U.S. DEPARTMENT OF VETERANS AFFAIRS

FY 2026 BUDGET SUBMISSION

Medical Programs

Volume 2 of 5

May 2025

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Budget Overview

Mission Statement

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

Budget Request

Discretionary Appropriations

In 2026, the Budget requests discretionary appropriations of $114.9 billion for VA Medical Care, $16.5 billion less than the $131.4 billion requested in discretionary advance appropriations for 2026 in the 2025 President's Budget and enacted in the Full-Year Continuing Appropriations and Extensions Act, 2025 (P.L. 119-4). For 2027, the budget requests $122.3 billion in discretionary advance appropriations for VA medical care. VA Medical Care consists of four appropriation categories: Medical Services, Medical Community Care, Medical Support and Compliance, and Medical Facilities.

Mandatory Appropriations

The Budget also requests appropriations in the Cost of War Toxic Exposures Fund (TEF) to ensure that there is sufficient funding available to cover costs associated with providing health care and benefits to Veterans exposed to environmental hazards. In 2026, the Budget requests $49.8 billion in TEF funding for VA medical care, and in addition, includes a 2027 advance appropriation TEF request of $51.7 billion for medical care. Finally, the Budget includes funds appropriated in section 707 of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022 (P.L. 117-168) for major medical facility leases, of $400 million in 2026 and $450 million in 2027. Combined, the budget includes mandatory funding of $50.2 billion in 2026 and $52.2 billion in 2027 for VA Medical Care.

Medical Care Collections Fund (MCCF)

The Budget reflects estimated medical care collections of $4.6 billion in 2026 and $4.8 billion in 2027.

When combining the requests for mandatory and discretionary appropriations in 2026 and 2027, together with all other funding sources, this Budget Request fulfills the Administration's commitment to provide reliable and timely resources to support the delivery of accessible and high-quality medical services for Veterans.

Summary of Appropriations 2025-2027

The 2026 Medical Care funding request for discretionary and mandatory appropriations combined is $165.1 billion, an increase of $24.4 billion (17.3%) above the 2025 Current Estimate. The 2027 Medical Care funding request for discretionary and mandatory appropriations combined is $174.5 billion, an increase of $9.3 billion (5.6%) above the 2026 request.

2025 Current Estimate
($ in millions)

	Discretionary			Mandatory	
	Appropriations 1/	Proposed Transfers 2/	Sub-total	Appropriations 3/	Grand Total
Medical Services	$71,000	($1,871)	$69,129	$11,884	**$81,013**
Medical Community Care	$20,382	$2,173	$22,555	$15,694	**$38,249**
Medical Support and Compliance	$11,800	($81)	$11,719	$0	**$11,719**
Medical Facilities	$9,549	($2)	$9,548	$200	**$9,748**
Total	**$112,731**	**$219**	**$112,951**	**$27,778**	**$140,729**

2026 Revised Request
($ in millions)

	Discretionary			Mandatory		Change 2026 vs. 2025	
	Appropriations 1/	Proposed Cancellations and Transfers 2/	Sub-total	Appropriations 3/	Grand Total	$	%
Medical Services	$75,039	($17,919)	$57,120	$35,370	**$92,490**	$11,477	14.2%
Medical Community Care	$37,000	($3,000)	$34,000	$14,030	**$48,030**	$9,781	25.6%
Medical Support and Compliance	$12,700	($610)	$12,090	$400	**$12,490**	$771	6.6%
Medical Facilities	$9,700	$2,030	$11,730	$400	**$12,130**	$2,382	24.4%
Total	**$134,439**	**($19,499)**	**$114,940**	**$50,200**	**$165,140**	**$24,411**	**17.3%**

2027 Advance Appropriations Request

($ in millions)

	Discretionary			Mandatory	Grand Total	Change 2027 vs. 2026	
	Appropriations 1/	Proposed Cancellations and Transfers 2/	Sub-total	Appropriations 3/		$	%
Medical Services	$59,858	N/A	$59,858	$36,542	**$96,400**	$3,910	4.2%
Medical Community Care	$38,700	N/A	$38,700	$14,500	**$53,200**	$5,170	10.8%
Medical Support and Compliance	$12,000	N/A	$12,000	$700	**$12,700**	$210	1.7%
Medical Facilities	$11,700	N/A	$11,700	$450	**$12,150**	$20	0.2%
Total	**$122,258**	N/A	**$122,258**	**$52,192**	**$174,450**	**$9,310**	**5.6%**

1/ Discretionary funding includes non-emergency appropriations provided in annual Appropriations Acts and in the 2026 President's Budget. The Disaster Relief Supplement Appropriations Act, 2025, P.L. 118-158 is not included.
2/ 2025 Current Estimate includes proposed transfers among Medical Care and other VA accounts. 2026 Request reflects proposed cancellations and transfers among Medical Care accounts; in Medical Community Care it reflects an annual appropriation adjustment of $3.0 billion and a proposed equivalent cancellation of $3.0 billion to extend the period of availability, for a net discretionary appropriation of $34.0 billion, equal to the enacted advance appropriation. 2027 Advance Appropriations Request does not propose cancellations or transfers. All years are pre-transfer to the joint VA-DoD health care accounts.
3/ Reflects appropriations enacted or requested in the TEF for Medical Care in Medical Services, Medical Community Care, and Medical Support and Compliance; reflects funds appropriated in section 707 of the PACT Act of 2022 (P.L. 117-168) for major medical facility leases in Medical Facilities. Does not include a proposed realignment of unobligated balances amongst Medical Care categories.
Note: Dollars may not add due to rounding in the charts and tables contained in this chapter.

Estimated Obligations Levels 2025-2027

When combining the funding above with all other sources of funds, including medical care collections, unobligated balances, and reimbursements, and after accounting for transfers from the Medical Care accounts to the two joint VA-DoD health care accounts, the 2026 Medical Care estimated total obligations level is $171.2 billion, an increase of $16.9 billion (11%) above the estimated obligations level for 2025. The 2027 Medical Care estimated total obligations level is $179.1 billion, an increase of $7.8 billion (5%) above the 2026 total obligations estimate.

Medical Care Category Obligations (Dollars in thousands)	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Obligations by Category					
Medical Care Discretionary	$122,187,113	$120,543,702	$126,458,457	($1,643,411)	$5,914,755
Medical Care Mandatory:					
Cost of War Toxic Exposures Fund	$31,261,941	$49,800,000	$51,742,000	$18,538,059	$1,942,000
PACT Act, sec. 705	$69,710	$13,260	$12,438	($56,450)	($822)
PACT Act, sec. 707	$464,607	$872,380	$842,332	$407,773	($30,048)
VACAA, sec. 801	$16,682	$0	$0	($16,682)	$0
Veterans Choice Fund	$304,622	$0	$0	($304,622)	$0
Medical Care Mandatory [Subtotal]	$32,117,562	$50,685,640	$52,596,770	$18,568,078	$1,911,130
Medical Care [Total]	$154,304,675	$171,229,342	$179,055,227	$16,924,667	$7,825,885

2026 Advance Appropriations, 2026 Revised Request, and 2027 Advance Appropriations Funding Levels

The table below shows additional detail for discretionary and mandatory appropriations as