical Devices | $137,356 | $292,455 | $219,389 | $3,000 | -$216,389 | -98.6% |

The 2023 request includes $440.7 million for infrastructure readiness, which is a $511.1 million (53.7%) decrease relative to the 2022 President's Budget request level. This decrease is driven by the reduction in the number of hospitals requiring technology infrastructure upgrades compared to the number requiring it in 2022.

In 2023, the EHRM IO program strategy focuses on reducing the number of specialized interfaces by having more standardized workflows which creates efficiencies in the technology infrastructure deployment. Standardized workflows mean there is a reduced scope of infrastructure readiness activities relative to 2022 and is reflected in activities such as legacy system modifications and interfaces and medical devices.

With a focus on standardized workflows, EHRM IO will continue to place emphasis on CSRs to ensure sites are properly scoped and prepared for infrastructure readiness activities. This is especially important because information technology equipment must be ordered at least 32 months ahead of planned go-lives. In 2023, EHRM IO will conduct CSRs for multiple facilities. Through these site assessments, VA will determine the specific infrastructure gaps that will require mitigation. Analysis of CSRs performed to date provides a gauge of probable infrastructure upgrades VA will address at all sites across the enterprise, including upgrades to specific types of end user devices, monitors, printers, scanners, and card readers. These CSRs will provide VA with a better understanding of requirements in terms of infrastructure readiness and continue to build on a standardized workflow strategy that will continue to create operational efficiencies.

**Site Specific Costs – Request $57.9 million *(-$4.9 million, -7.8%)***

| | 2021 Enacted | 2022 Request | 2022 Current Estimate | 2023 Request | 23 Request vs 22 Estimate | |
|---|---|---|---|---|---|---|
| | | | | | $ | % |
| | | | ($ thousands) | | | |
| **Site Specific:** | **$133,672** | **$16,000** | **$62,906** | **$57,969** | **-$4,937** | -7.8% |
| End User Devices | $133,672 | $16,000 | $62,906 | $57,969 | -$4,937 | -7.8% |

This funding covers end user device information technology infrastructure costs at VA medical facilities to support implementation of the new EHR solution not currently covered by OIT or VHA funding. This includes costs directly related to facility IT infrastructure readiness, such as workstations, monitors, printers, scanners display boards and wall mounted items supporting End User Devices (EUD) equipment. EHRM IO works with VHA to coordinate their facilities' infrastructure costs to support EHRM IO and with OIT to coordinate IT costs aligned with their Infrastructure Refresh Plan (IRP).

**End User Devices – Request $57.9 million *(-$4.9 million, -7.8%)***

The funding for EUDs covers the Cerner-specific requirements for EUDs at each site and setup, maintenance and breakdown of training spaces and command centers in support of go-live activities. Training spaces are designed to provide clinicians hands-on training on the new EHR solution in an environment that resembles the VA clinical environment. Local site command centers are utilized to support go-live technical and programmatic activities. As OIT continues to make infrastructure upgrades, EHRM IO's infrastructure requirements have been reduced by approximately 50%. The CSR reports recommend expanding the number and types of EUD equipment at each site compared to current previous levels. EUD procurements are performed approximately 18 months before go-live to allow time for procurement, delivery, installation, and testing.

**Enterprise Costs – Request $192.8 million *(-$101.6 million, -34.5%)***

| | 2021 Enacted | 2022 Request | 2022 Current Estimate | 2023 Request | 23 Request vs 22 Estimate | |
|---|---|---|---|---|---|---|
| | | | | | $ | % |
| | | | ($ thousands) | | | |
| **Enterprise:** | **$232,175** | **$219,732** | **$294,417** | **$192,797** | **-$101,620** | -34.5% |
| Data Migration & Syndication | $34,403 | $18,988 | $34,071 | $24,283 | -$9,788 | -28.7% |
| Identity & Access Management | $25,198 | $43,472 | $44,061 | $39,124 | -$4,937 | -11.2% |
| Security | $36,705 | $77,146 | $67,031 | $47,277 | -$19,754 | -29.5% |
| Testing Activities | $60,508 | $57,807 | $70,476 | $52,026 | -$18,450 | -26.2% |
| Interoperability | $75,361 | $22,319 | $78,778 | $30,087 | -$48,691 | -61.8% |

This funding covers technology infrastructure costs that support implementation at the national level, including data migration and syndication, identity and access management, cybersecurity, testing and interoperability with the community and DoD. Enterprise costs are ongoing costs that broadly support EHRM IO and are not directly tied to site infrastructure.

**Data Migration & Syndication – Request $24.3 million *(-$9.8 million, -28.7%)***

This funding covers the overall data management required to ensure VA's VistA and the new EHR solution properly account for all existing Veteran's data. These efforts include the support to the VX-130 system, which provides a systematic method to replicate and transfer existing VistA data to the new system through a secure and effective method. This effort is critical as it ensures the new system will have all the relevant data on patients from the legacy system. Likewise, new data entered in the new system will need to be brought back into the VA legacy systems through a data syndication strategy. This will enable sites using the legacy systems and sites using the new EHR to share and update the same information on patients.

**Identity and Access Management – Request $39.1 million *(-$4.9 million, -11.2%)***
The funding for Identity and Access Management (IAM) includes the cost for Joint Patient Identity Management Services (JPIMS) provided by VA, DoD's Defense Manpower Data Center (DMDC) and Cerner. JPIMS is required to manage the patient population for both agencies in a single system, enabling VA's EHR solution to operate in a manner that minimizes patient safety risks. JPIMS will be used to manage patient identities for search and selection within the EHR. It is a critical component of the architecture and is needed to ensure that patients between VA and DoD are accurately correlated and true interoperability is achieved. To enable IAM, existing systems and services within VA and federally shared services must be upgraded, connected, and configured to support the new electronic health record. VA will work in close coordination with all stakeholders to ensure that service requirements for the new EHR solution are accurately communicated and in line with VA standards. This support also includes any additional credentials (e.g., personal identification verification [PIV] cards) and federation services, which are needed to access the electronic health record.

**Security – Request $47.3 million *(-$19.8 million, -29.5%)***
Cybersecurity is vital to keep Veteran's health care information safe and to assure that the new EHR operates to its fullest potential without interruption. The funding to support cybersecurity provides for additional security controls, authority to operate (ATO), joint security monitoring, medical device ATOs and security modifications and ATO updates, required to the Cerner hosting environments to account for additional VA capabilities. VA needs to collaborate closely with DoD on system monitoring as well as developing policies and processes to manage security controls across the EHR. Security expenses include the support to configuration management as well as coordination with VA's Office of Information Security. Security activities support evaluating, updating, and coordinating with DoD on VA's current security documentation to ensure all VA and DoD security requirements are met.

**Testing Activities – Request $52.0 million *(-$18.5 million, -26.2%)***
Provides for the design and fielding of pre-production test facilities, interconnecting with VA legacy systems (to include Joint Longitudinal Viewer), Cerner's data center and DoD's DMDC to validate systems are working properly prior to a respective go-live. Critical to a deployment is a robust testing methodology and plan. These activities include support for VA infrastructure and systems testing needed to ensure that EHR deployments do not disrupt patient safety or existing operations and have properly met VA standards. Testing services provides engineering expertise to conduct planning and assessments, as well as support for interagency coordination needed to test complex inter-agency workflows leveraging multiple systems in addition to the new EHR. Testing also includes coordination around both functional and technical testing.

**Interoperability – Request $30.1 million *(-$48.7 million, -61.8%)***
The new EHR solution is being implemented in phases to integrate health records between VA and DoD that can be shared externally. The departments work together to implement a seamless, interoperable platform that shares the same source of data. In an effort to ensure joint systems satisfy existing and emergent interoperability mandates and guidance, additional funding is required to enhance VA legacy products as well as joint (VA/DoD) shared solutions. These investments will ensure we can perform the upgrades necessary, including engineering, development, application interfaces and system upgrades required to ensure interoperable health data, images and processes are maintained.

**Hybrid Costs – Request $190.0 million *(-$404.5 million, -68.0%)***

| | 2021 Enacted | 2022 Request | 2022 Current Estimate | 2023 Request | 23 Request vs 22 Estimate | |
|---|---|---|---|---|---|---|
| | | | | | $ | % |
| | | | ($ thousands) | | | |
| **Hybrid:** | **$709,606** | **$716,065** | **$594,474** | **$189,973** | **-$404,501** | -68.0% |
| VA LAN | $150,639 | $130,375 | $45,435 | $15,980 | -$29,455 | -64.8% |
| Joint Security Architecture & WAN | $102,377 | $99,631 | $79,219 | $46,197 | -$33,022 | -41.7% |
| Legacy System Mods & Interfaces | $319,234 | $193,603 | $250,431 | $124,796 | -$125,635 | -50.2% |
| Medical Devices | $137,356 | $292,455 | $219,389 | $3,000 | -$216,389 | -98.6% |

Hybrid costs cover technology infrastructure that apply to both the physical medical facility and the enterprise national program level. For example, VA Network (LAN) consists of site-specific costs to upgrade core switch equipment as well as costs to provide engineering and deployment support for that equipment across the enterprise.

**VA Local Area Network (LAN) – Request $16.0 million *(-$29.5 million, -64.8%)***
The funding for the LAN modernization includes replacing aging network cables, fiber optic cables and LAN switches for wired and wireless networks, WIFI and Voice Over Internet Phones (VOIP) at all VAMCs, CBOCs, and Veteran Centers prior to go-live. VA coordinates with all stakeholders to develop a plan of action for managing responsibilities related to the modernization**.** Updates require engineering services to assess current infrastructure in place and provide optimizations of the current LAN to support the new EHR. This includes reviewing configurations and assessing the hardware currently deployed and supported by VA. The upgrade includes the addition of switches, routers, cables and adaptors as well as support needed to implement those items. The upgrades are focused on optimizations of information technology support to the EHR within a facility and as such are coordinated with capital improvements to the infrastructure. This includes configurations, upgrades and assessments to improve the wireless networking needed to support the additional traffic within a facility. LAN infrastructure improvements will also consider support to the data and information needs of biomedical devices.

**Joint Security Architecture and WAN – Request $46.2 million *(-$33.0 million, -41.7%)***
The funding for Joint Security Architecture and wide area network (WAN) provides for additional security controls, ATO, Joint Security monitoring, medical device ATOs and security modifications, and ATO updates required for the Cerner hosting environments to account for additional VA capabilities. VA needs to collaborate closely with DoD on system monitoring as

well as developing policies and processes to manage security controls across the EHR. Security expenses include the support to configuration management as well as coordination with VA's Office of Information Security. Security activities support evaluating, updating and coordinating with DoD on VA's current security documentation to ensure all VA and DoD security requirements are met.

The WAN MedCOI is an enterprise Multi-Protocol Label Switched Layer 3 Virtual Private Network (VPN) that provides a secure logical medical enclave. It serves as a key enabler for full personal health care information interoperability between DoD and VA. The MedCOI implementation provides the security context that allows for seamless electronic exchanges and health care record portability in a secure format to certify the highest quality and effective delivery of health care services for service members, Veterans and eligible family members. The funding for VA's MedCOI network and security boundary provides for telecommunications circuits, routers, security isolation equipment, security certificates and support for interface testing/on-boarding to Cerner and with DoD to obtain an authority to connect (ATC). To implement MedCOI, procurements of circuits, switches, and security hardware as well as engineering services to implement these items are needed. WAN improvements ensure efficient communications between sites and allow for VA to proactively manage the increase in the network traffic expected from the EHR deployment.

**Legacy System Modifications and Interfaces – Request $124.8 million *(-$125.6 million, -50.2%)***
This area covers the associated effort of developing interfaces to legacy systems that will no longer be connected to VistA but need to connect to other systems in the VA enterprise. Currently numerous systems are used to support the VA health care delivery process. These range from enterprise systems that provide common functions used by many users, facilities, and processes, regional or special purpose systems that integrate and support across a subset of VA facilities, and local systems and devices that are unique to installations. Many of these systems are custom, government-built systems, which often do not utilize national industry standards for data or interfaces. EHRM IO's strategy is to focus on interfaces that improve information and capabilities to the clinician and patients at the point of care. VA uses a set of complex systems to deliver a variety of benefits. Even though the native systems may not be substantially modified, existing VistA interfaces need to be changed to support the new electronic health record and ensure that business processes, such as benefits determination, do not have a break in functionality due to data loss. Interfaces must be designed, developed, tested, and secured in line with VA and DoD systems development methodologies.

**Medical Devices – Request $3.0 million *(-$216.4 million, -98.6%)***
Implementing the new EHR solution requires updates to existing healthcare technology such as medical devices such as infusion pumps, vital sign monitors, and other bedside patient monitors. These devices handle electronic patient data that will be automatically recorded into the new EHR solution. EHRM IO works with Cerner and other vendors to update the interfaces for these devices to ensure proper data transfer; older medical devices may need to be replaced with equipment that is compatible. Funding for medical devices will be used for medical device integration, clinical application interfaces and clinical imaging integration.

**Program Management - Request $199.1 million (-$86.6 million, -30.3%)**

| | 2021 Enacted | 2022 Request | 2022 Current Estimate | 2023 Request | 23 Request vs 22 Estimate | |
|---|---|---|---|---|---|---|
| | | | | | $ | % |
| ($ thousands) | | | | | | |
| **PMO** | **$212,721** | **$285,705** | **$285,705** | **$199,116** | **-$86,589** | -30.3% |
| PMO Support Contracts | $170,440 | $186,017 | $208,811 | $142,069 | -$66,742 | -32.0% |
| Pay & Benefits (including reimbursements) | $37,476 | $83,471 | $66,094 | $48,750 | -$17,344 | -26.2% |
| Travel | $598 | $5,342 | $1,898 | $1,461 | -$437 | -23.0% |
| Equipment, Supplies, Leases & Other | $4,207 | $10,875 | $8,902 | $6,836 | -$2,066 | -23.2% |

PMO is charged with providing oversight of VA's EHRM IO contract with Cerner, management of associated project risks and ensuring adherence to cost, schedule and performance objectives. The 2023 PMO request includes $199.1 million, which is an $86.6 million (30.3%) decrease relative to the 2022 President's requested level. The significant reduction in funding is a result of right-sizing the program. For PMO, we project federal staffing to increase from the current level of 174 staff, due to a strategic pause in recruitment, to 227, an increase of 53 staff (30%) to facilitate the deployment of the EHR solution to more facilities in 2023. In response to the COVID-19 pandemic, EHRM IO reduced the amount of travel that was originally anticipated. We project an increase in the pace of deployments from 7 go-lives in 2022 to 19 go-lives in 2023. With the deployments, we project an increase in the amount of travel to $1.5 million. As federal staff levels increase, the contract support staff will decrease to a more focused level. PMO will continue to lease space for its workforce and pay administrative support costs.

Refocusing the PMO function will improve the delivery of the EHR system to the more than 172 hospitals and 1,300 medical clinics across VA's enterprise. Having the appropriate number of personnel in place to ensure successful implementation is critical.

**PMO Support Contracts - Request $142.1 million *(-$66.7 million, -32.0%)***
Includes the cost for contractor support staff working on EHRM IO, including travel and other direct costs. This supports VA in its effort to provide oversight of all EHRM IO-related activities, to monitor Cerner's performance and to manage associated project risks while ensuring that VA infrastructure is ready for the EHR solution's deployment. Contractor staff will work with government personnel to provide expert oversight in a myriad of professional disciplines that include program management, clinical and technical engineering and architecture, security, testing, acquisition, contracting, data migration, communication, Independent Verification & Validation (IV&V), training, change management and governance. Additionally, this will also fund intra-agency financial services support and human resources management support.

**Pay and Benefits - Request $48.8 million *(-$17.3 million, -26.2%)***
Provides funding for pay and benefits of general services (GS) employees both direct and reimbursed to include Title 38 from VHA supporting EHRM IO. This funding level will support 227 direct staff and 37 detailed reimbursable federal support staff. Of the direct staff, a total of 7 are supporting the joint VA/DoD FEHRM project management effort. Additional information is in the EHRM staffing section.

**Travel, Equipment, Supplies, Leases and Other - Request $8.3 million *(-$2.5 million, -23.2%)***

Provides funding for travel, equipment, supplies, leases, and other required resources for government staff, in support of EHRM IO's operations. We will right-size administrative services, leasing cost, prioritize travel activities as we realign the staffing.

## Staffing and Organization Structure

EHRM Integration Office staffing and structure is organized into various workstreams under the Office of the Program Executive Director (PED), Office of the Functional Champion, Office of DCIO and the Program Management Office, as outlined below:

**Electronic Health Record Modernization Integration Office**
**Staffing Highlights**
**($ thousands)**

| | 2021 Actual | 2022 Request | 2022 Current Estimate | 2023 Request | 23 Request vs. 22 Estimate | |
|---|---|---|---|---|---|---|
| | | | | | FTE | % |
| **New Organizational Structure (EHRM IO):** | | | | | | |
| Program Executive Director (PED) | | | 4 | 4 | 0 | 0.0% |
| Office of the Functional Champion | | | 51 | 51 | 0 | 0.0% |
| Office of the Deputy Chief Information | | | 103 | 103 | 0 | 0.0% |
| Program Management Office | | | 69 | 69 | 0 | 0.0% |
| **Subtotal, New Org. Direct Staffing** | | | **227** | **227** | **0** | 0.0% |
| **Prior Organizational Structure (OEHRM):** | | | | | | |
| Office of the Executive Director | 3 | 4 | | | | |
| Chief of Staff and Administrative Support | 26 | 46 | | | | |
| Chief Medical Office | 30 | 80 | | | | |
| Program Management Office | 36 | 47 | | | | |
| Technology Integration Office | 81 | 160 | | | | |
| **Subtotal, Prior Prg. Direct Staffing** | **176** | **337** | | | | |
| **Federal Reimbursable Staff:** | | | | | | |
| Veterans Health Administration - Core Title 38 | 27 | 54 | 37 | 37 | 0 | 0.0% |
| Veterans Health Administration - Field Staff | 67 | 148 | 78 | 0 | -78 | -100.0% |
| **Total, Reimbursable Staff** | **94** | **202** | **115** | **37** | **-78** | -67.8% |
| **Total, Staff** | **270** | **539** | **342** | **264** | **-78** | -22.8% |
| **Full Time Equivalent (FTE):** | | | | | - | |
| Direct FTE | 175 | 337 | 222 | 227 | 5 | 2.3% |
| **Total, FTE** | **175** | **337** | **222** | **227** | **5** | 2.3% |

### Office of the Program Executive Director (4 FTE)

The Office of the Program Executive Director (PED) is responsible for cross organizational and cross functional coordination of communication and implementation strategies, to include functional, technical and program management. The PED has operational control over the OFC, the Office of the DCIO, and the PMO. In addition, the PED chairs the new EHR Integration Council, which ensures fully coordinated and timely decisions by receiving input from stakeholders across the VA.

### Office of the Functional Champion (51 FTE)

The new OFC consolidates functions from the former OEHRM Chief Medical Officer and the functions of the VHA Functional Champion. The OFC ensures appropriate clinical involvement

by having a principal role in processing and resolving patient safety concerns. The OFC bridges any divides between IT, the EHR vendor, and the care delivery teams to ensure that the needs of practicing clinicians and support staff are met.

**Office of the Deputy Chief Information Officer (103 FTE)**
The new DCIO will assume all information and technology integration functions for the program. The DCIO for EHRM IO is a newly created office that reports to the PED, but will also seek guidance and expertise from the Under Secretary for Health for issues related to adherence to OIT and VHA policies. The DCIO will ensures close bidirectional communication with technical staff at the local sites.

**Program Management Office (69)**
The PMO, led by an Executive Director, will be responsible for program management activities, including integrated scheduling, cost estimates, contract management, and risk management. The PMO seeks concurrence and expertise on matters related to program management and contract management through the Office of Acquisition, Logistics, and Construction. The PMO also seeks guidance with the Office of Management on budget formulation and execution, cost estimates, and audits.

# Appendix

## Appendix A: Obligations by Object Class

| Electronic Health Record Modernization Integration Office<br>Obligations by Object Class<br>($ thousands) | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 Actual | 2022 Request | 2022 Current Estimate 1/ | 2023 Request | 23 Request vs. 22 Estimate | |
| | | | | | $ | % |
| Personal Services | $30,535 | $56,217 | $38,635 | $39,369 | $734 | 1.9% |
| Travel | $598 | $5,342 | $1,898 | $1,461 | ($437) | -23.0% |
| Transportation of Things | $278 | $0 | $283 | $132 | ($151) | -53.3% |
| Rent, Communications and Utilities | $51,275 | $29,011 | $67,375 | $33,570 | ($33,805) | -50.2% |
| Printing and Reproduction | $19 | $25 | $25 | $25 | $0 | 0.0% |
| Other Services | $1,625,618 | $2,257,987 | $3,017,750 | $1,578,305 | ($1,439,445) | -47.7% |
| Supplies and Materials | $188 | $325 | $180 | $180 | $0 | 0.0% |
| Equipment | $252,189 | $314,093 | $257,318 | $105,957 | ($151,361) | -58.8% |
| Lands and Structures | $0 | $0 | $0 | $0 | $0 | |
| **Total Obligations** | **$1,960,700** | **$2,663,000** | **$3,383,465** | **$1,759,000** | **($1,624,465)** | -48.0% |

1/ The 2022 Current Estimate column includes carryover from prior years.

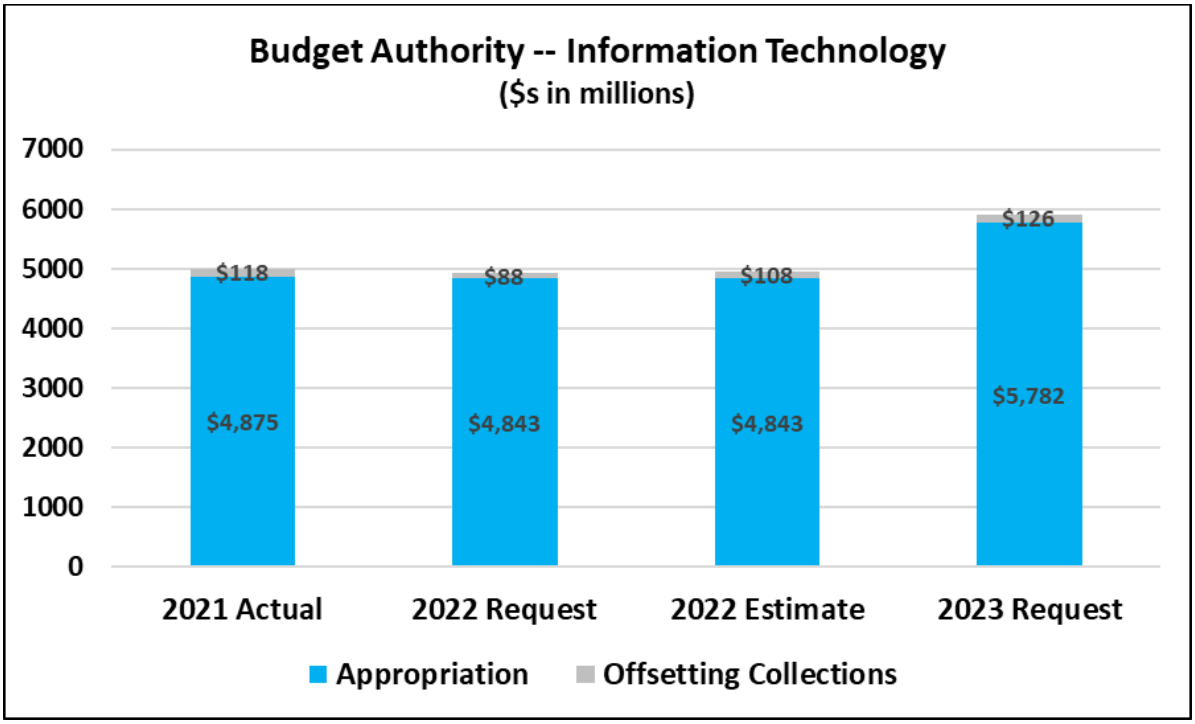
## Appendix B: End of Year Staffing Level by Grade

| EHRM IO Employment Summary By Grade | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 Actual | 2022 Request | 2022 Current Estimate | 2023 Request | 23 Request vs 22 | |
| | | | | | Staff | % |
| **Direct Staff:** | | | | | | |
| SES | 4 | 5 | 5 | 5 | 0 | 0.0% |
| ST | 0 | 1 | 1 | 1 | 0 | 0.0% |
| GS-15 | 22 | 45 | 30 | 30 | 0 | 0.0% |
| GS-14 | 71 | 123 | 93 | 93 | 0 | 0.0% |
| GS-13 | 66 | 127 | 83 | 83 | 0 | 0.0% |
| GS-12 | 6 | 18 | 12 | 12 | 0 | 0.0% |
| GS-11 | 4 | 14 | 3 | 3 | 0 | 0.0% |
| GS-9 | 3 | 4 | 0 | 0 | 0 | |
| **Total, Direct Staff** | **176** | **337** | **227** | **227** | **0** | **0.0%** |
| **Reimbursable VHA Staff:** | | | | | | |
| SES & SES EQV | 3 | 4 | 4 | 4 | 0 | 0.0% |
| VM-15 | 5 | 41 | 7 | 7 | 0 | 0.0% |
| VN-V | 3 | 15 | 5 | 5 | 0 | 0.0% |
| VN-IV | 9 | 45 | 11 | 11 | 0 | 0.0% |
| VN-III | 0 | 35 | 3 | 3 | 0 | 0.0% |
| GS-15 | 2 | 6 | 2 | 2 | 0 | 0.0% |
| GS-14 | 5 | 22 | 5 | 5 | 0 | 0.0% |
| GS-13 | 0 | 18 | 0 | 0 | 0 | |
| GS-12 | 0 | 16 | 0 | 0 | 0 | |
| VAMC Field Staff | 67 | 0 | 78 | 0 | -78 | -100.0% |
| **Subtotal, VHA Staff** | **94** | **202** | **115** | **37** | **-78** | **-67.8%** |
| **Total, Staffing** | **270** | **539** | **342** | **264** | **-78** | **-22.8%** |

The above chart reflects count of staff versus FTE levels

# *Information Technology*

## Budget Authority and Appropriation Language




Note: 2021 Actuals reflects a rescission of $37.5 million from unobligated balances required by P.L. 116-260, Consolidated Appropriations Act, 2021, Division J, Title II, section 254

### Appropriation Language

*For necessary expenses for information technology systems and telecommunications support, including developmental information systems and operational information systems; for pay and associated costs; and for the capital asset acquisition of information technology systems, including management and related contractual costs of said acquisitions, including contractual costs associated with operations authorized by section 3109 of title 5, United States Code, $5,782,000,000, plus reimbursements: Provided, That $1,494,230,000 shall be for pay and associated costs, of which not to exceed 3 percent shall remain available until September 30, 2024: Provided further, That $4,145,678,000 shall be for operations and maintenance, of which not to exceed 5 percent shall remain available until September 30, 2024: Provided further, That $142,092,000 shall be for information technology systems development, and shall remain available until September 30, 2024: Provided further, That amounts made available for salaries and expenses, operations and maintenance, and information technology systems development may*

*be transferred among the three subaccounts after the Secretary of Veterans Affairs submits notice thereof to the Committees on Appropriations of both Houses of Congress: Provided further, That amounts made available for the "Information Technology Systems" account for development may be transferred among projects or to newly defined projects: Provided further, That no project may be increased or decreased by more than $3,000,000 of cost prior to submitting notice thereof to the Committees on Appropriations of both Houses of Congress.*

**Explanation of Language Change**

The Department of Veterans Affairs (VA) is proposing that the threshold at which a notice is required to be made to both Houses of Congress prior to the transfer of funds between projects, be raised to $3 million. In order to apply more agile or incremental development practices to help modernize Information Technology at VA, VA's Office of Information and Technology (OIT) requires the ability to reallocate funds between development project lines. Obligation savings sometimes occur as acquisition strategies are refined and tasks are often consolidated in ways not originally anticipated as initial budget estimates are prepared. Advancing the threshold from $1 million to $3 million will improve and rejuvenate the IT budget management process as OIT responds to maturing individual facets of VA mission needs. The $1 million threshold represents 0.7% of the Development budget and the proposed $3 million threshold still only represents 2%.

The term "project" refers to VA's congressional development projects report located in the budget Appendix B.

# Appropriation Highlights

| Office of Information Technology<br>Appropriation Highlights<br>($s in thousands) | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 Actual | 2022 Request | 2022 Estimate | 2023 Request | 2023 Request vs. 2022 Estimate | |
| | | | | | $ | % |
| **Budgetary Resources:** | | | | | | |
| Development | $495,546 | $297,000 | $297,000 | $142,092 | ($154,908) | -52.2% |
| Operations and Maintenance | $3,205,216 | $3,131,585 | $3,131,585 | $4,145,678 | $1,014,093 | 32.4% |
| Staffing and Administrative Services | $1,211,238 | $1,414,215 | $1,414,215 | $1,494,230 | $80,015 | 5.7% |
| **Subtotal, Appropriation** [1/] | $4,912,000 | $4,842,800 | $4,842,800 | $5,782,000 | $939,200 | 19.4% |
| Base Development | $67,251 | | $12,383 | | ($12,383) | -100.0% |
| Base Operations and Maintenance | $106,097 | | $15,000 | | ($15,000) | -100.0% |
| Base Staffing and Administrative Support Services | $34,362 | | $10,040 | | ($10,040) | -100.0% |
| OEF/OIF Emergency Appropriation (P.L. 110-28) | $0 | | $2,283 | | ($2,283) | -100.0% |
| Choice Act Section 801 | $2,039 | | $1,026 | | ($1,026) | -100.0% |
| CARES Act Development | $11,877 | | | | | |
| CARES Act Operations and Maintenance | $890,376 | | | | | |
| CARES Act Staffing and Administrative Support Services | $123,784 | | | | | |
| American Rescue Plan Section 8003 | | | $100,000 | | ($100,000) | -100.0% |
| **Subtotal, Unobligated balance brought forward, Oct 1** | $1,235,786 | | $140,732 | | ($140,732) | -100.0% |
| Base Development | $2,339 | | | | | |
| OEF/OIF Emergency Appropriation (P.L. 110-28) | $2,618 | | | | | |
| Choice Act Section 801 | $949 | | | | | |
| CARES Act Development | $363 | | | | | |
| CARES Act Operations and Maintenance | | | | | | |
| CARES Act Staffing and Administrative Support Services | | | | | | |
| **Subtotal, Recoveries** | $6,269 | | | | | |
| Recission of Prior Year Funds | ($37,500) | | | | | |
| North Chicago Facility Transfers | ($8,085) | ($7,993) | ($7,993) | ($8,085) | ($92) | 1% |
| VHA Transfer (P.L. 117-43 Section 151) | | | $9,578 | | ($9,578) | -100% |
| VHA CARES Act Transfer (P.L.116-270) | $45,000 | | | | | |
| Transformational Fund Operations and Maintenance | | $670,000 | $718,133 | | ($718,133) | -100% |
| Mandatory Appropriation, American Rescue Plan Section 8002 | | | $611,361 | $630,057 | $18,696 | 3% |
| Mandatory Appropriation, American Rescue Plan Section 8003 | $100,000 | | | | | |
| Collections for Reimbursable | $118,068 | $88,112 | $108,067 | $126,037 | $17,970 | 17% |
| COVID-19 Emergency Leave Reimbursement | $207 | | | | | |
| **Subtotal, Budgetary Resources** | **$6,371,745** | **$5,592,919** | **$6,422,678** | **$6,530,009** | **$107,331** | 1.7% |
| Base funding | ($461) | | | | | |
| CARES Act | ($9) | | | | | |
| **Subtotal, Unobligated Balance Expiring** | **($470)** | | | | | |
| Base Development | ($12,383) | | | | | |
| Base Operations and Maintenance | ($15,000) | | | | | |
| Base Staffing and Administrative Support Services | ($10,040) | | | | | |
| Choice Act Section 801 | ($1,026) | | | | | |
| OEF/OIF Emergency Appropriation (P.L. 110-28) | ($2,283) | | | | | |
| American Rescue Plan Section 8003 | ($100,000) | | | | | |
| **Subtotal, Unexpired Unobligated Balance** | **($140,732)** | | | | | |
| **Total, Obligations** | **$6,230,543** | **$5,592,919** | **$6,422,678** | **$6,530,009** | **$107,331** | **1.7%** |

Numbers may not add due to rounding

1/ Numbers exclude reimbursements. Numbers shown are prior to transfers to and from other accounts

**Office of Information Technology**
**Appropriation Highlights (continued)**
($s in thousands)

| | 2021 Actual | 2022 Request | 2022 Estimate | 2023 Request | 2023 Request vs. 2022 Estimate | |
|---|---|---|---|---|---|---|
| | | | | | FTE/$ | % |
| Development | $515,253 | $297,000 | $309,383 | $142,092 | ($167,291) | -54.1% |
| Operations and Maintenance | $3,292,317 | $3,128,014 | $3,152,542 | $4,142,015 | $989,473 | 31.4% |
| Staffing and Administrative Support Services | $1,231,010 | $1,409,793 | $1,419,883 | $1,489,808 | $69,925 | 4.9% |
| Choice Act, Section 801 | $1,963 | $0 | $1,026 | $0 | ($1,026) | -100.0% |
| CARES Act Development | $57,240 | $0 | $0 | $0 | $0 | |
| CARES Act Operations and Maintenance | $890,367 | $0 | $0 | $0 | $0 | |
| CARES Act Staffing and Administrative Support Services | $123,784 | $0 | $0 | $0 | $0 | |
| OEF/OIF Emergency Appropriation (P.L. 110-28) | $335 | $0 | $2,283 | $0 | ($2,283) | -100.0% |
| Transformational Fund Operations and Maintenance | $0 | $670,000 | $718,133 | $0 | ($718,133) | -100.0% |
| American Recovery Plan Section 8002 | $0 | $0 | $611,361 | $630,057 | $18,696 | 3.1% |
| American Recovery Plan Section 8003 | $0 | $0 | $100,000 | $0 | ($100,000) | -100.0% |
| **Subtotal, Direct Obligations** | $6,112,268 | $5,504,807 | $6,314,611 | $6,403,972 | $89,361 | 1.4% |
| **Reimbursable Obligations by Program Activity** | | | | | | |
| IT Systems, Reimbursable Obligations | $118,068 | $88,112 | $108,067 | $126,037 | $17,970 | 16.6% |
| COVID-19 Emergency Leave Reimbursement | $207 | | | | | |
| **Subtotal, Reimbursable Obligations** | $118,275 | $88,112 | $108,067 | $126,037 | $17,970 | 16.6% |
| **Total, Obligations** | **$6,230,543** | **$5,592,919** | **$6,422,678** | **$6,530,009** | **$107,331** | **1.7%** |
| **Full Time Equivalent (FTE):** | | | | | | |
| Base | 7,638 | 8,668 | 8,668 | 8,918 | 250 | 2.9% |
| CARES Act | 483 | | | | | |
| **Subtotal, Direct FTE** | 8,121 | 8,668 | 8,668 | 8,918 | 250 | 2.9% |
| Reimbursable FTE | 65 | 98 | 78 | 75 | (3) | -3.8% |
| **Total FTE** | **8,186** | **8,766** | **8,746** | **8,993** | **247** | 2.8% |

Numbers may not add due to rounding

## Budget Overview

| 2023 Budget Request at a Glance ($s in thousands) | |
|---|---|
| 2022 President's Budget | $4,842,800 |
| 2022 Recurring Expenses Transformational Fund | $670,000 |
| Program Changes | $269,200 |
| 2023 Budget Request | $5,782,000 |
| Change from 2022 President's Budget | 5% |

**Budget Request**

The 2023 request of $5.782 billion is an increase of $269.2 million (5%) relative to the 2022 President's Budget that includes the use of the Recurring Expenses Transformational Fund in 2022. OIT is seeking a budget that will support our commitment to meeting our strategic goals and objectives to include the ability to meet the needs of our stakeholders, [VA Administrations (VHA, VBA, NCA) and staff offices], support our business automation initiatives with agile/modernized IT platforms that allow OIT to transition to a "buy before build" model, and invest in "buy" solutions that reduce further accumulation of technical debt by outsourcing to vendors. "Buy" solutions are six times faster than developed inhouse software (90 days vs. 584 days). The 2023 budget request supports an ongoing increase in "buy" solutions. The number of "buy" solutions has been increasing year after year: 57 in 2020 and 68 in 2021.

The 2023 budget request strengthens platforms to support emerging business requirements and accelerates adoption and rollout of VA Administrations-requested Software as a Service (SaaS) products. This is necessary to respond to increased demand for new IT capabilities, increased growth identified by our business partners requesting new space and facility activations, as well as increased modernization to enhance and optimize IT infrastructure.

The 2023 OIT cost drivers include:

- Continued support for the COVID-19 response initiatives:
  - Increases in Tele-Services (Telehealth, Telework, Bandwidth)
  - VA.GOV, expansion and enhancement of VA Contact Centers
- Increased investment to prevent cyber threats such as: cyber incident response, data loss prevention, and mitigating or reducing cybersecurity vulnerabilities
- Increased mobility and remote access

Growth of VA staffing, space, and equipment budgetary increases in the 2023 request allow OIT to support existing IT infrastructure and recurring operational expenses, focus IT growth identified by our stakeholders, and transform IT with investments in new service capabilities.

The budget request is separated into the following subaccounts:

**Development** – The request of $142.1 million is $154.9 million (52%) below the 2022 President's Budget. The decrease in funding is to more appropriately align to VA's business line requirements

by prioritizing Commercial Off the Shelf (COTS) products and shifting from developing new software, getting out of the business of building our own applications, and relying more on cloud managed and shared services to enhance or modernize products already in production. The request of $142.1 million supports mission-critical areas, including Community Care, Digital Health Platform, Health Data Interoperability, Pharmacy and Enterprise Supply Chain (eSC).

The Portfolio sections detail the OIT programs supporting these priorities.

**Operations and Maintenance (OM)** – The request of $4.146 billion is $344.1 million (9%) above the 2022 President's Budget and the Recurring Expenses Transformational Fund. The increase in funding supports VA IT infrastructure modernization to support the growth and demand of our partners, the continued reduction of the technical debt, increase VA cyber investments, and the ability to stay current with technology and new capabilities.

OM funding is necessary to support demand and growth in critical programs, including continued support for Supply Chain Management, Financial Management Business Transformation (FMBT), Infrastructure Readiness Program (IRP), Enterprise Command Center, Enterprise Service Desk (ESD), Veterans Customer Experience (VCE), Telehealth Services, the transition to VA's Enterprise Cloud Solution (VAEC) and existing maintenance activities that support Enterprise Systems across VA.

**Staffing and Administrative Support Services** – The request of $1.494 billion, which funds 8,918 full-time equivalents (FTE) (250 above the 2022 President's Budget), is $80.0 million (6%) above the 2022 President's Budget. The majority of these resources fund the hospital and regional office IT staff responsible for supporting VA's mission and invest in growing our cyber workforce.

**Reimbursements** – In addition to the appropriated level, OIT anticipates $126.0 million in reimbursements, which is $18.0 million (17%) above the 2022 estimated reimbursements amount: $113.8 million for non-pay and $12.2 million for pay. Reimbursements occur within VA, other Federal agencies, credit reform programs and non-appropriated insurance benefits programs. The increase in 2023 reflects funds received from the VBA Housing Program to support the VBA credit reform requirements.

## Executive Summary

**Mission**

The mission of OIT is to collaborate with our stakeholders VHA, VBA, NCA and staff offices to create the best experience for all Veterans. OIT provides strategic, technical, and customer-service direction, guidance, and policy to enhance and improve VA mission outcomes in the delivery of integrated IT services to Veterans and VA stakeholders.

**Vision**

OIT's vision is to become a world-class organization that provides a seamless, unified Veteran experience through the delivery of state-of-the-art technology. In 2023, OIT will continue to focus on building an IT infrastructure that is robust, adaptive, agile, secure, interoperable, and cost-effective.

**OIT Strategic Priorities**

OIT is at a significant crossroads in our history, striving toward our largest digital transformation in a generation. Achieving our goal to be a world-class IT organization in support of the VA's strategic priorities, OIT is supporting VA in the effort to (1) communicate with stakeholders; (2) deliver timely, accessible, high-quality benefits, care and services to all Veterans and their beneficiaries; (3) maintain trust with stakeholders through proven stewardship, transparency, and accountability; (4) strengthen governance, systems, data and management best practices to enhance the customer experience and increase accountability, security and emergency preparedness.

OIT's five ***Imperatives*** drive our strategy and outcomes:

- Exceptional Customer Experience – Deliver exceptional customer service by reinvigorating partnerships with VA business lines to understand customer needs, align them with true business problems, and deliver IT solutions based on Veteran-centered design and product management, culminating in a world-class customer experience.

- IT Modernization – Drive IT and VA capability modernization through digital transformation, refreshing and decommissioning software and infrastructure, and an OIT business value framework that is designed around customer-driven requirements.

- Strategic Sourcing – Transform procurement and acquisition processes to support aggressive modernization efforts by optimizing all available sourcing capabilities and streamlining processes for selecting the right capability for each digital transformation requirement.

- IT Workforce Transformation – Inspire a culture of digital transformation, IT modernization, and customer service in every OIT employee through education, training, reskilling, and professional certifications, while transforming recruiting efforts to make OIT an employer of choice for next generation IT workers, boosting recruitment of next generation professionals.

- Seamless and Secure Interoperability – Achieve seamless and secure data interoperability across VA, DoD, Federal, and commercial partners by identifying, documenting, and disseminating well-defined, standardized, and secure design, interfaces, and processes to access authoritative data that streamlines the Veteran experience.

VA will continue focusing its efforts on modernizing the infrastructure while transforming our health care system into an integrated network that better serves Veterans. VA will use programs like Community Care to partner with non-Federal health care providers and health systems experts to assist in designing a methodology that will streamline health care delivery based on population, demand, internal capacity, and external public and private-sector resources. OIT will also continue modernizing the infrastructure by replacing current legacy systems, moving to an VAEC, and implementing the IRP.

In support of OIT's Modernization Strategy, the 2023 request will fund the following focus areas:

- Manage Data: We are defining authoritative data sources and ensuring data is consistent and secure across VA so we can better leverage the vast data stores, improve data-driven decision making, and simplify the way Veterans interact with VA platforms.

- Migrate to the Cloud: We are migrating infrastructure and applications to commercial cloud providers to reduce operational costs and increase flexibility, allowing us to deliver services to Veterans more quickly and reliably.

- Improve Cybersecurity: We are developing an enterprise cybersecurity risk management framework, based on industry best practices, to stay at the forefront of protecting Veteran information from cyber threats.

- Digitize Business Processes: We are upgrading VA's customer-facing digital tools to give Veterans easier access to their care and benefits and using new technologies and services to streamline our internal business processes.

- Decommission Legacy Systems: We are moving critical functions from outdated and difficult to sustain platforms into more modern systems that operate at lower maintenance costs. This cost savings will be reinvested in projects to improve services for all Veterans.

- Recruit and Retain a World-Class IT Workforce: We are not only dedicated to recruiting next generation IT workers to OIT, we are also committed to training and re-skilling current employees and ensuring that VA has the right people powering its digital modernization when and where we need them.

**OIT Budget Submission Improvement and Prioritization**

To address Congress' request to improve the type, quality, and organization of information in the IT Budget submission, OIT has incorporated additional details explaining the steps taken to begin prioritizing projects.

OIT started this effort by prioritizing projects within portfolios in the 2023 Budget request, with the final goal of developing 1-N robust budget prioritization process. In the absence of uniform prioritization criteria, OIT prioritized projects based on stakeholders' priorities, the support of critical IT infrastructure capabilities, Veteran's services, and benefits delivery, etc.

The Enterprise, Corporate and Memorial Affairs Portfolios were prioritized by projects in the Portfolio sections in the Budget chapter. Due to budget structure limitations, OIT was unable to rank projects in priority order within the Health and Benefits Portfolios. The Health Portfolio identified the "must pay sub-projects (Sustainment Steady-State) as priority #1 and ranked the rest of the sub-projects outside of that category. The sub-projects in the Benefits Portfolio were prioritized as well (see Appendix M for Health and Benefits Portfolios prioritization).

Currently, OIT is working on a budget restructure that will increase transparency of major ongoing programs. This will allow a standardized 1-N prioritization of OIT's projects to better align with the reporting requirements from Office of Management and Budget (OMB) and Congress.

## President's Management Agenda

OIT supports the President's Management Agenda (PMA) toward achieving a more equitable, effective and accountable government that delivers results for all by (1) strengthening and empowering the Federal workforce, (2) delivering excellent Federal services and improved customer experience, and (3) managing the business of Government to build back better. OIT's 2023 budget request will allow VA to directly support the PMA by making investment proposals in the following priority areas:

| | |
|---|---|
| **PMA Priority: Strengthening and Empowering the Federal Workforce** | |
| Human Resources | Supports the implementation of modernized, automated, and standardized systems, tools, and capabilities to deliver a world-class workforce |
| **PMA Priority: Delivering Excellent, Equitable, and Secure Federal Services and Customer Experience** | |
| Community Care | Increases Veteran access to healthcare by utilizing partnerships in the private sector, academia and other government entities |
| Telehealth | Expands the ability to remotely diagnose, consult, treat, transfer medical data, and provides patient education both synchronously and asynchronously |
| Digital Helath | Provides access to coordinated VA healthcare services that allow Veterans and their caregivers choices for meeting clinical, pharmacy, scheduling, and administrative needs 24/7 |
| Veterans Benefits Management System (VBMS) | Ensures Veterans and their families continue receiving accurate and up-to-date information about benefit decisions and supports the processing of new compensation, pension and fiduciary claims |
| Connected Health | Provides VA digital technology to Veterans and health care professionals, through virtual technology which improves efficiency in medical center operations and reduces cost |
| VA.GOV | Integrates customer self-service applications and information, for use by Veterans, into one modernized platform |
| **PMA Priority: Managing the Business of Government to Build Back Better** | |
| Supply Chain | Enables the delivery of clinical care to Veterans by managing the flow of medical supplies and equipment |
| Infrastructure Readiness Program (IRP) | Identifies the current state of the IT infrastructure and manages the modernization strategy for IT assets |
| Information Security | Reduces information security risks across VA programs and systems and complies with Federal security and privacy regulations |
| Financial and Acquisition Management Modernization | Provides VA with a modern financial management solution by transforming and standardizing business processes and capabilities |

## Staffing and Administrative Support Services

In 2023, the OIT Staffing and Administrative Support Services request of $1.494 billion supports 8,918 direct FTE, which is 250 above the 2022 President's Budget. The 75 FTE funded via reimbursement is a decrease of 3 FTE from the 2022 Current Estimate.

The increase in funding will allow OIT to respond to the demand for new IT capabilities and continued growth in VA's administrations and staff offices. Although the staffing levels have increased in our stakeholder organizations, they have remained flat in OIT. OIT has adopted a phased approach for additional FTE by incrementally requesting another 250 FTE in 2023, rather than requesting an increase in FTE that's not feasible to hire in a year's time. An independent assessment of IT staffing requirements and results of the pre-COVID-19 OIT workforce planning analysis identified the need for additional skilled IT staff; a need that was exacerbated by the pandemic response. Other workload drivers include increasing telework support due to higher levels of mobile and telework employees and associated devices as well as the need for continued modernization of the infrastructure.

The additional IT staff will enable our OIT organizations to rapidly respond to emergencies, maintain our security posture and resolve incidents expeditiously, enabling service providers to maintain the capabilities required to provide services to Veterans. The new IT personnel will staff all major VA facilities. Some facilities currently lack requisite IT support onsite, causing delayed incident resolution due to the IT professional's need to travel to get onsite, meaning every incident requiring deskside support calls for an IT employee to travel to the facility and potentially extend resolution timeframes and pulling resources away from services needed at their primary sites.

In addition to salaries, the Staffing and Administrative Support Services budget provides funding for travel, training, administrative support contracts, leases (including those supporting data centers), office equipment, and supplies. It also supports the mass transit benefits program and worker's compensation for OIT employees. With the requested funding, OIT will continue to provide strategy and technical direction, guidance, and policy to ensure that IT resources are acquired and managed for the VA in a manner that adheres to applicable federal laws, regulations, and policies.

Additional detail on the Staffing and Administrative Support Services sub-account can be found in Appendices (J-L).

The table below displays Budget Authority (BA) FTE for all major organizational components within OIT:

| OIT Organizational Components | 2021 Actual | | 2022 Request | 2022 Estimate | 2023 Request | 2022-2023 |
|---|---|---|---|---|---|---|
| | Base Appropriation | CARES Act | Base Appropriation | Base Appropriation | Base Appropriation | Increase / Decrease |
| Information Technology Operations and Services (ITOPS) | 5,504 | 380 | 6,171 | - | - | - |
| Enterprise Program Management Office (EPMO) | 1,100 | 35 | 1,214 | - | - | - |
| Office of Information Security (OIS) | 240 | 14 | 281 | 281 | 281 | - |
| Office of Quality, Performance, and Risk (QPR) | 252 | 3 | 287 | 287 | 287 | - |
| IT Resource Management (ITRM) | 212 | 12 | 261 | 261 | 261 | - |
| Development, Security, and Operations (DevSecOps) | 152 | 2 | 218 | 7,603 | 7,603 | - |
| Strategic Sourcing | 125 | 27 | 157 | 157 | 157 | - |
| Account Management Office (AMO) | 54 | 10 | 79 | 79 | 79 | - |
| To Be Allocated[1/] | - | - | - | - | 250 | 250 |
| **Total FTE** | **7,638** | **483** | **8,668** | **8,668** | **8,918** | **250** |

Note: Numbers may not add due to rounding
In 2022, OIT has aligned ITOPS and EPMO subcomponents to DevSecOps
1/ In 2023, the additional 250 FTE will be allocated to OIT organizations based on the CIO's strategic priorities (please refer to the additional IT staff justification above)

The table below displays Reimbursable Authority (RA) FTE for all major organizational components within OIT:

| OIT Organizational Components | 2021 | 2022 | 2022 | 2023 | 2022-2023 |
|---|---|---|---|---|---|
| | Actual | Request | Estimate | Request | Increase / Decrease |
| Enterprise Program Management Office (EPMO) | 53 | 77 | - | - | - |
| Information Technology Operations and Services (ITOPS) | 12 | 19 | - | - | - |
| IT Resource Management (ITRM) | - | 2 | - | - | - |
| Development, Security, and Operations (DevSecOps) | - | - | 78 | 75 | (3) |
| Office of Information Security (OIS) | - | - | - | - | - |
| Office of Quality, Performance, and Risk (QPR) | - | - | - | - | - |
| Strategic Sourcing | - | - | - | - | - |
| Account Management Office (AMO) | - | - | - | - | - |
| **Total FTE** | **65** | **98** | **78** | **75** | (3) |

Note: Numbers may not add due to rounding
In 2022, OIT has aligned ITOPS and EPMO subcomponents to DevSecOps

## Office of Information Security (OIS)

The VA Office of Information Security (OIS) manages VA's Enterprise Cybersecurity Strategy Program (ECSP) and is committed to protecting the information of our Veterans, partners, and employees in support of the Department's mission. Under the ECSP, OIS continues to build upon the goals set forth by OIT's 2015 Enterprise Cybersecurity Strategy and evolve to combat growing cybersecurity threats, and the rapidly changing IT landscape. The ECSP consists of an updated 2017 version of the Enterprise Cybersecurity Strategy, revisions to VA's core cybersecurity and risk management policies, the establishment of a centralized policy and implementation guidance repository known as the Knowledge Service (KS), and implementation of the National Institute of

Standards and Technology (NIST) Cybersecurity Framework (CSF) and the Risk Management Framework (RMF).

**Office of Quality, Performance, and Risk (QPR)**
Quality, Performance, and Risk (QPR) is OIT's forward-leaning posture for addressing OIT's audit approach, oversight bodies, and material weaknesses. QPR's mission is to instill and promote a culture of quality, performance, and risk management, in collaboration with our stakeholders, to enable a better Veteran experience. QPR oversees all aspects of quality and compliance within OIT and its integration with other quality-focused activities across VA. QPR plays an integral role in helping OIT realize its Digital Transformation Strategy.

**IT Resource Management (ITRM)**
The Office of Information Technology Resource Management (ITRM) advises the Chief Information Officer (CIO) and other senior OIT officials on IT resource requirements. ITRM ensures that VA and OIT have the resources to best support our nation's Veterans and their families by linking the budget process to all IT operations and enterprise-wide management initiatives, fostering comprehensive human capital management and providing a safe and secure work environment for IT staff. These efforts allow VA to continue to provide exceptional services through state-of-the-art technology. Offices within the organization include IT Budget and Finance (ITBF), IT Corporate Business Office, and the Talent Management Office (TMO).

**Development, Security, and Operations (DevSecOps)**
DevSecOps is a formal organizational reflection of OIT's ongoing transition to the culture-based approach, which improves customer experiences and delivery on customer outcomes. DevSecOps is a mindset, culture, and set of technical practices that integrates software development (Dev), security practices (Sec), and IT operations (Ops). DevSecOps leverages Agile principles, a strategically integrated Authority to Operate (ATO) process, user-centered design, continuous monitoring and learning, and frequent IT releases to accelerate the customer requirement-to-solution delivery timeline. It fosters collaboration across multiple IT functions and prioritizes automation and ongoing solution-oriented communication to improve the way teams develop, deliver, and secure applications and services.

**Office of Strategic Sourcing**
Strategic Sourcing, one of OIT's five critical functions, is responsible for managing the entire sourcing lifecycle, creating transparency, and ensuring that funds used to acquire IT products provide the best value and services for their cost. Strategic Sourcing increases accountability, tying vendor performance to value for the Veteran while improving responsible stewardship of taxpayer money.

**Account Management Office (AMO)**
The Account Management Office (AMO) focuses on customer experience and serves as the liaison between OIT and its stakeholders. Information Technology Account Managers (ITAMs) and AMO Senior Advisors customize IT services to meet the needs of OIT's stakeholders and establish OIT as a trusted and valuable ally in serving Veterans. This team is dedicated to understanding the needs of their stakeholders, identifying, and defining innovative solutions, and representing their customers' interests directly to the VA Chief Information Officer.

An Account Manager serves as the lead IT executive reporting to the CIO and is responsible for the creation and management of the business partner's portfolio. An Account Manager provides strategic leadership to maximize value by managing IT project prioritization, balancing portfolios, and allocating resources. They are the primary contact between IT and the business partner, interfaces with industry, and serves as a catalyst to drive innovation. Account Managers and AMO Senior Advisors collect data about OIT performance throughout all of VA.

## 2023 Health Portfolio

The Health Portfolio provides advanced technology solutions positioned to ensure modern, high-quality and efficient medical care delivery capabilities to our Nation's Veterans. In 2023, the Health Portfolio funding will be used to support the Agency's top priorities while also supporting the maintenance of existing major medical systems.

In order to rapidly respond to the COVID-19 pandemic, the Health Portfolio utilized Coronavirus Aid, Relief, and Economic Security (CARES) Act funding in 2021. This work included modernizing an aging Bed Management Solution, significant expansion of the VA video connects capabilities, and replacement of the Occupational Health Record-Keeping System (OHRS) legacy tool used to manage mass vaccinations of the workforce. The 2023 Budget request will support the expansion of data collection capabilities to increase the number of data sources, providing the space to researchers and operation teams surveying and studying the virus, as well as testing various hypotheses around interventions and treatments. The 2023 Budget request includes the ongoing sustainment funding needed to maintain the recently deployed products as a result of the COVID-19 pandemic.

The 2023 Health Portfolio Budget Request consists of the following Congressional Projects details:

| Priority Order[1] | Congressional Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | | 2022-2023 Increase/ Decrease |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | | |
| | | DEV | OM | DEV | OM | DEV | OM | DEV | OM | |
| | Community Care | $ 27,956 | $ 114,406 | $ 3 | $ - | $ 34,853 | $ 97,368 | $ 37,879 | $ 102,591 | $ 8,249 |
| | Community Care - CARES Act | $ - | $ 870 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | Community Care - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 870 | $ - | $ 870 | $ - |
| | Supply Chain Management | $ 67,562 | $ 20,196 | $ 129 | $ - | $ 76,105 | $ 31,158 | $ 33,223 | $ 63,282 | $ (10,758) |
| | Supply Chain Management American Rescue Plan 8003 | $ - | $ - | $ - | $ 100,000 | $ - | $ - | $ - | $ - | $ - |
| | Telehealth Services | $ 5,505 | $ 6,472 | $ 181 | $ - | $ 6,600 | $ 6,423 | $ 13,657 | $ 9,104 | $ 9,738 |
| | Telehealth Services - CARES Act | $ - | $ 6,463 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | Telehealth Services - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 7,900 | $ - | $ 8,657 | $ 757 |
| | Healthcare Administration Systems | $ 11,153 | $ 79,239 | $ 8 | $ - | $ 20,710 | $ 82,423 | $ 10,054 | $ 80,991 | $ (12,088) |
| | Healthcare Administration Systems - CARES Act | $ - | $ 16,899 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | Healthcare Administration Systems - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 12,213 | $ - | $ 12,373 | $ 160 |
| | Purchased Care | $ 12,560 | $ 18,329 | $ 50 | $ - | $ 6,836 | $ 26,447 | $ 10,000 | $ 19,475 | $ (3,808) |
| | Patient Records [System (CPRS)] | $ 6,964 | $ 160 | $ 2,486 | $ - | $ 9,000 | $ 3,060 | $ 9,200 | $ 7,608 | $ 4,748 |
| | Patient Records [System (CPRS)] - CARES Act | $ - | $ 4,995 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | My HealtheVet | $ 3,200 | $ 15,423 | $ 12 | $ - | $ 4,684 | $ 14,480 | $ - | $ 20,366 | $ 1,202 |
| | My HealtheVet - CARES Act | $ - | $ 6,427 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | My HealtheVet - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 8,650 | $ - | $ 8,650 | $ - |
| | Research | $ 3,085 | $ 269 | $ 35 | $ - | $ 8,660 | $ 12,913 | $ 5,209 | $ 23,855 | $ 7,491 |
| | IT Support Contracts | $ - | $ 99,856 | $ - | $ - | $ - | $ 179,013 | $ - | $ 179,012 | $ (1) |
| | Software Maintenance | $ - | $ 225,688 | $ - | $ - | $ - | $ 149,753 | $ - | $ 149,753 | $ - |
| | Software Maintenance - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 4,790 | $ - | $ 5,064 | $ 274 |
| | Health Data Interoperability | $ 8,423 | $ 29,841 | $ 2,017 | $ - | $ 2,125 | $ 109,207 | $ - | $ 103,979 | $ (7,353) |
| | Digital Health Platform | $ 9,499 | $ 15,139 | $ 368 | $ - | $ 11,807 | $ 41,034 | $ - | $ 50,504 | $ (2,337) |
| | Hardware Maintenance | $ - | $ - | $ - | $ - | $ - | $ 43,000 | $ - | $ 43,000 | $ - |
| | Hardware Maintenance - CARES Act | $ - | $ 6,243 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | Hardware Maintenance - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 2,300 | $ - | $ 2,415 | $ 115 |
| | Pharmacy | $ 9,271 | $ 13,992 | $ 2,000 | $ - | $ - | $ 16,028 | $ - | $ 18,263 | $ 2,235 |
| | Connected Health/Mobile Apps | $ - | $ 7,793 | $ - | $ - | $ - | $ 14,230 | $ - | $ 14,950 | $ 720 |
| | Connected Health/Mobile Apps - CARES Act | $ - | $ 6,298 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | Connected Health/Mobile Apps - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 8,000 | $ - | $ 9,000 | $ 1,000 |
| | Scheduling | $ - | $ 11,482 | $ - | $ - | $ - | $ 12,150 | $ - | $ 13,110 | $ 960 |
| | Registries | $ 1,200 | $ 7,332 | $ - | $ - | $ - | $ 8,500 | $ - | $ 8,330 | $ (170) |
| | Genomic Information System for Integrative Service (GenISIS) | $ - | $ 2,193 | $ - | $ - | $ - | $ 5,279 | $ - | $ 5,500 | $ 221 |
| | Genomic Information System for Integrative Service (GenISIS) - CARES Act | $ - | $ 290 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | Genomic Information System for Integrative Service (GenISIS) - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 290 | $ - | $ 290 | $ - |
| | Beneficiary Travel | $ 2,540 | $ 801 | $ - | $ - | $ - | $ 2,750 | | $ 5,031 | $ 2,281 |
| | Beneficiary Travel - CARES Act | $ - | $ 315 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | Access & Billing | $ - | $ 5,021 | $ - | $ - | $ - | $ 4,500 | $ - | $ 4,514 | $ 14 |
| | Lab | $ - | $ 4,118 | $ - | $ - | $ - | $ 4,044 | $ - | $ 4,200 | $ 156 |
| | Registration, Eligibility, Enrollment | $ - | $ 227 | $ - | $ - | $ - | $ 3,500 | $ - | $ 2,000 | $ (1,500) |
| | Registration, Eligibility, Enrollment - CARES Act | $ - | $ 2,379 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | **Total Health Portfolio** | **$ 168,917** | **$ 729,158** | **$ 7,290** | **$ 100,000** | **$ 181,380** | **$ 912,273** | **$ 119,222** | **$ 976,737** | **$ 2,306** |

1/ See the Appendix M for the Health Portfolio sub-projects ranked by priority order.

**Community Care – $140.5 million** ***(Development - $37.9 million, Operations and Maintenance - $102.6 million)***

The 2023 Budget Request will be supplemented with $0.9 million from the American Rescue Plan (ARP) Section 8002 and includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Community Care (CC) Electronic Data Interchange (EDI) | $ 7,232 | $ 9,026 | $ - | $ - | $ 9,382 | $ - | $ 9,800 | $ - |
| Community Care Referral and Authorization (CCRA) | $ 8,101 | $ 33,088 | $ - | $ - | $ 7,350 | $ 36,000 | $ 7,500 | $ 35,200 |
| Claims Processing Business Transformation | $ 5,480 | $ - | $ - | $ - | $ 6,368 | $ - | $ 6,830 | $ 2,470 |
| Community Care (CC) Provider Payment Business | $ - | $ - | $ - | $ - | $ 6,668 | $ - | $ 6,500 | $ - |
| Community Care (CC) One Consult | $ - | $ - | $ - | $ - | $ 2,985 | $ - | $ 5,000 | $ 2,750 |
| Big Four | $ - | $ - | $ - | $ - | $ - | $ - | $ 2,249 | $ - |
| Community Care Reimbursement System (CCRS) | $ 1,430 | $ 16,762 | $ - | $ - | $ - | $ 8,640 | $ - | $ 10,500 |
| Community Care Reimbursement System (CCRS) CARES Act | $ - | $ 870 | $ - | $ - | $ - | $ - | $ - | $ - |
| Community Care Reimbursement System (CCRS) American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 870 | $ - | $ 870 |
| Community Care - Provider Profile Management System (PPMS) | $ - | $ 12,245 | $ - | $ - | $ - | $ 9,065 | $ - | $ 8,760 |
| Program Integrity Tool (PIT) | $ - | $ 5,804 | $ - | $ - | $ - | $ 7,500 | $ - | $ 6,900 |
| Community Care - Electronic Data Interchange Gateway (EDI GW) | $ - | $ - | $ - | $ - | $ - | $ 12,000 | $ - | $ 6,000 |
| CPAC Revenue Workflow Tools (ROWT) | $ - | $ - | $ - | $ - | $ - | $ 1,090 | $ - | $ 4,895 |
| Community Care Clinical and Business Intelligence Solution (EPRS) | $ - | $ 4,672 | $ - | $ - | $ - | $ 3,700 | $ - | $ 4,400 |
| Community Care (CC) Integrated Billing (IB) Accounts Receivable (AR) | $ 5,713 | $ 6,717 | $ - | $ - | $ - | $ 2,500 | $ - | $ 3,436 |
| Consult Toolbox (CTB) | $ - | $ 6,844 | $ - | $ - | $ - | $ 7,600 | $ - | $ 3,160 |
| Veteran Co-Payment Lockbox (VCPL) | $ - | $ 4,801 | $ - | $ - | $ - | $ 2,000 | $ - | $ 3,000 |
| Community Care - Customer Relationship Management (CommCare) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 2,800 |
| Consolidated Patient Account Center Patient Account Resource System (CPAC PARS) | $ - | $ 2,278 | $ - | $ - | $ - | $ 2,640 | $ - | $ 2,550 |
| Community Care Referral Documentation (REFDOC) | $ - | $ 1,232 | $ - | $ - | $ - | $ 1,350 | $ - | $ 2,350 |
| Business Information Office Business Intelligence Solution (BIO BIS) | $ - | $ 1,713 | $ - | $ - | $ - | $ 1,870 | $ - | $ 1,870 |
| State Veterans Home Program[1/] | $ - | $ - | $ - | $ - | $ 2,000 | $ - | $ - | $ - |
| Community Care Budget Management, Accounting, Accrual, Reconciliation | $ - | $ - | $ - | $ - | $ 100 | $ - | $ - | $ - |
| Community Care - Standardized Episodes of Care (CC-SEOC) | $ - | $ 765 | $ - | $ - | $ - | $ 1,000 | $ - | $ 1,550 |
| Community Care Software Licenses | $ - | $ - | $ - | $ - | $ - | $ 413 | $ - | $ - |
| Revenue Operation (CPACs) Business Tools | $ - | $ 5,699 | $ - | $ - | $ - | $ - | $ - | $ - |
| Community Care - Decision Support Tool | $ - | $ 2,761 | $ - | $ - | $ - | $ - | $ - | $ - |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 3 | $ - | $ - | $ - | $ - | $ - |
| **Community Care** | **$ 27,956** | **$ 115,276** | **$ 3** | **$ -** | **$ 34,853** | **$ 98,238** | **$ 37,879** | **$ 103,461** |

1/ State Veterans Home Program realigned from Registries Congressional Project to Community Care Congressional Project in 2022

Community Care is a nationwide program that utilizes partnerships with the private sector, academia, and government entities to improve access to care for Veterans. OIT works closely with VHA to identify operational efficiencies and innovative scalable technology solutions including secure email technology that provides a safe, fast, and efficient mechanism for VA staff to share Veterans' protected health information with community providers; a safe health information sharing system that allows community providers to securely view Veteran health information; and a referral documentation tool that automatically converts Veterans' paper medical records into a PDF format that can then be directly uploaded to a Community Care provider's system.

VA's goal is to provide Veterans with the care they need at the right time and from the right provider. In some cases, this requires eligible Veterans to receive care from a local Community Care provider, paid for by VA. Community Care allows Veterans, providers, and VA staff to access VA tools for care coordination, referral and authorization management, review and update medical information, provider portals, billing via Electronic Data Interchange (EDI), provider payments, and revenue operations.

The Community Care Program creates an efficient, intuitive, and Veteran-centric experience through streamlined eligibility criteria and administrative and clinical processes. Community Care supports Title IV of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 and recommendations required by Section 201 of the Veterans Access, Choice, and Accountability Act of 2014. Community Care supports the continuing growth of the available Community Care Program options, improving the referrals and authorization via the Community Care Network, the standardization of Community Care claims management systems and integration of Veteran's data with federal and community partners. Community Care has nationwide reach utilizing partnerships with the private sector, academia, and government entities to provide eligible Veterans easier access to care. Community Care supports and maintains IT products ranging from applications to assist Veterans with appointment scheduling and finding clinicians, to claims processing and reporting. Community-based care is driving significant enhancements and modernization of IT systems to improve Veteran's access to care, coordination of care, referrals and claims processing. The Community Care Program is developing numerous critical products and new capabilities to create and collect metrics to monitor effectiveness of billing and reimbursement processes, a new authorization process, and to introduce automation, including auto adjudication to billing and reimbursement processes.

Community Care Referral and Authorization (CCRA) solution is an integral component of the VA Community Care IT architecture which allows Veterans to receive care from non-VA community providers. The CCRA system will improve the Veterans access to Community Care and coordination of that care between community providers and the VA. This project provides an automated tool to generate, monitor, track, and process referrals and authorizations to Community Care Network (CCN) providers so that Veterans who meet requirements and who opt-in to Community Care receive care according to the Choice Act. This is done through improving the electronic exchange of health information used in referrals and authorizations. Community Care staff members use the CCRA SaaS package to generate referrals and authorizations for episodes of care to community providers within the CCN.

Future enhancements will expand the CCRA solution to include the ability to enter emergency and urgent care referrals and end to end testing with dependent systems, enhancing the reliability of

Veteran facing products. This project supports direct entry of Veteran emergency care events through the newly designed portal. This enhancement empowers automation to minimize administrative burdens, simplify emergency care claims on behalf of the Veteran, present a unified architecture with further improvements over time, and fully and flexibly integrate with systems like Cerner, Corporate Data Warehouse (CDW) and various financial systems.

Claims Processing Business Transformation supports the modernization of the VA legacy claims systems and the consolidation of Veteran Community Care claims management systems into a single standardized solution. This project encompasses CCN and non-network claims and Veteran Family Member Program (VFMP) claims. The VFMP future state solution supports integration with the new SaaS Claims Processing Business Transformation which provides enhanced efficiency and improved performance of eligibility, claims processing, exceptions processing, appeals workflow, auditing, and analytics on claims data for Veterans and their beneficiaries receiving care in foreign locations. The consolidated claims management solution allows VA direct reimbursement to the Third-Party Administrators (TPAs) and allows them to transmit the invoice and approved claims data back to VA for further validation checks in a consolidated claim processing system, supporting Veterans who are receiving Community Care.

In 2023, the development funds for the Claims Processing Business Transformation project will be used to fund multiple claims processing development efforts that will result in standardized, optimized, and modernized claims processing solutions that support enhancing the timely processing of Veteran and Veteran Beneficiary eligibility and claims. The transformation efforts include Consolidated Claims, DoD Payments, VFMP, claims, Eligibility and Claims Modernization (ECM), and a new Fee Schedule solution. The steady-state funding for the Claims Processing Business Transformation project will be used to fund the maintenance of the claims processing transformation solutions. The steady-state maintenance includes software licenses, applications maintenance, and database maintenance.

Community Care Reimbursement System (CCRS) is a highly automated system used in support of the Community Care Network to align with industry standard claim reimbursements to fully automate and integrate with other business systems including Referral and Authorization, Revenue, Fraud, Waste, and Abuse (FWA), data analytics and financial systems. This Sustainment-Enhancement funding will be used to integrate with other VA systems, develop new bi-directional feeds, update, and enhance critical workflow tools, enhance reporting, and improve fraud, waste, and abuse analysis to increase compliance and timeliness of payments. The continued enhancement of CCRS allows for new business processes to further streamline and improve the reimbursement process to the TPAs for Community Care.

Funding will also support the on-going enhancement of CCRS to support data requests for OCC Financial Data Systems for station budget estimates, predictive analytics, and auditing purposes. Additionally, it will allow for continued enhancement of the system in the areas of producing consistent, comparable, and reconcilable data across program activity and automating financial reporting.

The Community Care Provider Profile Management System (PPMS) is the implementation of a comprehensive non-VA provider directory containing multiple portfolios including: CCN, TriWest Patient-Centered Community Care (PC3) and Choice Program, Veteran Care Agreements

(VCA), VA Medical Center Local Contracts, Indian Health Service (IHS)/Indian Health Program, DoD facilities, and VA Medical Center prescribing providers. As the authoritative source of non-VA provider data, downstream systems rely on accurate provider status and current provider data in PPMS to locate community providers, complete referrals, pay claims, and conduct audits on these activities. PPMS is used by VA Medical Center (VAMC) Community Care staff to create VCAs and local contracts, track and validate provider status related to contract status, and maintain community provider credentials.

The system delivers enterprise-wide accessibility to a comprehensive database of provider information integrated with multiple provider locators, including one Veteran-facing tool, Veterans Health Information Systems and Technology Architecture (VistA), and Cerner Electronic Health Record (EHR). PPMS will continue to provide increased timeliness and quality service to Veterans by ensuring consistent monitoring of the system in production and promptly addressing issues that may impact system users. Planned enhancements include improved integration with the Cerner EHR and further granularity into provider availability and quality.

Community Care One Consult merges the Consult Toolbox and the Decision Support Tool into a single, web-based tool used by VA staff to identify the best care available to Veterans both within the VA and in the community. Moving to a web-based application and modern development methodology enables a rapid response to both emerging field user requirements and executive mandates. One Consult collects vital information about the Veteran's eligibility for in-house and community care and the medical care required. The ability to use a single consult care coordination both internally and externally reduces the administrative burden of producing and tracking internal and external consults. This will also provide comprehensive consults for Community Care and support consult tracking, monitoring, and engagement with community providers.

**Supply Chain Management – $96.5 million** ***(Development - $33.2 million, Operations and Maintenance - $63.3 million)***
The 2023 Budget Request for this Congressional Project includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Enterprise Supply Chain (eSC) | $ - | $ - | $ - | $ - | $ - | $ - | $ 33,223 | $ - |
| Supply Chain Services | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 52,282 |
| Supply Chain GUI | $ - | $ 9,283 | $ - | $ - | $ - | $ - | $ - | $ 11,000 |
| Defense Medical Logistics Standard Support (DMLSS) | $ - | $ 10,914 | $ - | $ - | $ 76,105 | $ 31,158 | $ - | $ - |
| Supply Chain LogiCole - VA Logistics Redesign (VALOR) | $ 67,562 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 129 | $ - | $ - | $ - | $ - | $ - |
| Unobligated balance brought forward, Oct 1 - ARP 8003 | $ - | $ - | $ - | $ 100,000 | $ - | $ - | $ - | $ - |
| **Supply Chain Management** | **$ 67,562** | **$ 20,196** | **$ 129** | **$ 100,000** | **$ 76,105** | **$ 31,158** | **$ 33,223** | **$ 63,282** |

Please note that the Defense Medical Logistics Standard Support (DMLSS) was the designated Supply Chain Management system during the 2022 President's Budget submission. Currently, VA is developing a plan to reopen a competition for developing the enterprise supply chain/medical logistic solution

VA's Supply Chain enables the delivery of clinical care to Veterans by managing the flow of medical supplies and equipment. The current Supply Chain system is comprised of VistA - based legacy and COTS systems and requires modernization and standardization. The lack of integration with other VA systems prevents the Department from achieving comprehensive financial, inventory, and Supply Chain management.

On September 21, 2021, the VA Deputy Secretary directed an enterprise-wide strategic analysis of VA's supply chain. That review includes assessing the DMLSS/LogiCole system. Pending results of Supply Chain Strategy Assessment will determine a way forward and a new deployment timeline. This effort will continue to support system agnostic activities which directly support Supply Chain Modernization which includes:

- VA Logistics environment development that will be the integration engine for all future supply chain system implementations
- Technical analysis to address gaps in the VA Supply Chain Business processes
- New Supply Chain enterprise data management strategy
- Integration planning with ServiceNow, FMBT, Prosthetics, Point of Use cabinets, Corporate Data Warehouse
- Evaluation and renewed support for the entire portfolio of supply chain systems current active in the VA
- Interagency Agreement with DHA which supports:
  - Continued sustainment of the Joint Medical Facility at N. Chicago
  - Conduct requirements validation with VA Medical Centers
  - Regional Readiness Center development and deployments
  - VA Supply Chain Solution Virtual Environment to be implemented at SimLEARN

The VA needs a modern, end-to-end healthcare logistics solution that will enable modernization and directly impact the quality of care, patient safety, and access to health care. The solution-agnostic efforts to deploy this will deliver the foundation for the transition of VA's Supply Chain from legacy applications to a modernized system across the VA. Supply Chain solution integration with VA EHR and iFAMS will simplify development of required interfaces across the VA's overall Modernization initiatives. Interface activities with partner systems will require deep dives into legacy and modernization requirements and synchronization of data, testing, and governance activities. Competitive prototyping to determine best supply chain management options. After Supply Chain Analysis is completed, VA will proceed for a competitive prototyping effort. Competitive prototyping evaluation will directly support long term selection of the modernized supply chain system solution for the VA. This will deliver best of breed fully integrated modernized supply chain solution that will ensure the quality, safety, data utilization and operational support of the material for Veteran care. VHA's Veterans Affairs Logistics Redesign (VALOR) program office and OIT is coordinating and executing the next generation solution.

Enterprise Supply Chain (eSC) is a part of VA's ongoing partnership with DoD on the delivery of a Joint EHR, which provides an opportunity for VHA to modernize and standardize the Supply Chain Management program. VHA will adopt a Supply Chain system that is compatible with the FMBT initiatives and supports VA's clinical, financial, and reporting requirements. This effort addresses the people, training, processes, data, and automated systems by:

- Establishing a standardized supply chain organizational structure
- Instituting a robust supply chain training and development program
- Creating an integrated data analysis capability, and
- Implementing a comprehensive equipment lifecycle management program
- Solution agnostic IT supply chain improvements
- Support supply chain modernization including foundation infrastructure and integration work support supply chain management future and legacy systems.

Supply Chain Services is maintaining existing Supply Chain systems/products until modernization occurs.

**Telehealth Services – $22.8 million (*Development - $13.7 million, Operations and Maintenance - $9.1 million)***
The 2023 Budget Request will be supplemented with $8.7 million from ARP Section 8002 and includes the following sub-projects:

| Sub-Projects *($s in thousands)* | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Telehealth Management Platform (TMP/CVT-TSS) | $ 1,484 | $ - | $ - | $ - | $ 2,400 | $ 1,723 | $ 8,657 | $ 5,700 |
| Telehealth Management Platform - CARES Act | $ - | $ 6,463 | $ - | $ - | $ - | $ - | $ - | $ - |
| Telehealth Management Platform - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 7,900 | $ - | $ 8,657 |
| Home Telehealth Reporting (HTR) | $ 4,021 | $ 426 | $ - | $ - | $ 4,200 | $ 1,700 | $ 5,000 | $ 1,725 |
| Web VistA Remote Access Management (WebVRam) | $ - | $ 3,870 | $ - | $ - | $ - | $ 3,000 | $ - | $ 1,679 |
| Clinical Video TeleConferencing (CVT) | $ - | $ 2,176 | $ - | $ - | $ - | $ - | $ - | $ - |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 181 | $ - | $ - | $ - | $ - | $ - |
| **Telehealth Services** | **$ 5,505** | **$ 12,935** | **$ 181** | **$ -** | **$ 6,600** | **$ 14,323** | **$ 13,657** | **$ 17,761** |

Telehealth Services increases patient access to high-quality health care by providing services when geographical distance separates the patient and practitioner. Telehealth Services will enhance all telehealth systems to accommodate an increase in virtual care which is currently increasing at 30 percent per year, partly due to increased demand by younger Veterans and the COVID-19 pandemic. By the end of 2026, it can be expected that nearly 100 percent of the Veteran population will have the ability to access clinical care via Telehealth Services. The astronomical growth of the existing critical clinical services provided via Telehealth has grown to approximately 909,000 Veterans in recent years. The refinement of Telehealth services provides cost-effective programs that permit our clinical staff to treat tens of thousands of Veterans each month as both patients and clinicians can operate from remote sites.

Telehealth Management Platform (TMP/CVT-TSS) is a customer relations management software system. TMP automates previously manual work for three elements of virtual care services: 1) Scheduling 2) Resource Management and 3) Administrative Management. TMP allows sites sharing resources to communicate critical information to activate, manage and support Veteran

virtual care/remote services. TMP is a critical software that supports the delivery of virtual care services that are a part of the overall Telehealth program growth and enable more efficient use of these services between the 970 VHA sites. TMP will help VHA meet the increasing need for clinical encounters for the 33 percent of all Veterans who live in rural areas and the 12 percent who live more than three hours from a tertiary care facility.

Home Telehealth Reporting (HTR) improves tools that Care Coordination nurses use to manage their panel of patients enrolled in the HT program. The data from the tools are used by the VHA Office of Telehealth Services in the OCC to assess and improve HT program outcomes. HTR supports the HT program in improving clinical outcomes and access to care by reducing complications, hospitalizations, and clinic or emergency room visits for Veterans who are at high risk due to a chronic disease. The enhancements will help Veterans continue to live independently and spend less time at medical visits while enhancing their knowledge and skills to effectively manage their health care needs. Based on reporting data collected by this program, Veterans enrolled in HT for non-institutional care needs and chronic care management had a 53 percent decrease in VA bed days of care and a 33 percent decrease in VA hospital admissions.

The Web VistA Remote Access Management (WebVRAM) enhancement initiatives will implement enterprise software enhancements for integrations of locally adopted software improvements. Further enhancements will include integration with Integrated Funds Control Accounting and Procurement (IFCAP), iMedConsentWeb, Two Factor Authentication, Computerized Patient Record System (CPRS) Photo, Telehealth Records Manager, Essentris, and other business product backlog requirements. Tier 2 and Tier 3 provides VA and contract resources to address defect repair and product sustainment support for WebVRAM to ensure the application is well-managed and maintains support for the customer base. This support includes communication, application baseline configuration, quality, risk, schedule, cost, and performance management and reporting. This support includes attending application sustainment meetings, providing technical management reports, subject matter expertise, and coordination to support integrated troubleshooting, issue analysis, and solution development. The maintenance function ensures continued access by clinicians who support Veterans to use this solution.

**Healthcare Administration Systems – $91.0 million (*Development - $10.0 million, Operations and Maintenance - $81.0 million)***
The 2023 Budget Request will be supplemented with $12.4 million from ARP Section 8002 and includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Occupational Health Record-Keeping System (OHRS) 2.0 | $ - | $ 395 | $ - | $ - | $ - | $ 9,756 | $ 3,194 | $ 3,000 |
| Occupational Health Record-Keeping System (OHRS) 2.0 - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 9,236 | $ - | $ 9,273 |
| HR Smart - Clinical Trainee Registration and Tracking System (CTRTS) | $ 1,925 | $ - | $ - | $ - | $ 4,280 | $ 8,540 | $ 3,000 | $ 1,000 |
| Caregiver Record Management Application (CARMA) - Caregivers Expansion | $ - | $ - | $ - | $ - | $ - | $ - | $ 2,260 | $ - |
| Enterprise Precision Scanning and Indexing Automation (EPSI) | $ - | $ - | $ - | $ - | $ 1,600 | $ - | $ 1,600 | $ 2,100 |
| Veterans Health Information Systems and Technology Architecture (VistA) | $ - | $ - | $ - | $ - | $ - | $ 19,578 | $ - | $ 29,113 |
| Health Application Project Management and Product Support | $ - | $ 8,608 | $ - | $ - | $ - | $ 7,000 | $ - | $ 8,500 |
| Signature Informed Consent (SIC) | $ - | $ 7,603 | $ - | $ - | $ - | $ 7,000 | $ - | $ 7,500 |
| Caregiver Record Management Application (CARMA) | $ - | $ - | $ - | $ - | $ - | $ 8,000 | $ - | $ 5,900 |
| VistA - Imaging (IMAGE) | $ - | $ 2,783 | $ - | $ - | $ - | $ 4,500 | $ - | $ 4,800 |
| Community Living Centers Resident Assessment Instrument | $ - | $ 4,609 | $ - | $ - | $ - | $ - | $ - | $ 4,200 |
| National Center for Patient Safety (NCPS) Patient Safety Operations | $ 1,243 | $ - | $ - | $ - | $ 1,530 | $ - | $ - | $ 3,130 |
| Environment of Care Assessment Compliance Tool (EOC) | $ - | $ 2,158 | $ - | $ - | $ - | $ 2,109 | $ - | $ 2,600 |
| Fee Basis Claims System (FBCS) | $ - | $ - | $ - | $ - | $ - | $ 1,598 | $ - | $ 1,925 |
| James A Lovell Federal Health Center (JAL FHCC) | $ - | $ - | $ - | $ - | $ - | $ 3,000 | $ - | $ 1,800 |
| VHA Geographic Information System (GIS) | $ - | $ - | $ - | $ - | $ - | $ 1,419 | $ - | $ 1,668 |
| Community Care Veteran Billing System (CCVBS) | $ - | $ - | $ - | $ - | $ - | $ 1,300 | $ - | $ 1,255 |
| Real Time Location System (RTLS) | $ - | $ - | $ - | $ - | $ - | $ 900 | $ - | $ 935 |
| Oversight and Accountability Reporting and Visualization Platform | $ 800 | $ - | $ - | $ - | $ 800 | $ 600 | $ - | $ 600 |
| Office of Integrity - Risk Management System | $ 350 | $ - | $ - | $ - | $ 1,900 | $ 1,000 | $ - | $ 500 |
| Clinical Staffing and Scheduling | $ 600 | $ - | $ - | $ - | $ 600 | $ - | $ - | $ 364 |
| Events Management Analytics Platform (EMAP) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 101 |

| Sub-Projects (continued) ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Caregiver Record Management Application (CARMA) - Caregivers Expansion | $ 5,105 | $ - | $ - | $ - | $ 10,000 | $ - | $ - | $ - |
| Minimum Data Set (MDS) | $ - | $ - | $ - | $ - | $ - | $ 3,942 | $ - | $ - |
| Messaging Administration Repository Maintenance Dashboard (MARM) | $ - | $ 767 | $ - | $ - | $ - | $ 825 | $ - | $ - |
| Patient Wristband ID | $ - | $ - | $ - | $ - | $ - | $ 700 | $ - | $ - |
| Voluntary Service System (VSS) | $ - | $ 70 | $ - | $ - | $ - | $ 656 | $ - | $ - |
| Geographic Information Systems (GIS) Healthcare Enterprise Support and Services and Infrastructure | $ 1,130 | $ 540 | $ - | $ - | $ - | $ - | $ - | $ - |
| VistA Maintenance | $ - | $ 18,210 | $ - | $ - | $ - | $ - | $ - | $ - |
| Caregivers | $ - | $ 15,790 | $ - | $ - | $ - | $ - | $ - | $ - |
| Non VA Care | $ - | $ 13,519 | $ - | $ - | $ - | $ - | $ - | $ - |
| JAL FHCC North Chicago Interfaces | | $ 2,624 | | | | | | |
| Patient Statement Enhancement | $ - | $ 800 | $ - | $ - | $ - | $ - | $ - | $ - |
| Real Time Location System (RTLS) Enterprise Systems Engineering (ESE) | $ - | $ 762 | $ - | $ - | $ - | $ - | $ - | $ - |
| Enterprise Scan Solution CARES Act | $ - | $ 16,099 | $ - | $ - | $ - | $ - | $ - | $ - |
| Enterprise Scan Solution American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 2,977 | $ - | $ 3,100 |
| Electronic Credentialing System VETPRO CARES Act | $ - | $ 800 | $ - | $ - | $ - | $ - | $ - | $ - |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 8 | $ - | $ - | $ - | $ - | $ - |
| **Healthcare Administration Systems** | **$ 11,153** | **$ 96,138** | **$ 8** | **$ -** | **$ 20,710** | **$ 94,636** | **$ 10,054** | **$ 93,364** |

Healthcare Administration Systems includes capabilities that deliver high quality, Veteran-centered care, and services as well as builds and maintains trust with Stakeholders through proven stewardship, transparency, and accountability. These products aim to streamline claims, automate eligibility determinations and payment processing, detect improper payments, and improve reporting.

Healthcare Administration Systems supports Occupational Health Record-Keeping System (OHRS) 2.0 programs which is vital to Veteran and Employee Patient Safety during the COVID-19 pandemic and beyond. OHRS 2.0 ensures that nearly 600,000 VHA employees, volunteers, trainees, students, and contractors (30 percent of whom are Veterans) are immunized against life-threatening communicable diseases, which supports safe and protected care to nearly 8.9 million enrolled Veterans. OHRS 2.0 will soon include employee tuberculosis screening, medical surveillance, integration with the voluntary service system. OHRS 2.0 project manages employee health records with features such as documentation, monitoring of compliance and aggregation of vaccination data. Sustainment-steady-state funding for this solution is critical for ongoing support of pandemic functions such as COVID-19 vaccination and CDC reporting; compliance with influenza vaccination documentation; and fulfilling federal requirements for the separation of occupational and personal health records. OHRS 2.0 provides all Employee Occupational Health

(EOH) providers in the field the ability to create, maintain, and monitor medical records for VA employees and generate site-specific reports at the National, Veterans Integrated Service Network (VISN), and facility levels. Enhancement of OHRS will allow employee tuberculosis screening, medical surveillance, integration with the voluntary service system, migration of the legacy OHRS 1.0 data, CPRS/VistA integration, and documentation of work-related visits (administrative and injury assessments).

HR Smart - Clinical Trainee Registration and Tracking System (CTRTS) is a SaaS Oracle PeopleSoft based Human Capital solution that is in production and accessible via web. HR Smart is the Authoritative Data Source for an Employee Record providing automated HR Information System services to HR Offices, VA managers and employees. This project supports the VA's Office of Human Resources and Administration (HR&A) mission of leading human resource management strategies, policies, and practices that cultivate an engaged, proficient, and diverse workforce to transform and continually improve services to Veterans and their families. HR Smart is currently undergoing a massive data cleansing effort that drives the reduction of payroll errors and equip HR Offices with automated solutions that drive accuracy of HR coding. HR Smart is mandated under the 2002 President's Management Agenda (to modernize HR using service providers) and the Chief Human Capital Officer Act of 2002.

CTRTS streamlines and consolidates the documentation for WOCs throughout the country and ensures compliance with Records Schedule DAA-0015.2016-0004. This technology provides a document repository solution for the WOC HR documents that will allow Human Resource users to download and view documents from the case file and add new documents to the case file.

Health Administration Systems also supports Caregiver Record Management Application (CARMA) which offers resources including education, respite care, and in some cases, financial stipends, and other benefits, to eligible caregivers of Veterans.

CARMA assists caregivers with the Veteran's treatment plan. Caregivers work in collaboration with the Veteran's health care team and are recognized as critical partners in the Veteran's care. They assist in navigating the complex health care system, ensuring Veterans have increased access to the care they need and have better treatment compliance which have the potential to impact long term costs. Caregivers also help Veterans maintain their independence to the extent possible and enable Veterans who may otherwise require institutional long-term care to remain in their homes. It gives Veterans and family caregivers access to the Program of Comprehensive Assistance for Family Caregivers including additional DoD benefits. Currently, approximately 1,500 users are required to track, monitor, and support the caregivers nationwide eligible for the caregiver programs.

Enterprise Precision Scanning and Indexing Automation (EPSI) will drastically reduce current backlog scanning time and importing requirements by standardizing the process across the enterprise through automated unattended robotics that operate 24/7, enabling the upload of approximately 15,000 records per license/application. EPSI attaches the community providers clinical notes from the Veteran's appointment to the appropriate consult in the Veterans VA Health Record. With this solution, Veterans' Community Care health information is made available to their treating VA care teams at an incredibly accelerated timeline without the need for overtime or staff re-assignment.

VistA is the core legacy system that supports VHA and the VA Medical Centers' clinical and administrative operations such as: Laboratory services, Radiology, Pharmacy/Mail Order Pharmacy, Ward Stock Replenishment, Shift Handoff, Nursing, Nutrition, Surgery, Admissions Discharge and Tracking. Provision of full life-cycle support for deployed VistA products is essential to ensure that issues impacting the business and clinical users are addressed efficiently and effectively. This funding will address defect repair and product support for over 100 VistA clinical and administrative applications.

The Signature Informed Consent (SIC) solution allows providing clear medical procedure information to Veterans and their beneficiaries quickly so that they can make informed decisions in undertaking procedures and facilitating their medical care. It is needed to provide VHA physicians with the essential tools to ensure Veterans receive consistent, legible, high-quality information regarding the healthcare options proposed by the healthcare team. SIC integrates informed consent into the electronic medical records process and reduces lost forms and improves patient safety by decreasing postponed procedures. SIC software provides VA practitioners with an electronic consent product customized to interface with CPRS and VistA Imaging. For treatments requiring signature consent, the SIC generates a customizable electronic consent form that is automatically populated with VA-approved information. This helps to standardize the consent processes to ensure patients receive consistent high-quality consent forms. It also supports documentation of informed requirements mandated in Title 38 Code of Federal Regulation (CFR) Section 17.32 and VHA Handbooks 1004.01 and 1004.05. SIC allows clinicians to meet ethical standards of practice required by law, regulation, and policy.

The Health Application Project Management and Product Support funding is broad in scope and covers IT Operations for over 400 VHA health care systems. As a mandatory 'keep the lights on' requirement, this funding supports all aspects of the VA Strategic Healthcare Goals by ensuring reliability and availability of all the systems that support the Veterans and clinicians providing greater choice and access to care. The benefit to the Veteran is keeping IT systems current with security. Keeping software operational and Veterans' data safe from cyber-attacks requires frequent software releases and production support. These systems provide the support tools that clinicians need for surgery, radiology, vitals measurement, and case management of homeless Veterans that make all the VAMCs run smoothly and efficiently.

Community Living Centers Resident Assessment Instrument provides a standard health assessment for Community Living Center (CLC) residents. The application is required for Veteran-centric care that is personalized, proactive, and patient-driven by capturing the voice of the CLC resident, enabling monitoring of functional status, facilitating evaluation of the quality of care received, and determining appropriate nurse staffing resources. The product includes supports and licenses for operations and maintenance activities, which is used by the geriatrics and extended care department of the VA CLCs. The CLC software manages the healthcare of community living center residents with real-time access to current, comprehensive patient medical information across the 137 CLCs for healthcare providers. It is required for Veteran-centric care that is personalized, proactive, and patient-driven by capturing the voice of the Community Living Center resident, enabling monitoring of functional status, facilitating evaluation of the quality of care received, and determining appropriate nurse staffing resources. This project provides steady-state sustainment to include Tier 3, break fix, adaptive maintenance, and compliance with security, technology, section 508, and other federal and VA technology standards for all applications under

the Community Living Center Resident Assessment Instrument. This effort improves productivity and user satisfaction of VHA healthcare providers, improves efficiency and quality of medical documentation, and ultimately enhances patient-centered care. The product will not be ensuring system capabilities.

National Center for Patient Safety (NCPS) Patient Safety Operations serves as an enterprise safety support system for a VHA wide network of VISN Patient Safety Officers, facility Patient Safety Managers, VISN Chief Logistics Officers, facility logistics staff and other VISN and facility safety personnel trained to facilitate documentation and analysis of adverse events related to patient healthcare. VHA learns about adverse events through these applications (reporting), investigates safety events or vulnerabilities occurring outside and within VHA facilities, and analyzes high risk events to understand the root cause/risks posed enterprise wide. Lessons learned are shared across VHA, actions (alerts/advisories/notices) are communicated to prevent and mitigate risk, and assignments are made to designated users who physically remove items capable of causing harm to Veterans from unsafe medical devices, products, pharmaceuticals, and food in the health care facilities.

James A Lovell Federal Health Center (JAL FHCC) provides medical services to Veterans and Navy active-duty service personnel in the Greater North Chicago and surrounding areas. The purpose of this funding request is to continue to provide sustainment services on the JAL FHCC applications (Joint Patient Registration, Orders Portability, Laboratory and Financial Management Reconciliation systems), Supply Chain Management system and the bi-directional connection and messaging between VA's VistA applications, and DoD's Armed Forces Health Longitudinal Technology Application (AHLTA) and Composite Health Care System (CHCS) applications. The outcome is continuing routine maintenance with development and testing activities to correct defects and improve the processes shared between VA and DoD to correct work items. The addition of sustainment-steady-state funding is to support synchronization of orders, improving the automated process of sending and receiving orders for clinical services. This synchronization of transactions between the two Electronic Health Record systems, a single Joint Patient Registration (JPR) application will be used to register and correlate patients in both systems, enabled by enterprise-level patient identity management systems: Master Veteran Index (MVI) and Defense Enrollment and Eligibility Reporting System (DEERS).

The VHA Office of Compliance and Business Integrity's (CBI) Oversight and Accountability Reporting and Visualization Platform (OARVP) will be a key tool towards achieving CBI's mission, as well as VHA's larger goal of being an accountable and transparent organization. The OARVP will consist of an interactive web application that will enable VHA leadership, CBI Officers, and key internal stakeholders to access VHA compliance program management and leadership reports data in an interactive and dynamic manner. The goal of the OARVP is to provide VHA leadership, CBI Officers, and key stakeholders with the needed intelligence to detect and address emerging compliance risks and isolated or systemic issues of noncompliance identified as having an adverse effect on a Veteran's experience. A centralized system will enable the nationwide comparison of facilities and VISNs and help with identifying outliers. With this capability, CBI seeks to increase awareness, transparency, and accountability as well as to promote Actions towards achieving an integrated VHA-wide compliance program.

The Clinical Staffing and Scheduling system will replace manual staffing methods by addressing deficits that currently exist in nursing workforce management data, thus replacing various commercial systems that have been acquired independently by numerous facilities/VISN's, and addressing potential security/privacy vulnerabilities that have emerged and that are currently being investigated. This funding is necessary for implementing a unified COTS/managed solution for the enterprise that will modernize and replace the manual staffing methods currently being used by VA while addressing security vulnerabilities that exist within the various commercial systems that have been acquired independently by numerous facilities/VISN's.

**Purchased Care – $29.5 million (*Development - $10.0 million, Operations and Maintenance – 19.5)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Medical Care Collections Fund (MCCF) EDI Transaction Applications Suite | $ 4,200 | $ 18,329 | $ - | $ - | $ 6,836 | $ 7,447 | $ 10,000 | $ - |
| Medical Care Collections Fund Transactions Applications Suite (MCCF EDI TAS) | $ 8,360 | $ - | $ - | $ - | $ - | $ 19,000 | $ - | $ 19,475 |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 50 | $ - | $ - | $ - | $ - | $ - |
| **Purchased Care** | **$ 12,560** | **$ 18,329** | **$ 50** | **$ -** | **$ 6,836** | **$ 26,447** | **$ 10,000** | **$ 19,475** |

The Purchased Care Congressional Project supports the Medical Care Collections Fund (MCCF) EDI Transaction Applications Suite product. Health Insurance Portability & Accountability Act (HIPPA) requires industry -wide standardization of Electronic Data Interchange (EDI) transactions to achieve improved efficiency and cost effectiveness in US healthcare. Purchased Care adds system checks and reporting functions to the MCCF and extends eInsurance standards to eligibility, benefits and claims, data content, eligibility compliance, and insurance verification. As the project remains in compliance with Federal mandates, it reduces stress and financial impact on Veterans, beneficiaries, and family members by keeping the products aligned with new federal and national compliance standards. This project is necessitated by congressional legislative mandates.

Upgrades to the MCCF will maintain Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance. VHA must implement periodic changes to standards and implement new data fields and data field values. Upgrading to new EDI Standards and Operating rules allows VHA to continue exchanging data with insurance payers and maintaining the flow of revenue to VHA. Project is necessitated by congressional legislative mandates. Compliance is dictated by the Administration Simplification portion of the HIPAA X12 EDI transactions, as amended by the Patient Protection and Affordable Care Act (PPACA). Administrative Simplification requires standardizations across the MCCF. MCCF supports continued operations and maintenance of systems assuring Veterans and family members receive timely and accurate charges for non-service-connected care. This yearly $3 billion revenue stream additionally offsets VHA budgets.

**Patient Records [System (CPRS)] – $16.8 million (*Development - $9.2 million, Operations and Maintenance - $7.6 million)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Methadone Dispensing Tracking | $ 830 | $ - | $ - | $ - | $ 3,000 | $ - | $ 3,200 | $ 2,250 |
| VistA - Computerized Patient Record System (CPRS) | $ 5,374 | $ - | $ - | $ - | $ 6,000 | $ 1,880 | $ 6,000 | $ 2,000 |
| LGBT Program (10P4Y) | $ 760 | $ - | $ - | $ - | $ - | $ - | $ - | $ 3,030 |
| CPRS Cloud VISN 17 | $ - | $ - | $ - | $ - | $ - | $ 980 | $ - | $ 328 |
| eScreening Alternative Suicide Prevention Efforts | $ - | $ 160 | $ - | $ - | $ - | $ 200 | $ - | $ - |
| COVID-19 Patient Manager - Clinical Decision Support - CARES Act | $ - | $ 4,995 | $ - | $ - | $ - | $ - | $ - | $ - |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 2,486 | $ - | $ - | $ - | $ - | $ - |
| **Patient Records [System (CPRS)]** | **$ 6,964** | **$ 5,155** | **$ 2,486** | **$ -** | **$ 9,000** | **$ 3,060** | **$ 9,200** | **$ 7,608** |

Methadone Dispensing Tracking improves patient outcomes and treatment for Veterans supporting best practices and quality by ensuring safe drug administration with proper documentation practices. The purpose of this is to improve surveillance of medication-assisted treatments of opioid use disorders across the Veteran population served by VA. Methadone Dispensing Tracking will manage referrals for the medication-assisted treatment of a Veteran participating in an opioid use disorder program so that VA can ensure Veterans have seamless and timely access to mental health care. This will improve the coordination of care for Veterans in methadone treatment, reduce time involved in duplicating documentation of methadone orders in two systems and reduce errors including the potential for more episodes of intensive or acute care.

VistA - Computerized Patient Record System (CPRS) is a VistA computer application and is the system interface used by providers, nurses, and other clinical staff to view patient information. It is also the electronic medical record that is used throughout VA in all health care settings (inpatient, outpatient, long-term care), covering all aspects of patient care and treatment. The primary goal of CPRS is to provide a fast and easy-to-use application that provides a framework that supports clinical workflow. CPRS provides an integrated patient record system for clinicians, managers, QA staff, and researchers through the development based on their requirements. CPRS is the system interface used by providers, nurses, and other clinical staff to view patient centric information. The application integrates many other packages and provides an environment where coordinated care is reviewed, documented and preserved. This project's enhancements improve the quality and efficiency of Veterans' experiences in VA clinical settings. Each of the improvements in functionality directly improves a user's ability to navigate CPRS and more efficiently complete their documentation of Veteran care, as well as the use of tools to communicate next steps in that care, including placing orders and consults. Improvements in a user's efficiencies allow for more time for direct patient care. CPRS includes the tools to improve the ability to conduct medication reconciliation, improve alerts, and reduce the inadvertent use of unsafe medications. VA pioneered EHR development with VistA. However, after more than 40 years of use, VistA lacks the interoperability with DoD and Community Care partners required to

better serve Veterans. It is extremely costly to maintain as VA's sole health information system and limits the Department's ability to provide Veterans with a seamless care experience.

VA has explored various options to modernize VistA since 2001, but these VistA modernization initiatives failed to truly transform the EHR system or achieve interoperability. Until the new electronic health record is deployed, legacy VistA, its components, and other clinical systems need to be maintained. Moreover, VistA consists of over 170 clinical, financial, and administrative applications and the legacy system supports more than 1,600 VA facilities nationwide as part of the largest integrated delivery network in the U.S. As VA's legacy EHR system, VistA has been essential to the Department's ability to deliver health care to more than nine million Veterans and their families.

The Lesbian, Gay, Bisexual and Transgender (LGBT) Program (10P4Y) project tailors the VistA EHR to best meet the needs of Veterans with transgender and related identities. Transgender and Gender Diverse (TGD) Veterans have been shown to experience several health disparities. The LGBT Health Program has a healthcare directive on TGD Veterans to address health inequities and provide clinically and culturally responsive care. VHA Directive 1341(2) 'Providing Health Care for Transgender and Intersex Veterans' stipulates that 'It is VHA policy that Veterans must be addressed based upon their self-identified gender identity; the use of Veteran's preferred name and pronoun is required.' Currently, there is no field to enter this information, so it will become lost in the Progress Notes, requiring other providers to potentially ask patients the same question. We propose the changes to the electronic medical record in support of this policy statement. With a designated data field for preferred name, preferred pronouns and administrative sex, different providers will not have to ask the patient these same questions again and again. When healthcare providers have this information in a designated field, they will be able to improve patient-provider communication, improve assessment, increase engagement, and promote better health outcomes. If the information is in a designated field, patients do not have to answer these questions again and again, which they find very frustrating. In addition to improving timely and integrated care, the Government Accountability Office (GAO) has recently (2020) required VHA to systematically collect gender identity data and use this data to assess patient outcomes. The proposed IT program supports VHA goals by creating a new field in the electronic medical record for preferred pronouns, increases visibility to the preferred name field, and allows Veterans at Cerner facilities to determine the sex they would like used for administrative purposes, rather than defaulting to potentially erroneous DEERs gender information.

**My HealtheVet – $20.4 million (*Operations and Maintenance)***
The 2023 Budget will be supplemented with $8.7 million from ARP Section 8002 and includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| My HealtheVet (MHV) | $ - | $ 15,423 | $ - | $ - | $ - | $ 12,664 | $ - | $ 20,366 |
| My HealtheVet (MHV) CARES Act | $ - | $ 6,427 | $ - | $ - | $ - | $ - | $ - | $ - |
| My HealtheVet (MHV) American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 8,650 | $ - | $ 8,650 |
| MHV Infrastructure and Interface | $ 1,100 | $ - | $ - | $ - | $ 2,092 | $ 908 | $ - | $ - |
| MHV Veteran-Facing | $ 2,100 | $ - | $ - | $ - | $ 2,592 | $ 908 | $ - | $ - |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 12 | $ - | $ - | $ - | $ - | $ - |
| **My HealtheVet** | **$ 3,200** | **$ 21,850** | **$ 12** | **$ -** | **$ 4,684** | **$ 23,130** | **$ -** | **$ 29,016** |

My HealtheVet (MHV) is a web-based application that creates a new, online environment where Veterans, families, and clinicians may come together to optimize Veterans' health care. This web technology combines essential health record information enhanced by online health resources to enable and encourage patient/clinician collaboration. It improves Veteran health care by providing easy access to health information and online resources. It also facilitates patient/health care provider interactions. MHV gives the Veteran access to VA benefits, special programs, and health information and services. MHV also provides the Veteran with web-based tools to increase their knowledge about health conditions, manage their health records, and communicate with health care providers. Veterans can now take a more proactive approach to managing their health and utilizing VA health services and benefits.

The MHV project has two enhancement efforts to improve the current system. Interface and Integration is to maintain the MHV cloud platform and interfaces. It also allows to adjust for continued increase usage by 2.5 million active Veteran users and over 35 thousand VA clinical staff. It can also modify systems to keep pace with the evolving security requirements to create interfaces for enterprise monitoring of critical system components and features. It also maintains a 99.99 percent system platform uptime. MHV will support the interfaces for the DoD and VA health portal to provide a Longitudinal electronic health record to Active-Duty members and Veterans.

MHV provides significant services to Veterans and families by providing an online tool to simplify the management of the Veterans health care. MHV provides access to a number of services including the electronic medical record, radiology images, laboratory test results via secure e-mail service (using Secure Messages (SM)) to VA providers, a place to track self-entered data in 24 different domains, the ability to electronically request a VA appointment, opportunities to reorder prescription refills and renewals, tracking prescription deliveries, access to the specialized Veterans Health Library, and the ability to download and share the electronic health record.

**Research – $29.1 million (*Development - $5.2 million, Operations and Maintenance - $23.9 million)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| VHA Innovation Ecosystem | $ 3,085 | $ 269 | $ - | $ - | $ 5,060 | $ 4,425 | $ 5,209 | $ 4,795 |
| VA Informatics and Computing Infrastructure (VINCI) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 8,842 |
| Million Veteran Program Online/CHAMPION IAA (MVP Online) | $ - | $ - | $ - | $ - | $ - | $ 8,488 | $ - | $ 7,400 |
| Box Cloud Content Management (Box) - VA-Academic Collaboration Space | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 2,618 |
| Research Electronic Data Capture (VA REDCap) for Research | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 200 |
| VA-Academic Collaboration Space for Research, Education and Innovation | $ - | $ - | $ - | $ - | $ 3,000 | $ - | $ - | $ - |
| VAMC-Affiliate External Interconnections for Research & Education | $ - | $ - | $ - | $ - | $ 600 | $ - | $ - | $ - |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 35 | $ - | $ - | $ - | $ - | $ - |
| **Research** | **$ 3,085** | **$ 269** | **$ 35** | **$ -** | **$ 8,660** | **$ 12,913** | **$ 5,209** | **$ 23,855** |

The Research Congressional Project provides collaboration on grant writing, publication writing and other shared documents to VA investigators, educators, and innovators and non-VA colleagues in academic affiliates and other agencies [e.g., National Institute of Health (NIH), National Cancer Institute (NCI)]. VHA Research will support development work for the VA-Academic Collaboration Space for Research, Education and Innovation, and enhancement work for the VAMC-Affiliate External Interconnections for Research & Education. This request builds on a long-standing requirement for having a collaboration workspace that is accessible by personnel from within and outside the VA.

Research includes the VHA Innovation Ecosystem which modernizes and enhances the customer experience for Veterans and their families by fostering Department-wide innovations that can quickly cultivate an idea from discovery to evaluation, to ultimately becoming implemented nationwide. Ideas within the core innovation ecosystem are generated through the VA Innovators Network, transformed into reality by the VHA Innovation Program, and are then disseminated throughout VA by the Diffusion of Excellence Initiative.

VHA Innovation Ecosystem will leverage existing VA strategic priorities such as the Innovators Network Portfolio (iNet), VA's Diffusion of Excellence (DoE), and Care & Transformational Initiatives (CTI) to build comprehensive and collaborative innovation communities that engage the broader VHA innovation community. VHA Innovation Ecosystem will oversee the innovation landscape while providing integration of all VHA Innovation activities through improved planning, coordinating, organizing, leading, and controlling of all innovation activities within the Innovation Lifecycle. Operations and maintenance will provide routine patches and fixes to meet continuous or recurring operation for all VHA Innovation Ecosystem products including Healthcare Initiatives including Light Electronic Action Framework (LEAF), Genomic Laboratory Information Management System (GLIMS), E-Screening, One VA Pharmacy, Digital Marketplace, and Future Technology Laboratory.

VA Informatics and Computing Infrastructure (VINCI) provides critical services to day-to-day operations for health research across the Department of Veterans Affairs. Services include access to secured environment, designed to carefully balance the needs of the researchers by providing the resources and tools necessary to conduct studies and analyze data with the VA's requirement to maintain security and privacy of that data. The VINCI environment consists of extensive storage area networks, drives, file shares, databases, a SharePoint farm for collaboration and correspondence sites, Statistical Analysis System (SAS)/Grid for advanced analytics and contains both physical and virtual machines with an extensive collection of software, including Government off the shelf (GOTS), COTS, and homegrown applications. Demand currently sits at 200+ active health research studies per month and 1,000+ active analysts per month on average. VINCI is comprised of over 70 physical servers and 300 virtual machines with approximately 7 Petabytes of data stored across 26 networked storage devices. This infrastructure is managed across a network of 48 Switches, 2 Routers, 2 Firewalls and 2 load balancers. Sustainment of the existing VINCI environment ensures that VINCI can continue to allow researchers' access to VA data and to facilitate the analysis of that data on a secure and stable platform. This also maintains Veterans' privacy and data security allowing data scientists to have analytical tools and a platform to create health data insights.

The Million Veteran Program (MVP) Computational Health Analytics for Medical Precision to Improve Outcomes Now (CHAMPION) effort is required to support joint VA, VHA and Department of Energy (DOE) medical research projects utilizing Veteran donated DNA as well as DOE Oak Ridge National Labs (ORNL) hosted Genome and Phenome Data types within the supercomputing enclave developed by VA and DOE at DOE ORNL. It includes data analytics expertise for extremely large data sets provided by the DOE ORNL. MVP CHAMPION supports the VA-DOE Interagency agreement supporting the following strategies: make VA data a national resource; make VA data more widely available; make clinical trials of quality more available to Veterans; transform VA Research into a Data Science Program for Big Data; fulfill the goal of the VHA Health Informatics Strategic Plan (HISP); and advance VA-DOE Objective for Healthcare and National Strategic Computing goals.

This data is being used to better understand, predict, diagnose, and treat pathologies including cancers, cardiovascular health and suicide contributing factors. This will allow for more favorable health outcomes for Veterans. The continued Genome and Phenome association analysis brings together a matrix of all possible associations between all genetic variants on the MVP genotyping chip. The mission is to accelerate medical research to the benefit of our nation’s Veterans and our citizens at large.

**IT Support Contracts – $179.0 million *(Operations and Maintenance)***
The IT Support Contracts Project is comprised of recurring payments for existing contracts for services and support for implemented IT systems in support of the Enterprise, VA Administrations and Staff Offices. IT Support Contracts is considered a ‘must pay’ requirement to support customer service level agreements.

SLA - Health represents the estimated steady-state charges for the 114 applications for the 11 Major Customer Codes (MCC) aligned to the Health Portfolio within the OIT Consolidated Agreement, also known as the Service Level Agreement (SLA), between the Infrastructure Operations (IO) Franchise Fund Enterprise Center and OIT. The IO Franchise Fund is one of eight

self-supporting VA Franchise Fund Enterprise Centers and is the sole provider of VA Franchise Fund Information Technology business segment products and services.

VHA IT Support Contracts represents the estimated steady-state charges for legacy system support for the specific and unique VHA systems that were not included in the SLA. With the DevSecOps Transformation, services have been consolidated and are managed, acquired, and provided centrally at the Enterprise level rather than the organizational level.

The VHA Research IT Support Sub-Project represents the estimated steady-state charges to support VHA's Office of Research and Development (ORD). The primary component is the Legacy System and Operational Support Contract which manages and maintains services for the information systems that are currently supporting the local and nationwide ORD operations and the associated infrastructure.

**Software Maintenance – $149.8** ***(Operations and Maintenance)***
The 2023 Budget Request will be supplemented with $5.1 million from ARP Section 8002 and includes the following sub-project:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| VHA Software License Maintenance | $ - | $ 225,688 | $ - | $ - | $ - | $ 149,753 | $ - | $ 149,753 |
| VHA Software License Maintenance - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 4,790 | $ - | $ 5,064 |
| **Software Maintenance** | **$ -** | **$ 225,688** | **$ -** | **$ -** | **$ -** | **$ 149,753** | **$ -** | **$ 154,817** |

Software License Maintenance covers VA's Enterprise License Agreements and hundreds of applications in use within VA. Costs are driven by the number of users and number of new applications and systems supporting these users.

VHA Software License Maintenance represents the estimated steady-state charges for legacy system support for the specific and unique VHA systems that were not included in the SLA. With the ITOPS Transformation, services have been consolidated and are managed, acquired, and provided centrally at the enterprise level rather than the organizational level. This project covers the bill-paying function of existing contracts for VHA and enables the ongoing operations and maintenance of VHA Software License Maintenance as required by VHA.

**Health Data Interoperability – $104.0 million** ***(Operations and Maintenance)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Corporate Data Warehouse (CDW) | $ - | $ - | $ - | $ - | $ - | $ 11,050 | $ - | $ 26,314 |
| Veterans Data Integration and Federation Enterprise Platform (VDIF-EP) | $ - | $ - | $ - | $ - | $ - | $ 23,000 | $ - | $ 23,000 |
| Standards and COTS Integration Platform (SCIP) | $ - | $ 9,578 | $ - | $ - | $ - | $ 15,000 | $ - | $ 15,000 |
| Joint Longitudinal Viewer | $ - | $ 13,294 | $ - | $ - | $ - | $ 14,007 | $ - | $ 13,002 |
| Direct Secure Messaging (DSM) | $ 6,423 | $ 720 | $ - | $ - | $ - | $ 5,801 | $ - | $ 5,935 |
| National Clozapine Registry (NCR) | $ 2,000 | $ 500 | $ - | $ - | $ 2,125 | $ 1,500 | $ - | $ 5,508 |
| Health Data Quality Tools | $ - | $ 3,994 | $ - | $ - | $ - | $ 4,000 | $ - | $ 4,600 |
| Veterans Health Information Exchange (VHIE) | $ - | $ - | $ - | $ - | $ - | $ 12,849 | $ - | $ 4,020 |
| Standards and Terminology Services (STS) [1/] | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 2,570 |
| Collaborative Terminology Tooling Data Management [1/] | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 2,030 |
| Clinical Data Repository/Health Data Repository | $ - | $ 1,755 | $ - | $ - | $ - | $ 2,000 | $ - | $ 2,000 |
| Business Intelligence Service Lines (BISL) Core Services | $ - | $ - | $ - | $ - | $ - | $ 20,000 | $ - | $ - |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 2,017 | $ - | $ - | $ - | $ - | $ - |
| **Health Data Interoperability** | **$ 8,423** | **$ 29,841** | **$ 2,017** | **$ -** | **$ 2,125** | **$ 109,207** | **$ -** | **$ 103,979** |

[1/]Standards and Terminology Services (STS) and Clinical Data Repository/Health Data Repository sub-projects have been realigned from Data Integration and Management Congressional Project to Health Data Interoperability Congressional Project in 2023

Health Data Interoperability supports the integration of Veterans information and products across VA by overseeing enterprise integrations to provide improved data availability, reduce duplicate product functions, and implement technological efficiencies. Health Data Interoperability supports clinical decision support/patient safety and research for 170 medical centers and over 1200 clinics, providing time-sensitive data services to Cerner for VA's Electronic Health Record Modernization, DoD, and other Federal agencies. Health Data Interoperability includes systems, applications, and capabilities that enable the interoperability of Veteran data between non-VA providers and VA, as well as between VistA and the Cerner EHR to ensure Veterans' EHRs remain current across providers. Additionally, continuous analysis and business intelligence on comprehensive data sets are being conducted to improve health care for all Veterans. With improved interoperability with other systems, VA makes it easier for Veterans and their families to receive the right benefits and meet their expectations for quality, timeliness, and responsiveness. Interoperability will help ensure that clinical data is retained, and the medical record is complete and up to date. Health Data Interoperability gives VA providers and their partners access to critical patient information and avoids the risk of inappropriate or duplicated services which may jeopardize patient care and put Veterans at risk.

CDW is comprised of over 700 servers with approximately 13 petabytes of data stored across 30 networked storage devices. This infrastructure is managed across a network of 60 switches, routers, and firewalls. Most of the equipment being used to support the infrastructure is nearing or at end-of-life and unable to keep pace with advanced computing demands. The services CDW provides are critical to the day-to-day operations of VA. Modernization of system infrastructure, security protocols, along with 24/7 support, ensures that CDW can support the Cerner Electronic Health

Record Modernization (EHRM), DoD, major financial/logistics transformation initiatives, MVP, Veteran population health, clinical decision support and daily point-of-care workflow.

The services provided by the CDW are critical to the day-to-day operations of VA. CDW serves over 100,000 customers and spans all organizations within the VA (e.g., OIT, the Electronic Health Records Management Integration Office (EHRM IO),VHA, and VBA) and key organizations outside of VA [Centers for Disease Control and Prevention (CDC), DOE, the White House and DoD]. Data is key to ensuring the success of major initiatives including but not limited to Access to Care, National Surveillance and bio-surveillance monitoring, Community Care, Electronic Quality Measures, Flu Measures, Suicide Prevention, EHRM, Data Syndication and clinical research projects. As a trusted partner to VHA Support Services Center Capital Assets (VSSC), CDW has been instrumental in responding to emergent requirements through the accelerated availability of operational data throughout the workday. This has expanded CDW's role as the de facto enterprise data hub for VA.

Veterans Data Integration and Federation Enterprise Platform (VDIF-EP) federates and caches patient records across all VistA instances which significantly improves federate VistA data access response times. Enhancements to the VDIF platform are necessary for the modernization of the platform to ensure the proper functionality of the platform and the capability with other VA IT products and COTS software. Clinical Data Repository/Health Data Repository provides bi-directional exchange of computable outpatient pharmacy and medication allergy data between DoD Clinical Data Repository (CDR), DoD's electronic health record, and VA Health Data Repository (HDR); it also enhances decision support by permitting data from VA / DoD repositories to be cross-referenced for drug-drug and drug-allergy interactions. Collaborative Terminology Tooling Data Management (CTTDM) requires sustainment-steady-state funding to continue supporting the Cerner implementation in direct support of the transition of VistA and Electronic Health Record Modernization. CTTDM supports interoperability connections to Health Data Repository, DoD, Cerner, etc. This standardization enables interoperability at the VA, allowing Veterans to transfer medical records under the MISSION Act. Collaborative Terminology Tooling Data Management supports that Interoperability and Meaningful Use as mandated under the 2014 National Defense Authorization Act.

The Standards and COTS Integration Platform (SCIP) is a suite of standards-based services and COTS products that support Veteran and Active-Duty Military clinical care. Previously known as the Bidirectional Health Information Exchange (BHIE) system, SCIP is a middleware hardware and software framework that provides a secure, bidirectional, real-time interagency exchange of clinical data and patient demographics between VA and DoD health information systems. SCIP is the only VA service for DoD data that populates data directly to VistA - CPRS where clinicians have reading and writing capabilities.

SCIP supports end-user viewer applications including CPRS, Joint Longitudinal Viewer (JLV); VistA Imaging; Health Artifact and Image Management Solution (HAIMS); and VistA Web. SCIP provides standards-based production services that allow clinicians and authorized administrative users to access VA Data from VistA, Master Veteran Index (MVI), and Central VistA Imaging Exchange (CVIX). SCIP Production services are also utilized by VA's VistA Imaging users as a critical element of the Medical Image data sharing. SCIP Production services allow VA clinicians and authorized administrative users to access DoD data from the following DoD data sources:

DMIX Exchange Service (DES), MHS Genesis (DoD Cerner Millennium); Armed Forces Health Longitudinal Technology Application (AHLTA), Theater Medical Data Store (TMDS), and Essentris (DoD inpatient care system).

Joint Longitudinal Viewer provides integrated health records viewing for over 5,000 monthly users comprised of VA Clinicians and Community Providers. JLV users retrieve critical information regarding Veteran patient care, accessing over 3.5 million health records per month. The purpose of the JLV program is to support the Congressional mandates for DoD/VA integrated health records management, as well as the Veterans Choice initiatives. The expected outcomes of JLV sustainment work are continued reliable health data sharing amongst providers and continued support of Veterans' benefits adjudication. The JLV supports the initiative to provide VA out-of-band, non-VA provider access to VA's VistA Health Records using DoD JLV configuration and product baseline. JLV supports improved access to care for Veterans and enhanced benefits support through a customizable web interface-based application for electronic health records viewing. DoD, VA, and community partners share and view data in an integrated platform.

The sustainment of JLV ensures the applications remain operational and functional for clinicians to access Veterans' health records and provide fully informed decisions. JLV jointly developed a customizable user interface with DoD that promotes workflow efficiency, facilitating better healthcare services and quicker benefits adjudication for the Veteran. JLV provides a view of VA-only health data to Community Providers in a secure electronic manner to support care of Veterans referred for treatment within their local communities by VA staff. JLV also reduces the administrative workload for VA Staff and helps manage Veteran referrals. JLV promotes the efficient communication between VA and community providers which improves the continuity of care to the Veteran and an overall better Veteran experience.

The National Clozapine Registry provides VA with the tools to authorize, track and report the safe prescription and administration of clozapine for Veterans with serious mental illnesses. The project will address issues in several VistA Mental Health and Pharmacy processes to register, prescribe, and monitor patients taking clozapine in accordance with the Food and Drug Administration (FDA) guidelines through daily transmission and parsing of clozapine administrative data from VA facilities. This ensures the data is correct in the National Clozapine Registry and adheres to the required reporting to the FDA.

The National Clozapine Registry FDA enhancements enable the VA National Clozapine Coordinating Center (NCCC) to fulfill this FDA mandate in a manner that is safe, cost effective, and provider and patient friendly. Clozapine is the most efficacious medication available for the treatment of schizophrenia and is the only medication proven to reduce the suicidality of schizophrenic patients. The FDA has mandated that all patients receiving clozapine enroll in a national clozapine registry to monitor Absolute Granulocyte Counts. NCC will work on moving the existing Clozapine tracking into a database structure that will meet VA standards and streamline the referral and approval process by providing an automated tool for management of referrals and approvals for initiating Clozapine therapy. NCC supports managing data by collecting and using data from several sources to adhere to FDA's Risk Evaluation and Mitigation Strategies (REMS) program by updating the allowable lab values to prescribe clozapine. Having NCC in place will significantly reduce the amount of work that needs to be done manually, saving time, increasing efficiencies, decreasing risk of errors, and allowing staff to work more effectively.

Veterans Health Information Exchange (VHIE) enables VA, participating community care providers, governmental agencies, and Veterans to securely share Veteran's health data electronically. VA increasingly relies upon external partners for healthcare services for Veterans – 75 percent of enrollees see both VA and community care providers (referrals and self-initiated care). By sharing health data electronically, VA and participating community care providers are better able to coordinate and improve Veterans' overall quality of care. VHIE's overarching goal is to make Veterans' health data consistently available to VA and community care providers at the right time and in a way that is easy for clinicians to use and rely upon. The Health Data Quality Tools impact the usability and value of the information VA sends and receives with external care providers and other stakeholders. The cost, accuracy, and care decisions will be better because of this project. Direct Secure Messaging activities will maintain confidentiality for Veteran health information while communicating health information with external health providers.

**Digital Health Platform – $50.5 million *(Operations and Maintenance)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Health Data and Analytics Platform | $ 7,279 | $ - | $ - | $ - | $ 6,402 | $ 13,074 | $ - | $ 17,557 |
| Mental Health Assistant | $ - | $ - | $ - | $ - | $ - | $ 3,000 | $ - | $ 7,150 |
| VistA - Blood Establishment Computer Software (VBECS) | $ - | $ 4,420 | $ - | $ - | $ - | $ 3,364 | $ - | $ 5,800 |
| Megabus Legislative Actions | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 4,701 |
| Enterprise Wide Speech Recognition (EWSR) | $ - | $ 3,274 | $ - | $ - | $ - | $ 4,000 | $ - | $ 4,000 |
| VistA Audit Solution (VAS) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 2,500 |
| Corporate Data Warehouse (CDW) Mental Health (MH) Service Transition | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 2,300 |
| Emergency Department Integration System (EDIS) | $ - | $ 288 | $ - | $ - | $ - | $ 1,200 | $ - | $ 1,900 |
| Blind Rehabilitation/VIST | $ - | $ 655 | $ - | $ - | $ - | $ 2,000 | $ - | $ 1,297 |
| 4-SIGHT Automated Eyeglass Ordering | $ - | $ - | $ - | $ - | $ 205 | $ - | $ - | $ 949 |
| VistA Integration Adapter (VIA) | $ - | $ 1,163 | $ - | $ - | $ - | $ 1,800 | $ - | $ 765 |
| Automated Patient Discharge | $ - | $ - | $ - | $ - | $ - | $ 1,606 | $ - | $ 605 |
| VistA - Radiology/Nuclear Medicine (RAD/NM) | $ - | $ - | $ - | $ - | $ - | $ 3,200 | $ - | $ 500 |
| Radiation Oncology | $ 120 | $ - | $ - | $ - | $ - | $ 400 | $ - | $ 280 |
| eScreening | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 200 |
| Posttraumatic Stress Disorder Checklist 5 (PCL-5) | $ 1,100 | $ - | $ - | $ - | $ 3,200 | $ - | $ - | $ - |
| Mental Health (MH) Screening and Identification | $ - | $ - | $ - | $ - | $ 2,000 | $ - | $ - | $ - |
| AudioCare | $ - | $ - | $ - | $ - | $ - | $ 3,390 | $ - | $ - |
| VistA Audit (VSRA) | $ - | $ - | $ - | $ - | $ - | $ 2,900 | $ - | $ - |
| Suicide High Risk Patient | $ 1,000 | $ - | $ - | $ - | $ - | $ 1,000 | $ - | $ - |
| Veterans Integrated Service Network (VISN) 10 Central Fabrication Unit | $ - | $ - | $ - | $ - | $ - | $ 100 | $ - | $ - |
| VistA Security Remediation | $ - | $ 3,058 | $ - | $ - | $ - | $ - | $ - | $ - |
| Suicide Prevention Package | $ - | $ 2,281 | $ - | $ - | $ - | $ - | $ - | $ - |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 368 | $ - | $ - | $ - | $ - | $ - |
| **Digital Health Platform** | **$ 9,499** | **$ 15,139** | **$ 368** | **$ -** | **$ 11,807** | **$ 41,034** | **$ -** | **$ 50,504** |

Digital Health Platform (DHP) includes capabilities that deliver high quality, Veteran-centered care that provides access to coordinated VA healthcare services. These products aim to enable VA to leverage existing data and knowledge to discover new information, identify early indicators of diseases and illnesses, determine the most effective treatments, determine best practices by using

algorithms to make inferences on individuals or cohorts and manage reports and inferences in clinical and administrative workflows. Digital Health supports expansion of the VA's Mental Health (MH) programs which provide a range of clinical services aimed at treating Veterans presenting with MH issues from mild, uncomplicated to severe issues, to those presenting in acute suicidal risk. VA MH is developing evidenced based approaches to treat five core conditions: PTSD, Substance Use, Depression, Pain, and Sleep Disorders with the goal of decreasing suicide by improving or enhancing suicide screening and assessments.

The Health Data and Analytics Platform enables VA to leverage existing data and knowledge to discover new information; identify early indicators of diseases and illnesses; determine the most effective treatments; determine best practices by using algorithms to make inferences on individuals or cohorts and manage reports and inferences in clinical and administrative workflows. This capability should result in identifying the most effective and efficient treatments for our Veterans, expedite the identification of diagnoses indicators, and improve the implementation of best practices for treatment. This platform also enables VA to transition from outdated, expensive, customized, and vertically integrated solutions to a best-practice approach based upon enterprise data integration and management leveraging a system of commercial SaaS platforms for improved treatment practices. This approach will also facilitate VHAs ability to focus on creating new methods and strategies using algorithms for improved operations management rather than creating uncoordinated solutions for every application.

The Mental Health Assistant (MHA) provides a Graphic User Interface (GUI) for VistA and Non-VistA mental health assessment and scoring information. The application provides a real-time web-based interface for assessing/determining patient mental health and suicide risk factors. The MHA supports the VA Suicide Prevention Program and Office of Mental Health & Suicide Prevention by providing the IT platform (also accessed from iPad and kiosk) specific to VA's suicide prevention efforts. The system captures the Capture At-Risk Veteran Data Initiative data elements, which are used for aggregating screening, referral, and assessment data for at-risk Veterans throughout their course of treatment. The system utilizes standardized assessment tools and risk assessments to reduce Veteran suicide rates through early identification of Veterans at high risk for suicide.

VA MH programs provide a range of clinical services aimed at treating Veterans presenting with MH issues ranging from mild or uncomplicated, to severe issues such as those presenting an acute suicidal risk. The guiding principles/goals of VA MH programs are: to provide Veteran-centric, recovery oriented care; maximize access to care; early and proactive identification of Veteran's mental health care needs and suicidal risk; utilize evidence and measurement based practices in the delivery of care; decrease stigma associated with mental health treatment; improv the health of Veterans by addressing whole health needs in the Patient Aligned Care Team setting; increase use of technology to facilitate efficient, quality care; and expand partnerships with other government agencies and communities. VA MH is developing evidenced based approaches to treat five core conditions: post-traumatic stress disorder (PTSD), substance abuse, depression, pain, and sleep disorders. The goal is to decrease suicide by improving or enhancing suicide screening and assessments. This effort directly impacts the VA's ability to reduce Veteran suicide. Specifically, this effort will add over 30 new instruments to the MHA package, which will allow clinicians to electronically administer mental health assessments to patients in support of VA's Suicide Risk Assessment & Measurement Based Care Initiative. This effort will make information for Veterans

at high risk for suicide available at the enterprise level and enable more rapid self-harm/suicidal identification and intervention processes across VA. Mental Health providers will have the tools to proactively monitor and support the progress of Veterans under their care.

The Blood Bank maintenance project produces patches to correct defects and maintain regulatory compliance for the transfusion of blood products by the VA Blood Bank hematologists. Regulatory inputs include College of American Pathologists, Food and Drug Administration, International Council for Commonality in Blood Banking Automation, and Joint Commission. This provides ongoing oversight, security, and support for any deployed VHA Blood Bank software product including regulatory compliance required as the medical device manufacturer.

Health care services related to Military Sexual Trauma (MST) have been offered to former service members with veteran status for many years, but there has never been a standardized way to denote this special eligibility in health care registration business processes. Due to Section 5301 of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (aka the Megabus Act), all MST-related health care services are now offered to Veterans and former Service Members with Other Than Honorable (OTH) discharge, increasing the patient population size further. VA Staff currently code non-enrollees seeking MST-related care using eligibility codes that are partially or wholly incorrect. Non-enrolled Veterans are usually coded as "Humanitarian"; this code is intended to be used for situations such as natural disasters and is incorrectly being used for MST patients. Non-enrolled OTH former Service members are coded as "Expanded MH Care Non-Enrollee"; this code is intended to be used for OTH patients eligible for mental health care only and does not correctly reflect that OTH MST survivors are now eligible for MST-related medical care as well. Enterprise-Wide Speech Recognition (EWSR) is a speech recognition system utilized by clinicians for non-radiology applications. To ensure continuation of quality patient care, VHA seeks to maintain and support the Medical-Specific Enterprise-Wide Front-End Speech Recognition System, which optimizes an enterprise-wide system; improves productivity and user satisfaction of clinicians; reduces cost of transcription; and improves accuracy and quality of medical documentation and ultimately enhances patient-centered care. This system also helps with sharing best practices, achieving operational efficiencies, and leveraging economies of scale.

4-Sight Automated Eyeglass Ordering is a business model that promotes standardization of procurement of eyeglasses for Veterans by using data to perform automation Actions in VistA. The 4-Sight Automated Eyeglass Ordering Program works by collecting the implementing site's consult data overnight from the VA CDW to be stored in the 4-Sight Automated Eyeglass Ordering database. The 4-Sight Automated Eyeglass Ordering application uses this data to perform automation Actions in VistA that cover both ordering and reconciling payments so that the VA cost of eyeglasses reflect accurately on patients' records. 4-Sight Automated Eyeglass Ordering has significantly reduced the burden of eyeglass ordering on purchasing agents and since 4-Sight Automated Eyeglass Ordering 's inception in July 2018, 4-Sight Automated Eyeglass Ordering has processed 112,347 orders across two VISNs. The number of hours saved ordering eyeglasses in 2018 with 4-Sight Automated Eyeglass Ordering is approximately 3,600 hours. The current process for eyeglasses is highly decentralized, repetitive, tedious, and riddled with inefficiencies. With 4-Sight Automated Eyeglass Ordering, purchasing agents no longer need to devote 20-25 hours per week ordering eyeglasses, reconciling those charges, and following up with orders that

either were not completed by the contract vendor or need to be re-done This has the effect of increasing overall procurement ability of the purchasing agent by approximately 19 percent.

2023 funding for the Digital Health Platform will continue ongoing operations and maintenance of the DHP products such as the Automated Patient Discharge, Blind Rehab, Emergency Department Integration System (EDIS), eScreening, Radiation Oncology, VistA - Radiology/Nuclear Medicine (RAD/NM), VistA Audit Solution (VAS) and VistA Integration Adapter (VIA).

**Hardware Maintenance – $43.0 million *(Operations and Maintenance)***
The 2023 Budget Request will be supplemented with $2.4 million from ARP Section 8002 and includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| VHA Hardware Maintenance | $ - | $ - | $ - | $ - | $ - | $ 43,000 | $ - | $ 43,000 |
| VHA Hardware Maintenance - CARES Act | $ - | $ 6,243 | $ - | $ - | $ - | $ - | $ - | $ - |
| VHA Hardware Maintenance - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 2,300 | $ - | $ 2,415 |
| **Hardware Maintenance** | **$ -** | **$ 6,243** | **$ -** | **$ -** | **$ -** | **$ 45,300** | **$ -** | **$ 45,415** |

The Hardware Maintenance Project is comprised of recurring payments for extended warranty and support for critical operational hardware components in support of the Enterprise, VA Administrations and Staff Offices. Hardware Maintenance is considered a 'must pay' requirement to support customer service level agreements. Hardware Maintenance also provides for emergent requirements to replace broken equipment to facilitate the timely restoration of IT operational systems. The VHA Hardware Maintenance represents the estimated steady-state charges for legacy system support for the specific and unique VHA systems that were not included in the SLA.

**Pharmacy – $18.3 million *(Operations and Maintenance)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| APPRISS Health PMP Gateway | $ - | $ - | $ - | $ - | $ - | $ 7,288 | $ - | $ 6,600 |
| Pharmacy Automated Dispensing Equipment | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 4,313 |
| Inbound ePrescribing (eRx) | $ 5,568 | $ 2,865 | $ - | $ - | $ - | $ 6,010 | $ - | $ 2,350 |
| Pharmacy Operational Updates | $ 2,371 | $ - | $ - | $ - | $ - | $ 1,130 | $ - | $ 2,200 |
| Advanced Medication Platform (AMPL) - Pharmacy Graphic User Interface (GUI) | $ - | $ 2,348 | $ - | $ - | $ - | $ 1,600 | $ - | $ 1,650 |
| VistA - Pharmacy: Inpatient Medications | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 1,150 |
| State Prescription Monitoring Program (PDMP) Integration | $ 1,332 | $ 8,779 | $ - | $ - | $ - | $ - | $ - | $ - |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 2,000 | $ - | $ - | $ - | $ - | $ - |
| **Pharmacy** | **$ 9,271** | **$ 13,992** | **$ 2,000** | **$ -** | **$ -** | **$ 16,028** | **$ -** | **$ 18,263** |

The Pharmacy Congressional Project contains a group of sub-programs that allow the service to continue to provide highly reliable cutting-edge service and enhanced safety in an efficient and consistent manner. Electronic Pharmacy products eliminate manual and paper prescriptions, support access to care and ensure compliance with mandated e-prescription use. Pharmacy will increase the safety and efficiency of the pharmacy workflow while providing consistent prescription processing services. Pharmacy ensures increased communication with the external pharmacy to confirm the patient is getting the prescription needed, support access to care by partnering with the patient's preferred provider and reduce prescription overdosing.

The APPRISS Health Prescription Monitoring Program (PMP) Gateway project funds VA's consumption of a service which provides the VA clinician with access to the States' Prescription Drug Monitoring Databases. This increased visibility into the Veteran's complete prescription history will also reduce the likelihood of over-prescription or abuse of controlled medications. The expected outcome is to continue to reduce the impact of opioid addiction among our Veterans.

The Pharmacy Automated Dispensing Equipment (PADE) software connects medication storage equipment to the VA EHR and allows for real-time inventory control. This project will enhance the PADE software so that new vendor products can be used at VA. The VA Nurse uses the equipment to retrieve medications as needed in the inpatient healthcare setting. Proper inventory control assures that the medications are available as needed. The PADE project, released at the end of 2016, left several apportioned requirements that have not been developed. These requirements are necessary to fully transition the workflow of inpatient pharmacy automation interfaces to a wholly internal Class I interface. The PADE software provides for accurate inventory control and availability of medications needed by Veterans in the inpatient setting. As medication storage equipment reaches end of life, it is replaced with newer equipment by the VA healthcare facilities. Enhancements are needed to update the software so it can continue to function with the newer vendor products.

The Inbound ePrescribing (eRx) project provides for the certification of the inbound prescription product, which allows VA to participate in the electronic receipt of prescriptions by community

providers to VA Pharmacists. As a result of this project, prescriptions written for the Veteran by non-VA healthcare providers are electronically transmitted to the VA to be filled. This transmission eliminates the need for the Veteran to bring a paper prescription to the VA for processing. Having the capability to receive electronic prescriptions from community providers will reduce errors that can be present on paper prescriptions, increase the Veteran's access to healthcare, and save the Pharmacist time that can be reallocated to providing care for the Veteran and delivering better customer experience. Prescriptions filled at the VA also save the Veteran copayment costs and improve the documentation of medications taken by the Veteran.

The Pharmacy Operational Updates project will provide enhancements to the VA Pharmacy software that will allow interoperability between the pharmacy software at different VA facilities. The enhancement will allow the Veteran to obtain VA-prescribed medications from any VA facility. The end-user of the product will be VA Pharmacists and other pharmacy staff who utilize VA's pharmacy software. The Pharmacist will electronically retrieve the prescription from the originating VA facility and use the existing clinical decision support logic to dispense the medication. This will reduce the wait time for Veterans to receive medications when they are not near their normal VA facility. With this enhancement, the Veteran will be able to obtain VA-prescribed medications from any VA facility. The current process for dispensing medications when away from the home facility requires a manual process. The Pharmacist will be able to provide fast and efficient fulfillment of the Veteran’s prescriptions at any VA facility. This is important to the modern, more mobile Veteran.

The Advanced Medication Platform (AMPL) - Pharmacy Graphic User Interface (GUI) project will maintain the GUI for VA Pharmacists and enable it to present data from multiple data sources which the Pharmacists currently must search for. By providing for hosting and support of the Pharmacy User Interface, the Veteran will be at reduced risk for negative outcomes due to inappropriate medication processing. The Pharmacist currently searches multiple data sources to find all the medications and other factors that impact the fulfillment of the prescription. This takes extra time and is subject to human error. The automation provided by this product will shorten this time-consuming process, as well as provide a reduction in processing errors.

The VistA - Pharmacy: Inpatient Medications project maintains the existing interfaces between the VA’s Electronic Health Record and the equipment which stores medications administered by the nursing staff within inpatient settings at the VA medical centers. Proper maintenance of this interface increases the likelihood that needed medications will be available to the Veteran in the inpatient settings. The interface allows the medication storage equipment to communicate with VA EHR to maintain a real-time inventory and request replenishments automatically.

**Connected Health/Mobile Apps – $15.0 million (*Operations and Maintenance)***
The 2023 Budget Request will be supplemented with $9.0 million from ARP Section 8002 and includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Mobile Application Platform (MAP) | $ - | $ - | $ - | $ - | $ - | $ 14,230 | $ - | $ 14,950 |
| Mobile Development | $ - | $ 7,793 | $ - | $ - | $ - | $ - | $ - | $ - |
| Mobile Development CARES Act | $ - | $ 6,298 | $ - | $ - | $ - | $ - | $ - | $ - |
| Mobile Development - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 8,000 | $ - | $ 9,000 |
| **Connected Health/Mobile Apps** | **$ -** | **$ 14,091** | **$ -** | **$ -** | **$ -** | **$ 22,230** | **$ -** | **$ 23,950** |

Connected Health/Mobile Apps supports the VA Mobile Application Platform (MAP) which is essential to VA telehealth visits, mobile applications for Veterans and staff members, Veteran facing websites, plus supporting databases and services. MAP hosts VA Video Connect, VA Online Scheduling, as well as services consumed by VA websites and My HealtheVet and is a common hosting framework that enables faster development, resulting in better customer experience. Without MAP, VA would never have adapted to meeting Veterans' needs since the beginning of the pandemic. VA's telehealth capabilities during the COVID-19 pandemic enabled record numbers of Veterans and VA healthcare professionals to use telehealth for the first time to access VA care safely and remotely. In 2021, VA provided Veterans more than 9.5 million VA Video Connect visits (healthcare appointments) in their homes via mobile devices, laptops, or desktop computers. That represents an increase of greater than 146 percent compared to 2020 and over 3,100 percent compared to 2019. In 2019, 99,300 unique Veterans used telehealth. That number jumped dramatically to 1,129,775 in 2020 and then expanded to 1,911434 in 2021. MAP supported each of those Veterans and every telehealth appointment those Veterans experienced. Additionally, 98 percent of VA mental health and 96 percent of VA primary care health care professionals have conducted at least one VA Video Connect visit, with the number of VA Video Connect visits peaking at more than 47,000 in a single day in 2021. This growth in telehealth appointments depended entirely upon the MAP. MAP's modernization and expansion is necessary to adapt to pandemic and post-pandemic treatment modality shifts along with the increasing demand that the younger, digitally native generation of Veterans will place on VA into 2028.

**Scheduling – $13.1 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| VistA - Scheduling (VSE) | $ - | $ 6,966 | $ - | $ - | $ - | $ 5,150 | $ - | $ 6,500 |
| VA Online Scheduling (VAOS) | $ - | $ 4,000 | $ - | $ - | $ - | $ 6,000 | $ - | $ 6,000 |
| Patient Centered Management Module Web (PCMM Web) | $ - | $ 515 | $ - | $ - | $ - | $ 1,000 | $ - | $ 610 |
| **Scheduling** | **$ -** | **$ 11,482** | **$ -** | **$ -** | **$ -** | **$ 12,150** | **$ -** | **$ 13,110** |

Scheduling provides a platform for Veterans to access Community Care and Telehealth services. Scheduling provides an immediate improvement in the Veteran experience by allowing more

timely access to care as well as improved employee satisfaction through use of modern interface which improves scheduler efficiency. This allows Veterans to self-schedule appointments, manage appointments, get tele-urgent care, and get access to community care. The ability to direct schedule reduces the need for staff to call Veterans and manually schedule appointments for clinical and community care.

The VistA Scheduling Enhancement (VSE) application is used by all schedulers to schedule all Veteran appointments for Veteran Affairs until Cerner is completely rolled out nationwide. VistA Scheduling is a scheduling solution bridge that the business is currently using as VA moves to the OEHRM/ Cerner solution. The VSE product provides the VA the ability to schedule an appointment for 158 VA facilities supporting nearly 54,000 scheduling personnel. VistA Scheduling is a scheduling solution bridge that the business is currently using as VA moves to OEHRM/Cerner solution. If VSE requirements are not funded the VA will be forced to revert the VistA roll and scroll interface which is slow, outdated, and provides minimal benefit to the user. VSE GUI is inadequate to meet scheduling needs until the Cerner solution is available as it requires scheduling in multiple systems. Inadequate funding would eliminate the capability for schedulers to efficiently schedule not only regular appointments but Telehealth appointments as well. The purpose is an immediate improvement in Veteran experience by more timely access to care. Another result is improved employee satisfaction through use of modern interfaces which improves scheduler efficiency.

VA Online Scheduling (VAOS) allows for self-scheduling and tracking the status of appointment requests, messages, and notifications about appointments. VAOS also allows Veterans to determine and request access to Community Care and helps schedule and manage Telehealth services and appointments. VAOS will also be utilized to schedule COVID vaccinations nationwide.

VAOS is critical to expand Veteran access to care and provide virtual healthcare services to Veterans who would rather not seek care in the community. Funding is required to sustain the existing Mobile Health infrastructure and will support the infrastructure for mobile applications including the Mobile Cloud pipeline hosted in Amazon Web Services (AWS).

The Patient Centered Management Module Web (PCMM Web) project establishes continued improvements necessary for VSE to support the scheduling priorities within the VA prior to the deployment of Cerner Scheduling System (CSS). An Enhancement that is currently being considered by VSE is the integration of telehealth scheduling into VSE that will ease and reduce errors in scheduling telehealth appointments as well as in converting current face-to-face to telehealth appointments. VSE is also looking to integrate Scheduling Manager within VAOS and other capabilities with respect to military sexual trauma. The purpose is an immediate improvement in Veteran experience by more timely access to care. The VSE product provides the VA with the ability to schedule an appointment for 158 VA facilities supporting nearly 54,000 scheduling personnel. VistA Scheduling is a scheduling solution bridge that the business is currently using as VA moves to the OEHRM/Cerner solution. VistA Scheduling served the Veterans with over 59 million completed appointments in 2020.

**Registries – $8.3 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Veterans Integrated Registries Platform (VIRP) | $ 1,000 | $ - | $ - | $ - | $ - | $ 7,000 | $ - | $ 6,455 |
| Clinical Case Registries (CCR) | $ - | $ 445 | $ - | $ - | $ - | $ 500 | $ - | $ 815 |
| Veteran Re-Entry Search Service (VRSS) | $ - | $ 288 | $ - | $ - | $ - | $ 200 | $ - | $ 555 |
| Homeless Management Information System (HMIS) | $ - | $ 342 | $ - | $ - | $ - | $ 250 | $ - | $ 275 |
| Cardiac Device Monitoring System | $ - | $ 548 | $ - | $ - | $ - | $ 550 | $ - | $ 150 |
| Veterans Administration Central Cancer Registry | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 80 |
| State Veterans Home Program[1/] | $ 200 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Implant Tracking Registry and Alert System (ITRAS) | $ - | $ 5,709 | $ - | $ - | $ - | $ - | $ - | $ - |
| **Registries** | **$ 1,200** | **$ 7,332** | **$ -** | **$ -** | **$ -** | **$ 8,500** | **$ -** | **$ 8,330** |

[1/] State Veterans Home Program realigned from Registries Congressional Project to Community Care Congressional Project in 2022

The Registries Project is responsible for the development and the operations and maintenance of Congressionally mandated registries. The Veterans Integrated Registries Platform (VIRP) is a centralized architectural platform for the national health registries and is comprised of standardized common patient data and registry-specific data elements. The primary function of each registry is to identify the Veterans with specific diseases and/or other conditions. The registry ensures and promotes the delivery of high-quality care to that Veteran. VIRP also provides clinician on-demand reporting capabilities and integrates ad-hoc reporting/query capabilities. Many of the VA registries are hosted on the VIRP.

Clinical Case Registries (CCR) provides a local VistA system program for population management. A national database exists for two of the populations: Hepatitis C and HIV. The national data are used by the HIV, Hepatitis, and Public Health Pathogens program office for the development, assessment, and improvement of national policy. The VA is required to provide annual maintenance and sustainment support to Clinical case Registries. The sustainment team can include additional registries through the same routine process as needed. This application contains important demographic and clinical data on VHA patients with these conditions, provides many capabilities to VA facilities that provide care, and treatment to patients with these conditions, including clinical categorization of patients and automatic transmission of data to the VA's National CCR. The CCR also provides clinical and administrative reports for local medical center use for the HEPC and HIV registries as well as 47 additional registries.

2023 funding for the Registries Project will continue ongoing operations and maintenance of the Health Registries products such as the Cardiac Device Monitoring System, CCR, Homeless Management Information System (HMIS) and Veteran Re-Entry Search Service (VRSS). To maintain and support the Eliminate Veteran Homelessness (EVH) National Homeless Registry, HMIS is an integral part of building a Homeless Registry within the VA. This Project aims to support the collection of Veteran's homeless data from what is called Continuum of Care (CoC) and provide the VA an integrated view of Veteran's homelessness. Veteran Re-Entry Search Service (VRSS) is an automated interface system designed to allow federal, state, and local correctional facility staff to upload their inmate registry listings at regularly scheduled intervals.

**Genomic Information System for Integrative Service (GenISIS) – $5.5 million (*Operations and Maintenance)***
The 2023 Budget Request will be supplemented with $0.3 million from ARP Section 8002 and includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Genomic Information System for Integrative Sciences (Genisis) | $ - | $ 2,193 | $ - | $ - | $ - | $ 5,279 | $ - | $ 5,500 |
| Genomic Information System for Integrative Sciences (Genisis) - CARES Act | $ - | $ 290 | $ - | $ - | $ - | $ - | $ - | $ - |
| Genomic Information System for Integrative Sciences (Genisis) - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 290 | $ - | $ 290 |
| **Genomic Information System for Integrative Service (GenISIS)** | **$ -** | **$ 2,483** | **$ -** | **$ -** | **$ -** | **$ 5,569** | **$ -** | **$ 5,790** |

The Genomic Information System for Integrative Sciences (GenISIS) Data Request Portal (GDRP) provides a central infrastructure to support VA genomic medicine studies for facilitating recruitment and enrollment of MVP participants, automating study-related logistics including study enrollment, capturing clinical study data, consent, blood-sample tracking, and genomic-data storage. GenISIS provides the secure, analytical infrastructure necessary to conduct robust genomic and bioinformatics-related data management and data analysis.

**Beneficiary Travel – $5.0 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Beneficiary Travel Self-Service System (BTSSS) | $ - | $ 801 | $ - | $ - | $ - | $ 2,750 | $ - | $ 2,748 |
| Beneficiary Travel Self-Service System (BTSSS) CARES Act | $ - | $ 315 | $ - | $ - | $ - | $ - | $ - | $ - |
| Vet Ride (VTSHS) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 2,283 |
| Veterans Transportation Service (VTS) Integration | $ 2,540 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| **Beneficiary Travel** | **$ 2,540** | **$ 1,116** | **$ -** | **$ -** | **$ -** | **$ 2,750** | **$ -** | **$ 5,031** |

Beneficiary Travel Self-Service System (BTSSS) is an MS Dynamics based self-service application designed to maximize Veteran experience (digital/online vs paper submission) and Agency efficiency/accuracy (automated rules engine and integration to financial payment system). The funds will be used to provide product and delivery management, systems architecture, software development, user research, user experience strategy, information architecture, integration support, and data analytics via the Power BI Tool to build and continuously improve

new and existing D365 solutions. This project will help to automate the manual and labor-intensive claims processing environment by providing program integrity tools to detect fraud, waste, and abuse, automating waiver exceptions, electronically passing vouchers for direct deposit, enhancing the audit process, and streamlining current work processes.

VetRide also continues to deploy RideShare Software (120 sites currently) to 172 VAMC's and identify critical VistA/CERNER integration points. Today the program is working closely with VA's Office of Rural Health, Homeless Program, Veteran Transportation Network (VTN) and Spinal Cord Injuries (SCI) Centers to improve the network of transportation services and increase access to VA services. VetRide will continue implementing the 2010 EVEAH/T-21 Veterans Transportation Service (VTS) Initiative. It will also improve travel and transportation services, implement Mobility Management, and establish a network of community transportation service providers that includes the Veteran Service Organizations (VSOs), community transportation providers and the federal, state, and local governments.

VetRide provides a potential first step in the creation of a transportation service through which an optimal and cost-effective ride is arranged and managed, providing Veterans with the most convenient and timely access to transportation services. VetRide provides travel to and from VA facilities for the large Veteran population located throughout the rural communities of the United States who would otherwise be unable to receive treatment from the VA. Veterans Transportation Program (VTP) provides transportation services to Veterans of all types of disabilities. It does this by tracking them through its pickup-appointment-and-return transportation service. It also provides for reimbursement for travel to VA facilities. The sustainment-steady-state use of these funds will continue to track and monitor Veteran travel requests within VA Medical Centers and prevent improper payment for beneficiary travel.

**Access & Billing – $4.5 million *(Operations and Maintenance)***
The 2023 Budget Request includes the following sub-project:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Claims Processing & Eligibility System (CP&E) | $ - | $ 5,021 | $ - | $ - | $ - | $ 4,500 | $ - | $ 4,514 |
| **Access & Billing** | **$ -** | **$ 5,021** | **$ -** | **$ -** | **$ -** | **$ 4,500** | **$ -** | **$ 4,514** |

Access & Billing supports the Claims Processing & Eligibility System (CP&E). The CP&E product handles the eligibility and claims payments functions for five Congressionally mandated programs: Civilian Health and Medical Program of the VA (CHAMPVA); CHAMPVA Caregiver; Children of Women Vietnam Veterans (CWVV); Foreign Medical Program (FMP); and Spina Bifida. The primary application is CHAMPVA, which is a comprehensive health care program in which the VA shares the cost of covered health care services and supplies with eligible beneficiaries. The end users of the application are VA Veteran and Family Member Program (VFMP) team members who process eligibility and claims. The Access & Billing programs support timely and accurate processing of VFMP claims. The CP&E system also processes

eligibility and reimburses providers for Community Care obtained by Veteran Family Members and Veterans in foreign locations. These payments enable Community Care providers to continue providing Community Care services to the Veterans and Veteran Family Members. Without CP&E, VA would have continued claims backlog system outages due to aging systems. This does not meet the needs of the MISSION Act, specifically Section 113 to meet regulatory guidelines and to modernize the CP&E System. The accuracy of these payments is a strict fiduciary responsibility.

**Lab – $4.2 million *(Operations and Maintenance)***
The 2023 Budget Request includes the following sub-project:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Laboratory System Reengineering PathNet (LSRP) | $ - | $ 4,118 | $ - | $ - | $ - | $ 4,044 | $ - | $ 4,200 |
| **Lab** | **$ -** | **$ 4,118** | **$ -** | **$ -** | **$ -** | **$ 4,044** | **$ -** | **$ 4,200** |

The Laboratory System Reengineering PathNet (LSRP) product delivers an industry-leading commercial Laboratory Information Management System for the Pathology & Laboratory Medicine Services at Department of Veterans Affairs. It is interfaced with the VA Electronic Health Record and is focused on patient-centric reporting and correcting patient safety issues. The Pathology and Laboratory services use this product to process and deliver results for all laboratory tests conducted at the facility. This product allows Veterans to receive timely and accurate care based on their lab values reported through the Laboratory System Reengineering product. This provides better information to clinicians, leading directly to improved outcomes for Veterans. The anticipated migration to the Cerner Electronic Health Record will provide for this function once the facility migrates in 2028.

**Registration, Eligibility, Enrollment – $2.0 million *(Operations and Maintenance)***
The 2023 Budget Request includes the following sub-project:

| Sub-Projects *($s in thousands)* | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Bed Management Solution (BMS) | $ - | $ 227 | $ - | $ - | $ - | $ 3,500 | $ - | $ 2,000 |
| Bed Management Solution (BMS) - CARES Act | $ - | $ 2,379 | $ - | $ - | $ - | $ - | $ - | $ - |
| **Registration, Eligibility, Enrollment** | **$ -** | **$ 2,607** | **$ -** | **$ -** | **$ -** | **$ 3,500** | **$ -** | **$ 2,000** |

The Bed Management Solution (BMS) provides a GUI for VistA and Non-VistA bed and patient movement information. The application provides a real-time web-based interface for tracking patient movement and determining bed availability. BMS pulls all bed status from VistA via a unidirectional feed. BMS provides reporting and other key features including individual Veterans clinical needs during evacuation to optimize patient movement in response to local, regional, and

national disasters. BMS is also currently being used by VHA leadership and the Health Operations Center (HOC) for daily operations monitoring as it is the sole source of key real-time occupancy data. Enhancements to the BMS further improve timely access to inpatient care by enabling VHA staff to monitor available beds (supply) and patient demand (patient pending bed placement list) to fully support enhanced and convenient access to care for Veterans.

BMS is the only mandated VHA software, per VHA Directive 1002, for this patient/bed tracking and management purpose. It expedites safe patient flow/transfers within, between and among VA medical facilities and community care medical facilities nationally to include VISNs. Enhancements of the application will improve and expand the application's flexibility to adapt to emerging health care issues (including COVID-19) while maintaining the ability and speed at which patients can be placed in beds. It continues to positively impact the ability of clinical and administrative staff to effectively coordinate available beds for patients. It also provides the ability to monitor bed availability and report the inventory of available beds for planning purposes. BMS will require continuing sustainment of vital operational needs such as Tier 3 support, defect repair, and break fixes.

## 2023 Benefits Portfolio

The Benefits Portfolio addresses the technology needs for the lines of business managed by the VBA: Compensation, Pension, Loan Guaranty, Insurance, Education, and Vocational Rehabilitation. The Benefits Portfolio provides support for essential programs and services to Veterans and their families.

In 2023, the Benefits Portfolio funding will be used to support VA priorities of Veterans Customer Experience (VCE) and Appeals Modernization.

The 2023 Benefits Portfolio Budget Request consists of the following Congressional Projects details:

| Priority Order[1/] | Congressional Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | | 2022-2023 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | | Increase/ Decrease |
| | | DEV | OM | DEV | OM | DEV | OM | DEV | OM | |
| | Other Benefits IT Systems | $ 830 | $ 9,448 | $ - | $ - | $ - | $ 21,370 | $ 8,000 | $ 41,489 | $ 28,119 |
| | Other Benefits IT Systems - CARES Act | $ - | $ 6,489 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | Veterans Customer Experience - VCE | $ 69,748 | $ 46,338 | $ 12 | $ - | $ 9,880 | $ 90,642 | $ 7,222 | $ 90,899 | $ (2,401) |
| | Veterans Customer Experience - VCE - CARES Act | $ 366 | $ 111,000 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | Veterans Customer Experience - VCE - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 84,899 | $ - | $ 84,899 | $ - |
| | Benefit Systems | $ 23,017 | $ 6,758 | $ 71 | $ - | $ 9,825 | $ 6,125 | $ 5,505 | $ 37,688 | $ 27,243 |
| | Veterans Benefits Management | $ 39,230 | $ 32,970 | $ 161 | $ - | $ 14,285 | $ 65,223 | $ - | $ 80,464 | $ 956 |
| | Veterans Benefits Management - VHA Transfer (P.L. 117-43 Section 151) | $ - | $ - | $ - | $ - | $ - | $ 9,578 | $ - | $ - | $ (9,578) |
| | Veterans Benefits Management - CARES Act | $ - | $ 1,109 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | IT Support Contracts | $ - | $ 124,724 | $ - | $ - | $ - | $ 79,000 | $ - | $ 79,000 | $ - |
| | Benefits Appeals | $ 6,000 | $ 5,815 | $ 76 | $ - | $ 3,400 | $ 16,443 | $ - | $ 13,397 | $ (6,446) |
| | Benefits Appeals - CARES Act | $ - | $ 2,436 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | Benefits Appeals - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 2,740 | $ - | $ 2,820 | $ 80 |
| | Education Benefits | $ 26,265 | $ 5,417 | $ 965 | $ - | $ 50,000 | $ 4,814 | $ - | $ - | $ (54,814) |
| | Education Benefits - VHA CARES Act Transfer | $ 45,000 | $ 26,573 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | **Total Benefits Portfolio** | **$ 210,456** | **$ 379,078** | **$ 1,284** | **$ -** | **$ 87,390** | **$ 380,834** | **$ 20,727** | **$ 430,656** | **$ (16,841)** |

1/ Please see the Appendix M for the Benefits Portfolio sub-projects ranked by priority order.

**Other Benefits IT Systems – $49.5** ***million (Development - $8.0 million, Operations and Maintenance - $41.5 million)***

The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Specially Adapted Housing/Special Housing Adaptations (SAH/SHA) | $ - | $ 1,259 | $ - | $ - | $ - | $ - | $ 8,000 | $ 1,052 |
| Digital GI Bill | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 15,262 |
| Benefits Enterprise Platform (BEP) | $ - | $ - | $ - | $ - | $ - | $ 10,140 | $ - | $ 11,743 |
| Education Legacy System Decommissioning | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 3,300 |
| Corporate WINRS (CWINRS) | $ - | $ 4,275 | $ - | $ - | $ - | $ - | $ - | $ 2,446 |
| Veterans Tracking Application (VTA) | $ - | $ 698 | $ - | $ - | $ - | $ 2,190 | $ - | $ 2,400 |
| Federal Case Management Tool (FCMT) | $ - | $ 1,339 | $ - | $ - | $ - | $ 1,803 | $ - | $ 1,857 |
| Quality Assurance Web Application (QAWEB) | $ - | $ 1,693 | $ - | $ - | $ - | $ 1,746 | $ - | $ 1,815 |
| Veterans Readiness and Employment Case Management Solution (VRE_CMS) | $ - | $ - | $ - | $ - | $ - | $ 1,404 | $ - | $ 1,116 |
| Life Insurance Policy Administration Solution (LIPAS) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 417 |
| Electronic Insurance (EIN) | $ - | $ 73 | $ - | $ - | $ - | $ - | $ - | $ 81 |
| Benefits Testing | $ - | $ - | $ - | $ - | $ - | $ 2,500 | $ - | $ - |
| Loan Guaranty | $ - | $ - | $ - | $ - | $ - | $ 915 | $ - | $ - |
| Beneficiary and Fiduciary Field System (BFFS) | $ - | $ - | $ - | $ - | $ - | $ 672 | $ - | $ - |
| Compensation Pension and Eligibility | $ 830 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Fiduciary Beneficiary System-Replacement (FBS-R) | $ - | $ 112 | $ - | $ - | $ - | $ - | $ - | $ - |
| Automated Performance Management System - CARES Act | $ - | $ 596 | $ - | $ - | $ - | $ - | $ - | $ - |
| Inquiry Routing and Information System (IRIS) - CARES Act | $ - | $ 5,893 | $ - | $ - | $ - | $ - | $ - | $ - |
| **Other Benefits IT Systems** | **$ 830** | **$ 15,937** | **$ -** | **$ -** | **$ -** | **$ 21,370** | **$ 8,000** | **$ 41,489** |

Other Benefits IT Systems supports the sustainment of critical operations, as well as continuous functionality improvement and system enhancements to various VBA IT systems to ensure reliable, accessible, and efficient benefits delivery for Veterans and their beneficiaries. This Congressional Project supports valuable insurance, education, and loan guaranty benefits processing that provides financial security, employment readiness, and housing adaptation grants vital to the needs of Veterans. Additionally, it supports development and modernization of the Special Adapted Housing/Special Housing Adaptations (SAH/SHA) grant program that ensures Veterans who have service-connected disabilities and require home/living accommodations will be better positioned to receive special adapted housing and/or special housing adaptations grants in a more expeditious manner. Other Benefits IT Systems Congressional Project supports the VA's strategic goal 2 and President's Management Agenda priority 2 by supporting the sustainment, enhancement and development of multiple systems and applications that play a key role in implementing benefits mandated by legislation and prioritized by OIT to our Veterans.

Special Adapted Housing/Special Housing Adaptations (SAH/SHA) will be contracting an agile delivery scrum team to re-design, re-develop, and build a standalone SAH/SHA application. This

is a complete re-write, modernization, deployment, and reconstruction of the application presently intertwined with the Loan Guaranty (LGY) Suite of Applications, thus making it a stand-alone application. This work involves developing increased grant expectations and the inclusion of better workflow processes and mechanisms into the application to enable LGY stakeholders to issue grants more efficiently and expeditiously.

SAH/SHA sustainment-steady-state sub-project will utilize a single team of individuals to support the present SAH/SHA application, ensuring operational readiness for the business line. This includes Authority to Operate (ATO) approval, patching and updates, new development production releases, as well as any emergencies that arise and cause production outages.

Digital GI Bill (DGIB) project is a joint effort between Education Services and OIT. DGIB aims to enhance VBA Education Claims Processing and technology services to provide world-class customer support and financial services. In 2023, OIT will continue to implement the DGIB capabilities; expedite and automate education claims and award processing; improve communications across various stakeholders; provide business analytics and reporting services as well as outreach customer services to schools and educational institutes. The end-to-end management service will ensure proper compliance and oversight of GI Bill programs, as well as the use of data and business intelligence to monitor and measure school and student outcomes. It allows for GI Bill students to engage with VA through electronic outreach and communications.

The 2023 sustainment-enhancement funding will allow OIT to enhance the enrollment manager capability which ensures faster, more accurate decisions for Veterans and beneficiaries, while also increasing efficient communication with schools and education providers. The effort will also involve data migration from Benefit Delivery Network (BDN) Mainframe to the Managed Services and VA Corporate Database which reduces VA’s organizational risk of reliance on outdated technology. Furthermore, improvements in claims processing automation leads to faster, more accurate, and more consistent benefits decisions for Veterans and beneficiaries.

The Benefits Enterprise Platform (BEP) ensures the continuation of Benefits Gateway Services (BGS) and VBA Corporate Database Data Architecture Services (DAS). Also, BEP provides the logical engineering and quality assurance necessary for sustainment requirements to VBA's legacy business systems to adjudicate claims, make payments, and maintain all VBA database auditing capabilities. Overall, BGS services are used by approximately 12 applications and 40,000 VA employees who support 20 million Veterans. BEP and BGS fulfill critical IT tasks by delivering integrated and interoperable services to ensure convenient and secure access to VA data and applications while improving the delivery of benefits, care and services for Veterans, Service members, their beneficiaries, VA partners and other stakeholders.

The Corporate, Waco, Indianapolis, Newark, Roanoke, Seattle (CWINRS) system tracks the services for disabled veterans and provides Vocational Rehabilitation Counselors (VRC), a case management toolset to provide counseling and training services. The benefits include Chapter 31 Veteran Readiness and Employment (VR&E), Chapter 35 (The Survivors and Dependents Educational Assistance Program), Chapter 36 (Educational and Career Counseling), and Chapter 18 (Benefits for Certain Children with Disabilities Born of Vietnam and Certain Korea Service Veterans). The 2023 funding request will be used to provide operations, maintenance, and

enhancement support for determining eligibility for the education benefits, as well as Generated Eligibility Determination (GED) Processing, Case Management, Voucher Processing, Setup and Administrations and Subsistence Allowance Awards Processing. CWINRS provides access for system users at VA Central Office and 57 of VA's Regional Offices (VARO) and their outstations as well as for VR&E Case Contractors.

Education Legacy System Decommissioning will facilitate the migration and transition of the functionalities of all education related legacy systems to DGIB managed services. The decommission tasks include the disconnection of system end points, termination of system operation, retirement of hardware, archiving of data, system procedure and documentation, etc.

The Education Legacy Systems that will be retired and transition to DGIB are listed below:

- VA Online Certification of Enrollment (VA ONCE)
- Web Enabled Approval Management System (WEAMS and WEAMS PUBLIC))
- Flight, On-the-job training, Correspondence, Apprenticeship System (FOCAS)
- Work Study Management System (WSMS)
- The Image Management System (TIMS)
- Web Automated Verification of Enrollment (WAVE)
- Long Term Solution Chapter 33 Claims Processing (CH33 Claims)
- BDN and all its subcomponents
- National Education WAVE Mass Address Navigator (NEWMAN)
- Electronic Certification Automated Processing (ECAP)

The Federal Case Management Tool (FCMT) supports VA priority, Business Systems Transformation to provide systems and technology enable employees to enhance the quality of the care and services to Veterans. FCMT supports OIT's OIT mission to collaborate with stakeholders and create the best experience for Veterans. Funding will continue the operation and maintenance support for FCMT including Application Maintenance, Security Management, Configuration Management, and Information Assurance.

The Quality Assurance Web Application (QAWEB) supports the VR&E program (also known as Chapter 31), which assists Veterans and Service members with service-connected disabilities and barriers to employment in their preparation to obtain and maintain suitable employment. QAWEB facilitates detailed analysis of case review results and tracks accuracy scores at each level to assist with identifying potential areas of improvement. Funding will continue the sustainment and maintenance support, which will provide the results and analysis of both national and local VR&E case reviews for quality assurance.

VR&E Case Management Solution (VRE_CMS) application, the modernization and replacement for legacy CWINRS, is a COTS/SaaS solution that provides VBA a case management solution service that enables Vocational Rehabilitation Counselors (VRC) engagement, data entry and documentation within a FedRAMP Certified cloud environment. The Funding acquires maintenance and help desk support for the CMS system, as well as sustainment for production functionality to ensure Veterans are paid appropriately and Veteran data is kept secure.

Life Insurance Policy Administration Solution (LIPAS) sustainment is required to provide the necessary resources for performing adaptive/perfective maintenance, providing support desk operations, and hosting for the insurance solution to provide our Veterans with the world-class service they deserve. Funds will provide operations and maintenance activities associated with the on-going support of the project. This includes the performance of routine, preventive, predictive, scheduled, and unscheduled actions aimed at preventing system/production failure and correcting software defects, with the goal of increasing efficiency and reliability on a continuous basis.

Electronic Insurance (EIN) is a suite of web applications for VA/Insurance to support the internal customers, as well as external customers (Veterans). Funds will provide professional support and software licenses to perform the sustainment work and keep the sub-project up and running. This will allow the VA to keep delivering the benefits/services to our customers.

**Veterans Customer Experience (VCE) – $98.1 million** ***(Development - $7.2 million, Operations and Maintenance - $90.9 million)***
The 2023 Budget Request will be supplemented with $84.9 million from ARP Section 8002 and includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| VA.GOV | $ 22,211 | $ 21,621 | $ - | $ - | $ 7,080 | $ 28,300 | $ 7,222 | $ 21,331 |
| VA.GOV CARES Act | $ 366 | $ 81,559 | $ - | $ - | $ - | $ - | $ - | $ - |
| VA.GOV American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 67,878 | $ - | $ 67,878 |
| Veterans Signals (VSignals) | $ 7,304 | $ 2,757 | $ - | $ - | $ - | $ 10,640 | $ - | $ 11,592 |
| Veterans Signals (VSignals) - CARES Act | $ - | $ 960 | $ - | $ - | $ - | $ - | $ - | $ - |
| Enrollment System | $ 8,555 | $ 4,013 | $ - | $ - | $ - | $ 13,120 | $ - | $ 9,885 |
| VA Knowledge Management System - eGain | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 6,166 |
| Patient Advocate Tracking System Replacement (PATS-R) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 5,808 |
| Community Care - Customer Relationship Management (CommCare) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 5,631 |
| Member Services - Customer Relationship Management | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 5,471 |
| Veterans Experience Integration Solution (VEIS) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 4,705 |
| E-Benefits Portal | $ - | $ - | $ - | $ - | $ - | $ 3,610 | $ - | $ 3,610 |
| Education Call Center (ECC) Customer Relationship Management (CRM) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 3,178 |
| Customer Experience Data Warehouse (CxDW) | $ 2,250 | $ 4,980 | $ - | $ - | $ - | $ 4,479 | $ - | $ 2,950 |
| Customer Experience Data Warehouse (CxDW) - CARES Act | $ - | $ 9,058 | $ - | $ - | $ - | $ - | $ - | $ - |
| Customer Experience Data Warehouse (CxDW) - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 11,481 | $ - | $ 11,481 |
| Customer Relationship Management Unified Desktop Optimization (CRM UDO) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 2,526 |
| Center for Development and Civics Engagement Portal (CDCEP) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 2,327 |
| White House VA Hotline (WHHL) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 1,842 |
| Veterans Crisis Line (VCL) | | | | | | | | $ 1,698 |
| Status Query and Response Exchange (SQUARES) | $ - | $ 1,481 | $ - | $ - | $ - | $ 1,583 | $ - | $ 1,583 |
| VistA Enrollment Application System | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 235 |
| Voluntary Service System (VSS) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 211 |
| Veterans Identification Card (VIC) Act 2015 | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 150 |
| Contact Center Solutions (CCS) | $ - | $ - | $ - | $ - | $ 2,800 | $ 10,745 | $ - | $ - |
| Customer Relationship Management (CRM) Platform | $ 27,929 | $ 7,955 | $ - | $ - | $ - | $ 18,165 | $ - | $ - |
| Customer Relationship Management (CRM) - CARES Act | $ - | $ 2,559 | $ - | $ - | $ - | $ - | $ - | $ - |
| Customer Relationship Management (CRM) - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 5,540 | $ - | $ 5,540 |
| Veterans Identification Card (VIC) | $ 1,500 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Enterprise Veterans Self Service (EVSS) | $ - | $ 3,531 | $ - | $ - | $ - | $ - | $ - | $ - |
| Enterprise Veterans Self Service (EVSS) - CARES Act | $ - | $ 16,863 | $ - | $ - | $ - | $ - | $ - | $ - |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 12 | $ - | $ - | $ - | $ - | $ - |
| **Veterans Customer Experience - VCE** | **$ 70,114** | **$ 157,338** | **$ 12** | **$ -** | **$ 9,880** | **$ 175,541** | **$ 7,222** | **$ 175,798** |

Veterans Customer Experience (VCE) achieves its mission of developing VA's customer experience capabilities through a portfolio of projects led by VA's Veterans Experience Office (VEO). These include:

- Customer Experience (CX) data, which provide real-time insights to inform service recovery and performance improvement efforts across VA administrations and staff offices
- Digital Modernization (DM), which delivers Veteran-friendly self-service tools through an intuitive mobile and web experience, and
- Contact Center Modernization (CCM), which delivers an enterprise model contact center while also consolidating the existing network of centers and integrating the VA Profile platform with Contact Centers' Customer Relationship Management (CRM) systems to provide the single source of Veteran contact information.

DM develops and integrates self-service tools to help Veterans navigate the catalog of VA services available to them and their families throughout their lifetime. DM platforms include VA.GOV, E-Benefits Portal and VA's flagship Health and Benefits mobile application. Through a plain-language, action-orientated approach, VA.GOV serves around 1.5 million unique users per month and links the top 20 tasks that 80 percent of users need, divided into four main benefit hubs: health care, disability, education, and records. Since its launch in late 2018, VA.GOV has seen overall customer satisfaction scores increase by 23 percent. The E-Benefits application suite includes the E-Benefits Portal, Stakeholder Enterprise Portal (SEP) and Veterans Online Application II Direct Connect (VDC). Since 2016, services available in E-Benefits have transitioned to VA.GOV. VA's flagship Health and Benefits mobile application launched in 2021 and is designed to service the 40 percent of VA.GOV users that access the site through their mobile device. In 2023, adequate sustainment funding is required to ensure these critical VA services remain operational to the Veterans that rely on them for health care, benefits and more. Further, enhancement funding needs to continue to DM projects like expansion of VA's flagship mobile application, sunsetting of E-Benefits, improvements to VA.GOV's self-service capabilities, and more.

Qualitative and quantitative CX data comes through Veterans Signals (VSignals). VSignals provides VA with multi-channel feedback mechanisms (digital surveys, comment cards, text analytics and social media listening) to gather Veteran and employee compliments, concerns and recommendations, identify Veterans in crisis, and ultimately improve Veteran experience across the spectrum of interactions that occur between Veterans, employees and VA. VSignals manages, analyzes and presents the experience data in an easy to use interface, providing VA leadership with the ability to understand what is working for customers and identify opportunities to improve the quality of benefits and services delivered to Veterans, their families, caregivers, survivors, and service members. By doing this, VA strengthens relationships with the Veteran and increases accountability, quality, service, and trust. VSignals is a SaaS application providing continuous customer experience insights to VA leadership across the enterprise. In 2023, VSignals must continue to maintain and enhance our Suicide Alert system so that the appropriate VA personnel are notified when an alert is triggered, aiding in suicide prevention - a key focus area for VA. VSignals aligns to the President and VA Secretary Priorities to listen to Veterans and build lifelong relationships and trust in VA; deliver excellent, equitable and secure Federal services and customer experience; and meet the 2023 OMB Planning Guidance Memo (IT Modernization and Cybersecurity Priorities) to improve customer experience.

The CCM initiative helps Veterans navigate the care, benefits, and services available to them within the VA through several national call centers. CCM efforts aim to modernize contact center technology and management capabilities through offering standard quality management, workforce management, data analytics, and customer relationship management tools. CCM provides a common technology platform for the existing network of VHA, VBA, NCA, and VA-wide contact centers, with the goal of providing contact center agents and management with a modern toolset. It also provides consistent and effective CX across VA's contact centers. These call centers include Community Care, VHA Member Services, VBA National Call Centers, Education Call Centers, VHA Patient Advocates, and operation of the White House Hotline. Collectively, over 140 million contacts and interactions (phone, chat, email, text) occur between Veterans and VA every year. In 2023, sustainment funding is vital for maintaining critical customer relationship management systems within these call centers. Sustainment-enhancement funding is crucial for incorporating omnichannel features (chat, email, text, etc.) throughout VEO Call centers.

**Benefit Systems – $43.2 million** ***(Development - $5.5 million, Operations and Maintenance - $37.7 million)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Other VBA System Transformation | $ - | $ - | $ - | $ - | $ - | $ - | $ 5,505 | $ 8,790 |
| Enterprise Management of Payments, Workload, and Reporting (eMPWR-VA) | $ 8,731 | $ 2,220 | $ - | $ - | $ - | $ - | $ - | $ 17,659 |
| Compensation and Pension Record Interchange (CAPRI) | $ 3,005 | $ - | $ - | $ - | $ - | $ 1,150 | $ - | $ 5,660 |
| Veterans Service Network (VETSNET) | $ - | $ 2,345 | $ - | $ - | $ - | $ 1,475 | $ - | $ 4,522 |
| VistA - CAPRI: Automated Medical Information Exchange | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 1,057 |
| Other VBA Legacy System Migration/ Decommissioning | $ 5,000 | $ - | $ - | $ - | $ 6,837 | $ 3,200 | $ - | $ - |
| BIRLS Migration / Decommissioning | $ - | $ 564 | $ - | $ - | $ 2,988 | $ - | $ - | $ - |
| VETSNET Claim Development Products | $ - | $ - | $ - | $ - | $ - | $ 300 | $ - | $ - |
| EFolder Enhancements | $ 4,280 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| VETSNET Decommissioning | $ 2,000 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| CAPRI C P Maintenance | $ - | $ 1,629 | $ - | $ - | $ - | $ - | $ - | $ - |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 71 | $ - | $ - | $ - | $ - | $ - |
| **Benefit Systems** | **$ 23,017** | **$ 6,758** | **$ 71** | **$ -** | **$ 9,825** | **$ 6,125** | **$ 5,505** | **$ 37,688** |

The Benefit Systems Congressional Project within the Benefits Portfolio supports VBA with current IT investments and systems for day-to-day operations of benefits processing for more than 5.5 million Veterans seeking disability compensation benefits from VBA. Systems within this Project support the 53 percent growth in disability benefits paid to Veterans from 2015 thru 2020,

as well as anticipated continued growth into the future. Benefit Systems Congressional Project supports the VA's strategic goal 2 and President's Management Agenda priority 2 by supporting the Board's mission in processing of claims in a secure and timely manner.

Other VBA System Transformation supports sustainment and enhancements to components such as DocGen, Benefits Processing Data Service API, Claims Service API and other components previously developed under this transformational sub-project which targets legacy and outdated components and technology). Steady-state requirements include "lights on support" (such as software licenses, production support, trouble shooting, break-fix efforts, and subsequent patching and fixes) which ensures that the component systems remain operational and reliable for processes that manage and provide benefits to Veterans. These components ensure the VBA is able to process claims and distribute critical benefits to Veterans in a timely and accurate manner. Enhancements deliver improved business functionality (meeting new legislative mandates, increased security, increased performance, improved storage structures, and improved automation) needed to ensure that claims are paid accurately and on time to Veterans. Modernizations include migrations to newer and more robust versions of middleware, operating systems, frameworks, and hardware. They may also target systems such as BDN, BGS, CSS, and VETSNET. This sub-project is cross cutting (i.e., crosses multiple product lines within the Benefits and Memorial Services portfolios) and supports systems that require modernization. Additionally, this sub-project covers the development of modern systems and services within the VBA ecosystem that provide new functionality and capabilities for the rapid and accurate processing and delivery of Veteran benefits.

Focus areas of Other VBA System Transformation include digitizing and constructively storing Veteran data (for effective use by other systems as well as improved automation and data analytics) and refactoring systems and services to allow them to process and automate claims and support the streamlining/modernizing of documentation generation more effectively. These activities will allow VBA to improve efficiencies and facilitate the transition away from legacy technology and processes. The Other VBA System Transformation also significantly improves VA processes and delivers benefits to Veterans and their beneficiaries by reducing the amount of wait time.

Enterprise Management of Payments, Workload, and Reporting (eMPWR-VA) system is a modern financial accounting and payment processing system that serves as a replacement system for the Finance and Accounting System (FAS) legacy system. This system supports both the information gathering and budgetary requirements for Disability Compensation, Pension and Chapter 31 benefits for VR&E Service programs. eMPWR-VA manages disbursements of over $129 billion in benefit payments to over 6 million Veterans and beneficiaries annually that reduces the risk of delayed or improper payments, thereby increasing the accuracy of benefits delivered to Veterans and improving the end user experience for over 500 VBA and Debt Management Center (DMC) employees. Sustainment includes Operations and Maintenance services, related testing services, help desk support and software license maintenance. eMPWR-VA is required to maintain compliance with legislative mandates, regulatory updates, or VA policies to ensure the system processes payments properly and meets all future expectations. Enhancements to eMPWR-VA will be required to support integration with Committee on Waivers and Compromises (COWC), Chapter 31, VAMS support DMC, Veteran Employment through Technology Education Courses

(VET TEC) and Science, Technology, Engineering and Math (STEM) automation, Financial Management Business Transformation (FMBT), Fraud detection algorithms/Investigative tool planning, Virtual Assistant automated text messaging like capabilities, Vendor Management for third party payees, FAS decommissioning and accounting rules and legislation updates. These enhancements will continue to ensure Veterans and their families will receive timely and accurate benefits while VA modernizes its payment systems. eMPWR-VA will continue to provide operation and maintenance support as well as decommission the FAS legacy system. VBA is currently undergoing significant transformation of its financial management business processes and financial legacy systems architecture. This effort includes improvement of user experience, automation of manual tasks, and re-engineering of business processes to build efficiencies within the financial management community. The enhancement funding for eMPWR-VA will support improved automations and efficiencies, strengthen VBA's internal controls, and ensure this increased workload does not result in delayed payment processing times for Veterans.

The Compensation and Pension Record Interchange (CAPRI) project requires funding for software requirements and one extra small system team for the sustainment and support services. The scope of this effort includes all activities needed to cover defect repair and user support with oversight provided by the CAPRI Integrated Product Team (IPT). This funding is required to continue to provide critical customer focused updates to maintain compliance to the Enterprise Disability Benefits Questionnaire used by VHA, VBA, DoD and contractor personnel to provide medical evidence to support Veterans' disability claims. This will entail updates for data accuracy, data security, and data standardization with all necessary systems.

CAPRI supports Compensation and Pension (C&P) exam information exchanged between VBA claims processing and VAMCs. This amounts to on average more than 1.5 million C&P medical disability exams processed each year. The CAPRI software acts as a bridge between the VBA and VHA information systems being the user interface to VistA. It offers VBA Rating Veteran Service Representatives and Decision Review Officers the ability to search and retrieve the evidence needed to build the rating decision documentation through online access to Electronic Health Record data found in the CPRS. It also offers VHA C&P staff an easy, standardized way of recording C&P Examination reports. CAPRI supports C&P exam management for tracking VBA exam requests and VHA exam fulfillment. It is the VHA clinicians' primary tool to provide VBA the medical evidence used to adjudicate Veteran disability claims.

Additionally, the CAPRI project requires funding to develop enhancements in CAPRI for any new requirements to include legislative changes (e.g., SSN Reduction, Toxic Exposure), support existing business needs for functional enhancements, PNCS Replacement (DBQ Management Tool), TRM updates (Delphi software and 3rd party software updates) as well as CERNER requirements in support of VHA VistA and VBA Exam Management changes.

The Veterans Service Network (VETSNET) project requires funding to maintain the lifecycle management of the VETSNET suite of applications (minus FAS & Tuxedo). This also supports about 60 batch processes and Oracle support for Veterans Benefits Management System (VBMS) products. VETSNET is a suite of applications that facilitates the entire C&P claims process. Within the suite, the end user can establish and develop Veterans claims; the rating decision, award and

notification letter are documented, and payment information is transmitted to Treasury which accomplishes the necessary accounting.

VETSNET is a custom-built suite of inter-related applications, designed and implemented to deliver critical business systems for compensation and pension claims processing. Throughout these activities, data is shared and passed between the applications to support end-to-end claims processing, customer service and notification. VETSNET is a fundamental component of VA's Enterprise Architecture in providing critical compensation and pension informational support to its customers through an integrated and technologically sound environment. The VETSNET applications support the payout of $4 billion a month in Veteran Benefits. VETSNET is a critical component of VBA, serving as the data source needed to support strategic VA initiatives, such as VBMS and Post 9/11 GI Bill/Chapter 33 educational benefits.

The modernization of VETSNET will allow decommissioning of interfaces from VETSNET and move those capabilities into VBMS or other authoritative OIT systems while increasing the speed at which claims can be processed by limiting the time VA users spend changing between systems. This also mitigates any risk of different data in multiple systems. This will quickly provide benefits and payments to Veterans and their families in a. Modernizing VETSNET will also allow the decommissioning of Visual Basic 6, which is an antiquated and unsupported software that is currently used in the VETSNET Suite of products. The functionality will be transferred to the VBMS Java software.

The VistA - CAPRI: Automated Medical Information Exchange (AMIE) project requires funding for a systems team which covers the sustainment and support of AMIE. The scope of this effort includes all activities needed to cover Tier 2 and Tier 3 sustainment support, defect repair and user support with oversight provided by the Compensation and Pension Integrated Product Team.

**Veterans Benefits Management – $80.5 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Veterans Benefits Management System (VBMS) | $ - | $ 25,114 | $ - | $ - | $ - | $ 53,236 | $ - | $ 65,770 |
| Veterans Benefits Management System (VBMS) - VHA Transfer (P.L. 117-43 Section 151) | $ - | $ - | $ - | $ - | $ - | $ 9,578 | $ - | $ - |
| Veterans Benefits Management System (VBMS) - CARES Act | $ - | $ 1,109 | $ - | $ - | $ - | $ - | $ - | $ - |
| Benefits Integration Platform (BIP) | $ 3,884 | $ - | $ - | $ - | $ 2,905 | $ 3,851 | $ - | $ 9,009 |
| Virtual VA | $ - | $ 3,147 | $ - | $ - | $ - | $ 1,400 | $ - | $ 2,420 |
| Veterans Assistance Discharge System (VADS) | $ - | $ 146 | $ - | $ - | $ - | $ - | $ - | $ 2,208 |
| CLAIMS | $ - | $ - | $ - | $ - | $ - | $ 5,808 | $ - | $ 1,057 |
| Claims Automation | $ 15,000 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Pension and Fiduciary Automation | $ - | $ - | $ - | $ - | $ 11,380 | $ - | $ - | $ - |
| Blue Water Navy (BWN) | $ 18,371 | $ 4,385 | $ - | $ - | $ - | $ 928 | $ - | $ - |
| Automated Rating for Select Disabilities | $ 1,975 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Benefits Integration Platform (BIP) Enhancement (Centralized Communications) | $ - | $ 178 | $ - | $ - | $ - | $ - | $ - | $ - |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 161 | $ - | $ - | $ - | $ - | $ - |
| **Veterans Benefits Management** | **$ 39,230** | **$ 34,079** | **$ 161** | **$ -** | **$ 14,285** | **$ 74,801** | **$ -** | **$ 80,464** |

Veterans Benefits Management (VBM) supports the continued operation and enhancement of IT solutions which enable greater efficiency in processing claims and delivering benefits to Veterans through high quality software development, platform system integration, data and analytics, and legacy technology modernization. Utilizing optimized business processes, the Benefits Integration Platform (BIP) and other key solutions (including VBMS), Veterans Assistance Discharge System (VADS), Virtual VA (VVA), and CLAIMS) this congressional project increases efficiencies for Veteran disability claims processing, improves the quality of service for end-users and Veterans, reduces the inventory backlog of Veteran claims and ensures the timely and accurate delivery of monthly disability benefits to Veterans. The Veterans Benefits Management Congressional Project supports the VA's strategic goals and President's Management Agenda by improving efficiency in processing claims for Veterans and ensures timely delivery of earned benefits.

Veterans Benefits Management System (VBMS) is the flagship application and system for VBA. VBMS provides continued viability of the mission critical primary functionalities of VBA automated claims processing. VBMS ensures Veterans and their families continue receiving accurate and up-to-date information about benefit decisions and supports the processing of new compensation, pension and fiduciary claims. VBMS claims processing automation reduces the risk of error created by manual VA staff processing while also reducing claims backlogs and increasing the accuracy and timeliness of claims. More specifically, VBMS will ensure the following: a seamless integrated and responsive customer service experience for Veterans by providing the back end single authoritative data source to VBA for the (1) automation of claims processing, elimination of errors associated with frequent duplicative data entry and additional burden; (2) improvements to eFolder to include access through Veteran facing applications; and (3) security

and integration of data and work queues enabling the increase of automated workflows and support tools.

Through this functionality, VBMS has increased efficiencies for Veteran disability claims processing, improved the quality of service for end-users and Veterans, reduced inventory backlog of Veteran claims and ensured the timely and accurate delivery of monthly disability benefits to Veterans. The VBMS enhancements will address the continued and future operational position of the system by correcting new defects, resolving root cause issues, enabling optimization of capabilities, and assisting in the resolution of user tickets requiring additional development work. Additionally, it makes required adjustments or enhancements to the system to improve application operations and performance. The addition of legislative mandates and changes to forms and letters require the support of enhancement teams. The system will increase the efficiencies of the users, providing benefits for our Veterans through these digitized and optimized business processes.

Modernizing VBMS will enable greater automation for claims establishment, increase timely requests for routine future claims management, expedite centralized outbound correspondence, provide instant access to education benefits, and reduce the VBA employee imprint. This will all be done while granting the Veteran more control of individual VBA benefits processing and empowering the Veteran to achieve real-time decisions through self-service. Through this enhanced functionality, VBMS will be able to maintain a baseline to enable development of discrete and defined capabilities without impacting existing code or requiring the downtime of the entire system. This will allow for faster development and release of new functionality to Veterans, thereby speeding up the overall claims processing effort.

Operations and Maintenance funding is required to sustain VBMS's production environment (i.e., software licenses, Help Desk, information assurance, Platform as a Service (PaaS)/SaaS, etc.) and deliver new electronic compensation, pension and fiduciary claims processing enhancements, capabilities, and automated features. The 2023 Budget request includes increases in personnel supporting Production Operations, Information Assurance (IA) Assessment and Authorization (A&A) and Help Desk, which is a result of an increase in the code base and quantity of work being nearly doubled in VBMS in 2020 and continuing into the future. These changes are necessary because of the inclusion of Pension Automation, Fiduciary, VVA, Modern Award Processing Development (MAP-D) letters and new Federal Tax Income functionality which has increased the mission, scope and capacity of VBMS beyond just supporting Compensation claims. The budget request also includes the cost of Cloud computing, commercial software costs and support staff to keep the system operational, reliable, and available. VBMS steady-state funding will ensure the continued viability of the mission critical primary functionalities of VBA automated claims processing. Steady-state funding ensures Veterans and their families continue receiving accurate and up-to-date information about benefit decisions while also supporting the processing of new compensation, pension and fiduciary claims. VBMS claims processing automation reduces the risk of manually processing Veteran claims with the added benefits of reducing claims backlogs and increasing the accuracy and timeliness of claims.

The Benefits Integration Platform (BIP) is a modern, flexible, cloud-based IT platform that improves the way VA manages and provides Veteran benefits, healthcare, and memorial services.

There are over 20 tenants on the platform, which supports benefits delivery (in both the VBA and NCA lines of business) to Veterans and their beneficiaries - valued at approximately $10 billion per month of benefits compensation to the Veteran. BIP steady-state requirements consist of "lights on support" such as software licenses for key tools (e.g., Twistlock, Consul, and Vault), production and non-production operational support, infrastructure and tool troubleshooting, break-fix efforts, patching and VA Enterprise Cloud (VAEC) Amazon Web Services (AWS) cloud credits. BIP enhancement efforts focus on strengthening the existing platform to support the growing needs of its tenants, as well as providing disaster recovery capabilities, enhanced infrastructure and tool automation, more robust API gateway capabilities, service mesh capabilities, enhanced messaging and queuing and enhanced application performance monitoring.

The VVA project requires funding for software requirements on the new Benefits Integration Delivery (BID) contract for the sustainment of VVA. The Virtual VA system is a document repository system for storing electronic documents relevant to claim processing, including legacy electronic storage of Federal Tax Information (FTI). Document Capture Technicians at the Pension Management Centers (PMC) prepare and scan original Veteran benefits claims and/or pension maintenance documentation into electronic folders. The Batch Files Import (BFI) services process and upload documents into the VBMS from over 50 data feeds for multiple business lines. The system stores electronic documents and images in a secure, restricted access environment and facilitates the gathering of documents, such as Veterans applications, awards, medical and dependency records, etc. Virtual VA provides simultaneous user access to the Veterans electronic claims folder along with the same level of record integrity that exists in the paper environment. Veterans can get quicker and more accurate answers when inquiring about the status of their claims because of the processing done within Virtual VA.

Veterans Assistance Discharge System (VADS) sustainment funding is required to keep the system operational and to make periodic changes to letters that are distributed to Veterans in order to notify them of benefits eligibility and provide information on how to apply for those benefits. VADS benefit eligibility notifications are an essential part of VBA claims processing and are necessary for the delivery of timely and immediate benefits to Veterans. New USB initiatives support the automation of claims, increase timely requests for routine future claims management, expedite centralized outbound correspondence and provide instant access to education benefits. This is all done while reducing the VBA employee imprint, granting the Veteran more control of individual VBA benefits processing, and empowering the Veteran to achieve real-time decisions through self-service. VADS also provides the VA with a way to effectively communicate those changes and encourage Veterans and their families to apply for the benefits they earned fighting for our country. VADS also provides Veterans and their families information about the benefits they are eligible to receive and how to apply for the benefits they have earned.

The CLAIMS project requires funding for one systems team for daily keep the lights on sustainment of the legacy system. The CLAIMS Authentication server, housed at Philadelphia Information Technology Center, in Philadelphia, PA is critical to the functioning of CAPRI. It supports connectivity for users from multiple program offices through the CAPRI system to all VAMCs and interfaces with VBA, allowing the setup and performance of the C&P exams. This project provides connectivity for the Suicide Hotline/Veterans Crisis Line (VCL), a critical service

provided by VHA. Additionally, it is used by other applications critical to Veteran care (e.g., VistA Remote Access Management (VRAM), JLV, VistAWeb, and Web VRAM.

**IT Support Contracts – $79.0 million (*Operations and Maintenance)***
The IT Support Contracts Project is comprised of recurring payments for existing contracts for services and support for implemented IT systems in support of the Enterprise, VA Administrations and Staff Offices. IT Support Contracts is considered a 'must pay' requirement to support customer service level agreements. The SLA - Benefits project represents the estimated steady-state charges for the 41 applications aligned to the Major Customer Code (MCC) Veterans Benefits Administration and Benefits Portfolio within the OIT Consolidated Agreement. This is also known as the SLA between the IO Franchise Fund Enterprise Center and OIT. The IT Support Contracts Congressional Project improves the customer experience through which federal and contractor employees are the customers. Services and resources are provided in order to achieve VA and OIT goals and work towards the mission to provide customer focused support services that exceed expectations and enable a safe and productive work environment which promotes excellence.

The SLA - Veteran Experience Services sub-project represents the steady-state charges for the eight applications aligned to the MCC Veterans Experience Services Portfolio within the SLA between the IO Franchise Fund Enterprise Center and OIT. Veteran/beneficiary/family members are derived from the individual applications themselves. The VBA & NCA IT Support Contracts represent the estimated steady-state charges for legacy system support for the specific and unique VBA and NCA systems that were not included in the SLA.

**Benefits Appeals – $13.4 million (*Operations and Maintenance)***
The 2023 Budget Request will be supplemented with $2.8 million from ARP Section 8002 and includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Appeals Modernization - Board of Veterans' Appeals (BVA) | $ 6,000 | $ 5,815 | $ - | $ - | $ 3,400 | $ 16,443 | $ - | $ 13,397 |
| Appeals Modernization - Board of Veterans' Appeals (BVA) - CARES Act | $ - | $ 2,436 | $ - | $ - | $ - | $ - | $ - | $ - |
| Appeals Modernization - Board of Veterans' Appeals (BVA) - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 2,740 | $ - | $ 2,820 |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 76 | $ - | $ - | $ - | $ - | $ - |
| **Benefits Appeals** | **$ 6,000** | **$ 8,251** | **$ 76** | **$ -** | **$ 3,400** | **$ 19,183** | **$ -** | **$ 16,217** |

Benefits Appeals maintains three primary systems of Caseflow, Appeals Resource Management System (ARMS), and Veterans Appeals Control and Locator System (VACOLS) that support the Board of Veterans Appeals (BVA) business processes. The continued support of these three systems is essential for the VA to process appeals to the Board, as well as higher-level reviews and supplemental claims reviews by Agencies of Original Jurisdiction. VA is on a path to complete Appeals modernization and replace VACOLS with a new automated, integrated, and end-to-end

system, Caseflow. This Appeals Modernization project is also developing ARMS, which is a relational database and associated web application that enables the Board to manage and report personnel and other resource data, both operationally and strategically.

The Benefits Appeals sub-project funding maintains all the Appeals PL systems that support the Board of Veteran's Appeals business processes. This support includes the operation and maintenance of the systems, ATO support, technical debt, application and 508 defects, Tier 2/3 help desk support, and VACOLS Decommissioning work. Continued support of these systems/products is essential for Agencies of Original Jurisdiction (AOJs) to deliver appeals to the Board and conduct higher-level reviews and supplemental claim reviews.

ARMS will implement an HR-specific data warehouse environment that will allow for an expanded analysis and creation of HR-related toolsets. Delivery of these systems will enable the achievement of both Veterans Appeals Improvement and Modernization Act of 2017 processing requirements of 365 days for the Board's direct appeal docket as well as 125 days for Higher-Level Review and Supplemental Claim decision reviews with the agency of original jurisdiction. The planned features will improve the efficiency, accuracy, and consistency of the adjudication of Veterans' and other appellants' appeals while reducing the VA workforce's reliance on multiple, outdated legacy applications.

Caseflow and ARMS digitize the entire appeals process. From the use of Caseflow eFolder Express for exporting a complete digital record into a single file in a matter of minutes to using Caseflow Hearings to schedule and track Veteran notifications, the seven Caseflow products have digitized nearly every step in the process and removed non-value-added steps for the staff. The ARMS system will modernize the Board's human capital management capabilities through enhanced resource management, workforce planning, program management and logistical activity. With the proper development effort, ARMS would assist the Board with in-house storing of pertinent employee information. This information currently exists in non-standardized, non-centralized, and not easily accessible formats. Additional ARMS capabilities would allow the Board to better manage the physical placement, location, and operational alignment of its human resources in a much more efficient and modernized manner.

OIT support is critical to ensure swift onboarding of new hires and operational capabilities to facilitate its goal of deciding over 130,000 appeals in 2023 while also targeting average days to complete goals for a decision of 365 days for direct docket appeals, 550 days for evidence docket appeals and 730 days for hearing docket appeals. Approximately 30 percent of the Board's decisions in 2021 are for at risk Veterans due to age, health, and or financial hardship, including COVID related challenges that allow appeals to be advanced on the docket and decided swiftly.

Delivery of these systems/products will enable the VA to meet the AMA processing requirements for appeals to the Board as well as higher-level reviews and supplemental claim reviews by Agencies of Original Jurisdiction (AOJ).

Modernizing the appeals process through the enhancement of Caseflow minimizes the dependency on legacy systems as well as having to use two systems to process appeals. Automation of the new

process will also improve system availability and decrease the wait times for appeals to the Board. This includes providing the following features:

- Support VSOs in the completion of tasks such as preparing for hearings and the creation of Informal Hearing Presentations
- Identifying and automating appeals-processing tasks subject to human error or inaccuracy
- Reader enhancements to improve productivity
- Interfacing with Centralized Mail portal to process incoming mail and add it to the Veteran's eFolder
- Data Analytics Data Warehouse that provides a flexible and scalable data repository architecture

## 2023 Memorial Affairs Portfolio

The Memorial Affairs Portfolio provides support for the modernization of applications and services for National Cemeteries cared for by the NCA at 155 locations nationwide.

In 2023, the Memorial Affairs Portfolio funding will be used to support the Agency's priority of replacing the Burial Operations Support System (BOSS). This legacy system has been around for 27 years and no longer fully meets the needs of NCA and Veterans.

The 2023 Memorial Affairs Portfolio Budget Request consists of the following Congressional Projects details:

| Priority Order | Congressional Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | | 2022-2023 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | | Increase/ Decrease |
| | | DEV | OM | DEV | OM | DEV | OM | DEV | OM | |
| 1 | Memorials Automation | $ 16,587 | $ 8,678 | $ 405 | $ - | $ 9,030 | $ 19,208 | $ - | $ 31,218 | $ 2,980 |
| 2 | Memorials Legacy | $ - | $ 1,622 | $ - | $ - | $ - | $ 4,000 | $ - | $ 3,649 | $ (351) |
| 3 | IT Support Contracts | $ - | $ - | $ - | $ - | $ - | $ 11,762 | $ - | $ 9,133 | $ (2,629) |
| | **Total Memorial Affairs Portfolio** | **$ 16,587** | **$ 10,300** | **$ 405** | **$ -** | **$ 9,030** | **$ 34,970** | **$ -** | **$ 44,000** | **$ -** |

### Memorials Automation – $31.2 million (*Operations and Maintenance)*

The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Memorial Benefits Management System (MBMS) | $ 16,587 | $ 6,484 | $ - | $ - | $ 9,030 | $ 19,208 | $ - | $ 22,036 |
| Veterans Legacy Memorial (VLM) | $ - | $ 2,194 | $ - | $ - | $ - | $ - | $ - | $ 6,108 |
| Business Intelligence National Cemetery Administration (BINCA) | $ - | | $ - | $ - | $ - | $ - | $ - | $ 2,549 |
| NCA GIS | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 525 |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 405 | $ - | $ - | $ - | $ - | $ - |
| **Memorials Automation** | **$ 16,587** | **$ 8,678** | **$ 405** | **$ -** | **$ 9,030** | **$ 19,208** | **$ -** | **$ 31,218** |

The Memorials Automation Congressional Project includes four sub-projects: a) MBMS, b) Veterans Legacy Memorials (VLM), c) Business Intelligence National Cemetery Administration (BINCA), and d) National Cemetery Administration Geographic/Geospatial Information System (NCA GIS).

Memorial Benefits Management System (MBMS)

MBMS is built on a Salesforce platform and leverages the BIP to continue building a cohesive enterprise system to replace NCA's legacy Burial Operations Support System Enterprise (BOSS-E). MBMS supports the daily operations of NCA in scheduling burials at 155 National Cemeteries.

MBMS, as the NCA's modernized, enterprise platform, aims to facilitate common workflows; enhance NCA and enterprise services solutions; streamline data capture and data quality; and modernize NCA capabilities and technology. It also aims to integrate and migrate the functionality of multiple, disparate systems to expedite memorial benefits processing and improve the overall Veteran experience. The modernized system aims to improve the quality and accessibility of memorial services to Veterans and their families at an emotionally difficult time (death of a loved one). Beneficial impacts to Veterans include improved efficiency of benefits tracking and delivery and increased customer service satisfaction with shorter claims processing times. Memorials Enterprise Letters (MEL) is a sub-component managed under MBMS.

MBMS sustainment funding supports contracted teams, utilization of the VAEC, Salesforce software licenses, and a Tier 3 Helpdesk team to maintain daily operational support (i.e., remains custody trading, real time Veteran claim status, ordering headstones and markers, and providing Presidential Memorial Certificates) for NCA services and memorial benefits for Veterans and dependents.

In 2023, MBMS will focus on self-service functionality to enable the Veteran community to plan services via an online portal and with 24/7 availability. Funding will also allow OIT to establish a strategy for a single user experience across NCA business functions and missions. OIT will focus on enhancing and augmenting features to reduce data entry, improve efficiency, streamline workflows and support more effective and expedient interactions with the Veteran community.

MBMS will also continue enhancements to provide the National Cemetery Scheduling Office (NCSO) agents with efficient access to submit scheduling requests for interments. These enhancements will decrease scheduling errors that cause disappointment and inconvenience to the Veteran/their family provide improved day-to-day functionality, end-to-end decedent chain of custody tracking, real time Veteran claim status display, state of the art remains tracking, and GIS coordinates and marker imaging. These capabilities promote the VA strategic goals of more effective delivery of services and improved NCA customer satisfaction in support of Veterans and their families.

MBMS aligns to the VA Strategic Goals by inspiring a culture of digital transformation, information technology modernization, and customer service. It aims to achieve seamless and secure data interoperability across VA, DoD, and Partners. It also seeks to modernize, automate, and enable efficient information sharing of NCA operations while closing operational gaps and better satisfying scheduling for cemeteries.

Veterans Legacy Memorial (VLM)

VLM is an online memorialization platform to maintain Veterans' legacies and enables the general population to share in NCA's mission to "honor all Veterans in perpetuity". Through the VLM portal, families, colleagues, friends, other VA stakeholders, and the public may search and contribute information and imagery via the VLM digital memorial space. This space includes a profile page for each of the approximately 4.2 million Veterans enabling a significantly elevated outreach, visibility, and digital presence. The platform is designed to honor the service and sacrifice of the nation's Veterans by paying their respects to Veterans interred at VA national cemeteries and state cemeteries. VLM's online portal includes digital pictures of headstones and

markers as well as burial records which family members, survivors, and friends may view. VLM has incorporated architecture and functionality specializing in Cloud infrastructure, principles, and protocols of user-experience (UX) as well as human-centered design. VLM is the latest from VA's Information Technology and Digital Modernization program which aligns with the PMA.

VLM funding will provide helpdesk support, an operations and maintenance team, cloud capacity, and annual software license to maintain the VLM platform. As a digital, cloud-based, and internet-enabled platform, VLM relies on sustainment for hosting and maintaining operational requirements to ensure that survivors and family members are able to digitally memorialize Veterans.

Business Intelligence for the National Cemetery Administration (BINCA)

NCA leveraged the Tableau server and software by implanting "BINCA", which provides data analysis capability via a cloud-based business intelligence and reporting platform to transform data from multiple sources into cloud-based dashboards to support and facilitate the NCA mission. BINCA identifies and corrects erroneous data impacting projections of space and availability at NCA locations and improves the overall customer experience to stakeholders in need of NCA metrics.

In 2023, funding for BINCA will continue to enhance and develop new dashboards to provide call data and reporting analysis to facilitate more efficient service delivery. Through the dashboards, NCA's senior leadership will have visibility and oversight into daily operations and performance.

BINCA aligns to VA Strategic Goals by providing governance, systems, data, and management best practices which strengthen the customer experience and increase accountability, security, emergency preparedness, quality, and outstanding service across the VA. Additionally, BINCA inspires a culture of digital transformation, IT modernization, and customer service. It achieves seamless and secure data interoperability across VA, DoD, and Partners. It also modernizes, automates, and enables efficient information sharing of NCA operations, closes operational gaps, and fosters better decision making via accurate data for memorial benefits, support, and operations.

National Cemetery Administration Geographic/Geospatial Information System (NCA GIS)

NCA GIS provides geographic information system capability for NCA by leveraging the CDW continuous Geographic Information System Business Intelligence Service Line (GeoBISL) enterprise services and infrastructure. Funding maintains the operational support for the services providing the day-to-day functions of NCA GIS. These services, which are formally defined in a renewable Memorandum of Agreement between GeoBISL and NCA, provide the IT/GIS architecture and technical execution to a) support global positioning system (GPS) collection of cemetery activities; b) develop GIS-based products to view, report, and analyze stored geospatial and photographic data; and c) provide ongoing support of GPS grave marker and interment collection in VA's national cemeteries. This effort also includes onboarding the national cemeteries onto the GIS Burial and Marker Accuracy Review Tool (GBMART), which is an application to validate and verify burial activity, GPS locations, and photographs for all interments and markers. Without NCA GIS, existing NCA applications relying on the GPS functionality would lose that component of functionality, thereby removing features already provided to the VA customer and reducing the quality of services provided by these applications.

In 2023, NCA GIS aims to transition from the Trimble Terraflex application to an ESRI based GPS collection capability to increase functionality and reduce data entry by NCA field personnel. NCA GIS will use BOSS data to verify field GPS data collection activities are being completed by cemetery personnel.

NCA GIS allows VA to consistently communicate with VA Veterans, customers, and partners to assess and maximize performance, evaluate needs, and build long-term relationships and trust, aligning to the VA Strategic Goals. As such, the service application inspires a culture of digital transformation, IT modernization, and customer service. It achieves seamless and secure data interoperability across VA, DoD, and Partners while modernizing, automating, and enabling efficient information sharing of NCA operations thus closing operational gaps for cemeteries.

**Memorials Legacy - $3.6 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-project:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Burial Operations Support System - Enterprise | $ - | $ 1,622 | $ - | $ - | $ - | $ 4,000 | $ - | $ 3,649 |
| **Memorials Legacy** | **$ -** | **$ 1,622** | **$ -** | **$ -** | **$ -** | **$ 4,000** | **$ -** | **$ 3,649** |

Burial Operations Support System - Enterprise (BOSS-E)
BOSS-E supports the continuous operational availability of NCA's legacy platform, systems, and capabilities throughout the transition into the modernized NCA MBMS. BOSS-E additionally supports the sustainment of the NCA enterprise technology applications and programs which serve Veterans, Veteran family members, and funeral homes requesting internment, inurnment, and all other memorial services and benefits. It is imperative that these Veterans, friends and family of the descendent are always treated with compassion and dignity.

In 2023, funding will maintain the BOSS-E systems while functionality is migrated into MBMS. Loss of funding may result in 1) contractual and government delays and 2) shutdown of systems and services. Each of these will adversely impact IT services and support with the NCA and memorial technology systems, ultimately having a negative downstream impact to Veterans, funeral homes, and Veteran beneficiaries/families.

BOSS-E delivers timely, accessible, high-quality benefits, care, and services to meet the unique needs of Veterans and beneficiaries.

**IT Support Contracts – $9.1 million (*Operations and Maintenance)***
IT Support Contracts includes sub-project Service Level Agreement (SLA) – Memorials Affairs.

Service Level Agreement (SLA) – Memorial Affairs

SLA-Memorial Affairs is the operational and maintenance funding of steady-state charges for applications aligned to the Major Customer Codes (MCC) NCA/Memorial Affairs Portfolio which are germane and unique to NCA. Specifically, this requirement funds the ten applications hosted by the Infrastructure Operations – Franchise Fund (IO-FF) Enterprise Center within the OIT Consolidated Agreement, also known as the "Service Level Agreement" between IO-FF and OIT. These services include application hosting services, application management, information assurance, data storage/back-up, and webhosting to deliver accessible, high-quality benefits, care, and services to meet the unique needs of Veterans, beneficiaries, and other VA partners and customers.

The SLA-Memorial Affairs aligns to the VA Strategic Goals via the ongoing, seamless, and secure data interoperability to operate and maintain all applications within the SLA.

## 2023 Corporate Portfolio

The Corporate Portfolio consists of the back-office operations that are major contributors to running the business lines of the Department and support for the Office of Management, Office of Acquisition, Logistics and Construction, General Counsel, Human Resources, etc.

In 2023, the Corporate Portfolio funding will be used to support the Secretary's priority of replacing the Financial Management System (FMS) and maintaining existing major corporate systems.

The 2023 Corporate Portfolio Budget Request consists of the following Congressional Projects details:

| Priority Order | Congressional Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | | 2022-2023 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | | Increase/ Decrease |
| | | DEV | OM | DEV | OM | DEV | OM | DEV | OM | |
| 1 | Financial and Acquisition Management Modernization[1/] | $ 98,826 | $ 17,990 | $ 832 | $ - | $ - | $ 133,886 | $ - | $ 122,886 | $ (11,000) |
| 2 | Human Resources[1/] | $ 13,972 | $ 11,965 | $ 8 | $ - | $ - | $ 69,571 | $ 2,143 | $ 62,293 | $ (5,135) |
| 3 | General Counsel | $ 1,853 | $ 5,937 | $ 2,147 | $ - | $ - | $ 1,950 | $ - | $ 18,517 | $ 16,567 |
| 4 | Other Corporate IT Systems | $ 3,500 | $ 47,108 | $ - | $ - | $ - | $ 16,315 | $ - | $ 24,167 | $ 7,852 |
| 5 | Construction and Facilities Mgmt | $ - | $ 2,843 | $ - | $ - | $ - | $ - | $ - | $ 465 | $ 465 |
| 6 | TAC Fees[2/] | $ - | $ - | $ - | $ - | $ - | $ 69,921 | $ - | $ 65,468 | $ (4,453) |
| 7 | IT Support Contracts | $ - | $ 21,286 | $ - | $ - | $ - | $ 91,943 | $ - | $ 145,846 | $ 53,903 |
| | **Total Corporate Portfolio** | **$ 118,151** | **$ 107,128** | **$ 2,987** | **$ -** | **$ -** | **$ 383,586** | **$ 2,143** | **$ 439,642** | **$ 58,199** |

1/ Congressional Projects Financial and Acquisition Management Modernization and Human Resources will be funded by Recurring Expenses Transformational Fund in the 2022 Request
2/ TAC Fees realigned from Enterprise Portfolio to Corporate Portfolio for 2021

### Financial and Acquisition Management Modernization – $122.9 million (*Operations and Maintenance)*

The 2023 Budget Request includes the following sub-projects:

| Sub-Projects *($s in thousands)* | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Financial Management Business Transformation (FMBT) | $ 98,826 | $ 17,990 | $ - | $ - | $ - | $ 114,106 | $ - | $ 103,106 |
| Integrated Financial Acquisition Management System (iFAMS) | $ - | $ - | $ - | $ - | $ - | $ 19,780 | $ - | $ 19,780 |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 832 | $ - | $ - | $ - | $ - | $ - |
| **Financial and Acquisition Management Modernization[1/]** | **$ 98,826** | **$ 17,990** | **$ 832** | **$ -** | **$ -** | **$ 133,886** | **$ -** | **$ 122,886** |

1/ Congressional Project Financial and Acquisition Management Modernization will be funded by Recurring Expenses Transformational Fund in the 2022 Request

The FMBT program is reforming VA IT systems responsible for financial and acquisition management. These reforms are required to handle VA's significant budget, funding, and procurement responsibilities. Implementation of an enterprise-wide financial and acquisition management system is well underway through the development and implementation of the Integrated Financial and Acquisition Management System (iFAMS). iFAMS is a modern Enterprise Resource Planning (ERP) solution that provides increased operational efficiency, productivity, agility, and flexibility for the more than 90,000 employees that service the Veteran. The new cloud solution will also provide additional security, storage, and scalability. In addition, iFAMS reduces the use of legacy systems and contributes to the goal of shifting human resources from low-value administrative work to high-value, mission-critical activities. With each wave of implementation completed, iFAMS will support all five OIT imperatives in driving strategy outcomes, while also acting as a force multiplier for the guiding principles of Transparency, Accountability, Innovation, and Teamwork. iFAMS will replace the 35-year-old FMS and multiple related legacy capabilities with a modern, easier-to-maintain system. FMS is a standardized, VA-wide system that interfaces externally with the Department of Treasury (USDT), the General Service Administration (GSA), the Internal Revenue Service (IRS), the Defense Logistics Agency (DLA), and various commercial vendors and financial institutions for electronic billing and payment purposes.

The FMBT program is in direct alignment with VA strategic goal 4: "Governance, systems, data, and management best practices strengthen the customer experience and improve accountability, security, emergency preparedness, quality, and service across VA and its ecosystem of partners". FMBT supports this goal by driving the continued modernization of our financial management and acquisitions systems, transforming the Department from numerous stovepipe legacy systems to a proven, flexible, integrated business transaction environment, thereby increasing the transparency, accuracy, timeliness, and reliability of financial information across VA, resulting in improved fiscal accountability to American taxpayers and improved services to those who serve our Veterans. It also aligns with Business strategy 4.3.2 "Modernize legacy systems and processes," and the OIT VA Digital Transformation Strategy Priority 3: Business Transformation "We empower employees to provide world-class customer service to Veterans by reforming IT systems responsible for HR management, finance, acquisition, and supply chains."

Additionally, FMBT directly supports the PMA mandate to "[enhance] mission effectiveness … through the increased utilization of cloud-based solutions" while gaining increased operational efficiency, productivity, agility, and flexibility from a modern Enterprise Resource Planning (ERP) system. The new cloud solution also provides additional security, storage, and scalability. In direct alignment with OMB guidance to prioritize IT modernization and cybersecurity, iFAMS is normalizing best practices by standardizing, integrating, and streamlining financial processes, including budgeting, procurement, accounting, and financial reporting. It facilitates effective management by providing stronger analytics and projections for planning purposes, advancing customer service, supporting the acquisition of goods and supplies for Veterans, and improving the speed and reliability of communicating financial information, both within and outside of VA, through timely, robust, and accurate financial reporting. The FMBT initiative is also enhancing VA's ability to execute its budget, pay Veterans accurately and efficiently, procure services in support of Veteran benefits and healthcare delivery, pay vendors, and produce accurate financial statements. Taxpayers and employees benefit from the transparent, accurate, timely, and reliable

financial information that iFAMS delivers. iFAMS is hosted in VA's Microsoft Azure Enclave, which provides advanced, multilayer cybersecurity to protect Veteran and VA data.

The FMBT program provides a modern integrated financial and acquisition management solution with transformative business processes and capabilities that enables VA to meet its goals and objectives in compliance with financial management legislation and directives, ultimately enhancing service to those who serve Veterans. 2023 funding will allow OIT to complete iFAMS configuration and deployment for VBA Loan Guaranty, all VA Staff Offices, and initiate the VBA Insurance and VHA Central Office waves.

Each go-live enables the FMBT to gradually transition a percentage of sustainment-steady-state costs billed to OIT and transfer costs to the Financial Services Center (FSC).

The FMBT program will leverage economies of scale by achieving the following:

- Increasing efficiency and accountability
- Reducing audit findings ensuring Veteran's data is fully secure
- Minimizing administrative burden while increasing integration
- Automating business processes and internal controls with advanced technology
- Reducing the current risk of delayed or inaccurate Veteran and beneficiary payments due to system failure

**Human Resources – $64.4 million** ***(Development - $2.1 million, Operations and Maintenance - $62.3 million)***

The 2023 Budget Request includes the following sub-projects:

| Sub-Projects *($s in thousands)* | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Human Resources Information System (HRIS) | $ - | $ 2,191 | $ - | $ - | $ - | $ - | $ - | $ 38,660 |
| Human Resources - Payroll Application Services (HR-PAS) | $ 539 | $ 6,533 | $ - | $ - | $ - | $ 9,023 | $ - | $ 10,125 |
| Enterprise Performance Management System (ePerformance) | $ - | $ - | $ - | $ - | $ - | $ 4,826 | $ - | $ 4,853 |
| VA Centralized Adjudication Background Investigation System (VA-CABS) | $ - | $ - | $ - | $ - | $ - | $ 10,620 | $ - | $ 3,700 |
| Data Warehouse & Business Intelligence | $ - | $ - | $ - | $ - | $ - | $ 4,500 | $ 2,143 | $ 3,000 |
| eClassification360 (eClass360) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 758 |
| Child Care Records Management System (CCRMS) | $ - | $ 157 | $ - | $ - | $ - | $ 294 | $ - | $ 461 |
| Workers Compensation - Occupational Safety Health Management Information System (WC-OSH) | $ - | $ - | $ - | $ - | $ - | $ 104 | $ - | $ 412 |
| Police Program Inspection Compliance (PPIC) | $ - | $ 261 | $ - | $ - | $ - | $ 280 | $ - | $ 324 |
| Human Resources Information System (HR Smart) (HRIS) | $ 9,749 | $ 2,355 | $ - | $ - | $ - | $ 38,660 | $ - | $ - |
| Talent Acquisition | $ - | $ - | $ - | $ - | $ - | $ 758 | $ - | $ - |
| Matter Tracking System (MTS)[2/] | $ - | $ 467 | $ - | $ - | $ - | $ 507 | $ - | $ - |
| Human Resources Line of Business (HRLOB) ePerformance | $ 2,836 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Automated Classification | $ 848 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 8 | $ - | $ - | $ - | $ - | $ - |
| **Human Resources[1/]** | **$ 13,972** | **$ 11,965** | **$ 8** | **$ -** | **$ -** | **$ 69,571** | **$ 2,143** | **$ 62,293** |

1/ Congressional Project Human Resources will be funded by Recurring Expenses Transformational Fund in the 2022 Request
2/ Matter Tracking System (MTS) was realigned from the Human Resources Congressional Project to the Other Corporate IT Systems Congressional Project in the 2023 Request

Continued investment and sustainment of Human Capital systems for improved management and optimization of HR Enterprise solutions resulting in enhanced employee experience, reuse of data across Enterprise systems, less manual data entry, fewer data errors, more accurate personnel records and decrease in HR Specialist transactional workload through workflow process automation. Investment in Human Capital Management (HCM) continues the collaboration with VA Administrations and Staff Offices to implement automated and modernized HR-IT solutions supporting VA front-line HR specialists and VA employees. These automated and modernized HR solutions improve HR data quality, decrease the use of redundant, obsolete technologies, automate HR processes, and decrease the number of employee data and pay errors. The data from these solutions are also used by VA's current payroll provider, supporting biweekly payroll processing, and interfacing with over 60 systems providing reliable data across VA HR systems to include identity and access management, on-boarding, hiring, credentialing medical personnel, and financial management, etc.

This Congressional Project will provide consistency through automation of manual business processes that will allow HR professionals to improve their services to VA employees and Veterans.

Human Resources Payroll and Accounting Services (HR-PAS) bridges the gaps between applications, tools, and databases by providing employee information to consumers. The technology serves as the access point for employee information, and it integrates systems of multiple business lines that receive and/or feed data from/to HR Smart.

Enterprise Performance Management System (ePerformance) (EPMS) capitalizes on existing human resource system capabilities to supply new, innovative core and non-core solutions between shared service resources and will serve as a system of record that will provide consistency in automated business processes. Additionally, it will optimize process improvements throughout the Enterprise VA. EPMS is intended to improve organizational performance and increased employee productivity and retention, meeting stakeholder needs, recommendations, and expectations. This technology provides for automation of performance plans and appraisals of VA employees. This will standardize VA human resource enterprise-wide data for efficient and reliable data.

eClassification360 (eClass360) provides a framework for positioning the right candidate in the right job/position and encourages uniformity and equity in hiring by establishing a common reference across VA. Technology automates classification processes and will serve to reduce labor hours associated with manual processes, streamline processes by reducing or eliminating disparate paper systems, and providing one standard system for the Enterprise.

Workers Compensation - Occupational Safety Health Management Information System (WC-OSH/MIS) supports VA by managing and tracking workers compensation claims by VA employees who filed with the Department of Labor (DOL). The service provides application operation and maintenance for this legacy application. Support includes managing data input/output to/from the product, reporting, troubleshooting, software updates and security.

**General Counsel – $18.5 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| eDiscovery Clearwell (SCW) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 9,100 |
| eDiscovery | $ 1,853 | $ 3,222 | $ - | $ - | $ - | $ - | $ - | $ 7,134 |
| General Counsel Legal Automation Workload System (GCLaws) | $ - | $ 2,714 | $ - | $ - | $ - | $ 1,950 | $ - | $ 2,283 |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 2,147 | $ - | $ - | $ - | $ - | $ - |
| **General Counsel** | **$ 1,853** | **$ 5,937** | **$ 2,147** | **$ -** | **$ -** | **$ 1,950** | **$ -** | **$ 18,517** |

The Congressional Project facilitates the discovery of electronic information as evidence in legal cases and is the IT support for the VA Office of General Counsel. The IT support includes the maintenance and enhancements of several IT systems and the contracts and resources to support those systems. The systems also provide support services to other VA Offices, including the Office of Whistleblower Protection (OAWP). The systems help ensure a legally sound claims appeals process for Veterans and defends VA adjudication of Veterans claims for compensation and other benefits. It contained 8,967 claims to the United States Court of Appeals in 2020, a 99 percent increase from 2015, and 102,663 BVA Decisions, an 84 percent increase over the same period and expected to grow annually. The system supports the law group responsible for collecting revenue from third parties, such as insurance companies, through mass litigation negotiation efforts. The systems support the collection of $79.4 million for Medical Care Collections Funds in 2020, a significant increase from the prior year and expected to grow annually. These funds go directly to the care of Veterans by directing it to the Medical Centers. For Veteran's Tort Claims, GCLaws supported the law group reducing the wait time for an administrative decision from 384 to 315 days in 2021. The system also supports the VA accreditation, discipline and fees program, which accredits and monitors the conduct of 22,527 attorneys and 21,057 agents and Veteran Service Organization (VSO) representatives who represent Veterans in the pursuit of their VA benefits claims. The average number of calendar days evidence can be collected from VA Email Servers and the average number of days to complete a whistle-blower investigation. Funding provides two sustainment projects and additional storage needs to maintain operations for over 1,000 users.

VA builds and maintains trust with Stakeholders through proven stewardship, transparency and accountability. The project aligns to this goal by assisting the VA in adhering to the Federal Rules of civil procedure to manage legal cases and providing discovery for legal cases in an efficient manner to prevent receiving sanctions from a court. Additionally, VA leaders, employees and partners are held accountable for providing quality customer experiences and satisfaction while also rewarding performance to promote and improve organizational and individual accountability and a just culture.

2023 funding supports licenses costs and two Scrum Teams maintaining and making enhancements to the General Counsel Legal Automation Workload System (GCLaws), which is the Office of General Counsel's (OGC) system of record for case, time, and personnel tracking. Scrum Teams will ensure that GCLaws is compliant with VA security

requirements to build an accredited database for Veteran's representatives and enhance VA's Revenue Collection for Veterans.

OGC receives Electronically Stored Information (ESI) requests for Freedom of Information Act (FOIA) requests, Congressional oversight, and by court order for litigations and investigations. The Federal Rules of Civil Procedure (FRCP) require the VA to use an eDiscovery tool to effectively preserve, collect, process, review, analyze, and produce ESI.

2023 funding will support a new eDiscovery Symantec Clearwell Platform (SCW). The planned eDiscovery solution reduces the risk of further court-imposed sanctions and meets Executive Order (EO) 13793 (Improving Accountability and Whistleblower Protection at the Department of Veterans Affairs) of 2017. The 2023 funding will also support the purchase of 40 terabytes (TB) of storage licenses and support the currently managed services contract with nine technical staff who specialize in investigative data handling for eDiscovery (SCW).

**Other Corporate IT Systems – $24.2 million *(Operations and Maintenance)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Financial Management System (FMS) | $ - | $ 3,956 | $ - | $ - | $ - | $ 5,800 | $ - | $ 5,654 |
| Enterprise Architecture Program Execution Support | $ - | $ - | $ - | $ - | $ - | $ 3,322 | $ - | $ 3,417 |
| Strategic Capital Investment Planning (SCP) | $ - | $ 511 | $ - | $ - | $ - | $ 522 | $ - | $ 2,987 |
| Case and Correspondence Management (VIEWS CCM) | $ - | $ - | $ - | $ - | $ - | $ 3,600 | $ - | $ 2,119 |
| VA Enterprise Architecture Management Suite (VEAMS) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 1,655 |
| VA Functional Organization Manual System (FOM) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 1,632 |
| Capital Asset Management System Business Intelligence (CAMS-BI) | $ - | $ 748 | $ - | $ - | $ - | $ 1,200 | $ - | $ 1,300 |
| Centralized Administrative Accounting Transaction System (CAATS) | $ - | $ 322 | $ - | $ - | $ - | $ 285 | $ - | $ 1,030 |
| Veterans Canteen Service Automated Information System (VCS AIS) | $ - | $ 2,216 | $ - | $ - | $ - | $ 300 | $ - | $ 820 |
| SnapWeb browser for PAID, FMS, NationWide or FEE financial reports Labor | $ - | $ - | $ - | $ - | $ - | $ 671 | $ - | $ 671 |
| Matter Tracking System (MTS)[1/] | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 558 |
| Quality Assurance Release Readiness Support | $ - | $ - | $ - | $ - | $ - | $ 545 | $ - | $ 545 |
| Veterans Enterprise Management System (VEMS) | $ - | $ 694 | $ - | $ - | $ - | $ - | $ - | $ 510 |
| GAO Module | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 481 |
| Open Data Publishing (ODP) | $ - | $ 377 | $ - | $ - | $ - | $ - | $ - | $ 365 |
| Veterans Canteen Service Point Of Sale (VCS POS) | $ - | $ 528 | $ - | $ - | $ - | $ 70 | $ - | $ 197 |
| PayVA | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 161 |
| Space Management Application (SM129) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 65 |
| Veteran Debt Processing (Fair Debt Notice) | $ 3,500 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| IT AMO - Technical Services Contract | $ - | $ 33,513 | $ - | $ - | $ - | $ - | $ - | $ - |
| VA Integrated Enterprise Workflow Solution (VIEWS) | $ - | $ 4,178 | $ - | $ - | $ - | $ - | $ - | $ - |
| Veterans Canteen Service Mobile Device Management (VCS MDM) | $ - | $ 65 | $ - | $ - | $ - | $ - | $ - | $ - |
| **Other Corporate IT Systems** | **$ 3,500** | **$ 47,108** | **$ -** | **$ -** | **$ -** | **$ 16,315** | **$ -** | **$ 24,167** |

1/ Matter Tracking System (MTS) was realigned from the Human Resources Congressional Project to Other Corporate IT Systems Congressional Project in the 2023 Request

Other Corporate IT Systems Sustainment includes products that support corporate administration areas such as financial management, project management, capital improvements, and policy

oversight. Other Corporate IT Systems products deliver services to Veterans by providing systems with greater efficiencies and processes for internal business practices that enable a more effective VA workforce.

Other Corporate IT Systems provides funding for over 18 systems providing critical back-office operations that maintain the business lines of the Department. This includes support for MISSION Act systems, FMS, Veteran Canteen Service, and products that support the Office of the Secretary, the Office of Congressional and Legislative Affairs, and the Office of Enterprise Integration.

2023 funding amounts reflect the necessary totals to sustain investments. Specific increases include funding solutions to support OMB's commitment to the Open Data Policy (M-13-13), VA's commitment to transparency through the continued support of the Veterans Affairs Integrated Enterprise Workflow Solution Case and Correspondence Management (VIEWS CCM) module, and ensuring VA is responsive to Government Accountability Office through use of the GAO Module.

Funding also supports sustainment of the Congressional Mandate to provide Veterans' debt notification electronically and with the capability to access data regarding their debt (VODA). OIT investments will sustain and modernize Veterans Canteen Service Automated Information.

Centralized Administrative Accounting Transaction System (CAATS) meets VA Strategic Goals by enabling the electronic input and approval for accounting source document/transaction, increased improvement of internal controls standardization of accounting entries, electronic audit trail, and separation of duties.

Capital Asset Management System (CAMS) supports VA Strategic Goals by providing the Office of Asset Enterprise Management (OAEM) with a business intelligence tool and system of record for the VA's real property inventory.

Veterans Enterprise Management System (VEMS) supports VA Strategic Goals by supporting efficient enrollment and verification of the status of Veteran-owned small business as well as a means for government acquisition staff to extend additional business opportunities to such firms. Governance, systems, data and management best practices strengthen the customer experience and increase accountability, security and emergency preparedness, quality and service across VA and the ecosystem of partners.

2023 funding will be used to support the following:

- FMS will serve as the primary financial and accounting system of the Department until the FMBT deployment of iFAMS has been completed.

- Capital Asset Management System Business Intelligence (CAMS-BI) and Strategic Capital Investment Planning (SCP) will sustain these two MISSION Act systems which support legislative mandates addressing assessment of VA healthcare markets, current capacity, performance, condition of facilities, and future opportunities for improvement.

- Veterans Canteen Service Automated Information System (VCS AIS) will provide contractor resources which will support the sustainment of VCS AIS. VCS AIS consists of an Oracle Retail Merchandising System (RMS), Financial Suite and backend Legacy applications. These subsystems support inventory management and financial reporting for goods bought and sold at Canteens nationwide.

- Veterans Enterprise Management System (VEMS) will provide contractor resources which will support the sustainment of the Office of Small and Disadvantaged Business Utilization (OSDBU) VEMS. This expands small business participation, particularly Service-Disabled Veteran and Veteran Owned Small Businesses (SDVOSB and VOSB) in Federal procurement opportunities.

- Veteran Canteens Service Point of Sale (VCS POS) will provide contractor support for the sustainment of the VCS POS information system which allows VCS to process transactions on a computer-based hardware terminal by accepting cash, credit cards, and other unique tenders at 200 Canteen locations.

- Space Management Application (SM129) will provide contractor support that will facilitate sustainment of the SM129, which manages the associated costs among multiple VA organizations for the space they occupy in various VACO buildings. The SM129 aids VACO in tasks such as relocating groups, making sure that space allocated to a person is in line with VA staffing guidelines, visualizing existing space based on occupancy, and other scenarios. The VA uses this system to generate invoices so that the total charges from General Services Administration (GSA) and Department of Homeland Security (DHS) are appropriately divided among VA organizations occupying the spaces leased.

**Construction and Facilities Mgmt – $0.5 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Real Property Project Tracking System (RPPTS) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 300 |
| Corporate and Regional Matrixed Budget System (CRMBS / CFM) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 165 |
| Veterans Affairs Centralized Adjudication and Background Investigation System(VA CABS) | $ - | $ 2,843 | $ - | $ - | $ - | $ - | $ - | $ - |
| **Construction and Facilities Mgmt** | **$ -** | **$ 2,843** | **$ -** | **$ -** | **$ -** | **$ -** | **$ -** | **$ 465** |

Construction and Facilities Management supports the VA with a wide array of services to include national design/construction standards and criteria, land acquisition, leasing and real property management, master planning, technical consults, and support of infrastructure issues with State Homes and Homeless Grants. Since the Capital Asset Realignment for Enhanced Services (CARES) decisions in 2004, 36 major construction projects have received full or partial funding with a total cost of $4.7 billion. Construction and Facilities Management supports the sustainment

of the Real Property Tracking System (RPPTS) applications and the Corporate and Regional Matrixed Budget System (CRMBS).

RPPTS will provide contractor resources which will support the sustainment of RPPTS. RPPTS provides VA Office of Real Property (VA ORP) with the ability to manage the acquisition of land and leasing space for the construction of facilities that service our nation's Veterans. The information managed by RPPTS includes key data such as project location, size, cost, scheduling, background, status, contractor information, and facility points of contact.

Key Initiatives: The CRMBS application is a customized Government off the Shelf (GOTS) software solution that provides a real-time web-enabled platform that captures the Office of Construction and Facilities Management (CFM) budgets and spend plans. CRMBS improves financial business processes such as spend controls, approval workflows and financial analytics with processes to ensure the correct funding is utilized. Over 717 transactions each fiscal year are processed, while also providing access to over 400 VA employees and contractors. This application provides CFM an audit trail for all transactions. The RPPTS application provides the Office of Real Property with real-time data pertaining to leases and land acquisitions. Data includes information about project location (including geolocation coordinates), the project manager, size, cost, scheduling, background, status, contractor information and facility point of contract. RPPTS has a robust reports engine capable of generating complex graphics, interactive reports, or documents for export. RPPTS provides the Office of Real Property actionable data to make leasing and land acquisition plans for the VA.

Construction and Facilities Management supports CFM by providing sustainment support for the CRMBS and RPPTS applications. Sustainment support for these sub projects provides critical services such as field support, maintenance of training and user documentation, system configuration support, software maintenance, and database maintenance, which ensures the continuous application availability.

The continued support of this project affects CFM's uninterrupted ability to capture construction related budgets, spend plans, and lease and land acquisition data. This directly impacts CFM's ability to procure, plan, design, and build new facilities that serve over 9 million Veterans each year. CFM supports the processes for allocation and tracking of funds throughout the funding lifecycle, supporting cost management on a real-time basis, integrating personnel actions with training and procurement, and connecting procurement with budget and mission execution. CFM also provides a platform for budgetary, financial and other performance analysis, as well as supporting CFM HR tracking functions. This directly supports VA Strategic Goals as governance, systems, data and management best practices strengthen the customer experience and increase accountability, security, and emergency preparedness, quality and service across VA and the ecosystem of partners. CRMBS and RPPTS create real-time, synchronized, coordinated budget execution information, data reporting, and enhanced audit capabilities, which ultimately increases accountability and quality of service from CFM to its customers. CFM must track all expenses and outlays, from micro-purchases and travel to major acquisitions, land/building leases, and land appropriations.

The CRMBS application provides technical contractor support services which are needed to ensure this system maintains compliance with VA security policies and procedures. CRMBS supports

VA's CFM budget and spend plan business practices. It facilitates financial business processes such as spend controls, approval workflows, and financial analytics.

**TAC Fees – $65.5 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-project:

| Sub-Projects *($s in thousands)* | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Office of Procurement, Acquisition, and Logistics (OPAL) | $ - | $ - | $ - | $ - | $ - | $ 69,921 | $ - | $ 65,468 |
| **TAC Fees** | **$ -** | **$ -** | **$ -** | **$ -** | **$ -** | **$ 69,921** | **$ -** | **$ 65,468** |

The Technology Acquisition Center (TAC) Fees funding will allow the Office of Acquisitions, Logistics, and Construction and the Office of Procurement, Acquisition, and Logistics (OPAL) to provide routine and customary acquisition-related services as required by OIT.

**IT Support Contracts – $79.0 million (*Operations and Maintenance)***
The ITRM Corporate Business Office funding for IT Support Contracts supports existing technologies and services that are critical to the success of maintaining the business lines of the office. This includes support for the Space and Facilities Management, Human Talent Management development, and mission essential budgeting infrastructures and services support.

Space and Facilities Management retains and maintains our current occupancy agreements with GSA for leased space and security agreements with DHS and Federal Protective Service. It also supports and maintains OIT facilities throughout the country by providing operational maintenance and upgrades to the facilities, which includes the ability to maintain 24/7/365 data operations and full facility preventative maintenances.

The SLA - Corporate Sub-Project represents the steady-state charges for the applications aligned to the Corporate Services Portfolio within the Consolidated Agreement between the IO Franchise Fund Enterprise Center and OIT. The IO Franchise Fund is one of eight self-supporting VA Franchise Fund Enterprise Centers and is the sole provider of VA Franchise Fund Information Technology business segment products and services. VA Franchise Fund organizations operate on a full cost recovery, fee-for-service basis and do not receive appropriations or other funding directly from Congress.

## 2023 Enterprise Portfolio

The Enterprise Portfolio provides the underlying infrastructure necessary to perform business functions and maintains a robust technology infrastructure for the Department. It includes cybersecurity, data centers, cloud services, telephony, enterprise software, end-user hardware, data connectivity and the IT activations program.

Unlike the other portfolios, it cuts across the entire organization and serves as the foundation upon which the other portfolios are built. The Enterprise Portfolio includes capabilities that comprise VA's core IT infrastructure and services. These capabilities underpin VA's IT mission application environment and are essential to VA's ability to deliver a secure, seamless, and unified Veteran experience through the delivery of state-of-the-art technology. Operations and maintenance programs that can be directly allocated to other portfolios are shown in those areas of this budget submission.

The 2023 budget includes an increased request to support modernization efforts such as the VA's VAEC and IRP.

The 2023 Enterprise Portfolio Budget Request consists of the following Congressional Projects details:

| Priority Order | Congressional Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | | 2022-2023 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | | Increase/ Decrease |
| | | DEV | OM | DEV | OM | DEV | OM | DEV | OM | |
| 1 | Telecommunications | $ - | $ 293,145 | $ - | $ - | $ - | $ 292,505 | $ - | $ 241,894 | $ (50,611) |
| | Telecommunications - CARES Act | $ - | $ 36,864 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | Telecommunications - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 42,034 | $ - | $ 42,236 | $ 202 |
| 2 | Network Operations Center | $ - | $ - | $ - | $ - | $ - | $ 39,866 | $ - | $ 33,673 | $ (6,193) |
| 3 | Cyber Security[2/] | $ 11,380 | $ 288,910 | $ - | $ - | $ 11,200 | $ 307,548 | $ - | $ 402,341 | $ 83,593 |
| | Cyber Security[2/] - CARES Act | $ - | $ 24,442 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | Cyber Security2/ - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 9,498 | $ - | $ 9,663 | $ 165 |
| 4 | Hardware Maintenance | $ - | $ 65,794 | $ - | $ - | $ - | $ 91,814 | $ - | $ 159,119 | $ 67,305 |
| | Hardware Maintenance - CARES Act | $ - | $ 6,590 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | Hardware Maintenance - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 4,347 | $ - | $ 4,477 | $ 130 |
| 5 | Software Maintenance | $ - | $ 431,235 | $ - | $ - | $ - | $ 243,983 | $ - | $ 442,767 | $ 198,784 |
| | Software Maintenance - CARES Act | $ - | $ 21,183 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 6 | Infrastructure Readiness Program (IRP)[1/] | $ - | $ 248,690 | $ - | $ - | $ - | $ 477,543 | $ - | $ 477,543 | $ - |
| | Infrastructure Readiness Program (IRP) - CARES Act | $ - | $ 43,666 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 7 | IT Support Contracts | $ - | $ 494,556 | $ - | $ 15,000 | $ - | $ 161,725 | $ - | $ 168,043 | $ 6,318 |
| | IT Support Contracts- CARES Act | $ - | $ 51,228 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | IT Support Contracts- American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 13,471 | $ - | $ 14,764 | $ 1,293 |
| 8 | Enterprise Service Desk | $ - | $ 50,469 | $ - | $ - | $ - | $ 77,737 | $ - | $ 63,195 | $ (14,542) |
| | Enterprise Service Desk - CARES Act | $ - | $ 3,742 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| 9 | Enterprise Command Center | $ - | $ - | $ - | $ - | $ - | $ 12,624 | $ - | $ 12,624 | $ - |
| 10 | Activations | $ - | $ 47,911 | $ - | $ - | $ - | $ 112,072 | $ - | $ 25,000 | $ (87,072) |
| | Activations - CARES Act | $ - | $ 147,556 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | Activations - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 66,494 | $ - | $ 66,494 | $ - |
| 11 | End User Operations | $ - | $ - | $ - | $ - | $ - | $ 52,000 | $ - | $ 50,021 | $ (1,979) |
| 12 | IT Service Management | $ - | $ 55,100 | $ - | $ - | $ - | $ 55,660 | $ - | $ 94,690 | $ 39,030 |
| 13 | Privacy & Records Management[2/] | $ - | $ 34,359 | $ - | $ - | $ - | $ 42,000 | $ - | $ 54,788 | $ 12,788 |
| 14 | Repositories | $ - | $ 2,018 | $ - | $ - | $ - | $ 3,299 | $ - | $ 2,974 | $ (325) |
| 15 | Data Integration and Management | $ 35,129 | $ 253,252 | $ - | $ - | $ 8,000 | $ 309,909 | $ - | $ 161,009 | $ (156,900) |
| | Data Integration and Management - CARES Act | $ 11,874 | $ 337,755 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | Data Integration and Management - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 342,865 | $ - | $ 357,385 | $ 14,520 |
| | TAC Fees - CARES Act | $ - | $ 18,553 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| | **Total Enterprise Portfolio** | **$ 58,382** | **$ 2,957,021** | **$ -** | **$ 15,000** | **$ 19,200** | **$ 2,758,995** | **$ -** | **$ 2,884,700** | **$ 106,505** |

1/ In 2022, Congressional Projects IRP will be funded by the Recurring Expenses Transformational Fund
2/ See Appendix N for Information Security details

**Telecommunications – $241.9 million (*Operations and Maintenance)***
The 2023 Budget Request will be supplemented with $42.2 million from the ARP Section 8002 and includes the following sub-projects:

| SubProjects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Enterprise Telecommunications | $ - | $ 293,145 | $ - | $ - | $ - | $ 274,047 | $ - | $ 238,408 |
| Enterprise Telecommunications - CARES Act | $ - | $ 36,864 | $ - | $ - | $ - | $ - | $ - | $ - |
| Enterprise Telecommunications - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 42,034 | $ - | $ 42,236 |
| EIS Transition | $ - | $ - | $ - | $ - | $ - | $ 18,458 | $ - | $ 3,486 |
| **Telecommunications** | **$ -** | **$ 330,009** | **$ -** | **$ -** | **$ -** | **$ 334,539** | **$ -** | **$ 284,130** |

The Telecommunications services are considered "must pay" requirements to support services that all VA Administrations rely upon to deliver services to Veterans as well as provide disaster recovery/continuity of operation (DR-COOP) for service capabilities. Telecommunications funds the recurring monthly payments for voice, data, mobile/cellular and video services in support of every VA physical location and business unit. It includes service for: VA Enterprise-Wide Area Network (WAN), VA Internet gateways, VA private Cloud access points, remote access (telework, telehealth, etc.), modern voice Session Initiation Protocol (SIP), legacy voice services - plain old telephony services (POTS), Local Exchange Carrier (LEC) / voice charges, long distance, mobile/cellular smartphones, cellular LTE/5G data plans, emergence satellite services for VSATs, Teams/WebEx/call-conferencing, videoconferencing, and telehealth.

**Network Operations Center - $33.7 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-project:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Network Operations Center | $ - | $ - | $ - | $ - | $ - | $ 39,866 | $ - | $ 33,673 |
| **Network Operations Center** | **$ -** | **$ -** | **$ -** | **$ -** | **$ -** | **$ 39,866** | **$ -** | **$ 33,673** |

The Network Operations Center (NOC) is responsible for the reliable and secure transport of voice/video/data to/from the Internet Edge to the Enterprise Regional demarcation points for VA. The NOC provides services for globally distributed network gateway architecture. The gateway architecture interconnects VA's computing infrastructure to the outside world, including the internet, other Government agencies (e.g., DoD), and stakeholders (e.g., VBA Payment to Portal). These interconnections are integral to VA's business of providing services to Veterans.

VA's Trusted Internet Connections (TIC) architecture enables secure and reliable computer network connectivity between entities as the protection of Veterans' data is of paramount

importance. The capabilities of this program directly support current and projected future DHS TIC requirements as outlined in the DHS TIC Reference Architecture Document, Version 2.0.

The NOC also implements and performs operations and maintenance on all devices that make up the TIC security stack. This ensures all data bound for the internet does not contain Personally Identifiable Information (PII) or Protected Health Information (PHI), while all inbound data is safe and secure as it traverses VA's circuits. Per the VA 6500 Handbook, information systems must be deployed in a manner that protects data confidentiality, integrity, and availability. The TIC must be able to scale to support up to 100 gigabits per second (Gbps) of mixed Internet Protocol (IP) traffic throughput to meet projected operational needs. FIPS 200, Minimum Security Requirements for Federal Information and Information Systems, section 3, requires the following: Organizations must implement plans for backup operations in case of an emergency; Organizations must monitor, control, and protect organizational communications at the external boundaries of the information system; Organizations must employ architectural designs that promote effective information security within organizational information systems.

**Cyber Security - $402.3 million (*Operations and Maintenance)***
The 2023 Budget Request will be supplemented with $9.7 million from the ARP Section 8002 and includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Information Security Operations (ISO) - Cyber Security Operations Center | $ - | $ 100,991 | $ - | $ - | $ - | $ 87,900 | $ - | $ 117,490 |
| Continuous Readiness in Information Security | $ - | $ 68,921 | $ - | $ - | $ - | $ 51,129 | $ - | $ 63,911 |
| Information Security Policy and Strategy (ISPS) - Enterprise CyberSecurity Plan | $ - | $ 92,847 | $ - | $ - | $ - | $ 60,000 | $ - | $ 60,000 |
| Identity and Access Management (IAM) | $ 11,380 | $ 22,382 | $ - | $ - | $ 11,200 | $ 21,800 | $ - | $ 45,040 |
| Information Security Operations (ISO) - Information Security Risk Management | $ - | $ - | $ - | $ - | $ - | $ 32,323 | $ - | $ 43,205 |
| Information Security Policy and Strategy (ISPS) - Enterprise Security Architecture | $ - | $ - | $ - | $ - | $ - | $ 16,100 | $ - | $ 21,521 |
| Information Security Policy and Strategy (ISPS) - CyberSecurity Technology and Metrics | $ - | $ - | $ - | $ - | $ - | $ 14,500 | $ - | $ 19,382 |
| Information Security Policy and Strategy (ISPS) - Information Security Policy and Compliance | $ - | $ - | $ - | $ - | $ - | $ 11,700 | $ - | $ 15,639 |
| Information Security Operations (ISO) - Privacy | $ - | $ - | $ - | $ - | $ - | $ 7,400 | $ - | $ 9,894 |
| Cybersecurity Program Integration | $ - | $ 3,276 | $ - | $ - | $ - | $ 3,040 | $ - | $ 4,063 |
| Field Security Service | $ - | $ - | $ - | $ - | $ - | $ 1,536 | $ - | $ 1,536 |
| Next Generation (NextGen) PIV | $ - | $ 494 | $ - | $ - | $ - | $ - | $ - | $ 500 |
| Information Security Operations (ISO) - Data Breach Response Services | $ - | $ - | $ - | $ - | $ - | $ 120 | $ - | $ 160 |
| Enterprise Cybersecurity Strategy Program - CARES Act | $ - | $ 22,348 | $ - | $ - | $ - | $ - | $ - | $ - |
| Enterprise Cybersecurity Strategy Program - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 4,000 | $ - | $ 4,000 |
| Cyber Security Program Services - CARES Act | $ - | $ 2,094 | $ - | $ - | $ - | $ - | $ - | $ - |
| Cyber Security Program Services - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 5,498 | $ - | $ 5,663 |
| **Cyber Security** | **$ 11,380** | **$ 313,352** | **$ -** | **$ -** | **$ 11,200** | **$ 317,046** | **$ -** | **$ 412,004** |

OIS integrates and collaborates with OIT entities to deliver enterprise-wide cybersecurity strategies, policy, governance, oversight, and network defenses to protect Veterans' information and VA's information systems. OIS provides the following activity:

- Drives alignment with federal cybersecurity priorities and requirements
- Delivers to the Veteran secure, multi-authenticated, easy access to their protected data
- Monitors, detects, reports, contains, and mitigates risks and threats to VA's network and infrastructure
- Independently verifies and validates VA's cybersecurity posture and leads emerging and imminent threat preparation and defense efforts
- Collaborates with DoD to increase reciprocity and improve customer and Veteran experience
- Identifies, assesses, and monitors risk to the confidentiality, integrity, and availability of VA's organizational assets

- Provides enterprise-level cybersecurity architecture governance requirements and advisory services
- Adapts to the evolving cybersecurity threat landscape by continually centralizing and refreshing VA's cybersecurity policy and guidance
- Recruits, develops, and retains a talented cybersecurity and privacy workforce
- Invests in technologies to support EO 14028 (e.g., Zero Trust, cloud services, encryption)

The 2023 Information Security request will support the following major areas:

**Information Security Operations (ISO) - $170.7 million**

| Cybersecurity Framework (CSF) | | | | | |
|---|---|---|---|---|---|
| Identify | Protect | Detect | Respond | Recover | Privacy |
| 36.5% | 23.5% | 19.9% | 18.2% | 0.5% | 1.4% |

ISO is responsible for Cyber Security Operations Center (CSOC), Information Security Risk Management, and VA Data Breach Response Service (DBRS)

- The mission of the CSOC is to protect VA's information daily by monitoring, reporting, and responding to cyber threats and vulnerabilities; managing the TIC gateways; conducting enterprise network security monitoring; and providing value-added network and security management services across the agency. In executing this mission, CSOC aims to provide customer-focused, reputable security services operations to facilitate consistent availability and protection of information.

- The Information Security Risk Management Team works to promote an agency-wide understanding of information security risk in alignment with OIS strategies and priorities. It also aims to maintain compliance with Federal requirements while anticipating new or emerging requirements and developing work plans to address them. The Team also oversees the Department's cybersecurity risk management activity, including Authorization processing, the Security Control Assessments (SCA) function, the PIV Card Issuance (PCI) Assessments, the Governance, Risk, and Compliance process (GRC), Case Manager function, and other information regarding security program support activity.

- The VA DBRS is responsible for handling all privacy and security related events that are entered into the Privacy and Security Events Tracking System (PSETS) on a global level. The DBRS team consists of individuals that have extensive experience in the Information Security and Privacy within the VA and VA HealthCare field. The team reviews each incident and decisions are based on Federal and VA-specific data breach response requirements. The DBRS works to ensure that all decisions on privacy and security related incidents are dealt with in a timely manner and in accordance with Federal and VA-specific incident resolution guidelines. Complex breaches are referred to the National Data Breach Core Team (DBCT).

**Continuous Readiness in Information Security – $63.9 million**

| Cybersecurity Framework (CSF) | | | | | |
|---|---|---|---|---|---|
| Identify | Protect | Detect | Respond | Recover | Privacy |
| 100.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |

- Continuous Readiness in Information Security Protection (CRISP) is designed to reduce systemic information security risks across VA programs and systems to comply with Federal security and privacy regulations. This effort enables VA to provide improved customer service and provide a more secure and seamless experience. This request will assist the Department in continuing to improve the security and resiliency of the underlying VA infrastructure facilitating enhanced visibility, access, and functionality across the spectrum of VA services for the Veteran. These investments help ensure Veterans and VA's data and systems are protected from cyber threats and attacks.

- Additionally, CRISP is designed to provide Subject Matter Expert (SME) and staff support in conjunction with the DSO Transformation Support Services (TSS). Services include providing direct support across the spectrum of operational functions including Cybersecurity Risk Management (CRM), Research and Development, Medical Device Protection, Systems Engineering, Configuration Management, Field Security Support, Vulnerability and Patch Management, Security Management, Access Management, and Continuity of Operations. The support provided is crucial to continuing past efforts designed to reduce information security risks across VA programs and systems as well as comply with Federal security and privacy regulations. This request provides direct operational cybersecurity support and includes remediation services related to material weakness findings, while offering surge support activity to address emerging shortfalls in capabilities.

**Enterprise Cybersecurity Program (formerly Cybersecurity Implementation Strategy) - $60.0 million**

| Cybersecurity Framework (CSF) | | | | | |
|---|---|---|---|---|---|
| Identify | Protect | Detect | Respond | Recover | Privacy |
| 64.1% | 24.8% | 7.6% | 3.5% | 0.0% | 0.0% |

Enterprise Cybersecurity Program (ECSP) oversees VA's efforts to advance the overall cybersecurity posture of VA through enhanced visibility into VA IT's systems and networks and by providing cutting edge guidance, support, and tools. It is responsible for the execution of OIT's cybersecurity strategy and for defining the set of actions, processes, and emerging security technologies required to further enhance the security state of VA's information and assets all while improving the resilience of VA networks.

**Information Security Policy and Strategy - $60.6 million**

| Cybersecurity Framework (CSF) | | | | | |
|---|---|---|---|---|---|
| Identify | Protect | Detect | Respond | Recover | Privacy |
| 63.3% | 30.1% | 4.5% | 1.2% | 0.9% | 0.0% |

Information Security Policy and Strategy is responsible for Enterprise Security Architecture, Policy and Compliance, and Cybersecurity Technology and Metrics.

- Enterprise Security Architecture integrates and aligns VA's security requirements with system and application engineering requirements throughout VA's system development lifecycle. Enterprise Security Architecture is an iterative, automated enterprise security process that encompasses security attributes from architecture domains and helps VA's ECSP implement prioritized cybersecurity capabilities. The team gathers input and requirements from VA stakeholders to support and inform Enterprise Security Architecture activities and collaborate with the Enterprise Cloud Services Broker (ECSB) to broker, define, and deliver cloud security standards and policies tailored to meet VA customer requirements.

- The Cybersecurity Technology and Metrics (CTM) group oversees the execution of capabilities and strategies to describe, assess, and continuously monitor VA's cybersecurity landscape in support of VA's cybersecurity program. It also leads the Security Architecture and Software Assurance (SASA) and Identity and Access Management (IAM) Teams to support compliance with the FISMA and government-wide guidance and requirements associated with Federal Identity, Credential, and Access Management (FICAM) services. The SASA IAM Team also helps analyze and ensure that VA's FICAM services are used to fulfill cybersecurity control requirements. Further, CTM captures and displays key performance metrics in a single view, which facilitates risk decision making and budget allocation prioritization for senior executives. CTM also provides technical security expertise in support of various technologies and methodologies executed by the offices responsible for 44 U.S. Code 3554 FISMA areas.

- Information Security Policy and Compliance is responsible for the development and maintenance of VA's cybersecurity policy, confirming that VA's policy is current and in compliance with Federal laws and regulations as well as The National Institute of Standards and Technology (NIST) guidelines. It also oversees the review of IT products and services that the Department plans to purchase to help facilitate compliance with Federal and Departmental cybersecurity policies and regulations. The Information Security Policy and Compliance team maintains the Knowledge Service (KS) to provide VA employees with a centralized, authoritative repository for VA policy guidance and to support the implementation of NIST Special Publication (SP) 800-53 and Committee on National Security Systems (CNSS) 1253 security controls throughout VA.

- VA Privacy Service oversees and directs the development of VA's privacy programs to help protect Veterans, their beneficiaries, and VA employees' personal information. VA Privacy Service advises and makes recommendations to senior officials on privacy priorities and preserves and protects the PII of Veterans, their beneficiaries, and VA employees by promoting a culture of privacy awareness and maintaining the trust of those we serve. VA Privacy Service ensures VA policies comply with regulatory requirements and legislated mandates governing those programs.

**Identity and Access Management - Enterprise (IAM) - $45.0 million**

| Cybersecurity Framework (CSF) | | | | | |
|---|---|---|---|---|---|
| Identify | Protect | Detect | Respond | Recover | Privacy |
| 100.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |

IAM mission-critical services provide Veterans, beneficiaries, stakeholders, and VA employees seamless authorized and authenticated access to over 950 VHA, VBA and NCA integrated applications that deliver health care services, process claims, and manage benefits. IAM provides enterprise-level identity, authentication, and authorization services for multiple internal and external systems. IAM supports the Veteran, beneficiary, and family member experience by providing both single sign-on and consistent identity and access for every user across the enterprise. This support is done both directly and indirectly. As more VA systems integrate with IAM, data security and data quality across the enterprise will continue to improve, resulting in increased customer and employee satisfaction. IAM improves Veteran and customer experience through support for VA's enhanced caregiver program, managing the identities and relationships between caregivers and Veterans, support for DoD's expansion of patronage, and integration with Login.gov.

This effort provides enterprise level authentication and authorization services that authenticate VA persons of interest and automate the granting, maintenance, and removal of electronic permissions to regulate access to VA technology systems, resources, and data. This effort also provides enterprise level identity services that uniquely and accurately identify individuals across the VA. It also helps to determine which VA systems the individuals and their associated identifiers are located in. The 2023 request for Cyber Security Project Operations and Maintenance will support OIT efforts such as maintaining the cyber security software and COTS solution for the suite of identity and security services and VAEC MS Azure Government (MAG) environment.

**Cybersecurity Program Integration - $4.1 million**

| Cybersecurity Framework (CSF) | | | | | |
|---|---|---|---|---|---|
| Identify | Protect | Detect | Respond | Recover | Privacy |
| 87.1% | 12.9% | 0.0% | 0.0% | 0.0% | 0.0% |

Cybersecurity Program Integration is responsible for overseeing the composition of executive-level correspondence, preparation of congressional testimony, and speeches and responses to public relations inquiries. This office manages OIS performance reporting within OI&T as well as the Department and external stakeholders, such as the Office of Management and Budget. Additional areas of responsibility for the Cybersecurity Program Integration include budget and contracts, business administration, mission support/executive assistants, strategic planning and organization oversight, and security program integration.

**Network Operations Security (End User Operations) - $1.5 million**

| Cybersecurity Framework (CSF) | | | | | |
|---|---|---|---|---|---|
| Identify | Protect | Detect | Respond | Recover | Privacy |
| 0.0% | 100.0% | 0.0% | 0.0% | 0.0% | 0.0% |

End User Operations is a virtual organization that includes the Information Security Officers (ISOs) that supports our VA Medical Centers, Regional Offices, Data Centers, Field Program Offices, and VA Central Offices. ISOs are the on-site experts in security plans, policies, and controls. Field Security Service (FSS) ensures the confidentiality, integrity, and availability of Veteran and beneficiary sensitive information, networks, and systems. FSS also strengthens Veteran and public confidence in the quality of VA services and decreases risks to healthcare operations and benefits processing through prevention and remediation of security breaches.

**Hardware Maintenance – $159.1 million (*Operations and Maintenance)***
The 2023 Budget Request will be supplemented with $4.5 million from the ARP Section 8002 and includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Enterprise Hardware Maintenance | $ - | $ 46,923 | $ - | $ - | $ - | $ 91,332 | $ - | $ 158,637 |
| Enterprise Hardware Maintenance - CARES Act | $ - | $ 5,515 | $ - | $ - | $ - | $ - | $ - | $ - |
| Enterprise Hardware Maintenance - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 4,347 | $ - | $ 4,477 |
| Enterprise Facility Allowance | $ - | $ 18,872 | $ - | $ - | $ - | $ 482 | $ - | $ 482 |
| Enterprise Facility Allowance - CARES Act | $ - | $ 1,075 | $ - | $ - | $ - | $ - | $ - | $ - |
| **Hardware Maintenance** | **$ -** | **$ 72,385** | **$ -** | **$ -** | **$ -** | **$ 96,161** | **$ -** | **$ 163,596** |

Hardware Maintenance represents the Operations and Maintenance request to support the Enterprise-level customer service level agreements for Network, Server, Storage, Tapes/Drives, PBX, Printers/Scanners, Paging Systems, OIT Tools, and VTC Hardware. The major requirements include:

- Cisco Enterprise Service Agreement (aka SmartNet)
- PBX Maintenance (7 consolidated contracts that support the various vendor telephony equipment in use in the VA)
- Riverbed Enterprise Services Agreement (WAN Acceleration)
- ForeScout Counter Act
- NetApps Consolidation and NetApps Converged Infrastructure (CVI) (storage)

The Hardware Maintenance Project is comprised of recurring payments for extended warranty and support for critical operational hardware components in support of the Enterprise, VA Administrations and Staff Offices. Hardware Maintenance is considered a 'must pay' requirement to support customer service level agreements. Hardware Maintenance also provides for emergent requirements to replace broken equipment to facilitate the timely restoral of IT operational systems as well as the maintenance of Private Branch Exchange (PBX), Paging Systems, Printers/Scanners, VTC Equipment, Servers, Storage and Network Infrastructure.

Cost drivers include costs from prior year activations and the age of equipment, which results in higher failure rates and less efficient operations due to insufficient investment in lifecycle refresh and end of life support equipment. New Enterprise Service Agreements (ESA) will consolidate existing contracts which result in fewer higher cost contracts.

The Enterprise Facility Allowance, also known as Break/Fix, provides for emergent requirements to replace broken equipment to facilitate the timely restoral of IT operational systems including Network, Server, Storage, Tapes/Drives, PBX, Printers/Scanners, Paging Systems, OIT Tools, and VTC Hardware. These purchases typically range from $100 to $100K. In some cases, they represent bulk purchases of small items and in other cases, they represent unplanned purchases of single items.

Facility Operations Allowance funds the purchase of hundreds of smaller items that keep the operational gears moving at a rate necessary to fuel overall OIT progress. Fully funding this program means that workers who depend on operational systems will be able to trust the availability of those systems and operate in accordance with set processes and policy. System owners can meet their operational level agreements with internal customers and support them in delivering solutions to Veterans. Employee morale is significantly boosted by functioning processes with high reliability that allows them to focus on performing their primary function and therefore the overarching objectives of the VA.

**Software Maintenance – $442.8 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Microsoft ELA | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 400,000 |
| Enterprise Software License Maintenance | $ - | $ 431,235 | $ - | $ - | $ - | $ 243,983 | $ - | $ 42,767 |
| Enterprise Software License Maintenance - CARES Act | $ - | $ 10,016 | $ - | $ - | $ - | $ - | $ - | $ - |
| VHA Software License Maintenance - CARES Act | $ - | $ 11,166 | $ - | $ - | $ - | $ - | $ - | $ - |
| **Software Maintenance** | **$ -** | **$ 452,417** | **$ -** | **$ -** | **$ -** | **$ 243,983** | **$ -** | **$ 442,767** |

In 2021, Enterprise Software License Maintenance amount includes Microsoft ELA

The Software Maintenance Project is comprised of recurring payments for existing software and licenses in support of the Enterprise, VA Administrations and Staff Offices. Software License Maintenance is considered a "must pay" requirement to support customer service level agreements. Software License Maintenance covers the VA's Enterprise License Agreements and hundreds of applications in use within the VA. Costs are driven by the number of users and number of new applications and systems supporting these users.

The main cost driver is the Enterprise License Agreements (ELA). The standard Oracle Enterprise License Agreement has been awarded since 2014. The contract covers all Oracle software costs across all of VA. The contract negotiated by OSS has been structured as a base with two option

periods. The bulk of the cost is incurred in the base period and the next Oracle ELA will be awarded in 2023 (May 1, 2023).

Almost every VA service to, or interaction with, our Veteran clients is supported by VA's operational IT systems. This sub-project provides the ongoing operations and maintenance of Enterprise Software License Maintenance. The beneficial impacts on the Veteran, or beneficiary/family members are derived from the individual applications themselves.

The Microsoft ELA provides the continuation of Microsoft licensing, software assurance, and services for a broad range of Microsoft products for various offices, projects, and initiatives throughout VA. The ELA allows VA to continue to use and upgrade Microsoft products to maximize VA's investment in Microsoft products (server and desktop) deployed within the VA infrastructure. Annual true-up of licensing is required.

VA currently owns roughly $1 billion in Microsoft licenses and maintains them through ELAs, which are one-year base and four option period years. MS-ELA-5 was awarded in March 2017 and replaced MS-ELA-4 which was awarded in April 2012. MS-ELA 5 licensing was converted from device-based to user-based and re-baselined from 360,000 devices to roughly 480,000 users. Unit pricing was re-baselined from 2012-unit pricing to 2017-unit pricing. A recompete for MS-ELA-6 will be required in 2023 with licensing to be re-baselined to the current 2016-unit pricing or later, if available.

The Microsoft ELA provides the contract vehicle for VA to acquire Azure Cloud Credits for use with the VAEC. However, the cost to procure the cloud credits is borne by the project/system that is utilizing them and are not included within the base Microsoft ELA CLINs. The projections are based on resetting the unit pricing from 2016 levels and the inclusion of new items such as GitHub Enterprise Subscriptions.

Enterprise Software License Maintenance sub-project represents the costs of the ELA negotiated by Office of Strategic Sourcing (OSS) and hundreds of other software licenses in use across the VA.

Most of the costs are contained within the ELAs, such as:

- Microsoft ELA
- Oracle ELA
- VMWare ELA
- Red Hat SW Maintenance
- Enterprise Key Management Infrastructure
- Citrix SW Maintenance
- Adobe Acrobat Pro licenses
- Attachmate (Reflection) SW maintenance
- Red Hat Enterprise Service Agreement
- Cisco Enterprise Level Agreement

**Infrastructure Readiness Program (IRP) – $477.5 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-projects:

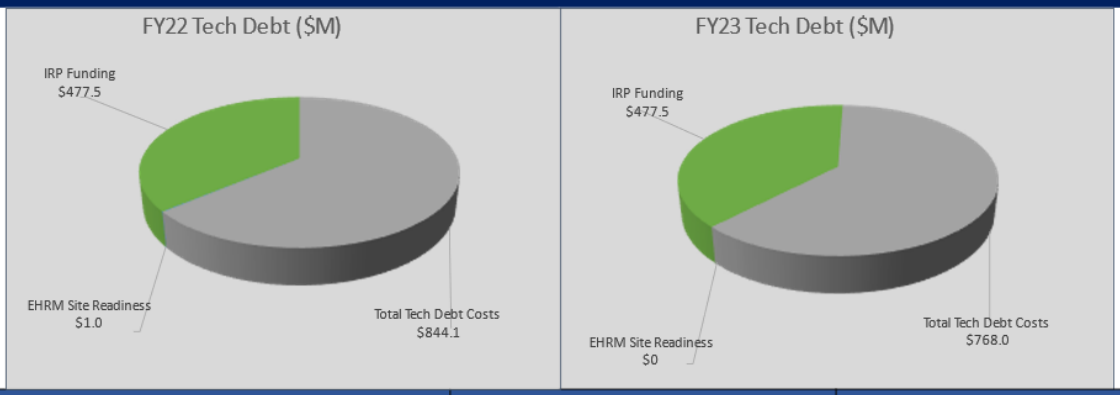
| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Desktop Infrastructure | $ - | $ 74,000 | $ - | $ - | $ - | $ 150,000 | $ - | $ 125,000 |
| Miscellaneous: Printers, VSAT, Video, Wireless | $ - | $ 2,580 | $ - | $ - | $ - | $ 26,543 | $ - | $ 117,543 |
| Server/Storage Farm Infrastructure | $ - | $ 53,407 | $ - | $ - | $ - | $ 115,000 | $ - | $ 98,000 |
| Network Infrastructure | $ - | $ 66,502 | $ - | $ - | $ - | $ 135,000 | $ - | $ 95,000 |
| Unified Communications | $ - | $ 40,201 | $ - | $ - | $ - | $ 51,000 | $ - | $ 42,000 |
| Printer/Scanner Infrastructure - CARES Act | $ - | $ 43,666 | $ - | $ - | $ - | $ - | $ - | $ - |
| WAN Bandwidth Capacity Baseline | $ - | $ 12,000 | $ - | $ - | $ - | $ - | $ - | $ - |
| **Infrastructure Readiness Program (IRP)** | **$ -** | **$ 292,356** | **$ -** | **$ -** | **$ -** | **$ 477,543** | **$ -** | **$ 477,543** |

The Infrastructure Readiness Program (IRP) guides the ongoing refresh and replacement of the IT Infrastructure that sustains all VA IT operations. IRP identifies the current state of the IT Infrastructure and provides analysis for the strategy to refresh and modernize IT Infrastructure assets. Business drivers of "Technical Debt" include equipment age, expiration of warranty, support limitations, lifecycle estimates, business requirements, technology roadmaps, software life cycle elements, financial planning, vendor supply and policy changes. The term "Technical Debt" is normally associated with software development and is generally understood to relate to making short term decisions and trade-offs that can cause significant rework to address in the long term. With the adoption of DevSecOps framework, "Technical Debt" refers to the cost needed to bring legacy infrastructure components to a state of full efficacy. Inadequately resourced technical debt accumulates year over year and reduces the available technology resources for other VA business priorities.

Subsequent consequences of accumulated infrastructure "Technical Debt" are: an increased risk of catastrophic failure of critical systems, new software application performance inhibited by inherent limitations of existing operating systems, security requirements that cannot be enforced, technology that is no longer supported by the manufacturer, increasing operational maintenance costs (eclipsing the cost of acquiring new replacement technology), and legacy technology that is unable to respond to new and/or changing business requirements. Reducing technical debt enables VA to rapidly deliver IT solutions for VA business priorities that enable the exceptional customer experience, care, benefits, and services for Veterans.

Operational efficiency is based upon a robust, healthy IT infrastructure necessary to ensure delivery of reliable, available, and responsive IT services to all VA staff offices and administration customers as well as Veterans. In addition to continuing to facilitate a successful transition to the new EHR, VA must ensure the existing infrastructure is modernized and optimized in support of all modernization efforts (e.g., Finance, Supply Chain, etc.) while achieving a continuous readiness state for all common core technologies incorporated into the IRP plan.

## IRP Common Core Technology Hardware Lifecycle Funding and Projections




| Congressional Project / Sub-Project | Budget ($ in Millions) | Program Request ($M) |
|---|---|---|
| | FY2022 | FY2023 |
| **Infrastructure Readiness Program (IRP)** | **$477** | **$477** |
| Desktop Infrastructure | $97.667 | $150.000 |
| Miscellaneous printers, Zero Trust, Video, Mitre | $134.991 | $35.543 |
| Network Infrastructure | $108.3 | $135.000 |
| Server/Storage Farm Infrastructure | $98.885 | $115.000 |
| Unified Communications | $37.7 | $42.000 |
| WAN Bandwidth Capacity Baseline | $0 | $0 |
| **Total for IRP Major Programming Drivers** | **$477.543** | **$477.543** |

In 2023, OIT will use the IRP resources to support several IT infrastructure initiatives. OIT completed an enterprise-wide assessment of each of the critical infrastructure components identified to determine the scope of the IRP program. Each component used criteria unique to that specific infrastructure element to derive the needs for improvement and basic capability evolution. For instance, desktop computing requirements were derived from a review of literature for industry standard life cycle refresh recommendations (example: Gartner), a review against our installed base using automated tools such as Microsoft's System Center Configuration Manager (SCCM), and a replacement strategy informed by that research to create an optimized schedule of replacement. Bandwidth utilized a model based upon years of experience supporting business requirements across three administrations as well as utilization and consumption metrics from automated discovery tools to map out a logical, efficient, and cost-conscious provisioning schedule.

Current Readiness Initiatives: In terms of Infrastructure Readiness by location/site, it is determined by the business drivers and individual assessment of the infrastructure items. For example, Network Bandwidth would be applied based upon present status and targeting locations of high utilization currently being provisioned on older copper-based technology.

- Revitalize End User Desktop Infrastructure: OIT has significantly increased the in-service operational population of desktops/laptops as a direct result of COVID-19 expansion requirements. IRP has not yet fully realized the impact of this increase on technical debt in this category. However, it is expected to positively impact our ability to retire and refresh out of lifecycle assets associated with the end user experience. 2023 funding will continue to support the downward trend of refreshing these end user devices.
  OIT continues to modernize our end user experience by providing a dynamic and agile framework utilizing a Provisioning-as-a-Service (PVaaS) model that will enhance

customer satisfaction and allow us to rapidly meet changing business requirements. Essential characteristics of our PVaaS environment include logistical management of the end user devices inclusive of initial setup/imaging, provisioning, asset and inventory management and lifecycle removal/refresh of managed equipment. PVaaS will also include a shift to computing devices with solid state drives (SSD) and support for iterative attendant operating software.

Transitioning the current capital expense approach to an operations expense model will also add value in providing consistency of performance and obviating the current risks associated with diversion of funds for other needs. In addition, OIT will explore alternate solutions including solutions that allow a "bring your own device" and a completely managed service desktop environment ("seat management").

- Modernizing Very Small Aperture Transmission (VSAT) Infrastructure: OIT needs to modernize and uplift our legacy continuance of operation VSAT infrastructure over the next three years to increase capacity and ensure Federal Information Processing Standard (FIPS) 140-2 encrypted transmissions.
- Reengineer and Upgrade Printer/Scanner Infrastructure: OIT manages an operational fleet of over 140,000 print/scan capable devices. Our end user experience modernization objective is to migrate from single function to multifunction devices where possible under a Managed Print Services (MPS) framework. Technology life cycle refresh in this category is routinely accomplished when the device is either no longer fit-for-purpose, device performance is sufficiently degraded or when it is no longer viable to retain.

- Expand, Refresh, and Modernize Server/Storage Farm Infrastructure: The strategy for reduction of technical debt in this category is to utilize the Infrastructure as a Managed Service (IaaMS) contract and update/refresh on premise mission essential servers/storage infrastructure. The 2023 request supports the business need to refresh over 4,000 systems with an allocation for growth and technological uplifts. The overall focus of Server/Storage modernization is to standardize the platform to support the Data Center Optimization Initiative (DCOI) and attendant support structure. To be able to achieve this, there is a requirement for similar platforms and storage at all Corporate Data Centers (CDC), Mission Support Centers (MSC), Campus Support Centers (CSC) and modernization of the hosting.
  OIT recently implemented a Storage Resource Management (SRM) tool that now provides us with in depth metrics regarding performance of our storage stack. OIT plans to utilize the data gathered from SRM and engage our stakeholders via the AMO to develop optimal SLAs balancing customer requirements with operational efficiency. OIT currently manages six unique infrastructure designs at a typical Campus Support Center. Through modernization and reengineering, we can streamline this into two tactical infrastructure solutions (with split life cycle, so they refresh at different intervals) and realize cost avoidance from unnecessary maintenance on underutilized technology hardware. OIT will pursue "Storage on Demand" options as a subscription service and move forward to annually replace multiple VA Medical Center hosted storage arrays that reach a lifecycle

maturity of expired support [aka - Last Date of Support (LDoS)] and migrate to a "hyper-converged" replacement strategy for on-premises systems (next generation evolution).

- Modernizing Network Infrastructure: OIT has reduced its technical debt in this category by 21 percent to date. The 2023 request will support refresh of several thousand devices across the Enterprise of which over 50,000 are at end of life. OIT's modernization strategy is to utilize a best value approach to move to a homogenous network stack and then deploy an agile self-service network with expandable services to our business and Veterans as well as to all consumers of our network resources. This will shift VA from using 20-year-old open standard protocols to modern vendor integrated expandable solutions. As we modernize our network, the demand for artificial intelligence to be incorporated will be significant to promote additional capabilities, automation and agility. The focus is to utilize increased virtualization and a scalable architecture to better support modern and evolving technologies (e.g., Quantum Computing and Internet of Things (IoT)) to improve integration with other solutions such as security storage and Unified Communications (UC) critical to support health and benefits delivery outcomes in the future.
- Modernize and Converge Unified Communications: Our expanding business requirements specify the need for enhanced capabilities that handle integrated internal and external client communications. Our ability to provide enhanced collaboration and offer self-service capabilities are dependent upon reengineered and refreshed communication infrastructure. OIT completed the foundational work for phase 1 and is nearing completion of phase 2, which will encompass all 168 major and associated remote sites requiring convergence and modernization. The focus of the Unified Communications (UC) and Video Teleconferencing (VTC) effort is to implement a standardized and modernized enterprise-wide Unified Communication and collaboration infrastructure that enables the capability to support full convergence of all electronic communications onto a single, IP-based enterprise system that seamlessly unifies all voice, video, and collaboration traffic supporting all VA end-users and Veterans.

  Our expected outcomes are implementation of enterprise standards, infrastructure duplication, reduction of VA's Total Cost of Ownership (TCO) and the elimination of standalone communication silos. This will also position the VA enterprise with the necessary expandability to support future transitions to new services and features inclusive of managed service capabilities integration. Enterprise Contact Center and Clinical Contact Center are expected to be the initial capabilities provided to the enterprise. This will reduce the overall complexity and footprint of the VA's existing UC environment and provide the foundational elements for the migration to enterprise-class UC applications and services.

  As part of our IP-based modernization strategy, OIT has moved to a model where all phone systems in a VISN are from the same Original Equipment Manufacturer (OEM). This allows Unified Communications to enable VISN-centric business models and enhance interoperability. OIT will also modernize the Video Teleconferencing (VTC) Codec system that has reached Last Date of Support (LDoS) and no longer supports security baselines. The modernization strategy includes implementing Enterprise Contact Center, Clinical Contact Center, Enterprise Private Cloud session control, and building a foundation to allow exploration of telephony-as-a-service options and capabilities (such as contact center applications, voice mail, and cloud hosted Enterprise-Wide voice services).

Emerging Readiness Initiatives

- Remote End User Experience Modernization/Remote Access Modernization: Remote End User Experience/Remote Access Modernization efforts aim to enhance end users' experiences, services, and collaboration capabilities while streamlining processes through technology. OIT will establish a cohesive implementation strategy to collect, measure, and display end users' experiences via automation and translate the data into actionable information utilizing dashboards to illustrate/illuminate improvement in remote end users' experiences (i.e., job efficiency, remote service performance, financial costs, inventory, usage, and technical capabilities). This effort is integral to our Cloud native virtualization and remote access solutions such as TIC 3.0 compliant solutions, Virtual Private Network (VPN) as a Service, and Cloud-based Virtual Desktops.

- Architect and re-engineer "Zero Trust Security Architecture": Our primary directive targeting these efforts is codified by Executive Order 14028, published in May 2021. Increased adoption of cloud and internet services external to VA are driving the need for TIC 3.0 and Zero Trust architectures to support these changing use cases with fidelity and performance resiliency. Zero Trust concepts are based on the premise of "Never Trust, Always Verify", and are needed to enable secure remote access from "anywhere" and "any device". Adaptation and implementation of this new security posture provides a robust and strategic approach for addressing systemic deficiencies for VA (e.g., enterprise security governance, foundational capability gaps, lack of data and identity governance). This posture initiates a paradigm shift across existing VA security resources from the current compliance-mindset to a mindset that assumes breach and embraces adoption of Zero Trust capabilities as a first step.

The OIT IRP continues to evolve in its maturity and delivery. From new legislative emerging requirements to existing IT infrastructure, the major success factor is a properly funded IRP program that continues on the path to reduce the accumulated technical debt that occurred due to lack of funding.

Management of such a diversified program like IRP requires Executive oversight, program administration, strategy development, and disciplined delivery modes and governance. As such, OIT has established the IRP Executive Working Group (EWG) responsible for providing a cadre of OIT Executive Leaders who will ensure timely resource allocation, program delivery, financial guidance, and strategic leadership towards the program's primary directive. This IRP EWG has been formalized and incorporated into VA OIT's established IT governance structure for compliance and direction.

The IRP Executive Working Group has established an operational IRP program office dedicated to the tactical management, reporting and assimilation of artifacts, tasks, performance metrics and communications related to the individual projects initiated by the program. Quality, performance, security, service level management and risk management have also been incorporated into this program and administered by the program office.

**IT Support Contracts – $168.0 million (*Operations and Maintenance)***
The IT Support Contracts Project is comprised of recurring payments for existing contracts for services and support for implemented IT systems in support of the Enterprise, VA Administrations, and Staff Offices. IT Support Contracts is considered a "must pay" requirement to support customer service level agreements. Costs are driven by the number of users and number of new applications and systems supporting these users. As viewed from the traditional tiered IT support model, the contractual services provided range from basic tier support to advanced top-level tier III support. The project also includes IT support contracts which provide database administration, systems administration, systems architecture, and other support services. These have the intent of maximizing system up time, ensuring that all components work together as a coherent system.

The Enterprise IT Support Contracts represents the charges for IT Support contracts used by DSO IO Appropriated and Solution Delivery Organizations to support operations across the VA. The major requirements include:

- Enterprise Endpoint Protection-Antivirus (AV)/Firewall/DeviceControl/Whitelisting
- Mobile Device Management and Identify Access Management
- Active Directory Modernization
- EIS-Enterprise Telecommunications Expense Management integrated platform/ Solution (eTEMS) - Service Contract (transferred from EIS Transition)
- PIV Operations, Sustainment, and Integration Contract
- Talent Management System Support
- Consolidated Mail Order Pharmacy (CMOP) Database Administration Support
- Microsoft System Center Configuration Server Support
- Content Distribution Network Technical Support

**Enterprise Service Desk – $63.2 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-project:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Enterprise Service Desk (ESD) Managed Services | $ - | $ 50,469 | $ - | $ - | $ - | $ 77,737 | $ - | $ 63,195 |
| Enterprise Service Desk (ESD) Managed Services - CARES Act | $ - | $ 3,742 | $ - | $ - | $ - | $ - | $ - | $ - |
| **Enterprise Service Desk** | **$ -** | **$ 54,211** | **$ -** | **$ -** | **$ -** | **$ 77,737** | **$ -** | **$ 63,195** |

Enterprise Service Desk (ESD) Managed Services Contract funds the operation of VA's ESD which provides centralized 24/7/365 help desk support to all of VA's employees and contractors as the single point of contact for requesting IT services and reporting IT incidents and outages. ESD services are provided through a managed services contract that provides a single point of contact services for IT support related to all VA applications, hardware, software, data, and services. ESD is also responsible for the end-to-end ticket management for all approved VA technologies and works across all IT organizational entities and third-party IT service providers to

ensure VA employees and VA designated third parties are not impeded or prevented from conducting daily business operations. ESD receives more than 3.2 million phone calls a year and processes more than 5.6 million tickets to enable or restore IT capabilities for VA staff across all Administrations. ESD aligns to OIT Imperatives/Goals including Exceptional Customer Experience, IT Modernization, IT Workforce Transformation, and Seamless and Secure Interoperability.

**Enterprise Command Center – $12.6 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-project:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Enterprise Command Center | $ - | $ - | $ - | $ - | $ - | $ 12,624 | $ - | $ 12,624 |
| **Enterprise Command Center** | **$ -** | **$ -** | **$ -** | **$ -** | **$ -** | **$ 12,624** | **$ -** | **$ 12,624** |

Enterprise Command Center (ECC) provides 24/7/365 operations and performance monitoring services across the VA enterprise. ECC also conducts disaster relief and disaster recovery (DR), devolution, and Business Continuity operations. ECC operations are tightly coupled with the Enterprise Service Desk and Major Incident and Problem Management teams for the enterprise.

ECC provides end-to-end operational performance monitoring for the VA enterprise, including monitoring of more than 150 critical or high systems supporting all VA Administrations. ECC responds to more than 4.5 million events per year to proactively and expeditiously resolve incidents, preventing and minimizing service disruptions to VA staff reliant upon IT systems to provide services to Veterans. ECC also provides enterprise DR and emergency preparedness asset deployment and expertise during natural disasters such as extreme weather events. ECC aligns to OIT Imperatives/Goals including Exceptional Customer Experience, IT Modernization, and Seamless and Secure Interoperability.

Providing end-to-end monitoring of Telehealth sessions between doctors and patients has allowed OIT engineers to proactively respond to technical issues before they cause interruptions to telehealth appointments. This has resulted in a 20 percent reduction in the number of errors and degradations experienced in telehealth sessions.

**Activations - $25.0 million (*Operations and Maintenance)***
The 2023 Budget Request will be supplemented with $66.5 million from the ARP Section 8002 and includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Activations | $ - | $ - | $ - | $ - | $ - | $ 112,072 | $ - | $ 25,000 |
| VHA Growth | $ - | $ 30,076 | $ - | $ - | $ - | $ - | $ - | $ - |
| VHA Growth - CARES Act | $ - | $ 82,611 | $ - | $ - | $ - | $ - | $ - | $ - |
| VHA Growth - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 66,494 | $ - | $ 66,494 |
| VHA Construction | $ - | $ 17,835 | $ - | $ - | $ - | $ - | $ - | $ - |
| VHA Construction - CARES Act | $ - | $ 64,945 | $ - | $ - | $ - | $ - | $ - | $ - |
| **Activations** | **$ -** | **$ 195,467** | **$ -** | **$ -** | **$ -** | **$ 178,566** | **$ -** | **$ 91,494** |

Activations funds the purchase, issuance and installation of IT equipment for new employee hiring growth across all Administrations, all physical VA facility expansion/modification (e.g., major, minor, non-reoccurring maintenance, local "halls and walls" projects and leasing activity), and IT expenses occurring from changes to business practices or patterns of business activity (ex: shifting staff to telework, replacing laptops with tablets for VBA Fiduciary Hub employees, provisioning smart phones to additional VA staff for a valid business requirement, etc.).

An IT activation is the process by which the VA's administrations work with the OIT field managers to provide IT support for:

- Opening a new VA facility
- Remodeling non-clinical to clinical space (e.g., new exam rooms)
- Memorial services (e.g., new, expanded, or consolidated cemeteries)
- Expanded services and FTE growth

The size of an IT activation can range from a new VAMC to a small renovation project at a Regional Office. IT activations can include everything from endpoint devices for new employees, telecom circuits, Local Area Network (LAN)/ WAN switches, and wireless installs. They can also include items such as desk phones and patch cables to set up the space.
Activation funding is available for costs associated with new space, new program expansion, space reductions, or space reconfigurations including:

- Major/Minor Construction
- Non-Recurring Maintenance
- Station Level Projects
- Community Based Outpatient Clinics (CBOC)-New or Expansion
- Vet Centers-New or Expansion
- National Mandated Programs-New
- Leased Space-New or Expansion (not identified in categories listed above including "As-Built" clinics)

**Starting Point:** An IT activation starts when the need for IT support is identified for a new VA Capital Project which includes major construction, minor construction, leased facilities, and NRM (Non-Recurring Maintenance) projects. For leased facilities, funding projections would start when the need is identified.

**Ending Point**: An IT activation ends when the requirements for full initial IT operational capabilities are met.

Activations must-pay requirements for new construction or space renovations are dictated by the actual construction schedule. New Space/New Lease outfitting must be done for space to be occupied and usable, and New Growth FTE costs cover outfitting new employees with equipment.

Activations costs are directly driven by the growth of the VA - both in staff and facilities. Over the last 5 years, the VHA construction budget alone has grown by an average of 13 percent per fiscal year. VA staff growth continues to increase by 11K each fiscal year with an additional 15K staff projected in 2023 for VHA alone. DSO/End User Operations (EUO) is working closely with the Chief Executive Office (CXO) to prioritize the projects for funding and DSO/OSS have worked closely to combine acquisition strategies to ensure the best pricing.

**IT Service Management - $94.7 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-project:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| IT Service Management | $ - | $ 55,100 | $ - | $ - | $ - | $ 55,660 | $ - | $ 94,690 |
| **IT Service Management** | **$ -** | **$ 55,100** | **$ -** | **$ -** | **$ -** | **$ 55,660** | **$ -** | **$ 94,690** |

The Service Management Office (SMO) delivers enterprise-wide IT service strategy, policy, governance, oversight, processes, and tools to manage and track the services provided to OIT customers via the IT Service Management Project.

Base year support encompasses the full depth and breadth of the IT Infrastructure Library (ITIL) IT Service Lifecycle to underpin and bolster the VA's digital business technology ServiceNow Platform transformation. The IT Service Management (ITSM) Support Services contract is a Time & Material/Firm Fixed Price hybrid allowing flexibility to the SMO while transformation requirements are burgeoning. The ITSM Support Services contract is operating with the future in mind whereby product-based business needs drive the rapid, agile, and efficient evolution of continuously modernized cloud-first ITSM ServiceNow Platform applications.

The ITSM Support Services increases efficiency and productivity by utilizing a single web-based tool for multiple services. It also automates IT Service Management products and processes and services through SaaS to comply with Cloud First Initiatives. In addition, it consolidates disparate legacy tools into a single cloud-based platform and enhances Leadership decision making through consolidation of data in a single tool.

**Privacy & Records Management – $54.8 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects *($s in thousands)* | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| VA Interoperability, Standards Development and Coordination | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 8,643 |
| OIT-Wide Communication Support | $ - | $ 8,002 | $ - | $ - | $ - | $ 12,566 | $ - | $ 6,143 |
| Data Analytics Contract | $ - | $ 2,286 | $ - | $ - | $ - | $ 4,900 | $ - | $ 5,050 |
| Quality Continuous Improvement Organization (QCIO) | $ - | $ 4,423 | $ - | $ - | $ - | $ 4,500 | $ - | $ 4,636 |
| CIO Strategic Support Contract_FFRDC | $ - | $ 2,966 | $ - | $ - | $ - | $ 3,432 | $ - | $ 3,570 |
| Grant Thorton Support to QPR | $ - | $ - | $ - | $ - | $ - | $ 3,266 | $ - | $ 3,396 |
| IRB Support | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 3,080 |
| CIO Front Office Cyber Services | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 3,000 |
| Federal Managers Financial Integrity (FMFIA) - Statement of Assurance | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 2,378 |
| CIO Balanced Score Card | $ - | $ - | $ - | $ - | $ - | $ 2,142 | $ - | $ 2,228 |
| E-FOIA Express | $ - | $ - | $ - | $ - | $ - | $ 1,780 | $ - | $ 1,850 |
| IT Strategic Support Services - OIT Front Office | $ - | $ 8,049 | $ - | $ - | $ - | $ 1,670 | $ - | $ 1,720 |
| IT Governance Support Contract | $ - | $ - | $ - | $ - | $ - | $ 1,325 | $ - | $ 1,350 |
| SQAS - IV&V Support Contract | $ - | $ 1,303 | $ - | $ - | $ - | $ 1,175 | $ - | $ 1,263 |
| OIT Front Office EA Support Contract | $ - | $ - | $ - | $ - | $ - | $ 1,152 | $ - | $ 1,210 |
| FOIA Support Services | $ - | $ - | $ - | $ - | $ - | $ 990 | $ - | $ 1,125 |
| Gartner support for Front office and QPR | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 900 |
| OIG FISMA/FISCAM Audit Support Contract | $ - | $ 1,357 | $ - | $ - | $ - | $ 855 | $ - | $ 879 |
| Control Unclassified Information | $ - | $ 732 | $ - | $ - | $ - | $ 850 | $ - | $ 852 |
| Business Office Budget Support | $ - | $ - | $ - | $ - | $ - | $ 810 | $ - | $ 825 |
| ERM - Technology Risk Registry SLA | $ - | $ 25 | $ - | $ - | $ - | $ 312 | $ - | $ 320 |
| ERM - Technology Operations & Maintenance Support Contract | $ - | $ 235 | $ - | $ - | $ - | $ 275 | $ - | $ 275 |
| DOJ required Public Access Link | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 61 |
| Cloud Credit in support of the Enterprise Risk Registry | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 27 |
| CIO Front Office Site B Communications | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 7 |
| Federally Funded Research and Development Centers (FFRDC) Support | $ - | $ 4,981 | $ - | $ - | $ - | $ - | $ - | $ - |
| **Privacy & Records Management** | **$ -** | **$ 34,359** | **$ -** | **$ -** | **$ -** | **$ 42,000** | **$ -** | **$ 54,788** |

| Cybersecurity Framework (CSF) | | | | | |
|---|---|---|---|---|---|
| Identify | Protect | Detect | Respond | Recover | Privacy |
| 66.0% | 17.0% | 12.0% | 5.0% | 0.0% | 0.0% |

The purpose of the Quality, Performance, and Risk (QPR) Cybersecurity Framework is strict adherence and compliance with federally mandated laws, regulations, and policies. Furthermore, to posture OIT with achieving the SECVA's four priorities, there is an emphasis placed on improving customer service and remaining compliant with the following legislatively mandated requirements, Freedom of Information Act (FOIA), Federal Records Act (FRA), Release of Names and Addresses (RONA), and Controlled Unclassified Information (CUI), all while transforming VA's business systems. Each of these mandated requirements continue to evolve based on continued Congressional, GAO and OIG oversight. FOIA processing of Veterans Claims folders has been modified based on an OIG recommendation which immediately generated a significant ongoing negative impact on the FOIA backlog and the need for additional resources and improved processing tools. The backlog is tracked by Congress and is reportable to the Department of Justice annually by the VA Chief FOIA Officer (Assistant Secretary or higher mandate).

Enhancements to the FOIA program (with the volume and processing times increasing based on complexity of incoming FOIA requests) continue to be a Congressional priority, as evidenced by the currently proposed VA FOIA Reform Act. Part of the requirement in the Act is to mandate technology enhancements to further improve access to Veteran records and improve the overall customer experience. Major impacts are projected based on the U.S. National Archives and Records Administration's (NARA) mandated closing of Federal storage facilities and the requirement to digitize paper and begin using commercial storage facilities. Funding and personnel issues will be critical decision points in VA's ability to adhere to the potential change in scope and handling of both temporary and permanent records. OMB mandates require the agency to develop a significant new Records Management electronic recordkeeping system that will manage VA documents and official records throughout the document life cycle. This effort will impact the entire agency workforce and push towards a more efficient and accountable Records Management program.

A significant increase in Congressional RONA requests continue to put a burden on both the agency RONA office and the supporting OIT processing centers. Workforce requirements to support both the increase in FOIA requests and RONA requests continues to place an undue burden on the current workforce. Along with that burden is the talent pool and expertise needed to be successful as a significant number of resources are retirement eligible. The focus with workforce succession planning will be a critical issue that must be addressed. The mandated department-wide CUI mandated program continues to grow with implementation dates at risk based on decision making authority levels. CUI requires a level of high visibility across the agency with requirements to support other programs within VA that provide security and privacy controls of Veterans records.

Furthermore, QPR will oversee the enterprise-wide CUI program and provide supervision of the VA Agency Records Officer while continuously improving OIT capabilities by focusing on the CIO's five imperatives. Current and proposed systems will accurately process and track FOIA requests, legally release names and addresses, enhance role-based training, and provide Veteran services within the law and as allowed by policy. The compliance requirements are set forth by

various statutes and regulations to include the Privacy Act, HIPAA, FISMA, FOIA, Clinger Cohen Act, OMB Circular A-108, OMB Circular A-130, FITARA, and various OMB mandates for records management activity to include electronic recordkeeping capabilities by the close of each calendar year.

Additionally, the office evaluates and delivers enterprise-wide reporting with current compliance and sustainability postures of privacy, FOIA, and records management programs. It also ensures that all VA records are managed in the most effective and cost-efficient manner. This simultaneously ensures that VA's records management practices comply with the Federal Records Act of 1950. This project will enhance and sustain performance efforts of modernization within cybersecurity regarding the following sub projects, CIO Balanced Score Card, CIO Strategic Support Contract Federally Funded Research and Development Center (FFRDC), Quality Continues Improvement Organization (QCIO), and IT Investment Board (Governance) Support.

**End User Operations – $50.0 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-project:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| End User Operations | $ - | $ - | $ - | $ - | $ - | $ 52,000 | $ - | $ 50,021 |
| **End User Operations** | **$ -** | **$ -** | **$ -** | **$ -** | **$ -** | **$ 52,000** | **$ -** | **$ 50,021** |

End User Operations funds ongoing operations and maintenance requirements that are executed by the DSO End User Operations (EUO) organization. End User Operations provides onsite customer support at every VA point of presence and business unit via low dollar, high volume actions for: break/fix repairs, fulfilling approved customer requests or changes, operational support for deployed IT services, and emergency support.

End User Operations provides direct IT support services to VA's ~390,000 employees across all Administrations as well as the approximately 100,000 contractors who are issued government-furnished equipment, including the completion of over 1.4 million incident tickets a year to issue, repair or replace equipment. End User Operations aligns to OIT Imperatives/Goals including Exceptional Customer Experience and IT Workforce Transformation.

**Repositories – $3.0 million (*Operations and Maintenance)***
The 2023 Budget Request includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Administrative Data Repository (ADR) | $ - | $ 682 | $ - | $ - | $ - | $ 1,800 | $ - | $ 1,800 |
| Health Data Repository (HDR II) | $ - | $ 1,337 | $ - | $ - | $ - | $ 1,499 | $ - | $ 1,174 |
| **Repositories** | **$ -** | **$ 2,018** | **$ -** | **$ -** | **$ -** | **$ 3,299** | **$ -** | **$ 2,974** |

Repositories contains the collection, management, and secure dissemination of Transactional enterprise data sets through the Administrative Data Repository (ADR) and Healthcare Data

Repository (HDR). The ADR serves as the Transactional data layer for the Enrollment System – a key Veteran facing application for determining healthcare eligibility and facilitating enrollment for VHA. ADR also serves numerous reporting and compliance functions through the support of Affordable Care Act reporting and demographic details and demand for care in geographic regions. HDR serves as a key role in the creation of the legal electronic healthcare for Veterans through the integration of healthcare data from VistA, Cerner, and DoD sources. HDR delivers near real-time data concerning active prescriptions, appointments, labs, vitals, allergies and other healthcare conditions and services to more than 20 consuming applications in the VA ecosystem. Without HDR, many Veteran facing systems would be without visibility to key healthcare data concerning Veterans served by VA as well as dual-enrolled service members.

**Data Integration and Management – $161.0 million (*Operations and Maintenance)***
The 2023 Budget Request will be supplemented with $357.4 million from the ARP Section 8002 and includes the following sub-projects:

| Sub-Projects ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| Salesforce Application (SAC) | $ - | $ - | $ - | $ - | $ - | $ 8,971 | $ - | $ 40,125 |
| Digital Veterans Platform (DVP) | $ - | $ 13,696 | $ - | $ - | $ - | $ 33,198 | $ - | $ 27,290 |
| Digital Veterans Platform (DVP) - CARES Act | $ - | $ 41,950 | $ - | $ - | $ - | $ - | $ - | $ - |
| Digital Veterans Platform (DVP) - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 63,522 | $ - | $ 66,654 |
| VA Profile | $ 15,358 | $ 2,843 | $ - | $ - | $ - | $ 5,886 | $ - | $ 12,032 |
| EPMD Operations Support | $ - | $ - | $ - | $ - | $ - | $ 7,083 | $ - | $ 9,580 |
| ACOE Advanced Tools and Support | $ - | $ - | $ - | $ - | $ - | $ 8,175 | $ - | $ 8,175 |
| Section 508 Compliance | $ - | $ 4,325 | $ - | $ - | $ - | $ 7,956 | $ - | $ 7,956 |
| Operations Triage Group (OTG) | $ - | $ 2,193 | $ - | $ - | $ - | $ 11,000 | $ - | $ 7,110 |
| Digital Transformation Center (DTC) | $ - | $ 44,977 | $ - | $ - | $ - | $ 39,814 | $ - | $ 5,671 |
| Digital Transformation Center (DTC) CARES Act | $ 11,874 | $ 210,509 | $ - | $ - | $ - | $ - | $ - | $ - |
| Digital Transformation Center (DTC) American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 201,283 | $ - | $ 208,168 |
| Veteran Identity/Eligibility Reporting System (VIERS) | $ - | $ - | $ - | $ - | $ - | $ 5,860 | $ - | $ 4,531 |
| DevSecOps Advanced Tools and Support | $ - | $ - | $ - | $ - | $ - | $ 9,000 | $ - | $ 4,477 |
| Enterprise Testing Service Development and Acquisition Support | $ - | $ - | $ - | $ - | $ - | $ 4,426 | $ - | $ 4,426 |
| VA Product Line Accountability & Reporting System (VA PARS) | $ - | $ 4,974 | $ - | $ - | $ - | $ 4,000 | $ - | $ 4,000 |
| Tools Support Services | $ - | $ - | $ - | $ - | $ - | $ 3,983 | $ - | $ 3,983 |
| DevSecOps Technical and Business Management Support | $ - | $ 3,000 | $ - | $ - | $ - | $ 3,000 | $ - | $ 3,000 |
| Software Configuration Management Services | $ - | $ - | $ - | $ - | $ - | $ 3,000 | $ - | $ 2,953 |
| Demand Management Operational Support | $ - | $ - | $ - | $ - | $ - | $ 2,750 | $ - | $ 2,750 |
| Technical Reference Model (TRM) | $ - | $ - | $ - | $ - | $ - | $ 1,650 | $ - | $ 2,650 |
| Data Access Services (DAS) | $ - | $ - | $ - | $ - | $ - | $ 13,000 | $ - | $ 2,596 |
| Information Assurance Management Support Services | $ - | $ 1,925 | $ - | $ - | $ - | $ 2,000 | $ - | $ 2,000 |
| VA/DoD Identity Repository (VADIR) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 1,636 |
| Agile SAFe Transformation | $ - | $ 7,000 | $ - | $ - | $ - | $ 5,550 | $ - | $ 1,500 |
| VA Enterprise Content Management System (TeamSite) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 1,500 |
| Veterans Information Solution (VIS) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 1,068 |
| VA Enterprise Cloud Solutions (VAEC) | $ - | $ 55,142 | $ - | $ - | $ - | $ 61,635 | $ - | $ - |
| VA Enterprise Cloud Solutions (VAEC) - CARES Act | $ - | $ 43,128 | $ - | $ - | $ - | $ - | $ - | $ - |
| VA Enterprise Cloud Solutions (VAEC) - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 28,044 | $ - | $ 29,446 |

| Sub-Projects (continued) ($s in thousands) | 2021/2022 | | | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|
| | Year 1 Actual | | Year 2 of 2 year Availability | | Estimate | | Request | |
| | DEV | OM | DEV | OM | DEV | OM | DEV | OM |
| API Management | $ 7,068 | $ - | $ - | $ - | $ 8,000 | $ - | $ - | $ - |
| API Management - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 24,742 | $ - | $ 25,709 |
| Enterprise Project Manangement Office Support | $ - | $ - | $ - | $ - | $ - | $ 29,790 | $ - | $ - |
| Platform Services Support | $ - | $ - | $ - | $ - | $ - | $ 10,123 | $ - | $ - |
| Voice Access Modernization (VAM) Infrastructure | $ - | $ 3,440 | $ - | $ - | $ - | $ 5,000 | $ - | $ - |
| Software Resiliency Tools | $ - | $ 9,346 | $ - | $ - | $ - | $ 4,000 | $ - | $ - |
| Robotics Process Automation (RPA Platform) | $ - | $ - | $ - | $ - | $ - | $ 3,423 | $ - | $ - |
| Robotics Process Automation (RPA Platform) - CARES Act | $ - | $ 2,498 | $ - | $ - | $ - | $ - | $ - | $ - |
| VIS VADIR Support | $ 3,087 | $ 773 | $ - | $ - | $ - | $ 2,850 | $ - | $ - |
| Enterprise Technical Design Standards | $ - | $ - | $ - | $ - | $ - | $ 2,750 | $ - | $ - |
| Standards and Terminology Services (STS) | $ - | $ 2,465 | $ - | $ - | $ - | $ 2,533 | $ - | $ - |
| EPMO Action Tracking and SharePoint | $ - | $ - | $ - | $ - | $ - | $ 2,450 | $ - | $ - |
| Collaborative Terminology Tooling Data Management | $ 650 | $ 1,176 | $ - | $ - | $ - | $ 2,320 | $ - | $ - |
| Web Solutions Services (WSS) | $ - | $ - | $ - | $ - | $ - | $ 1,750 | $ - | $ - |
| Code Sharing Services | $ - | $ - | $ - | $ - | $ - | $ 983 | $ - | $ - |
| Core Enterprise Services (CES) | $ 6,965 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Enterprise Cloud Fax (ECFax) | $ 2,000 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Veterans Data Integration and Federation (VDIF) | $ - | $ 21,945 | $ - | $ - | $ - | $ - | $ - | $ - |
| Veterans Data Integration and Federation (VDIF) EP (HS Sustainment Services) - CARES Act | $ - | $ 2,799 | $ - | $ - | $ - | $ - | $ - | $ - |
| Veterans Data Integration and Federation (VDIF) EP (HS Sustainment Services) - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 12,575 | $ - | $ 14,600 |
| EPMD Executive Director Support | $ - | $ 11,769 | $ - | $ - | $ - | $ - | $ - | $ - |
| Business Intelligence Service Lines (BISL) Core Services | $ - | $ 11,204 | $ - | $ - | $ - | $ - | $ - | $ - |
| Business Intelligence Service Lines (BISL) Core Services - CARES Act | $ - | $ 36,872 | $ - | $ - | $ - | $ - | $ - | $ - |
| Business Intelligence Service Lines (BISL) Core Services - Americn Rescue Plan | $ - | $ - | $ - | $ - | $ - | $ 6,581 | $ - | $ 6,689 |
| Benefits Gateway Services | $ - | $ 10,334 | $ - | $ - | $ - | $ - | $ - | $ - |
| Intake Analysis Support Services | $ - | $ 9,904 | $ - | $ - | $ - | $ - | $ - | $ - |
| ETS IT Support Contracts | $ - | $ 8,152 | $ - | $ - | $ - | $ - | $ - | $ - |
| Million Veterans Program (MVP) - CHAMPION VA-DOE Doss Center | $ - | $ 6,150 | $ - | $ - | $ - | $ - | $ - | $ - |
| Business Rules Engine Tools Licensing and Maintenance | $ - | $ 3,321 | $ - | $ - | $ - | $ - | $ - | $ - |
| DAS Enterprise Shared Service Combined Support | $ - | $ 3,290 | $ - | $ - | $ - | $ - | $ - | $ - |
| DAS Enterprise Shared Service Combined Support - American Rescue Plan 8002 | $ - | $ - | $ - | $ - | $ - | $ 6,119 | $ - | $ 6,119 |
| Military Service Data Sharing (MSDS) | $ - | $ 3,219 | $ - | $ - | $ - | $ - | $ - | $ - |
| Capacity and Performance Engineering Services (CPE) | $ - | $ 2,557 | $ - | $ - | $ - | $ - | $ - | $ - |
| OneVA TRM Support Services | $ - | $ 1,452 | $ - | $ - | $ - | $ - | $ - | $ - |
| Data Warehouse for Performance Management Analytics | $ - | $ 1,000 | $ - | $ - | $ - | $ - | $ - | $ - |
| ReachVet Storm | $ - | $ 982 | $ - | $ - | $ - | $ - | $ - | $ - |
| Dell Quest Tools Licensing and Maintenance | $ - | $ 507 | $ - | $ - | $ - | $ - | $ - | $ - |
| IBM Rational Tools Licensing and Maintenance | $ - | $ 194 | $ - | $ - | $ - | $ - | $ - | $ - |
| Unobligated balance brought forward, Oct 1 | $ - | $ - | $ 417 | $ - | $ - | $ - | $ - | $ - |
| **Data Integration and Management** | **$ 47,002** | **$ 591,008** | **$ 417** | **$ -** | **$ 8,000** | **$ 652,774** | **$ -** | **$ 518,394** |

The Data Integration and Management Congressional Project provides for development of self-service API gateways, building out VA's capacity for cloud computing and administration of numerous data, testing, and supercomputing research services that support the entire VA OIT enterprise. The nature and scope of these shared services covers a wide range including: 1) Building API gateways to enable self-service capability where Veteran facing IT applications can enable provisioning and integration to backend shared services themselves; 2) Expanding VA's enterprise cloud hosting capacity and infrastructure to establish a foundation for migrating VA IT systems out of localized private hosting solutions to an approved public federal cloud that can scale on demand while realizing cost savings for VA; 3) Provisioning of data services ranging from authoritative Veteran data via efforts such as VA Profile which provide centralized access to source data; and 4) Providing standardized frameworks and constructs within which data is housed, ingested, tested, manipulated, and exchanged inside and outside of VA. The API Management Platform also ensures that tailored, integrated test environments and appropriate risk-based test services for evaluating software product quality is available to OIT organizations, VA administrations, and other external agencies focused on improving patient safety and Veteran services.

The Salesforce Application allows automation of business workflows, connects users to business processes, and streamlines/optimizes business operations. It serves business customers via one shared security package and Authority to Operate on the entire Salesforce platform. This is a dedicated end user support whereby one helpdesk manages all Salesforce-specific user issues and centralized platform management, thereby enabling one platform team to manage all environment maintenance and license utilization. Funding will provide the continued use of 90+ existing, in-Production Salesforce modules and the 99.9 percent uptime/availability licenses. The centrally managed VA Salesforce platform enables low-code application solutions that are extensible across the enterprise, including VBA, VHA, NCA, VACO and OIT organization. The efforts will include core competencies of reusable customer relationship management and case functionality.

Digital Veterans Platform (DVP) provides efficient and secure access to APIs across all VA administrations and systems while enabling teams to build high-quality, modern APIs in a cost-effective and timely manner. It enables effective data and service access from several underlying systems including VistA, VBMS-Master Person Index (MPI), CDW, Benefits Gateway Services (BGS), VA Profile, Veteran-facing Services Platform (VSP), and Enterprise Military Information Service (eMIS). APIs and functionality will increase the number of third-party innovative applications available to Veterans and VA, thus improving access to key VA data and information. This will enable our Veterans to make more informed decisions and access benefits and services in a seamless and secure way via more digital touchpoints. The Lighthouse Delivery Infrastructure, one of the key components of DVP, enables teams to quickly, efficiently, and securely build APIs and applications consuming them. The Lighthouse Internal Developer Platform allows VA teams to discover and integrate with APIs while the third-party developers use the Lighthouse External API Platform to discover and integrate with VA APIs and core APIs supporting all administrations.

VA Profile modernizes VA systems by ensuring VA customer common data is synchronized and shared across the VA, regardless of the channel used to update the information. VA Profile provides one source of truth for Veteran contact information. By modernizing the VA data management processes, VA Profile provides an accessible and reliable customer profile that can

be shared across the VA. VA Profile continues to integrate with VA systems and business lines so Veterans' identity, contact information, military service, enrollment, eligibility for VA services and benefits, socio-economic, demographic, customer experience, interaction history and shared data from VHA, VBA, and NCA is automatically synchronized across VA systems. VA Profile is key to the VA's successful compliance with numerous Executive Orders, Laws, Policies and Directives.

The Data Integration and Management Congressional Project supports the DevSecOps Agile Center of Excellence providing ACOE advanced tools, tools support services, DevSecOps Scaled Agile Framework (SAFe) transformation services and VA Product Line Accountability and Reporting System (VA PARS) support. VA PARS tracks and monitors IT performance and limitations in support of management oversight for Veteran-focused Integration Process (VIP) product line management governance. VA PARS is the central repository for all VA IT projects/products data that is reported to the OMB and Congress. It provides coordination of product/project reviews by senior leadership and facilitates the consistency and reporting of investments through the OMB 300B process in support of the Federal IT Acquisition Reform Act (FITARA) and Clinger-Cohen Act (CCA).

The Section 508 Compliance Program Office provides accessibility guidance and support for all projects under the Secretary's Initiatives including 450+ Hyper Text Markup Language (HTML) Web environments, training and support for 11,000 employees with targeted disabilities, and tools to help developers achieve 508 compliance in application development. Section 508 Enablement provides support to 60+ VA legacy applications, 508 Accessibility Compliance Scanning and Services, new National Aeronautics and Space Administration (NASA) Solutions for Enterprise-Wide Procurement (SEWP) Buy for Software License Upgrade and Maintenance - Common Look, New NASA SEWP Buy for Software License Upgrade and Maintenance - Dragon Professional, New NASA SEWP Buy for Software License Upgrade and Maintenance of Job Access with Speech (JAWs), Section 508 Accessibility, and Tools and Training Support. The 508 Program Office provides accessibility guidance and support services to ensure disabled Veterans and employees have access to information and communications technology that has been procured, used, maintained, or developed by the VA. The 508 Program Office supports VAs compliance with Section 508 of the Rehabilitation Act (29 U.S.C 794 (d)) through training, consultation, auditing, and reporting.

The Section 508 Office has an ongoing relationship with the VSO and Blinded Veterans Association (BVA), which represents most of the blinded Veterans that seek services from the VA. Over the last year, the 508 Office has met with the BVA and worked to validate VA forms used by BVA, such as documents and applications that may have been difficult or impossible for blinded Veterans to use. These include My HealtheVet, Veterans Crisis Line, and a range of forms and PDF documents that they need to access. The 508 Office has worked to engage the appropriate project managers and developers to ensure the needs of BVA are being met regarding inaccessible Information and Communications Technology (ICT) and that these products meet their needs. BVA is working alongside the 508 Office which has also been directly in touch with VA developers to improve access to applications, especially for blind or low-vision Veterans. On-going efforts are being made with eBenefits and VBMS to improve accessibility on a regular basis using technology that blinded Veterans will use to access these applications.

The Operations Triage Group's (OTG) core objective is to ensure VA's systems' availability and reliability for end users. Engineers and technical analysts work with development teams during the build and delivery process and assist with operations once an application has moved to production. OTG provides technical improvement and system performance recommendations and facilitates executive communications for all major system issues. The team partners with DSO divisions and others in VA OIT through DevOps and System Reliability Engineering (SRE) practices.

When systems and applications within VA are down or degraded, end users cannot give the services to Veterans that are needed in providing health care, benefits, or memorial services. OTG applies system and industrial experts to resolve system problems, thereby making systems and applications more reliable and available to end users. This in turn enables them to better and more efficiently provide services to our Veterans.

Digital Transformation Center (DTC) is a digital transformation and service delivery program that enables the effective implementation and lifecycle management of low-code and no-code SaaS and PaaS solutions. It supports Veterans through rapid, incremental improvements in IT capabilities which, in turn, drive a genuine working partnership between the business and OIT. Modernized systems and technology are enabling VA to enhance the quality of the care and services Veterans deserve including customer service and taking care of Veterans, caregivers, family members and survivors in ways that increase their trust in VA.

Veteran Identity/Eligibility Reporting System (VIERS) provides Veteran military history information that is consolidated across multiple data sources. VEIRS enables business line applications and systems to automate eligibility decisions that otherwise would require manual processing. It removes the "burden of proof" on Veterans to provide paper evidence (e.g., DD-214) when requesting access to healthcare or applying for benefits.

VA/DoD Identity Repository (VADIR) provides real-time authoritative DoD personnel records (pre and post separation from DoD) and is the VA's sole authoritative data source for military service information. VADIR stores and shares military history data with multiple lines of business for the purpose of benefits determination, supporting workflows across 50 lines of business, impacting 47 million Veterans and thousands of customer support members. VADIR provides the needed data to conduct and improve processes for determining benefit eligibility for healthcare and benefits for current and former Service members, their families, and caregivers. VADIR provides a seamless transition from active military to Veteran status.

VA Enterprise Content Management System (TeamSite) supports the Enterprise Content Management System and tools that support over 827 production internet and intranet sites, including the majority of VA.GOV. These tools are used by 1860+ users creating and reviewing site content daily. This effort will fund, as an example, OpenText TeamSite software and Web Content Management System support staff to include Tier 1 helpdesk personnel, system administrators, technical advisors, security patching and software updates. Funding will also facilitate decommissioning content and functionality as it is moved to the modernized VA.GOV platform.

Veteran Information Solution (VIS) is a standalone application which displays VADIR (and other) data and enables the bi-directional sharing of information between the DoD and VA, which improves automation, processing efficiencies, and supports current and future high priority initiatives such as EHRM, Customer Experience Service Recovery, and Mental Health Executive Order 13822.

## Accomplishments

**Health Portfolio**

- The Clinical Ancillary Product Line released the State Prescription Monitoring Program (PDMP) Integration solution, which helps VA prescribers avoid over-prescribing habit-forming medications such as opioids to Veterans

- The Revenue Operations Workflow Enhancement (ROWTE) team released five Robotic Process Automation (RPA) robots to process data entry, eliminating the need for manual data entry. As a result, 49,000 full time equivalent hours were redirected to direct Veteran Service tasks, reducing the Veteran Service backlog by 26 percent

- Joint Longitudinal Viewer (JLV) improved patient flags and postings in Veterans' electronic health care records to emphasize COVID-19 and the necessary document retrieval for prompt, comprehensive care during the COVID-19 pandemic. JLV also implemented retrieval of Individual Longitudinal Exposure Record (ILER) data from the Department of Defense, which facilitates care and adjudication

- Occupational Health Record-Keeping System (OHRS) 2.0 implemented a Salesforce solution to manage 600,000 VHA employee health records with features such as COVID-19 exposure tracking, influenza immunization tracking, and COVID-19 immunization tracking and reporting. In addition, OHRS provides reporting to the CDC and VHA Support Services Center Capital Assets (VSSC) Database within 78 days

- The Veterans Data Integration and Federation Enterprise Platform (VDIF-EP) COVID-19 Vaccine Transmission CDC integration ensures vaccine availability for Veterans and their families. VA is required to collect and electronically transmit data elements to CDC within 24 hours of administration. This integration provides an accurate/current status of administered COVID-19 vaccines to Veterans and VA staff to maximize protection to all during the current pandemic

**Benefits Portfolio**

- The Instant Loan project began in early January and was deployed on May 26, ahead of the planned schedule, as a self-service feature on the VBA Life Insurance website. In response to COVID-19 and the need for Veterans to easily access available funds, the necessity for an instant loan process was realized. The team worked to upgrade the web system known as Electronic Insurance (EIN) as well backend legacy systems known as Veterans Insurance Claims Tracking and Response System (VICTARS) and Insurance Payment System (IPS) to allow Veterans to select an option for an instant loan and have the loan amount directly deposited to their bank accounts within a few days, or a paper check can be sent to those without direct deposit. Instant Loan is available to more than 350,000 Veterans with insurance policies that have loan value and to more than 42,000 Veterans with current loans

- The Appeals Product Line produced enhancements to Caseflow that enables the Board to process appeals with unrecognized appellants, to add and update Power Of Attorney (POA) information for a specific appeal, to edit claim labels, and improves the docketing of Virtual Tele-Hearings

- Life Insurance Policy Administration Solution (LIPAS) project completed a second major release with the conversion of all New Business and Service-Disabled Veterans Insurance policies into the VISION system

- Veterans Service Network developed a weekly batch process that greatly reduced the average processing time of additional benefits for Service-Connected Veterans hospitalized within the VA Healthcare System. The weekly patch greatly reduced the average processing time for this work from 1,130 days to 12.7 days

- The Compensation & Pension Record Interchange (CAPRI) development team implemented Information Exchange Packet Documentation 2.1 allowing all disability benefit producers, i.e., VHA clinics, contract vendors, CERNER, and consumers VBSM, DAS and DoD to align under the same data schema, which will ensure information can be seamless ingested into the VBMS eFolder to improve claims adjudication and decrease the claims backlog

- VA.GOV Education successfully implemented a digital form in record time to support the Veteran Rapid Retraining Assistance Program, which offers education and training in high-demand fields to Veterans who are unemployed because of the COVID-19 pandemic

- Cleveland application databases have been copied over to the newly created webserver to address and Service Organization Controls findings. Loan Guaranty (LGY) completed security enhancements for passwords and Personally Identifiable Information updates for the Cleveland applications and redirected them to a new server in Cleveland on June 16

- The VBA Enterprise Data Warehouse (VD2) completed migration from Oracle M5-32 Servers to the SuperCluster M8 allowing decommissioning of old servers. The decommissioning of these servers freed up assets allowing for infrastructure cost-savings for VD2

**Memorial Affairs Portfolio**

- In October 2020, Business Intelligence – National cemetery Administration (BINCA) migrated and conducted extensive testing to support and accomplish the move of Tableau and all dashboards to the VAEC from on premises (Quantico Information Technology Center (QITC)), with zero percent downtime

- In June 2021, all 12-legacy management and decision support dashboards were relocated to the Amazon Web Services (AWS) cloud to remove dependencies requiring manual input to the dashboards

- In June 2021, Single Sign-On Integration (SSOi) for the Burial Operations Support System-Enterprise (BOSS-E) Eligibility Office Automation System (EOAS) was implemented, which centralizes and consolidates logging into applications for NCA end-users and systems

- In December 2020, Memorial Benefits and Management System (MBMS) enhancements were released for the inclusion of pre-need cases in the Descendent search functionality, which increased the efficiency of the National Cemetery Scheduling Office (NCSO) agents for scheduling across approximately 155 cemeteries

- In June 2021, MBMS enhancements were released, which integrated the VA Master Person Index (MPI) in order to meet the VA and OMB mandates to use a single, accurate, and authoritative data source for case establishment, alleviate reliance on social security numbers, and reduce record duplication

- In December 2020, crafted and integrated the following enhancements into the Veterans Legacy Memorials (VLM): 1) the Great Seal of the United States was added as a default seal for a decedent who does not have a listed Service Branch listed, 2) scheduled interment date field was added to the Veteran's profile, and 3) the Application Programming Interface (API) was decommissioned as the project established a direct connection to the Memorials Data Warehouse

**Corporate Portfolio**

- As part of OIT's retention efforts in 2021, Human Capital Management (HCM) successfully prepared and executed the group retention incentive for cyber security professionals for the fourth year in OIT

- HCM successfully received approval to extend the current group retention incentive for front line OIT staff who continued to work in the VAMCs alongside the doctors and nurses throughout the COVID-19 Pandemic. Over 2,800 OIT employees received the incentive

- Successfully launched the LEAF program for OIT as an Intake portal for all recruitment Actions

- End User Operations HR services were centralized from 140+ different Human Resources Offices to a single servicing Human Resources Office. Human Resources Management and Consulting Services (HRMACS), as the single servicing HR Office, will be able to provide consistent customer service, eliminate inconsistencies and reduce delays in services provided to employees as well as contributing to End User Operations' ability to meet strategic goals. The transition to a single source HR servicing office will result in the realignment of 2,700 employees

**Enterprise Portfolio**

- In May 2021, Enterprise Service Desk (ESD) was selected as a 2021 FedHealthIT Innovation Award Winner for its Robotic Process Automation (RPA) program. This effort has improved the customer experience and enabled the team to more accurately route and address incidents

- ECC instrumented monitoring solutions on an additional 225 critical systems/applications, including 77 COVID critical systems/applications, providing 24/7 eyes on glass monitoring of these systems/applications

- In response to Cybersecurity and Infrastructure Security Agency (CISA) Emergency Directive (ED) 21-01, the ECC Acted immediately to take offline CISA mandated instances of SolarWinds Orion servers. In bringing these back online, the ECC performed security hardening, upgraded Operating Systems, and implemented measures to improve the overall security posture of the Orion product. These Actions reduced the Orion attack area, helping to ensure Veterans' data is secure

- Delivered new circuit upgrades at 38 sites providing more bandwidth, in order to provide better support for Telehealth, Cloud Based Solutions, and ultimately to support the use of the new EHR

- Implemented the new Joint Security Architecture (JSA) at 17 sites supporting the new EHR and the ability to better support our customers in managing security on Medical Devices, Specialized Devices and Research Scientific Devices

- VA received an "A" on the Data Center Optimization Initiative (DCOI) Federal Information Technology Acquisition Reform Act (FITARA) Scorecard, which was a full grade higher from the previous year. National Data Center Operations and Logistics (NDCOL) managed the closure of 13 data centers which exceeded the OMB target of 11, resulting in $7.8 million in cost savings for the VA

- Deployed McAfee Data Loss Prevention (DLP) Device Control to the enterprise. This replaces the outdated Holistic Enterprise Automation Techniques (HEAT) instance at a license cost savings of $750,000

- Infrastructure Readiness Program (IRP) 8 replacement of 47 large and medium and Converged virtualization Infrastructure appliances across the enterprise

- IT Modernization - Community Resource and Referral Center (CRRC) VMware farm technical refresh and capacity expansion completed in May2021

- Eliminated Client reboots during duty hours increasing productivity by minimizing disruptions and downtime during peak work hours

- Established a single Incident Resolver group with the VA's ticketing system, ServiceNOW, or SNOW

- Printer Security Management Service Line has been consolidated to one management entity to centrally target 63K printers for central management. Additionally, the printer team is baselining future procurements to reduce security issues in printer fielding and management prior to printer purchases

- In coordination with VA Cyber Security Operations Center (CSOC) (RedTeam) the UNM team was able to recommend and implement remediation path for critical vulnerabilities within the VA by removing hardcoded credentials for more than 250 Servers

- Supported SolarWinds transformation to create and achieve ATO decision for VA's rebuilt SolarWinds tool suite within 11 calendar days

- The Veterans-Focused Integration Process (VIP) Guide 4.0 was updated to become leaner, and more simplified. The new VIP lifecycle has been streamlined from 28 to 5 pages in the body, and the lifecycle steps were reduced from 14 steps to 3 steps

- Established a Hazardous Chemical Shipment support for OIT managed sites; this supply chain support provides a method to ship hand sanitizers (hazardous material) from a centralized storage (Hines) facility to the field offices as required

- In September 2021 the Enterprise Mail Management sponsored and successfully completed the Authority to Operate (ATO) FedRAMP certification process of the Pitney Bowes Send Pro 360

*Information Security*

- Increased Software Assurance support for systems development teams that have or are in the process of adopting DevSecOps across the agency. Newly deployed pipeline and container technologies were integrated with the latest releases of the OIS-licensed Fortify software

- Developed Banned Vendors Dashboard to provide visibility on the status of remediation of devices banned from VA / Federal Agencies in accordance with NDAA 2019 Sec 889

- Developed the Veteran-Focused Integration Process (VIP) Security Guide, a companion to the VIP guide, to integrate security and privacy requirements into all phases of the VA's SDLC, resulting in a common understanding for authorization stakeholders on integrating security requirements into an operational system lifecycle framework

- Successfully decommissioned the first-generation Continuous Diagnostics and Mitigation (CDM) Dashboard to make way for the second-generation dashboard. The new dashboard will provide scalability and flexibility for VA to quickly identify vulnerabilities that exist on hardware and software assets and in FISMA systems
- VA CSOC successfully completed over 163 Persons of Interest (POI) inquiries in support of the Department's Insider Threat Program

- VA Directive 6500, VA Cybersecurity Program and VA Handbook 6500, Risk Management Framework For VA Information Systems VA Information Security Program were successfully updated and published on February 24, 2021

- Initiated development of a database tool that will convert and transpose the data accumulated across more than 600 completed Enterprise Risk Analysis (ERA) reports into a common database backend resource

- PIV Card Issuance Assessment and Validation (PCIAV) Team launched the Annual Lifecycle Walkthrough (ALW) process that assists PIV Card Issuance Facilities (PCIF) in meeting the obligation to self-evaluate their PIV Card Issuance processes

- VA implemented an automated High Value Asset (HVA) criteria and assignment on the VA instance of Enterprise Mission Assurance Support Service (eMASS) based on the Department of Homeland Security (DHS) guidance

- A FedRAMP overlay was implemented in Enterprise Mission Assurance Support System (eMASS) to provide appropriately selected security controls for FedRAMP packages. Designed/implemented eMASS basic system information export to correlate SwA Static Code Scan results with parent FISMA inventory systems

- Completed eight projects under the Enterprise Cybersecurity Program (ECSP) supporting VA's strategic cybersecurity goals and initiatives, proactively addressing enterprise-wide cybersecurity risks, remediating cybersecurity threats, increasing operational efficiency, and protecting the information of Veterans, partners, and employees in support of the VA’s mission

- Modernized Privacy Security Event Tracking System (PSETS) improving timely processing and response to reported events

- Successfully completed Health Information Technology for Economic and Clinical Health (HITECH) event reporting, ensuring VA remains compliant with Federal laws and regulations. Over 500 HITECH reportable events were processed with the 60-day timeframe and reported to HHS

- Established the Social Security Number Reduction (SSNR) Program Management Office (SSNR PMO) to move VA away from the use of SSNs to protect Veterans from identity theft

# Appendix A: Development Subaccount

| Information Technology<br>Development Activities Highlights<br>($s in thousands) | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2021/2022 | 2022 | | 2023 | 2022-2023 |
| | Actual | Year 2 of 2-year Availability | Request | Estimate | Request | Increase/ Decrease |
| **Obligations by Program Activities** | | | | | | |
| Health Management Platform | 71,755 | 5,088 | 69,096 | 69,096 | 70,736 | 1,640 |
| Clinical Applications | 97,162 | 2,202 | 103,624 | 103,624 | 43,277 | (60,347) |
| Health Research and Development | - | - | 8,660 | 8,660 | 5,209 | (3,451) |
| Benefits Systems | 165,090 | 1,284 | 87,390 | 87,390 | 20,727 | (66,663) |
| Benefits Systems - CARES Act | 45,366 | - | - | - | - | - |
| Other IT Systems | 118,151 | 2,987 | - | - | 2,143 | 2,143 |
| Cyber Security | 11,380 | - | 11,200 | 11,200 | - | (11,200) |
| Information/Infrastructure Management | 35,129 | 417 | 8,000 | 8,000 | - | (8,000) |
| Information/Infrastructure Management - CARES Act | 11,874 | - | - | - | - | - |
| Memorial Affairs | 16,587 | 405 | 9,030 | 9,030 | - | (9,030) |
| **Total Direct Obligations by Program Activities** | **$572,492** | **$12,383** | **$297,000** | **$297,000** | **$142,092** | **(154,908)** |
| **Obligations by Funding Sources** | | | | | | |
| Appropriation | 515,253 | 12,383 | 297,000 | 297,000 | 142,092 | (154,908) |
| CARES Act | 12,240 | - | - | - | - | - |
| VHA CARES Act Transfer (P.L.116-270) | 45,000 | - | - | - | - | - |
| **Total Direct Obligations by Funding Sources** | **$572,492** | **$12,383** | **$297,000** | **$297,000** | **142,092** | **(154,908)** |
| **Total Development Obligations** | **$572,492** | **$12,383** | **$297,000** | **$297,000** | **$142,092** | **(154,908)** |

Note: 2021 Actuals includes prior year unobligated balance brought forward, Oct. 1, recoveries, and unobligated CARES Act balance brought forward Oct. 1

# Appendix B: Congressional Report Summary

| Information and Technology<br>Total Budget Authority<br>($s in thousands) | | | | | | |
|---|---|---|---|---|---|---|
| | 2021/2022 | 2021/2022 | 2022 | | 2023 | 2022-2023 |
| | Actual | Year 2 of 2-year Availability | Request | Estimate | Request | Increase / Decrease |
| Development | | | | | | |
| Health Management Platform | $ 71,755 | $ 5,088 | $ 69,096 | $ 69,096 | $ 70,736 | $ 1,640 |
| Clinical Applications | $ 97,162 | $ 2,202 | $ 103,624 | $ 103,624 | $ 43,277 | $ (60,347) |
| Health Research and Development | $ - | $ - | $ 8,660 | $ 8,660 | $ 5,209 | $ (3,451) |
| Benefits Systems | $ 165,090 | $ 1,284 | $ 87,390 | $ 87,390 | $ 20,727 | $ (66,663) |
| Benefits Systems - CARES Act | $ 45,366 | $ - | $ - | $ - | $ - | $ - |
| Other IT Systems | $ 118,151 | $ 2,987 | $ - | $ - | $ 2,143 | $ 2,143 |
| Cyber Security | $ 11,380 | $ - | $ 11,200 | $ 11,200 | $ - | $ (11,200) |
| Information/Infrastructure Management | $ 35,129 | $ 417 | $ 8,000 | $ 8,000 | $ - | $ (8,000) |
| Information/Infrastructure Management - CARES Act | $ 11,874 | $ - | $ - | $ - | $ - | $ - |
| Memorial Affairs | $ 16,587 | $ 405 | $ 9,030 | $ 9,030 | $ - | $ (9,030) |
| Development Subtotal (incl. CARES Act) | **$ 572,492** | **$ 12,383** | **$ 297,000** | **$ 297,000** | **$ 142,092** | **$ (154,908)** |
| Sustainment/O&M | | | | | | |
| Health Operations and Maintenance | $ 677,978 | $ - | $ 867,260 | $ 867,260 | $ 929,418 | $ 62,158 |
| Health Operations and Maintenance - CARES Act | $ 51,180 | $ - | $ - | $ - | $ - | $ - |
| Benefits Operations and Maintenance | $ 231,470 | $ - | $ 276,274 | $ 276,274 | $ 342,937 | $ 66,663 |
| Benefits Operations and Maintenance - CARES Act | $ 147,607 | $ - | $ - | $ - | $ - | $ - |
| Corporate Operations and Maintenance | $ 107,128 | $ - | $ 180,129 | $ 180,129 | $ 439,642 | $ 259,513 |
| Enterprise Operations and Maintenance | $ 2,265,440 | $ 15,000 | $ 1,772,952 | $ 1,772,952 | $ 2,389,681 | $ 616,729 |
| Enterprise Operations and Maintenance - CARES Act | $ 691,581 | $ - | $ - | $ - | $ - | $ - |
| Memorial Operations and Maintenance | $ 10,300 | $ - | $ 34,970 | $ 34,970 | $ 44,000 | $ 9,030 |
| Sustainment Subtotal (incl. CARES Act) | **$ 4,182,684** | **$ 15,000** | **$ 3,131,585** | **$ 3,131,585** | **$ 4,145,678** | **$ 1,014,093** |
| | | | | | | |
| Development | $ 515,253 | $ 12,383 | $ 297,000 | $ 297,000 | $ 142,092 | $ (154,908) |
| Development - CARES Act | $ 12,240 | $ - | $ - | $ - | $ - | $ - |
| Development - VHA CARES Act Transfer (P.L.116-270) | $ 45,000 | $ - | $ - | $ - | $ - | $ - |
| Sustainment/O&M | $ 3,292,317 | $ 15,000 | $ 3,131,585 | $ 3,131,585 | $ 4,145,678 | $ 1,014,093 |
| Sustainment/O&M - CARES Act | $ 890,367 | $ - | $ - | $ - | $ - | $ - |
| Sustainment/O&M - VHA Transfer (P.L. 117-43 Section 151) | $ - | $ - | $ - | $ 9,578 | $ - | $ (9,578) |
| Staffing and Administration | $ 1,231,010 | $ 10,040 | $ 1,414,215 | $ 1,414,215 | $ 1,494,230 | $ 80,015 |
| Staffing and Administration - CARES Act | $ 123,784 | $ - | $ - | $ - | $ - | $ - |
| OEF/OIF Supplemental (P.L. 110-28) | $ 335 | $ 2,283 | $ - | $ - | $ - | $ - |
| | | | | | | |
| **Subtotal** [1/] | **$ 6,110,305** | **$ 39,706** | **$ 4,842,800** | **$ 4,852,378** | **$ 5,782,000** | **$ 929,622** |
| | | | | | | |
| VACAA Section 801 (includes VACAA recovery) | $ 1,963 | $ 1,026 | $ - | $ - | $ - | $ - |
| American Rescue Plan Act (P.L. 117-2 Section 8002) | $ - | $ - | $ - | $ 611,361 | $ 630,057 | $ 18,696 |
| American Rescue Plan Act (P.L. 117-2 Section 8003) | $ - | $ 100,000 | $ - | $ - | $ - | $ - |
| Recurring Expenses Transformational Fund | $ - | $ - | $ 670,000 | $ 718,133 | $ - | $ (718,133) |
| | | | | | | |
| **Total (includes VACAA and Recurring Expenses Transformational Fund)** | **$ 6,112,268** | **$ 140,732** | **$ 5,512,800** | **$ 6,181,872** | **$ 6,412,057** | **$ 230,185** |
| | | | | | | |
| **Reconciliation (SF-133) report** | | | | | | |
| Reimbursable Obligations | $ 118,068 | $ - | $ - | $ - | $ - | $ - |
| COVID-19 Emergency Leave Reimbursement | $ 207 | $ - | $ - | $ - | $ - | $ - |
| Total | $ 118,275 | $ - | $ - | $ - | $ - | $ - |
| **Grand Total** | **$ 6,230,543** | **$ 140,732** | **$ 5,512,800** | **$ 6,181,872** | **$ 6,412,057** | **$ 230,185** |

1/ 2021 Actual includes prior year unobligated balance brought forward, Oct. 1, recoveries, and unobligated CARES Act balance brought forward Oct. 1

# Appendix C: Congressional Report Details

## Development

| Information and Technology Development Detail ($s in thousands) | 2021/2022 Actual | 2021/2022 Year 2 of 2-year Availability | 2022 Request | 2022 Estimate | 2023 Request | 2022-2023 Increase / Decrease |
|---|---|---|---|---|---|---|
| **Health Management Platform** | **$ 71,755** | **$ 5,088** | **$ 69,096** | **$ 69,096** | **$ 70,736** | **$ 1,640** |
| Community Care | $ 27,955 | $ 3 | $ 34,853 | $ 34,853 | $ 37,879 | $ 3,026 |
| Telehealth Services | $ 5,505 | $ 181 | $ 6,600 | $ 6,600 | $ 13,657 | $ 7,057 |
| Purchased Care | $ 12,560 | $ 50 | $ 6,836 | $ 6,836 | $ 10,000 | $ 3,164 |
| Patient Records [System (CPRS)] | $ 6,964 | $ 2,486 | $ 9,000 | $ 9,000 | $ 9,200 | $ 200 |
| Digital Health Platform | $ 9,499 | $ 368 | $ 11,807 | $ 11,807 | $ - | $ (11,807) |
| Pharmacy | $ 9,271 | $ 2,000 | $ - | $ - | $ - | $ - |
| **Clinical Applications** | **$ 97,162** | **$ 2,202** | **$ 103,624** | **$ 103,624** | **$ 43,277** | **$ (60,347)** |
| Supply Chain Management | $ 67,562 | $ 129 | $ 76,105 | $ 76,105 | $ 33,223 | $ (42,882) |
| Healthcare Administration Systems | $ 11,153 | $ 8 | $ 20,710 | $ 20,710 | $ 10,054 | $ (10,656) |
| My HealtheVet | $ 3,200 | $ 12 | $ 4,684 | $ 4,684 | $ - | $ (4,684) |
| Health Data Interoperability | $ 8,423 | $ 2,018 | $ 2,125 | $ 2,125 | $ - | $ (2,125) |
| Research | $ 3,085 | $ 35 | $ - | $ - | $ - | $ - |
| Beneficiary Travel | $ 2,540 | $ - | $ - | $ - | $ - | $ - |
| Registries | $ 1,200 | $ - | $ - | $ - | $ - | $ - |
| **Health Research and Development** | **$ -** | **$ -** | **$ 8,660** | **$ 8,660** | **$ 5,209** | **$ (3,451)** |
| Research | $ - | $ - | $ 8,660 | $ 8,660 | $ 5,209 | $ (3,451) |
| **Benefits Systems** | **$ 210,456** | **$ 1,284** | **$ 87,390** | **$ 87,390** | **$ 20,727** | **$ (66,663)** |
| Other Benefits IT Systems | $ 830 | $ - | $ - | $ - | $ 8,000 | $ 8,000 |
| Veterans Customer Experience (VCE) | $ 69,748 | $ 12 | $ 9,880 | $ 9,880 | $ 7,222 | $ (2,658) |
| Veterans Customer Experience (VCE) - CARES Act | $ 366 | $ - | $ - | $ - | $ - | $ - |
| Benefits Systems | $ 23,017 | $ 71 | $ 9,825 | $ 9,825 | $ 5,505 | $ (4,320) |
| Education Benefits | $ - | $ - | $ 50,000 | $ 50,000 | $ - | $ (50,000) |
| Education Benefits - CARES Act | $ 45,000 | $ - | $ - | $ - | $ - | $ - |
| Veterans Benefits Management | $ 39,230 | $ 161 | $ 14,285 | $ 14,285 | $ - | $ (14,285) |
| Benefits Appeals | $ 6,000 | $ 76 | $ 3,400 | $ 3,400 | $ - | $ (3,400) |
| Colmery Act | $ 26,265 | $ 965 | $ - | $ - | $ - | $ - |
| **Other IT Systems** | **$ 118,151** | **$ 2,987** | **$ -** | **$ -** | **$ 2,143** | **$ 2,143** |
| Human Resources | $ 13,972 | $ 8 | $ - | $ - | $ 2,143 | $ 2,143 |
| Financial and Acquisition Management Modernization | $ 98,826 | $ 832 | $ - | $ - | $ - | $ - |
| Other Corporate IT Systems | $ 3,500 | $ - | $ - | $ - | $ - | $ - |
| General Counsel | $ 1,853 | $ 2,147 | $ - | $ - | $ - | $ - |
| **Cyber Security** | **$ 11,380** | **$ -** | **$ 11,200** | **$ 11,200** | **$ -** | **$ (11,200)** |
| Cyber Security | $ 11,380 | $ - | $ 11,200 | $ 11,200 | $ - | $ (11,200) |
| **Information/Infrastructure Management** | **$ 47,002** | **$ 417** | **$ 8,000** | **$ 8,000** | **$ -** | **$ (8,000)** |
| Data Integration and Management | $ 35,129 | $ 417 | $ 8,000 | $ 8,000 | $ - | $ (8,000) |
| Data Integration and Management - CARES Act | $ 11,874 | $ - | $ - | $ - | $ - | $ - |
| **Memorial Affairs** | **$ 16,587** | **$ 405** | **$ 9,030** | **$ 9,030** | **$ -** | **$ (9,030)** |
| Memorials Automation | $ 16,587 | $ 405 | $ 9,030 | $ 9,030 | $ - | $ (9,030) |
| **Grand Total** | **$ 572,492** | **$ 12,383** | **$ 297,000** | **$ 297,000** | **$ 142,092** | **$ (154,908)** |

Note: 2021 Actual includes prior year unobligated balance brought forward, Oct. 1, recoveries, and unobligated CARES Act balance brought forward Oct. 1

## Appendix D: Operations and Maintenance Categories

| | |
|---|---|
| Sustainment - Enhancement | Upgrades to new versions of software (SW) including operating systems, deployment of new hardware (HW) platforms, which are significantly different from current operational HW where new skills, equipment and software may be needed |
| Sustainment - Modernization | Migrations to new computing platforms, e.g., virtualization, cloud computing migrations where new skills, equipment and software may be needed to operate the application, system or infrastructure |
| Sustainment - Steady - State | Operations & Maintenance Costs refers to the expenses required to operate and maintain an IT asset that is operating in a production environment. O&M costs include costs associated with operations, maintenance activity, and maintenance projects needed to sustain the IT asset at the current capability and performance levels. It includes Federal and contracted labor costs, corrective hardware and software maintenance, voice and data communications maintenance and service, replacement of broken or obsolete IT equipment, overhead costs, business operations and commercial services costs, and costs for the disposal of an asset |

# Appendix E: Operations and Maintenance Subaccount

| Information Technology<br>Operations and Maintenance Highlights<br>($s in thousands) | 2021 | 2021/2022 | 2022 | | 2023 | 2022-2023 |
|---|---|---|---|---|---|---|
| | Actual | Year 2 of 2-year Availability | Request | Estimate | Request | Increase/ Decrease |
| **Obligations by Program Activities** | | | | | | |
| Health Operations and Maintenance | 677,978 | - | 867,260 | 867,260 | 929,418 | 62,158 |
| Health Operations and Maintenance - CARES Act | 51,180 | - | - | - | - | - |
| Health Operations and Maintenance - ARP 8002 | - | - | - | 45,012 | 47,319 | 2,306 |
| Health Operations and Maintenance - ARP 8003 | - | 100,000 | - | - | | - |
| Benefits Operations and Maintenance | 231,470 | - | 276,274 | 293,195 | 342,937 | 49,742 |
| Benefits Operations and Maintenance - CARES Act | 147,607 | - | - | - | - | - |
| Benefits Operations and Maintenance - ARP 8002 | - | - | - | 87,639 | 87,719 | 80 |
| Corporate Operations and Maintenance | 107,128 | - | 372,586 | 383,586 | 439,642 | 56,056 |
| Enterprise Operations and Maintenance | 2,265,775 | 17,283 | 2,246,874 | 2,276,664 | 2,386,018 | 109,354 |
| Enterprise Operations and Maintenance - CARES Act | 691,581 | - | - | - | - | - |
| Enterprise Operations and Maintenance - ARP 8002 | - | - | - | 478,710 | 495,020 | 16,310 |
| Memorial Operations and Maintenance | 10,300 | - | 34,970 | 34,970 | 44,000 | 9,030 |
| **Total Direct Obligations by Program Activities** | **$4,183,019** | **$117,283** | **$3,797,964** | **$4,467,036** | **4,772,072** | **$305,036** |
| **Obligations by Funding Sources** | | | | | | |
| Appropriation | 3,292,317 | 15,000 | 3,131,585 | 3,131,585 | 4,145,678 | 1,014,093 |
| CARES Act | 890,367 | - | - | - | - | - |
| VHA Transfer (P.L. 117-43 Section 151) | - | - | - | 9,578 | - | (9,578) |
| American Rescue Plan Act (P.L. 117-2 Section 8002) | - | - | - | 611,361 | 630,057 | 18,696 |
| American Rescue Plan Act (P.L. 117-2 Section 8003) | - | 100,000 | - | - | - | - |
| OEF/OIF Supplemental (P.L. 110-28) | 335 | 2,283 | - | - | - | - |
| Recurring Expenses Transformational Fund | - | - | 670,000 | 718,133 | - | (718,133) |
| North Chicago Transfer | - | - | (3,621) | (3,621) | (3,663) | (42) |
| **Total Direct Obligations by Funding Sources** | **$4,183,019** | **$117,283** | **$3,797,964** | **$4,467,036** | **4,772,072** | **$305,036** |
| Reimbursable Obligations incurred | 108,918 | - | 68,951 | 97,488 | 115,258 | 17,770 |
| **Total Operations and Maintenance Obligations** | **$4,291,937** | **$117,283** | **$3,866,915** | **$4,564,524** | **4,887,330** | **$322,806** |

Note: (1) 2021 Actual includes prior year unobligated balance brought forward, Oct. 1, recoveries, and unobligated CARES Act balance brought forward Oct. 1
(2) Table does not include VACAA 801

# Appendix F: Operations and Maintenance Details

| Operations and Maintenance (Sustainment) | | | | | |
|---|---|---|---|---|---|
| ($s in thousands) | | | | | |
| Congressional Program/Congressional Project | 2021 Actual | 2022 Request | 2022 Estimate | 2023 Request | 2022-2023 Increase / Decrease |
| **Sustainment - Steady State** | **$ 3,053,657** | **$ 2,903,864** | **$ 3,415,036** | **$ 3,589,667** | **$ 174,630** |
| **Health Operations and Maintenance** | **$ 590,143** | **$ 823,853** | **$ 852,215** | **$ 890,475** | **$ 38,260** |
| IT Support Contracts | $ 99,856 | $ 179,013 | $ 179,013 | $ 179,012 | $ (1) |
| Software Maintenance | $ 225,688 | $ 149,753 | $ 149,753 | $ 149,753 | $ - |
| Software Maintenance - ARP 8002 | $ - | $ - | $ 4,790 | $ 5,064 | $ 274 |
| Health Data Interoperability | $ 25,990 | $ 104,356 | $ 104,356 | $ 93,971 | $ (10,385) |
| Community Care | $ 73,856 | $ 85,899 | $ 85,899 | $ 84,690 | $ (1,209) |
| Community Care - ARP 8002 | $ - | $ - | $ 870 | $ 870 | $ - |
| Healthcare Administration Systems | $ 68,978 | $ 74,467 | $ 74,467 | $ 78,310 | $ 3,843 |
| Healthcare Administration Systems - ARP 8002 | $ - | $ - | $ 4,213 | $ 4,373 | $ 160 |
| Healthcare Administration Systems - CARES Act | $ 90 | $ - | $ - | $ - | $ - |
| Supply Chain Management | $ 15,830 | $ 31,158 | $ 31,158 | $ 63,282 | $ 32,124 |
| Hardware Maintenance | $ - | $ 43,000 | $ 43,000 | $ 43,000 | $ - |
| Hardware Maintenance - ARP 8002 | $ - | $ - | $ 2,300 | $ 2,415 | $ 115 |
| Digital Health Platform | $ 9,774 | $ 40,034 | $ 40,034 | $ 31,294 | $ (8,740) |
| Research | $ - | $ 11,425 | $ 11,425 | $ 23,855 | $ 12,430 |
| Purchased Care | $ - | $ 19,000 | $ 19,000 | $ 19,475 | $ 475 |
| Connected Health/Mobile Apps | $ 7,793 | $ 14,230 | $ 14,230 | $ 14,950 | $ 720 |
| Connected Health/Mobile Apps - ARP 8002 | $ - | $ - | $ 8,000 | $ 9,000 | $ 1,000 |
| Connected Health/Mobile Apps - CARES Act | $ 6,298 | $ - | $ - | $ - | $ - |
| My HealtheVet | $ 12,814 | $ 12,664 | $ 12,664 | $ 14,480 | $ 1,816 |
| Scheduling | $ 3,124 | $ 12,150 | $ 12,150 | $ 13,110 | $ 960 |
| Pharmacy | $ 8,851 | $ 14,128 | $ 14,128 | $ 11,750 | $ (2,378) |
| Telehealth Services | $ 1,080 | $ 6,423 | $ 6,423 | $ 9,104 | $ 2,681 |
| Telehealth Services - ARP 8002 | $ - | $ - | $ 7,900 | $ 8,657 | $ 757 |
| Telehealth Services - CARES Act | $ 6,463 | $ - | $ - | $ - | $ - |
| Registries | $ 7,332 | $ 6,000 | $ 6,000 | $ 6,430 | $ 430 |
| Genomic Information System for Integrative Service (GenISIS) | $ 2,193 | $ 5,279 | $ 5,279 | $ 5,500 | $ 221 |
| Genomic Information System for Integrative Service (GenISIS) - ARP 8002 | $ - | $ - | $ 290 | $ 290 | $ - |
| Access & Billing | $ 5,021 | $ 4,500 | $ 4,500 | $ 4,514 | $ 14 |
| Patient Records [System (CPRS)] | $ 3,434 | $ 2,080 | $ 2,080 | $ 4,370 | $ 2,290 |
| Lab | $ 4,118 | $ 4,044 | $ 4,044 | $ 4,200 | $ 156 |
| Beneficiary Travel | $ 801 | $ 750 | $ 750 | $ 3,756 | $ 3,006 |
| Beneficiary Travel - CARES Act | $ 285 | $ - | $ - | $ - | $ - |
| Registration, Eligibility, Enrollment | $ 227 | $ 3,500 | $ 3,500 | $ 1,000 | $ (2,500) |
| Registration, Eligibility, Enrollment - CARES Act | $ 245 | $ - | $ - | $ - | $ - |
| **Benefits Operations and Maintenance** | **$ 285,331** | **$ 260,887** | **$ 335,877** | **$ 351,217** | **$ 15,340** |
| Veterans Customer Experience (VCE) | $ 33,824 | $ 81,063 | $ 81,063 | $ 81,138 | $ 75 |
| Veterans Customer Experience (VCE) - ARP 8002 | $ - | $ - | $ 67,647 | $ 67,647 | $ - |
| Veterans Customer Experience (VCE) - CARES Act | $ 63,131 | $ - | $ - | $ - | $ - |
| IT Support Contracts | $ 124,724 | $ 79,000 | $ 79,000 | $ 79,000 | $ - |
| Veterans Benefits Management | $ 28,492 | $ 59,415 | $ 59,415 | $ 69,130 | $ 9,715 |
| Veterans Benefits Management - CARES Act | $ 1,109 | $ - | $ - | $ - | $ - |
| Other Benefits IT Systems | $ 9,336 | $ 21,370 | $ 21,370 | $ 30,069 | $ 8,699 |
| Other Benefits IT Systems - CARES Act | $ 6,489 | $ - | $ - | $ - | $ - |
| Benefit Systems | $ 6,758 | $ 6,125 | $ 6,125 | $ 17,679 | $ 11,554 |
| Benefits Appeals | $ 4,849 | $ 9,100 | $ 16,443 | $ 6,554 | $ (9,889) |
| Benefits Appeals - CARES Act | $ 1,200 | $ - | $ - | $ - | $ - |
| Education Benefits | $ 3,250 | $ 4,814 | $ 4,814 | $ - | $ (4,814) |
| Colmery Act | $ 2,168 | $ - | $ - | $ - | $ - |
| **Corporate Operations and Maintenance** | **$ 83,352** | **$ 269,480** | **$ 269,480** | **$ 285,401** | **$ 15,921** |
| IT Support Contracts | $ 21,508 | $ 91,943 | $ 91,943 | $ 145,846 | $ 53,903 |
| TAC Fees [2/] | $ - | $ 69,921 | $ 69,921 | $ 65,468 | $ (4,453) |
| Human Resources[1/] | $ 9,349 | $ 69,571 | $ 69,571 | $ 20,994 | $ (48,577) |
| Financial and Acquisition Management Modernization[1/] | $ - | $ 19,780 | $ 19,780 | $ 19,780 | $ - |
| Other Corporate IT Systems | $ 46,430 | $ 16,315 | $ 16,315 | $ 18,104 | $ 1,789 |
| General Counsel | $ 3,222 | $ 1,950 | $ 1,950 | $ 14,744 | $ 12,794 |
| Construction and Facilities Mgmt | $ 2,843 | $ - | $ - | $ 465 | $ 465 |

| Operations and Maintenance (Sustainment) Detail Cont. | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| ($s in thousands) | | | | | | | | | | |
| Congressional Program/Congressional Project | | 2021 Actual | | 2022 Request | | 2022 Estimate | | 2023 Request | | 2022-2023 Increase / Decrease |
| **Enterprise Operations and Maintenance** | **$** | **2,084,531** | **$** | **1,526,872** | **$** | **1,934,692** | **$** | **2,040,922** | **$** | **106,230** |
| Software Maintenance | $ | 430,262 | $ | 243,983 | $ | 243,983 | $ | 442,767 | $ | 198,784 |
| Software Maintenance - CARES Act | $ | 5,544 | $ | - | $ | - | $ | - | $ | - |
| Cyber Security | $ | 221,102 | $ | 257,781 | $ | 257,781 | $ | 262,469 | $ | 4,688 |
| Cyber Security - ARP 8002 | $ | - | $ | - | $ | 9,498 | $ | 9,663 | $ | 165 |
| Cyber Security - CARES Act | $ | 2,094 | $ | - | $ | - | $ | - | $ | - |
| Telecommunications | $ | 293,145 | $ | 274,047 | $ | 274,047 | $ | 238,408 | $ | (35,639) |
| Telecommunications - ARP 8002 | $ | - | $ | - | $ | 42,034 | $ | 42,236 | $ | 202 |
| IT Support Contracts | $ | 489,554 | $ | 161,725 | $ | 161,725 | $ | 168,043 | $ | 6,318 |
| IT Support Contracts - ARP 8002 | $ | - | $ | - | $ | 13,471 | $ | 14,764 | $ | 1,293 |
| IT Support Contracts - CARES Act | $ | 15,026 | $ | - | $ | - | $ | - | $ | - |
| Data Integration and Management | $ | 244,260 | $ | 269,996 | $ | 299,786 | $ | 161,009 | $ | (138,777) |
| Data Integration and Management - ARP 8002 | $ | - | $ | - | $ | 242,186 | $ | 254,197 | $ | 12,012 |
| Data Integration and Management - CARES Act | $ | 143,091 | $ | - | $ | - | $ | - | $ | - |
| Hardware Maintenance | $ | 51,987 | $ | 91,814 | $ | 91,814 | $ | 159,119 | $ | 67,305 |
| Hardware Maintenance - ARP 8002 | $ | - | $ | - | $ | 4,347 | $ | 4,477 | $ | 130 |
| Enterprise Service Desk | $ | 50,469 | $ | 77,737 | $ | 77,737 | $ | 63,195 | $ | (14,542) |
| Privacy & Records Management | $ | 32,217 | $ | 42,000 | $ | 42,000 | $ | 54,788 | $ | 12,788 |
| End User Operations | $ | - | $ | 52,000 | $ | 52,000 | $ | 50,021 | $ | (1,979) |
| Network Operations Center | $ | - | $ | 39,866 | $ | 39,866 | $ | 33,673 | $ | (6,193) |
| Enterprise Command Center | $ | - | $ | 12,624 | $ | 12,624 | $ | 12,624 | $ | - |
| Repositories | $ | 2,018 | $ | 3,299 | $ | 3,299 | $ | 2,974 | $ | (325) |
| IT Service Management | $ | 55,100 | $ | - | $ | - | $ | - | $ | - |
| Activations | $ | 30,110 | $ | - | $ | - | $ | - | $ | - |
| Activations - ARP 8002 | $ | - | $ | - | $ | 66,494 | $ | 66,494 | $ | - |
| TAC Fees - CARES Act [2/] | $ | 18,553 | $ | - | $ | - | $ | - | $ | - |
| **Memorial Operations and Maintenance** | **$** | **10,300** | **$** | **22,772** | **$** | **22,772** | **$** | **21,652** | **$** | **(1,120)** |
| IT Support Contracts | $ | - | $ | 11,762 | $ | 11,762 | $ | 9,133 | $ | (2,629) |
| Memorials Automation | $ | 10,300 | $ | 7,010 | $ | 7,010 | $ | 8,870 | $ | 1,860 |
| Memorials Legacy | $ | - | $ | 4,000 | $ | 4,000 | $ | 3,649 | $ | (351) |

| Operations and Maintenance (Sustainment) Detail Cont. | | | | | |
|---|---|---|---|---|---|
| ($s in thousands) | | | | | |
| Congressional Program/Congressional Project | 2021 Actual | 2022 Request | 2022 Estimate | 2023 Request | 2022-2023 Increase / Decrease |
| **Sustainment - Enhancement** | **$ 752,268** | **$ 369,575** | **$ 527,475** | **$ 609,073** | **$ 81,598** |
| **Health Operations and Maintenance** | **$ 131,649** | **$ 43,407** | **$ 60,057** | **$ 81,062** | **$ 21,005** |
| Digital Health Platform | $ 836 | $ 1,000 | $ 1,000 | $ 19,210 | $ 18,210 |
| Community Care | $ 40,551 | $ 11,469 | $ 11,469 | $ 15,901 | $ 4,432 |
| Community Care - CARES Act | $ 870 | $ - | $ - | $ - | $ - |
| Health Data Interoperability | $ 3,851 | $ 4,851 | $ 4,851 | $ 6,808 | $ 1,957 |
| Pharmacy | $ 5,140 | $ 1,900 | $ 1,900 | $ 6,513 | $ 4,613 |
| My HealtheVet | $ 1,048 | $ 1,816 | $ 1,816 | $ 5,886 | $ 4,070 |
| My HealtheVet - ARP 8002 | $ - | $ - | $ 8,650 | $ 8,650 | $ - |
| My HealtheVet - CARES Act | $ 6,427 | $ - | $ - | $ - | $ - |
| Healthcare Administration Systems | $ 10,078 | $ 7,956 | $ 7,956 | $ 2,681 | $ (5,275) |
| Healthcare Administration Systems - ARP 8002 | $ - | $ - | $ 8,000 | $ 8,000 | $ - |
| Healthcare Administration Systems - CARES Act | $ 16,809 | $ - | $ - | $ - | $ - |
| Patient Records [System (CPRS)] | $ - | $ 980 | $ 980 | $ 3,238 | $ 2,258 |
| Patient Records [System (CPRS)] - CARES Act | $ 4,995 | $ - | $ - | $ - | $ - |
| Registries | $ - | $ 2,500 | $ 2,500 | $ 1,900 | $ (600) |
| Beneficiary Travel | $ - | $ 2,000 | $ 2,000 | $ 1,275 | $ (725) |
| Beneficiary Travel - CARES Act | $ 30 | $ - | $ - | $ - | $ - |
| Registration, Eligibility, Enrollment | $ - | $ - | $ - | $ 1,000 | $ 1,000 |
| Registration, Eligibility, Enrollment - CARES Act | $ 2,134 | $ - | $ - | $ - | $ - |
| Purchased Care | $ 18,329 | $ 7,447 | $ 7,447 | $ - | $ (7,447) |
| Research | $ 269 | $ 1,488 | $ 1,488 | $ - | $ (1,488) |
| Scheduling | $ 8,357 | $ - | $ - | $ - | $ - |
| Hardware Maintenance - CARES Act | $ 6,243 | $ - | $ - | $ - | $ - |
| Telehealth Services | $ 5,392 | $ - | $ - | $ - | $ - |
| Genomic Information System for Intergrative Service - CARES Act | $ 290 | $ - | $ - | $ - | $ - |
| **Benefits Operations and Maintenance** | **$ 91,747** | **$ 15,387** | **$ 44,957** | **$ 71,983** | **$ 27,026** |
| Benefit Systems | $ - | $ - | $ - | $ 15,975 | $ 15,975 |
| Other Benefits IT Systems | $ - | $ - | $ - | $ 11,420 | $ 11,420 |
| Other Benefits IT Systems - CARES Act | $ 26,573 | $ - | $ - | $ - | $ - |
| Veterans Customer Experience (VCE) | $ 12,514 | $ 9,579 | $ 9,579 | $ 9,761 | $ 182 |
| Veterans Customer Experience (VCE) - ARP 8002 | $ - | $ - | $ 17,252 | $ 17,252 | $ - |
| Veterans Customer Experience (VCE) - CARES Act | $ 46,074 | $ - | $ - | $ - | $ - |
| Veterans Benefits Management | $ 4,385 | $ 5,808 | $ 5,808 | $ 7,912 | $ 2,104 |
| Veterans Benefits Management - VHA Transfer (P.L. 117-43 Section 151) | $ - | $ - | $ 9,578 | $ - | $ (9,578) |
| Benefits Appeals | $ 965 | $ - | $ - | $ 6,843 | $ 6,843 |
| Benefits Appeals - ARP 8002 | $ - | $ - | $ 2,740 | $ 2,820 | $ 80 |
| Benefits Appeals - CARES Act | $ 1,236 | $ - | $ - | $ - | $ - |
| **Corporate Operations and Maintenance** | **$ 5,786** | **$ 103,106** | **$ 114,106** | **$ 112,818** | **$ (1,288)** |
| Financial and Acquisition Management Modernization[1/] | $ - | $ 103,106 | $ 114,106 | $ 103,106 | $ (11,000) |
| General Counsel | $ 2,714 | $ - | $ - | $ 3,773 | $ 3,773 |
| Other Corporate IT Systems | $ 717 | $ - | $ - | $ 3,300 | $ 3,300 |
| Human Resources[1/] | $ 2,355 | $ - | $ - | $ 2,639 | $ 2,639 |
| **Enterprise Operations and Maintenance** | **$ 523,086** | **$ 195,477** | **$ 296,157** | **$ 320,862** | **$ 24,705** |
| Cyber Security | $ 32,510 | $ 27,745 | $ 27,745 | $ 97,984 | $ 70,239 |
| Cyber Security - CARES Act | $ 22,348 | $ - | $ - | $ - | $ - |
| IT Service Management | $ - | $ 55,660 | $ 55,660 | $ 94,690 | $ 39,030 |
| Activations | $ 17,801 | $ 112,072 | $ 112,072 | $ 25,000 | $ (87,072) |
| Activations - CARES Act | $ 147,556 | $ - | $ - | $ - | $ - |
| Telecommunications - CARES Act | $ 36,864 | $ - | $ - | $ - | $ - |
| IT Support Contracts - CARES Act | $ 36,202 | $ - | $ - | $ - | $ - |
| Hardware Maintenance | $ 13,807 | $ - | $ - | $ - | $ - |
| Hardware Maintenance - CARES Act | $ 6,590 | $ - | $ - | $ - | $ - |
| Data Integration and Management | $ 6,815 | $ - | $ - | $ - | $ - |
| Data Integration and Management - ARP 8002 | $ - | $ - | $ 100,680 | $ 103,188 | $ 2,508 |
| Data Integration and Management - CARES Act | $ 183,210 | $ - | $ - | $ - | $ - |
| Enterprise Service Desk - CARES Act | $ 3,742 | $ - | $ - | $ - | $ - |
| Software Maintenance | $ 0 | $ - | $ - | $ - | $ - |
| Software Maintenance - CARES Act | $ 15,639 | $ - | $ - | $ - | $ - |
| **Memorial Operations and Maintenance** | **$ -** | **$ 12,198** | **$ 12,198** | **$ 22,348** | **$ 10,150** |
| Memorials Automation | $ - | $ 12,198 | $ 12,198 | $ 22,348 | $ 10,150 |

| Operations and Maintenance (Sustainment) Detail Cont. | | | | | |
|---|---|---|---|---|---|
| ($s in thousands) | | | | | |
| Congressional Program/Congressional Project | 2021 Actual | 2022 Request | 2022 Estimate | 2023 Request | 2022-2023 Increase / Decrease |
| **Sustainment - Modernization** | **$ 377,094** | **$ 528,146** | **$ 528,146** | **$ 576,996** | **$ 48,850** |
| **Health Operations and Maintenance** | **$ 7,366** | **$ -** | **$ -** | **$ 5,200** | **$ 5,200** |
| Health Data Interoperability | $ - | $ - | $ - | $ 3,200 | $ 3,200 |
| Community Care | $ - | $ - | $ - | $ 2,000 | $ 2,000 |
| Supply Chain Management | $ 4,366 | $ - | $ - | $ - | $ - |
| My HealtheVet | $ 1,560 | $ - | $ - | $ - | $ - |
| Digital Health Platform | $ 1,255 | $ - | $ - | $ - | $ - |
| Healthcare Adminstration Systems | $ 183 | $ - | $ - | $ - | $ - |
| **Benefits Operations and Maintenance** | **$ 2,000** | **$ -** | **$ -** | **$ 7,456** | **$ 7,456** |
| Benefits Systems | $ - | $ - | $ - | $ 4,034 | $ 4,034 |
| Veterans Benefits Management | $ 93 | $ - | $ - | $ 3,422 | $ 3,422 |
| Veterans Customer Experience (VCE) - CARES Act | $ 1,796 | $ - | $ - | $ - | $ - |
| Other Benefits IT Systems | $ 112 | $ - | $ - | $ - | $ - |
| **Corporate Operations and Maintenance** | **$ 17,990** | **$ -** | **$ -** | **$ 41,423** | **$ 41,423** |
| Human Resources[1/] | $ - | $ - | $ - | $ 38,660 | $ 38,660 |
| Other Corporate IT Systems | $ - | $ - | $ - | $ 2,763 | $ 2,763 |
| Financial and Acquisition Management Modernization[1/] | $ 17,990 | $ - | $ - | $ - | $ - |
| **Enterprise Operations and Maintenance** | **$ 349,739** | **$ 528,146** | **$ 528,146** | **$ 522,917** | **$ (5,229)** |
| Infrastructure Readiness Program (IRP)[1/] | $ 248,690 | $ 477,543 | $ 477,543 | $ 477,543 | $ - |
| Infrastructure Readiness Program (IRP) - CARES Act | $ 43,666 | $ - | $ - | $ - | $ - |
| Cyber Security | $ 35,633 | $ 22,022 | $ 22,022 | $ 41,888 | $ 19,866 |
| Telecommunications | $ - | $ 18,458 | $ 18,458 | $ 3,486 | $ (14,972) |
| Data Integration and Management | $ 2,178 | $ 10,123 | $ 10,123 | $ - | $ (10,123) |
| Data Integration and Management - CARES Act | $ 11,454 | $ - | $ - | $ - | $ - |
| IT Support Contracts | $ 5,002 | $ - | $ - | $ - | $ - |
| Privacy & Records Management | $ 2,143 | $ - | $ - | $ - | $ - |
| Software Maintenance | $ 972 | $ - | $ - | $ - | $ - |
| **GRAND TOTAL** | **$ 4,183,019** | **$ 3,801,585** | **$ 4,470,657** | **$ 4,775,735** | **$ 305,078** |

Note: Numbers may not add due to rounding.

The 2022 Request, 2022 Estimate and 2023 Request include funds allocated for the N. Chicago transfer

1/ In 2022, Congressional Projects will be funded by Recurring Expenses Transformational Fund

2/ TAC Fee realigned from Enterprise Portfolio to Corporate Portfolio for 2021

# Appendix G: Amounts Available for Obligation

| Information and Technology Systems Appropriation/Obligations ($s in thousands) | | | | | |
|---|---|---|---|---|---|
| | 2021/2022 | 2022 | | 2023 | 2022 - 2023 |
| Description | Actual | Request | Estimate | Request | Increase / Decrease |
| **IT Systems Appropriation** | **$4,912,000** | **$4,842,800** | **$4,842,800** | **$5,782,000** | **$939,200** |
| **Rescission from Unobligated Balance** | **($37,500)** | | | | |
| **Total IT Appropriations** | **$4,874,500** | **$4,842,800** | **$4,842,800** | **$5,782,000** | **$939,200** |
| | | | | | |
| **Reimbursements** | | | | | |
| IT Non-Pay Reimbursements | 108,918 | 68,951 | 97,488 | 115,258 | 17,770 |
| IT Pay Reimbursements | 9,150 | 19,161 | 10,579 | 10,779 | 200 |
| COVID-19 Emergency Leave reimbursement, (P.L. 116-260) | 207 | | | | |
| **Total Reimbursements** | **$118,275** | **$88,112** | **$108,067** | **$126,037** | **$17,970** |
| | | | | | |
| **Budgetary Resources** | **$4,992,775** | **$4,930,912** | **$4,950,867** | **$5,908,037** | **$957,170** |
| Unobligated Balance (SOY) | 207,710 | | 37,423 | | (37,423) |
| Available Balance (EOY) (+) | (37,423) | | | | |
| Veterans Choice Act 801 (SOY) | 2,039 | | 1,026 | | (1,026) |
| Veterans Choice Act 801 (EOY) | (1,026) | | | | |
| CARES Act, P.L. 116-136 (SOY) | 973,938 | | | | |
| VHA Transfer (P.L. 117-43 Section 151) | | | 9,578 | | (9,578) |
| VHA CARES Act Transfer (P.L.116-270) | 45,000 | | | | |
| American Rescue Plan [P.L. 117-2 Section 8002] | | | 611,361 | 630,057 | 18,696 |
| American Rescue Plan [P.L. 117-2 Section 8003] (SOY) | 100,000 | | 100,000 | | (100,000) |
| American Rescue Plan [P.L. 117-2 Section 8003] (EOY) | (100,000) | | | | |
| OEF/OIF Supplemental (P.L. 110-28) SOY | 0 | | 2,283 | | (2,283) |
| OEF/OIF Supplemental (P.L. 110-28) EOY | (2,283) | | | | |
| Recoveries | 58,368 | | | | |
| North Chicago Transfers | (8,085) | (7,993) | (7,993) | (8,085) | (92) |
| Appropriations transferred from other accounts (Treas Acct)[1/] | | 670,000 | 718,133 | | (718,133) |
| Unobligated Expiring | (461) | | | | |
| Unobligated Expiring CARES Act | (9) | | | | |
| **Change in Unobligated Balance (non-add)** | **$1,237,768** | **$662,007** | **$1,471,811** | **$621,972** | **($849,839)** |
| Unobligated Balance Expiring (Lapse) | | | | | |
| **Total Obligations** | **$6,230,543** | **$5,592,919** | **$6,422,678** | **$6,530,009** | **$107,331** |
| | | | | | |
| **Outlays, Gross** | **$5,576,991** | **$5,019,000** | **$6,438,000** | **$5,797,000** | (641,000) |
| Less Collections | (94,679) | (88,112) | (108,067) | (126,037) | (17,970) |
| **Outlays, Net** | **$5,482,312** | **$4,930,888** | **$6,329,933** | **$5,670,963** | **(658,970)** |
| | | | | | |
| Direct civilian full-time equivalent employment | 7,638 | 8,668 | 8,668 | 8,918 | 250 |
| Reimbursable civilian full-time equivalent employment | 65 | 98 | 78 | 75 | (3) |
| CARES Act , (P.L. 116-136) civilian full-time equivalent employment | 483 | | | | |
| **Total Full Time Equivalents (FTE)** | **8,186** | **8,766** | **8,746** | **8,993** | **247** |

Note: Numbers may not add due to rounding
1/Reflects transfer to OIT from Recurring Expenses Transformational Fund

# Appendix H: Object Classification

| Office of Information and Technology | | | | | |
|---|---|---|---|---|---|
| **Object Classification** ($s in thousands) | | | | | |
| | **2021 Actual** | **2022 Request** | **2022 Estimate** | **2023 Request** | **2022 - 2023 Increase / Decrease** |
| **Direct Obligations:** | | | | | |
| **Personnel Compensation:** | | | | | |
| Full-time permanent | 780,105 | 942,873 | 880,361 | 934,570 | 54,209 |
| Full-time permanent - CARES Act, P.L. 116-136 | 75,413 | | | | |
| **Total Personnel Compensation** | **$855,519** | **$942,873** | **$880,361** | **$934,570** | **$54,209** |
| Civilian personnel benefits | 305,263 | 314,157 | 379,193 | 402,425 | 23,232 |
| Civilian personnel benefits - CARES Act, P.L.116-136 | 30,103 | | | | |
| Travel and transportation of persons | 1,110 | 13,047 | 12,769 | 15,669 | 2,899 |
| Travel and transportation of persons - CARES Act, P.L.116-136 | 56 | | | | |
| Communications, utilities, and miscellaneous charges | 1,098,579 | 979,324 | 887,634 | 1,089,153 | 201,519 |
| Communications, utilities, and miscellaneous charges - CARES Act, P.L. 116-136 | 4,736 | | | | |
| 8002] | | | 135,000 | 139,128 | |
| Other services from non-Federal sources | 2,352,098 | 1,956,466 | 2,409,507 | 2,956,536 | 547,028 |
| Other services from non-Federal sources - VHA Transfer (P.L. 117-43 Section 151) | | | 9,578 | | |
| Other services from non-Federal - Choice Act, P.L.113-146, Sec. 801 | 1,963 | | | | |
| Other services from non-Federal - CARES Act, P.L. 116-136 | 740,003 | | | | |
| Other services from non-Federal sources - American Rescue Plan [P.L. 117-2 Section 8002] | | | 378,361 | 389,932 | 11,571 |
| Other services from non-Federal sources - American Rescue Plan [P.L. 117-2 Section 8003] | | | 100,000 | | (100,000) |
| Other services from non-Federal sources - Recurring Expenses Transformational Fund | | 670,000 | 718,133 | | (718,133) |
| Supplies and materials | 2,371 | 19,509 | 18,523 | 22,728 | 4,205 |
| Supplies and materials - CARES Act, P.L. 116-136 | 20 | | | | |
| Equipment | 499,055 | 609,060 | 286,552 | 351,608 | 65,056 |
| Equipment - CARES Act, P.L. 116-136 | 221,059 | | | | |
| Equipment - American Rescue Plan [P.L. 117-2 Section 8002] | | | 98,000 | 100,997 | |
| Land and structures | 22 | | | | |
| Insurance claims and indemnities | 311 | 370 | 1,000 | 1,227 | 227 |
| **Subtotal, Direct obligations** | **$6,112,268** | **$5,504,807** | **$6,314,611** | **$6,403,972** | **$89,361** |
| **Reimbursable obligations:** | | | | | |
| Personal compensation: | | | | | |
| Full-time permanent | 7,229 | 11,914 | 7,405 | 7,545 | 140 |
| COVID-19 Emergency Leave reimbursement, P.L. 116-260 | 207 | | | | |
| Civilian personnel benefits | 1,921 | 3,971 | 3,174 | 3,234 | 60 |
| Communications, utilities, and miscellaneous charges | 14,366 | 6,747 | 1,412 | 1,412 | |
| Other services from non-Federal sources | 50,548 | 48,431 | 51,362 | 60,862 | 9,500 |
| Equipment | 44,004 | 17,048 | 44,714 | 52,984 | 8,270 |
| **Subtotal, Reimbursable obligations** | **$118,275** | **$88,112** | **$108,067** | **$126,037** | **$17,970** |

Note: Numbers may not add due to rounding

# Appendix I: Budgetary Resources

| Office of Information and Technology | | | | | |
|---|---|---|---|---|---|
| **Budgetary Resources** ($s in thousands) | | | | | |
| | **2021 Actual** | **2022 Request** | **2022 Estimate** | **2023 Request** | **2022 - 2023 Increase / Decrease** |
| **Budgetary resources:** | | | | | |
| **Unobligated balance:** | | | | | |
| Unobligated balance brought forward, Oct 1 | 209,750 | | 40,732 | | (40,732) |
| Unobligated balance brought forward, Oct 1 - CARES Act, P.L. 116-136 | 973,938 | | | | |
| Unobligated balance brought forward, Oct 1 - American Rescue Plan [P.L. 117-2 Section 8003] | | | 100,000 | | (100,000) |
| Recoveries of prior year unpaid obligations | 58,368 | | | | |
| **Unobligated balance (total)** | **$1,242,055** | | **$140,732** | | **-$140,732** |
| **Budget authority:** | | | | | |
| Appropriation | **$4,912,000** | **$4,842,800** | **$4,842,800** | **$5,782,000** | **$939,200** |
| Appropriations transferred to other accounts [1/] | (8,085) | (7,993) | (7,993) | (8,085) | (92) |
| Rescission from Unobligated Balance | (37,500) | | | | |
| VHA Transfer (P.L. 117-43 Section 151) | | | 9,578 | | |
| VHA CARES Act Transfer (P.L.116-270) | 45,000 | | | | |
| American Rescue Plan [P.L. 117-2 Section 8002] | | | 611,361 | 630,057 | **18,696** |
| American Rescue Plan [P.L. 117-2 Section 8003] | 100,000 | | | | |
| Recurring Expenses Transformational Fund | | 670,000 | 718,133 | | **(718,133)** |
| **Appropriation (total)** | **$5,011,415** | **$5,504,807** | **$6,173,879** | **$6,403,972** | **$230,093** |
| Spending authority from offsetting collections: | | | | | |
| Collected | 118,068 | 88,112 | 108,067 | 126,037 | 17,970 |
| COVID-19 Emergency Leave reimbursement, P.L. 116-260 | 207 | | | | |
| Spending authority from offsetting collections, (total) | **$118,275** | **$88,112** | **$108,067** | **$126,037** | **$17,970** |
| **Budget authority (total)** | **$6,253,470** | **$5,504,807** | **$6,314,611** | **$6,403,972** | **$89,361** |
| **Total budgetary resources available** | **$6,371,745** | **$5,592,919** | **$6,422,678** | **$6,530,009** | **$107,331** |
| Unobligated balance expiring | (461) | | | | |
| Unobligated balance expiring - CARES Act, P.L. 116-136 | (9) | | | | |
| Unexpired unobligated balance, end of year | (40,732) | | | | |
| Unexpired unobligated balance, end of year - American Rescue Plan [P.L. 117-2 Section 8003] | (100,000) | | | | |

1/ Reflects transfers from OIT to the North Chicago Facility
Note: Numbers may not add due to rounding

# Appendix J: Staffing and Admin Support by Object Class

| Staffing & Administrative Support Services by Object Class ($s in thousands) | 2021 Actual | 2022 Request | 2022 Estimate | 2023 Request | 2022-2023 Increase / Decrease |
|---|---|---|---|---|---|
| **Total Full-Time Equivalent (FTE) Employment** | **8,186** | **8,766** | **8,746** | **8,993** | **247** |
| Direct civilian full-time equivalent employment | 7,638 | 8,668 | 8,668 | 8,918 | 250 |
| Reimbursable civilian full-time equivalent employment | 65 | 98 | 78 | 75 | (3) |
| CARES civilian full-time equivalent employment | 483 | | | | |
| **Direct Obligations:** | | | | | |
| Personnel compensation: | | | | | |
| Full-time permanent | 780,105 | 942,873 | 880,361 | 934,570 | 54,209 |
| Full-time permanent - CARES Act, P.L. 116-136 | 75,413 | | | | |
| **Total personnel compensation** | **$855,519** | **$942,873** | **$880,361** | **$934,570** | **$54,209** |
| Civilian personnel benefits | 305,263 | 314,157 | 379,193 | 402,425 | 23,232 |
| Civilian personnel benefits - CARES Act, P.L.116-136 | 30,103 | | | | |
| Travel and transportation of persons | 1,045 | 10,000 | 12,682 | 13,316 | 634 |
| Travel and transportation of persons- CARES Act, P.L. 116-136 | 56 | | | | |
| Communications, utilities, and miscellaneous charges | 859 | | 149 | 157 | 7 |
| Other services from non-Federal | 143,016 | 137,413 | 144,849 | 136,552 | (8,296) |
| Other services from non-Federal - CARES Act, P.L. 116-136 | 17,787 | | | | |
| Supplies and materials | 312 | 5,000 | 1,400 | 1,470 | 70 |
| Equipment | 98 | 5,455 | 250 | 263 | 13 |
| Equipment - CARES Act, P.L. 116-136 | 424 | | | | |
| Insurance claims and indemnities | 311 | 400 | 1,000 | 1,050 | 50 |
| Direct obligations | 1,354,794 | 1,409,843 | 1,419,883 | 1,489,802 | 69,919 |
| Reimbursable obligations | 9,150 | 19,161 | 10,579 | 10,779 | 200 |
| COVID-19 Emergency Leave reimbursement, P.L. 116-260 | 207 | | | | |
| **Total new obligations, unexpired accounts** | **$1,364,151** | **$1,429,004** | **$1,430,462** | **$1,500,581** | **$70,119** |

Note: Numbers may not add due to rounding

## Appendix K: Employment Summary – FTE by Grade

| # of FTE | 2021 Actual | 2021 CARES Act | 2022 Request | 2022 Estimate | 2023 Request | 2022-2023 Increase/ Decrease |
|---|---|---|---|---|---|---|
| **SES** | 32 | - | 39 | 34 | 35 | 1 |
| **GS-15** | 248 | 5 | 273 | 270 | 278 | 8 |
| **GS-14** | 1,167 | 32 | 1,237 | 1,280 | 1,316 | 36 |
| **GS-13** | 2,532 | 80 | 3,062 | 2,791 | 2,869 | 78 |
| **GS-12** | 1,468 | 22 | 1,646 | 1,592 | 1,637 | 45 |
| **GS-11** | 1,969 | 151 | 2,142 | 2,266 | 2,330 | 64 |
| **GS-10** | - | - | 2 | - | - | - |
| **GS-9** | 203 | 80 | 262 | 302 | 311 | 9 |
| **GS-8** | 1 | - | 2 | 1 | 1 | 0 |
| **GS-7** | 60 | 110 | 71 | 181 | 186 | 5 |
| **GS-6** | 19 | 2 | 25 | 22 | 23 | 1 |
| **GS-5** | 5 | 1 | 5 | 6 | 7 | 1 |
| **GS-4** | - | - | - | - | - | - |
| **GS-3** | - | - | - | - | - | - |
| **GS-2** | - | - | - | - | - | - |
| **GS-1** | - | - | - | - | - | - |
| **TITLE 38** | - | - | - | - | - | - |
| **Wage Grade (non-GS)** | - | - | - | - | - | - |
| **Total Number of FTE** | **7,703** | **483** | **8,766** | **8,746** | **8,993** | **247** |

Note: Numbers may not add due to rounding
Table includes reimbursable and BA FTE's and CARES Act

# Appendix L: Staffing and Admin Support by OIT Organizations

| ($s in thousands) | 2021 Actual | | 2022 Request | | 2022 Estimate | | 2023 Request | |
|---|---|---|---|---|---|---|---|---|
| | Staffing | Administrative Support Services | Staffing | Administrative Support Services | Staffing | Administrative Support Services | Staffing | Administrative Support Services |
| ITOPS | $ 720,686 | $ 18,776 | $ 894,630 | $ 5,822 | $ - | $ - | $ - | $ - |
| ITOPS - CARES Act | $ 91,488 | $ 7,072 | $ - | $ - | $ - | $ - | $ - | $ - |
| EPMO | $ 186,342 | $ 6,681 | $ 175,998 | $ 5,198 | $ - | $ - | $ - | $ - |
| EPMO - CARES Act | $ 5,947 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| OIS | $ 43,818 | $ 192 | $ 40,737 | $ 1,063 | $ 50,706 | $ 1,060 | $ 55,614 | $ 1,108 |
| OIS - CARES Act | $ 2,246 | $ 56 | $ - | $ - | $ - | $ - | $ - | $ - |
| QPR | $ 42,236 | $ 1,683 | $ 41,607 | $ 1,877 | $ 52,374 | $ 1,877 | $ 52,047 | $ 8,299 |
| QPR - CARES Act | $ 702 | $ 7,849 | $ - | $ - | $ - | $ - | $ - | $ - |
| ITRM | $ 36,500 | $ 118,298 | $ 38,240 | $ 122,001 | $ 42,533 | $ 124,020 | $ 37,531 | $ 112,145 |
| ITRM - CARES Act | $ 1,504 | $ 1,690 | $ - | $ - | $ - | $ - | $ - | $ - |
| DevSecOps | $ 26,592 | $ - | $ 31,604 | $ - | $ 1,072,801 | $ 16,520 | $ 1,111,170 | $ 13,292 |
| DevSecOps - CARES Act | $ 730 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Strategic Sourcing | $ 19,894 | $ 12 | $ 22,761 | $ 1,121 | $ 26,398 | $ 1,121 | $ 28,593 | $ 1,221 |
| Strategic Sourcing - CARES Act | $ 1,830 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| AMO | $ 9,301 | $ - | $ 11,453 | $ 15,731 | $ 14,742 | $ 15,731 | $ 15,520 | $ 15,731 |
| AMO - CARES Act | $ 1,070 | $ 1,600 | $ - | $ - | $ - | $ - | $ - | $ - |
| To Be Allocated [1/] | $ - | $ - | $ - | $ - | $ - | $ - | $ 36,519 | $ 1,017 |
| **Total [2/]** | **$ 1,190,885** | **$ 163,909** | **$ 1,257,030** | **$ 152,813** | **$ 1,259,554** | **$ 160,329** | **$ 1,336,995** | **$ 152,813** |

Note: Numbers exclude reimbursements and transfers
In 2022, OIT has aligned ITOPS and EPMO subcomponents to DevSecOps
1/ In 2023, the additional 250 FTE will be allocated to OIT organizations based on the CIO's strategic priorities
2/ After North Chicago Transfer
Note: 2022 Current Estimate includes $10M unobligated balance brought forward, Oct. 31

# Appendix M: IT Portfolio Prioritization by Sub-Projects

## Health Portfolio Prioritization by Sub-Projects

| Priority Order | Health Portfolio Sub-Projects | 2023 Request ($s in thousands) |
|---|---|---|
| 1 | **Must Pay Sub-Projects (Sustainment-Steady-State)** | |
| | 4-SIGHT Automated Eyeglass Ordering | $ 949 |
| | Advanced Medication Platform (AMPL) - Pharmacy Graphic User Interface (GUI) | $ 1,650 |
| | APPRISS Health PMP Gateway | $ 6,600 |
| | Automated Patient Discharge | $ 605 |
| | Bed Management Solution (BMS) | $ 1,000 |
| | Beneficiary Travel Self-Service System (BTSSS) | $ 2,575 |
| | Blind Rehab | $ 1,297 |
| | Box Cloud Content Management (Box) - VA-Academic Collaboration Space | $ 2,618 |
| | Business Information Office Business Intelligence Solution (BIO BIS) | $ 1,870 |
| | Cardiac Device Monitoring System | $ 150 |
| | Caregiver Record Management Application (CARMA) | $ 5,900 |
| | Claims Processing & Eligibility System (CP&E) | $ 4,514 |
| | Claims Processing Business Transformation | $ 2,470 |
| | Clinical Case Registries (CCR) | $ 815 |
| | Clinical Data Repository/Health Data Repository | $ 2,000 |
| | Clinical Staffing and Scheduling | $ 364 |
| | Collaborative Terminology Tooling Data Management | $ 2,030 |
| | Community Care - Customer Relationship Management (CommCare-CRM) | $ 2,800 |
| | Community Care - Electronic Data Interchange Gateway (EDI GW) | $ 6,000 |
| | Community Care - Provider Profile Management System (PPMS) | $ 5,710 |
| | Community Care - Standardized Episodes of Care (CC-SEOC) | $ 1,550 |
| | Community Care Clinical and Business Intelligence Solution (EPRS) | $ 4,400 |
| | Community Care Referrals and Authorization (CCRA) | $ 31,500 |
| | Community Care Referral Documentation (REFDOC) | $ 2,350 |
| | Community Care Reimbursement System (CCRS) | $ 10,500 |
| | Community Care Veteran Billing System (CCVBS) | $ 1,255 |
| | Community Living Centers Resident Assessment Instrument | $ 4,200 |
| | Consolidated Patient Account Center Patient Account Resource System (CPAC PARS) | $ 2,550 |
| | Consult Toolbox (CTB) | $ 3,160 |
| | Corporate Data Warehouse (CDW) | $ 23,114 |
| | CPAC Revenue Workflow Tools (ROWT) | $ 1,930 |
| | Supply Chain Services | $ 52,282 |
| | Direct Secure Messaging (DSM) | $ 2,635 |
| | Emergency Department Integration System (EDIS) | $ 1,900 |
| | Enterprise Precision Scanning and Indexing Automation (EPSI) | $ 2,100 |
| | Enterprise Wide Speech Recognition (EWSR) | $ 4,000 |
| | Environment of Care Assessment Compliance Tool (EOC) | $ 2,600 |
| | eScreening | $ 200 |
| | Fee Basis Claims System (FBCS) | $ 1,925 |
| | Genomic Information System for Integrative Sciences (Genisis) | $ 5,500 |
| | Health Application Project Management and Product Support | $ 8,500 |
| | Health Data and Analytics Platform | $ 8,498 |
| | Health Data Quality Tools | $ 4,600 |
| | Home Telehealth Reporting (HTR) | $ 1,725 |
| | Homeless Management Information System (HMIS) | $ 275 |
| | HR Smart - Clinical Trainee Registration and Tracking System (CTRTS) | $ 1,000 |
| | Inbound ePrescribing (eRx) | $ 2,350 |
| | James A Lovell Federal Health Center (JAL FHCC) | $ 1,800 |

| Priority Order | Health Portfolio Sub-Projects Cont. | 2023 Request ($s in thousands) |
|---|---|---|
| 1 | **Must Pay Sub-Projects (Sustainment-Steady-State) Cont.** | |
| | Joint Longitudinal Viewer | $ 13,002 |
| | Laboratory System Reengineering PathNet (LSRP) | $ 4,200 |
| | LGBT Program (10P4Y) Phase 1 | $ 120 |
| | Medical Care Collections Fund Transactions Applications Suite (MCCF EDI TAS) | $ 19,475 |
| | Mental Health Assistant | $ 4,000 |
| | Methadone Dispensing Tracking | $ 2,250 |
| | Million Veteran Program Online/CHAMPION IAA (MVP Online) | $ 7,400 |
| | Mobile Application Platform (MAP) | $ 14,950 |
| | My HealtheVet (MHV) | $ 14,480 |
| | National Center for Patient Safety (NCPS) Patient Safety Operations | $ 550 |
| | National Clozapine Registry | $ 2,000 |
| | Occupational Health Record-Keeping System (OHRS) 2.0 | $ 3,000 |
| | Office of Integrity - Risk Management System | $ 500 |
| | Oversight and Accountability Reporting and Visualization Platform | $ 600 |
| | Patient Centered Management Module Web (PCMM Web) | $ 610 |
| | Program Integrity Tool (PIT) | $ 6,900 |
| | Radiation Oncology | $ 280 |
| | Real Time Location System (RTLS) | $ 935 |
| | Research Electronic Data Capture (VA REDCap) for Research | $ 200 |
| | Signature Informed Consent (SIC) | $ 7,500 |
| | SLA - Health | $ 106,208 |
| | Standards and COTS Integration Platform (SCIP) | $ 15,000 |
| | Standards and Terminology Services (STS) | $ 2,570 |
| | Supply Chain Management GUI | $ 11,000 |
| | Telehealth Management Platform (TMP/CVT-TSS) | $ 5,700 |
| | VA Informatics and Computing Infrastructure (VINCI) | $ 8,842 |
| | VA Online Scheduling (VAOS) | $ 6,000 |
| | Vet Ride (VTSHS) | $ 1,181 |
| | Veteran Co-Payment Lockbox (VCPL) | $ 1,000 |
| | Veteran Re-Entry Search Service (VRSS) | $ 555 |
| | Veterans Administration Central Cancer Registry | $ 80 |
| | Veterans Data Integration and Federation Enterprise Platform (VDIF-EP) | $ 23,000 |
| | Veterans Health Information Exchange (VHIE) | $ 4,020 |
| | Veterans Health Information Systems and Technology Architecture (VistA) | $ 29,113 |
| | Veterans Integrated Registries Platform (VIRP) | $ 4,555 |
| | VHA Geographic Information System (GIS) | $ 1,668 |
| | VHA Hardware Maintenance | $ 43,000 |
| | VHA Innovation Ecosystem | $ 4,795 |
| | VHA IT Support Contracts | $ 66,275 |
| | VHA Research IT Support | $ 6,529 |
| | VHA Software License Maintenance | $ 149,753 |
| | VistA - Blood Establishment Computer Software (VBECS) | $ 5,800 |
| | VistA - Computerized Patient Record System (CPRS) | $ 2,000 |
| | VistA - Pharmacy: Inpatient Medications | $ 1,150 |
| | VistA Audit Solution (VAS) | $ 2,500 |
| | VistA Imaging (IMAGE) | $ 4,800 |
| | VistA Integration Adapter (VIA) | $ 765 |
| | VistA Radiology/Nuclear Medicine (RAD/NM) | $ 500 |
| | VistA - Scheduling (VSE) | $ 6,500 |
| | Web VistA Remote Access Management (WebVRam) | $ 1,679 |
| | **Total Must Pay Sub-Projects (Sustainment-Steady-State)** | **$859,806** |

| Priority Order | Health Portfolio Sub-Projects Cont. | 2023 Request ($s in thousands) |
|---|---|---|
| 2 | Vet Ride (VTSHS) | $ 1,102 |
| 3 | Pharmacy Operational Updates | $ 2,200 |
| 4 | HR Smart - Clinical Trainee Registration and Tracking System (CTRTS) | $ 3,000 |
| 5 | VistA - Computerized Patient Record System (CPRS) | $ 6,000 |
| 6 | Methadone Dispensing Tracking | $ 3,200 |
| 7 | Corporate Data Warehouse (CDW) Mental Health (MH) Service Transition | $ 2,300 |
| 8 | VHA Innovation Ecosystem | $ 5,209 |
| 9 | Veterans Integrated Registries Platform (VIRP) | $ 1,900 |
| 10 | Mental Health Assistant | $ 3,150 |
| 11 | Beneficiary Travel Self-Service System (BTSSS) | $ 173 |
| 12 | National Center for Patient Safety (NCPS) Patient Safety Operations | $ 2,580 |
| 13 | Home Telehealth Reporting (HTR) | $ 5,000 |
| 14 | Telehealth Management Platform (TMP/CVT-TSS) | $ 8,657 |
| 15 | Enterprise Supply Chain (eSC) | $ 33,223 |
| 16 | My HealtheVet | $ 5,886 |
| 17 | Health Data and Analytics Platform | $ 9,059 |
| 18 | Pharmacy Automated Dispensing Equipment | $ 4,313 |
| 19 | VA National Clozapine Registry | $ 3,508 |
| 20 | CPRS Cloud VISN 17 | $ 328 |
| 21 | Direct Secure Messaging | $ 3,300 |
| 22 | Enterprise Precision Scanning and Indexing (EPSI) Automation | $ 1,600 |
| 23 | Occupational Health Record-Keeping System 2.1 | $ 3,194 |
| 24 | LGBT Program (10P4Y) | $ 2,910 |
| 25 | Community Care (CC) Integrated Billing (IB) Accounts Receivable (AR) | $ 3,436 |
| 26 | CPAC Revenue Workflow Tools (ROWT) | $ 2,965 |
| 27 | Medical Care Collections Fund (MCCF) EDI Transaction Applications Suite (Development) | $ 10,000 |
| 28 | Veteran Co-Payment Lockbox (VCPL) | $ 2,000 |
| 29 | Events Management Analytics Platform (EMAP) | $ 101 |
| 30 | Community Care - Provider Profile Management System (PPMS) | $ 3,050 |
| 31 | Community Care (CC) Electronic Data Interchange (EDI) | $ 9,800 |
| 32 | Community Care (CC) One Consult (Sustainment-Enhancement) | $ 2,750 |
| 33 | Community Care (CC) One Consult (Development) | $ 5,000 |
| 34 | Community Care Referral and Authorization (CCRA) (Development) | $ 7,500 |
| 35 | Community Care Referral and Authorization (CCRA) (Sustainment-Enhancement) | $ 3,700 |
| 36 | Community Care (CC) Provider Payment Business | $ 6,500 |
| 37 | Big Four | $ 2,249 |
| 38 | Claims Processing Business Transformation | $ 6,830 |
| 39 | Bed Management Solution (BMS) | $ 1,000 |
| 40 | Caregiver Record Management Application (CARMA) - Caregivers Expansion | $ 2,260 |
| 41 | Corporate Data Warehouse (CDW) | $ 3,200 |
| 42 | Megabus Legislative Actions | $ 4,701 |
| | **Total Health Portfolio** | **$ 1,048,640** |

## Benefits Portfolio Prioritization by Sub-Projects

| Priority Order | Benefits Portfolio Sub-Projects | 2023 Request ($s in thousands) |
|---|---|---|
| 1 | SLA - Benefits | $ 58.586 |
| 2 | Veterans Signals (VSignals) | $ 11.592 |
| 3 | VBA & NCA IT Support Contracts | $ 12.203 |
| 4 | VA.GOV | $ 28.553 |
| 5 | Veterans Benefits Management System (VBMS) | $ 65.770 |
| 6 | E-Benefits Portal | $ 3.610 |
| 7 | Digital GI Bill | $ 15.262 |
| 8 | VA Knowledge Management System - eGain | $ 6.166 |
| 9 | Education Legacy System Decommissioning | $ 3.300 |
| 10 | White House VA Hotline (WHHL) | $ 1.842 |
| 11 | Appeals Modernization - Board of Veterans' Appeals (BVA) | $ 13.397 |
| 12 | Community Care - Customer Relationship Management (CommCare) | $ 5.631 |
| 13 | Benefits Integration Platform (BIP) | $ 9.009 |
| 14 | Member Services - Customer Relationship Management | $ 5.471 |
| 15 | Enterprise Management of Payments, Workload, and Reporting (eMPWR-VA) | $ 17.659 |
| 16 | Patient Advocate Tracking System Replacement (PATS-R) | $ 5.808 |
| 17 | Life Insurance Policy Administration Solution (LIPAS) | $ 0.417 |
| 18 | Education Call Center (ECC) Customer Relationship Management (CRM) | $ 3.178 |
| 19 | Benefits Enterprise Platform (BEP) | $ 11.743 |
| 20 | Customer Relationship Management Unified Desktop Optimization (CRM UDO) | $ 2.526 |
| 21 | Veterans Service Network (VETSNET) | $ 4.522 |
| 22 | Veterans Experience Integration Solution (VEIS) | $ 4.705 |
| 23 | Other VBA System Transformation | $ 14.295 |
| 24 | Enrollment System | $ 9.885 |
| 25 | Corporate WINRS (CWINRS) | $ 2.446 |
| 26 | Customer Experience Data Warehouse (CxDW) | $ 2.950 |
| 27 | Federal Case Management Tool (FCMT) | $ 1.857 |
| 28 | Quality Assurance Web Application (QAWEB) | $ 1.815 |
| 29 | Specially Adapted Housing/Special House Adaptation SAH/SHA | $ 9.052 |
| 30 | Compensation and Pension Record Interchange (CAPRI) | $ 5.660 |
| 31 | CLAIMS | $ 1.057 |
| 32 | Veterans Assistance Discharge System (VADS) | $ 2.208 |
| 33 | Electronic Insurance (EIN) | $ 0.081 |
| 34 | Veteran Readiness and Employment Case Management Solution (VRE_CMS) | $ 1.116 |
| 35 | Virtual VA | $ 2.420 |
| 36 | VistA - CAPRI: Automated Medical Information Exchange | $ 1.057 |
| 37 | Veterans Tracking Application (VTA) | $ 2.400 |
| 38 | Status Query and Response Exchange (SQUARES) | $ 1.583 |
| 39 | SLA - Veteran Experience Services | $ 8.211 |
| 40 | Center for Development and Civis Engagement Portal (CDCEP) | $ 2.327 |
| 41 | Veterans Crisis Line (VCL) | $ 1.698 |
| 42 | Veterans Identifiation Card (VIC) Act 2015 | $ 0.150 |
| 43 | VistA Enrollment Application System | $ 0.235 |
| 44 | Voluntary Service System (VSS) | $ 0.211 |
| | **Total Benefits Portfolio** | **$ 363.664** |

# Appendix N: Information Security Details

| Information Security Details ($s in thousands) | 2021 Actual | | 2022 Request | | 2022 Estimate | | 2023 Request | | 2022-2023 Increase/ Decrease | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Development | OM | Development | OM | Development | OM | Development | OM | Development | OM |
| Information Security Operations | $ - | $ 100,991 | $ - | $ 127,743 | $ - | $ 127,743 | $ - | $ 170,749 | $ - | $ 43,006 |
| CRISP Operations | $ - | $ 69,256 | $ - | $ 51,129 | $ - | $ 51,129 | $ - | $ 63,911 | $ - | $ 12,782 |
| Information Security Policy and Strategy | $ - | $ 96,122 | $ - | $ 45,340 | $ - | $ 45,340 | $ - | $ 60,605 | $ - | $ 15,265 |
| Enterprise CyberSecurity Program (formerly Cybersecurity Implementation Strategy) | $ - | $ - | $ - | $ 60,000 | $ - | $ 60,000 | $ - | $ 60,000 | $ - | $ - |
| Enterprise CyberSecurity Program (formerly Cybersecurity Implementation Strategy) - ARP 8002 | $ - | $ - | $ - | $ - | $ - | $ 9,498 | $ - | $ 9,663 | $ - | $ 165 |
| Enterprise CyberSecurity Program (formerly Cybersecurity Implementation Strategy) - CARES Act | $ - | $ 24,442 | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Privacy & Records Management | $ - | $ 34,359 | $ - | $ 42,000 | $ - | $ 42,000 | $ - | $ 54,788 | $ - | $ 12,788 |
| Cyber Security | $ 11,380 | $ 22,876 | $ 11,200 | $ 21,800 | $ 11,200 | $ 21,800 | $ - | $ 45,540 | $ (11,200) | $ 23,740 |
| Network Operations Security[1/] | $ - | $ - | $ - | $ 1,536 | $ - | $ 1,536 | $ - | $ 1,536 | $ - | $ - |
| **Subtotals** | **$ 11,380** | **$ 348,047** | **$ 11,200** | **$ 349,548** | **$ 11,200** | **$ 359,046** | **$ -** | **$ 466,792** | **$ (11,200)** | **$ 107,746** |
| **TOTAL Development and OM** | **$** | **359,427** | **$** | **360,748** | **$** | **370,246** | **$** | **466,792** | **$** | **96,546** |

[1/]In 2021, Network Operations Center (NOC) being reclassified as a Delivery program and supports IT Infrastructure

# Appendix O: IT Investments by Portfolio

| Information and Technology 2023 VA IT Investment by Portfolio ($s in thousands) | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Portfolio | Investment | Unique | 2021 Actual | | | | 2022 Estimate | | | | 2023 Request | | | | |
| | | | DME | OM | RA | FTE | DME | OM | RA | FTE | DME | OM | RA | FTE | |
| **HEALTH** | | | **$ 306,093** | **$ 2,300,192** | **$ -** | **626** | **$ 352,192** | **$ 3,915,215** | **$ -** | **656** | **$ 209,082** | **$ 2,331,395** | **$ -** | **659** | |
| Access to Care | Major | 029-555555300 | $ 13,060 | $ 28,553 | $ - | 27 | $ 2,001 | $ 46,439 | $ - | 23 | $ 2,275 | $ 49,778 | $ - | 23 | |
| Health Data & Information | Major | 029-555555301 | $ 26,061 | $ 75,242 | $ - | 167 | $ 26,955 | $ 146,468 | $ - | 165 | $ 26,744 | $ 139,766 | $ - | 168 | |
| Health Management Platform | Major | 029-555555302 | $ 150,882 | $ 138,394 | $ - | 185 | $ 98,275 | $ 204,257 | $ - | 175 | $ 118,947 | $ 199,146 | $ - | 174 | |
| Electronic Health Record Modernization (EHRM) | Major | 029-555555305 | $ - | $ 1,960,700 | $ - | 176 | $ - | $ 3,383,596 | $ - | 227 | $ - | $ 1,759,000 | $ - | 227 | |
| Supply Chain Management | Major | 029-777777502 | $ 74,047 | $ 16,712 | $ - | 17 | $ 177,960 | $ 31,877 | $ - | 17 | $ 35,022 | $ 64,032 | $ - | 17 | |
| Other Medical IT Systems | Non-Major | 029-555555306 | $ 38,223 | $ 76,815 | $ - | 44 | $ 36,674 | $ 84,434 | $ - | 40 | $ 20,735 | $ 88,829 | $ - | 41 | |
| Health Research | Non-Major | 029-555555303 | $ 3,820 | $ 3,776 | $ - | 10 | $ 10,327 | $ 18,144 | $ - | 9 | $ 5,359 | $ 30,843 | $ - | 9 | |
| **BENEFITS** | | | **$ 312,497** | **$ 223,754** | **$ 83,200** | **382** | **$ 140,379** | **$ 299,025** | **$ 86,167** | **387** | **$ 107,661** | **$ 315,842** | **$ 106,168** | **385** | |
| Benefits Appeals | Major | 029-666666400 | $ 8,201 | $ 7,108 | $ - | 6 | $ 6,216 | $ 17,306 | $ - | 6 | $ 9,663 | $ 7,454 | $ - | 6 | |
| Benefits Payments | Major | 029-666666401 | $ 20,188 | $ 9,716 | $ - | 27 | $ 11,003 | $ 8,715 | $ - | 27 | $ 23,383 | $ 17,141 | $ - | 27 | |
| Veterans Benefits Management | Major | 029-666666402 | $ 43,709 | $ 36,835 | $ 7,743 | 41 | $ 29,832 | $ 65,457 | $ 6,813 | 42 | $ 11,334 | $ 75,276 | $ 6,919 | 41 | |
| Customer Relationship Management | Major | 029-666666404 | $ 132,262 | $ 111,775 | $ 4,477 | 94 | $ 38,149 | $ 160,793 | $ - | 94 | $ 36,183 | $ 161,378 | $ - | 97 | |
| Other Benefits IT Systems | Non-Major | 029-666666403 | $ 108,137 | $ 58,320 | $ 70,980 | 214 | $ 55,179 | $ 46,754 | $ 79,354 | 218 | $ 27,098 | $ 54,593 | $ 99,249 | 214 | |
| **CORPORATE** | | | **$ 149,497** | **$ 483,861** | **$ 4,779** | **534** | **$ 129,164** | **$ 794,831** | **$ 4,100** | **590** | **$ 164,164** | **$ 779,447** | **$ 4,234** | **841** | |
| Financial Management | Major | 029-777777501 | $ 116,816 | $ 19,612 | $ - | 6 | $ 114,939 | $ 20,643 | $ - | 6 | $ 103,106 | $ 20,679 | $ - | 6 | |
| Other Corporate IT Systems | Non-Major | 029-777777503 | $ 25,288 | $ 84,507 | $ 2,479 | 88 | $ 2,299 | $ 100,207 | $ 2,688 | 87 | $ 53,120 | $ 67,657 | $ 2,822 | 88 | |
| VA Franchise Fund_IT Spending | Non-Major | 029-777777212 | $ 8,011 | $ 172,876 | $ - | - | $ 11,926 | $ 301,169 | $ - | - | $ 7,938 | $ 301,186 | $ - | - | |
| eGov LoB Benefits.Gov | Non-Major | 029-444440020 | $ - | $ 347 | $ - | - | $ - | $ 337 | $ - | - | $ - | $ 285 | $ - | - | |
| eGov LoB E-Rulemaking | Non-Major | 029-444440060 | $ - | $ 218 | $ - | - | $ - | $ 270 | $ - | - | $ - | $ 283 | $ - | - | |
| eGov LoB Grants.gov | Non-Major | 029-444440160 | $ - | $ 150 | $ - | - | $ - | $ 152 | $ - | - | $ - | $ 238 | $ - | - | |
| eGov LoB Integrated Award Environment | Non-Major | 029-444440230 | $ - | $ 2,731 | $ - | - | $ - | $ 2,731 | $ - | - | $ - | $ 2,731 | $ - | - | |
| eGov LoB Financial Management | Non-Major | 029-444441100 | $ - | $ 159 | $ - | - | $ - | $ 159 | $ - | - | $ - | $ 159 | $ - | - | |
| eGov LoB Human Resources Management | Non-Major | 029-444441200 | $ - | $ 274 | $ - | - | $ - | $ 274 | $ - | - | $ - | $ 274 | $ - | - | |
| eGov LoB Geospatial | Non-Major | 029-444443100 | $ - | $ 25 | $ - | - | $ - | $ 25 | $ - | - | $ - | $ 25 | $ - | - | |
| eGov LoB Budget Formulation and Execution | Non-Major | 029-444443200 | $ - | $ 120 | $ - | - | $ - | $ 120 | $ - | - | $ - | $ 120 | $ - | - | |
| eGov LoB Disaster Assistance Improvement Plan | Non-Major | 029-444444100 | $ - | $ 66 | $ - | - | $ - | $ 66 | $ - | - | $ - | $ 66 | $ - | - | |
| Corporate IT Support ITRM | Non-Major | 029-777777015 | $ (618) | $ 202,776 | $ 2,300 | 440 | $ - | $ 368,678 | $ 1,412 | 497 | $ - | $ 385,744 | $ 1,412 | 747 | |
| **ENTERPRISE** | | | **$ 937,449** | **$ 3,510,627** | **$ 30,136** | **6,803** | **$ 843,920** | **$ 3,509,481** | **$ 17,300** | **7,323** | **$ 843,779** | **$ 3,691,996** | **$ 15,135** | **7,322** | |
| Enterprise Data Services | Major | 029-888888601 | $ 250,659 | $ 369,205 | $ 9,840 | 119 | $ 18,540 | $ 238,107 | $ 1,046 | 111 | $ - | $ 140,291 | $ 1,099 | 112 | |
| Enterprise Security Services | Standard | 029-888888600 | $ 104,014 | $ 355,777 | $ - | 518 | $ 60,967 | $ 416,447 | $ - | 576 | $ 139,872 | $ 446,815 | $ - | 576 | |
| EPMO Enterprise Support | Standard | 029-888888610 | $ - | $ 65,583 | $ 1,894 | 142 | $ 100,680 | $ 353,613 | $ 2,649 | 149 | $ 103,188 | $ 315,869 | $ 2,716 | 149 | |
| IT Operations Network | Standard | 029-888888603 | $ 155,196 | $ 306,814 | $ 1,137 | 276 | $ 164,458 | $ 358,085 | $ 1,133 | 292 | $ 140,486 | $ 325,168 | $ 1,167 | 297 | |
| IT Operations Data Center and Cloud | Standard | 029-888888604 | $ 53,449 | $ 154,106 | $ - | 140 | $ 98,000 | $ 141,191 | $ - | 271 | $ 98,000 | $ 329,285 | $ - | 305 | |
| IT Operations Platform | Standard | 029-888888608 | $ - | $ 56,251 | $ - | 313 | $ - | $ 112,334 | $ - | 466 | $ - | $ 122,470 | $ - | 514 | |
| IT Operations End User | Standard | 029-888888605 | $ 369,129 | $ 1,522,590 | $ 17,265 | 3,957 | $ 345,615 | $ 1,047,198 | $ 12,472 | 3,824 | $ 267,543 | $ 1,199,924 | $ 10,153 | 3,677 | |
| IT Operations Application | Standard | 029-888888606 | $ 5,002 | $ 550,420 | $ - | 790 | $ - | $ 713,597 | $ - | 1,015 | $ - | $ 679,558 | $ - | 1,032 | |
| IT Operations Delivery | Standard | 029-888888607 | $ - | $ 129,881 | $ - | 548 | $ 55,660 | $ 128,909 | $ - | 619 | $ 94,690 | $ 132,615 | $ - | 660 | |
| **MEMORIAL AFFAIRS** | | | **$ 16,586** | **$ 13,299** | **$ 160** | **17** | **$ 21,633** | **$ 13,455** | **$ 500** | **17** | **$ 22,348** | **$ 14,468** | **$ 500** | **13** | |
| Memorials Automation | Major | 029-666666700 | $ 16,586 | $ 13,299 | $ 160 | 17 | $ 21,633 | $ 13,455 | $ 500 | 17 | $ 22,348 | $ 14,468 | $ 500 | 13 | |
| | | | | | | | | | | | | | | | |
| **TOTAL** | | | **$ 1,722,122** | **$ 6,531,733** | **$ 118,275** | **8,362** | **$ 1,487,288** | **$ 8,532,007** | **$ 108,067** | **8,973** | **$ 1,347,034** | **$ 7,133,147** | **$ 126,037** | **9,220** | |
| **TOTAL REPORTED in VA IT PORTFOLIO (Exhibit 53)** | | | **$** | | **8,372,130** | **8,362** | **$** | | **10,127,362** | **8,973** | **$** | | **8,606,218** | **9,220** | |

Note: The table above reflects the VA IT investment structure for 2021, 2022 and 2023. Per OMB guidance, it reflects all non-pay/pay Budget Authority and Reimbursable Authority funding sources which includes the American Rescue Plan, CARES Act, and Transformational Funds. The information in the table gets submitted to the OMB IT Collect; The DME column includes Development, Sustainment-Modernization and Sustainment-Enhancement funding (shown separately in the Operations and Maintenance appendix). OM includes Sustainment Steady-State funding only

# Appendix P: TBM Matrix

| 2021 IT Investment Porftolio TBM Matrix | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ($s in thousands) | IT Towers | | | | | | | | | | | |
| | | Data Center | Compute | Storage | Network | Platform | End User | Application | Delivery | Output | Security & Compliance | IT Management | Grand Total Cost Pool |
| Cost Pools | External Labor | 16,146 | 248,013 | 84,141 | 224,306 | 136,297 | 186,417 | 1,522,886 | 298,399 | 40,000 | 217,624 | 432,925 | 3,407,154 |
| | Facilities & Power | | 2 | | 117 | 11 | 5,304 | 3 | | | | 188 | 5,625 |
| | Hardware | | 9,992 | 12,061 | 273,312 | 5,944 | 311,381 | 46,504 | 24 | | 52,211 | 33,141 | 744,570 |
| | Internal Labor | 170 | 11,655 | 10,976 | 33,454 | 29,144 | 665,731 | 309,551 | 68,962 | | 150,936 | 273,966 | 1,554,545 |
| | Internal Services | | | | | | | | | | | 4,090 | 4,090 |
| | Other | | 780 | | 13 | 5,907 | 84,248 | 1,602 | 41 | | 3,468 | 35,368 | 131,427 |
| | Outside Services | | 93,461 | 59,562 | 49,439 | 49,418 | 19,927 | 470,429 | 42,147 | | 18,629 | 48,943 | 851,955 |
| | Software | | 34,132 | 12,542 | 262,697 | 20,544 | 215,407 | 594,110 | 61,970 | | 117,401 | 35,253 | 1,354,056 |
| | Telecom | | 71 | 5,131 | 263,548 | 36 | 19,238 | 22,369 | 5 | | 8,310 | | 318,708 |
| | **Grand Total IT Towers** | **16,316** | **398,106** | **184,413** | **1,106,886** | **247,301** | **1,507,653** | **2,967,454** | **471,548** | **40,000** | **568,579** | **863,874** | **8,372,130** |

Note: The 2021 VA IT Investment Portfolio total amount of $8,372.130 million includes the following funding sources:
1) OIT Prior Year Obligations in the amount of $4,866.030 million plus $118.275 million Reimbursable
2) Unobligated balance brought forward, Oct 1 in the amount of $170.210 million
3) PY Recoveries in the amount of $2.339 million
4) OEHRM Prior Year Obligations in the amount of $1,960.700 million
5) Prior Year CARES Act and Prior Year CARES Act Recoveries in the amount of $1,026.391
6) VA Franchise Fund in the amount of $180.887 million
7) VHA CARES Act Transfer in the amount of $45.000 million
8) VACAA 801 in the amount of $1.963 million
9) OEF/OIF Supplemental (P.L.110-28) in the amount of $.335 million

| 2022 IT Investment Porftolio TBM Matrix | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ($s in thousands) | IT Towers | | | | | | | | | | | |
| | | Data Center | Compute | Storage | Network | Platform | End User | Application | Delivery | Security & Compliance | IT Management | Grand Total Cost Pool | |
| Cost Pools | External Labor | 536 | 234,528 | 41,902 | 119,401 | 160,183 | 77,773 | 1,246,640 | 317,908 | 87,275 | 653,078 | 2,939,224 | |
| | Facilities & Power | 830 | | | | 10 | 4,749 | 26 | | 85 | 34,691 | 40,391 | |
| | Hardware | | 278,910 | 4,522 | 41,061 | 48,515 | 483,456 | 6,588 | 20 | 53,555 | 6,399 | 923,026 | |
| | Internal Labor | 2,692 | 17,710 | 22,527 | 39,266 | 39,088 | 772,980 | 306,271 | 82,495 | 171,696 | 193,074 | 1,647,799 | |
| | Internal Services | | | | | | | | | | 4,134 | 4,134 | |
| | Other | | 696 | | 15 | 5,273 | 360 | 1,577 | 45 | 24,953 | 1,135,785 | 1,168,704 | |
| | Outside Services | | | 333 | 12,811 | 5,842 | 105,909 | 294,710 | 55,660 | 82,164 | 88,711 | 646,140 | |
| | Software | | 4,408 | 31 | 955 | 1,349 | 243,983 | 1,781,259 | 39,931 | 72,993 | 77,107 | 2,222,016 | |
| | Telecom | | | | 512,212 | | 12 | 23,704 | | | | 535,928 | |
| | **Grand Total IT Towers** | **4,058** | **536,252** | **69,315** | **725,721** | **260,260** | **1,689,222** | **3,660,775** | **496,059** | **492,721** | **2,192,979** | **10,127,362** | |

Note: The 2022 VA IT Investment Portfolio total amount of $10,127.362 million includes the following funding sources:
1) OIT Request in the amount of $4,842.800 million plus $108.067 million in Reimbursements
2) Unobligated balance brought forward, Oct 1 in the amount of $40.732 million
3) Recurring Expenses Transformational Fund in the amount of $718.133 million
4) OEHRM Budget Request in the amount of $2,663 million plus $720.596 million unobligated balance brought forward, Oct 1
5) Franchise Funds Spending Projection in the amount of $313.095 million
6) American Rescue Plan Act [P.L. 117-2 Section 8003] in the amount of $100 million
7) American Rescue Plan Act [P.L. 117-2 Section 8002] in the amount of $611.361 million

8) VHA CARES Act transfer [P.L. 117-43 Section 151] in the amount of $9.578 million

| 2023 IT Investment Porftolio TBM Matrix | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ($s in thousands) | | IT Towers | | | | | | | | | | |
| | | Data Center | Compute | Storage | Network | Platform | End User | Application | Delivery | Security & Compliance | IT Management | Grand Total Cost Pool |
| Cost Pools | External Labor | 620 | 181,168 | 35,420 | 65,618 | 220,588 | 38,524 | 902,048 | 258,527 | 113,542 | 351,115 | 2,167,170 |
| | Facilities & Power | | | | | 5 | 3,815 | | | | 39,362 | 43,182 |
| | Hardware | | 348,266 | 2,094 | 19,014 | 46,903 | 357,083 | 3,051 | 9 | 20,247 | 2,964 | 799,631 |
| | Internal Labor | 10,075 | 6,222 | 740 | 3,534 | 134,063 | 305,854 | 1,102,963 | 18,591 | 22,566 | 86,936 | 1,691,544 |
| | Internal Services | | | | | | | | | | 4,181 | 4,181 |
| | Other | | 322 | | 11 | 2,443 | 187 | 959 | 34 | 13,034 | 372,037 | 389,027 |
| | Outside Services | | | 262 | 139 | 4,814 | 76,073 | 466,812 | 108,093 | 230,352 | 37,775 | 924,320 |
| | Software | | 2,057 | 24 | 442 | 15,574 | 442,767 | 1,535,266 | 33,703 | 36,448 | 74,089 | 2,140,370 |
| | Telecom | | | | 436,439 | | 6 | 10,341 | | 7 | | 446,793 |
| | **Grand Total IT Towers** | **10,695** | **538,035** | **38,540** | **525,197** | **424,390** | **1,224,309** | **4,021,440** | **418,957** | **436,196** | **968,459** | **8,606,218** |

Note: 2023 VA IT Investment Portfolio total amount of $8,806,218 million includes the following funding source
1) OIT Request in the amount of $5,782 million plus $126.037 million Reimbursable
2) OEHRM Budget Request in the amount of $1,759 million
3) Franchise Funds Spending Projection in the amount of $309.124 million
4) American Rescue Plan Act [P.L. 117-2 Section 8002] in the amount of $630.057 million

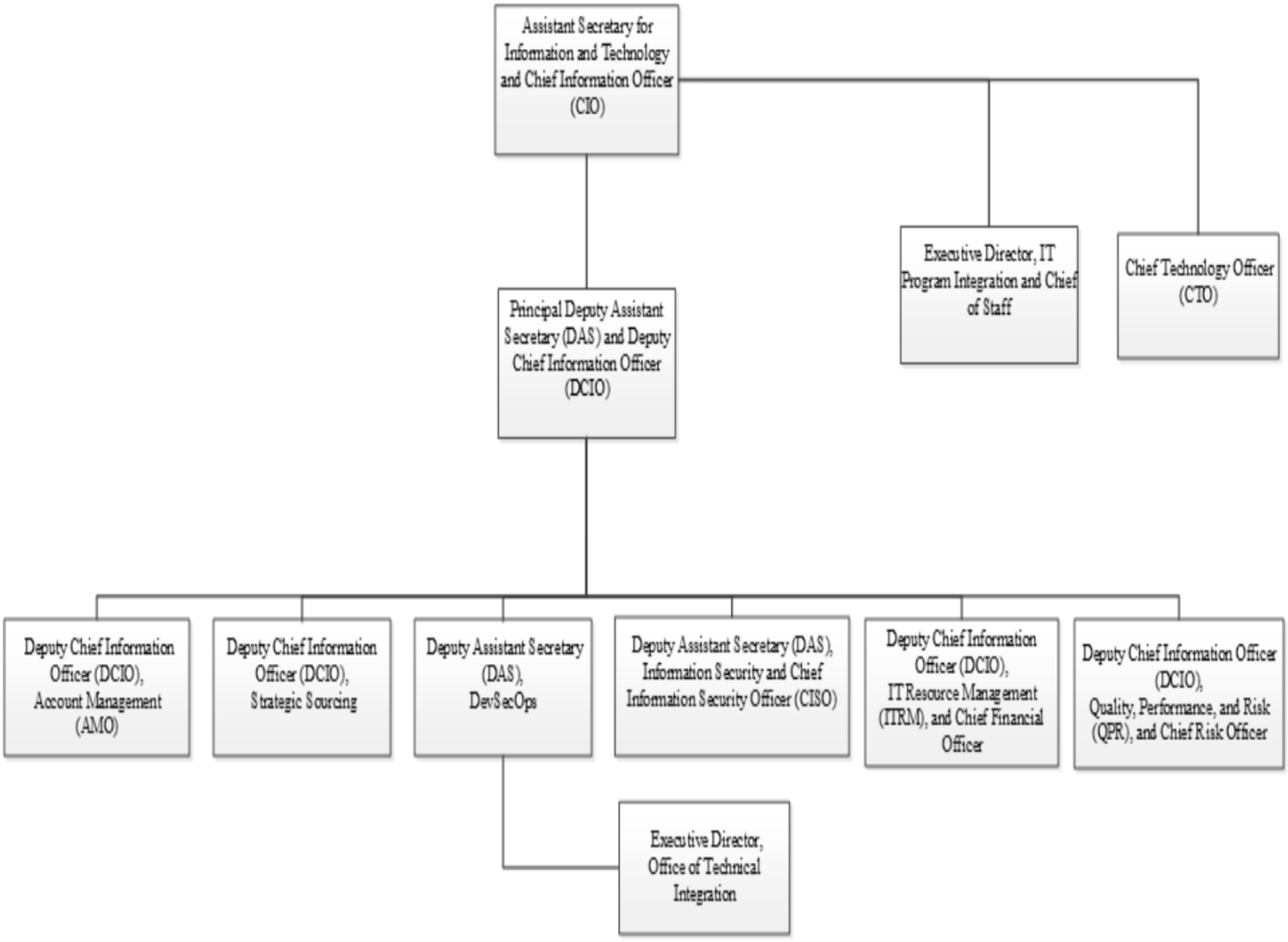
## Appendix Q: IT Systems Appropriations History

($s in thousands)

| | Budget Request to Congress | Appropriation | FTE |
|---|---|---|---|
| **2009** | 2,442,066 | 2,539,391[1/] | 6,710 |
| **2010** | 3,307,000 | 3,307,000 | 6,853 |
| **2011** | 3,307,000 | 2,993,604[2/] | 7,004 |
| **2012** | 3,161,376 | 3,111,376 | 7,311 |
| **2013** | 3,327,444 | 3,323,053 | 7,362 |
| **2014** | 3,683,344 | 3,703,344 | 7,291 |
| **2015** | 3,903,344 | 3,902,278 | 7,419 |
| **2016** | 4,133,363 | 4,133,363 | 7,745 |
| **2017** | 4,278,259 | 4,270,259 | 8,334[3/] |
| **2018** | 4,055,500 | 4,055,500 | 7,899 |
| **2019** | 4,184,571 | 4,103,000 | 8,138 |
| **2020** | 4,343,000 | 4,371,615 | 7,890 |
| **2021** | 4,912,000 | 4,874,500 | 8,251 |
| **2022** | 4,842,800 | 4,842,800 | 8,766 |
| **2023** | 5,782,000 | | 8,993 |

Note: The Information Technology Systems account was established in P.L.109-114
FTE includes Reimbursements
1/Includes $50 million in emergency funding provided in P.L.111-5
2/The 2011 appropriation was $3.141 billion (including ATB rescission) with an additional $147 million in unobligated balances rescinded
3/ FTE includes VACAA FTE funded by the IT Appropriation

# Appendix R: Office of Information Technology Organization Chart



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# Department of Veterans Affairs
# Office of the Assistant Secretary for Management
# www.va.gov/budget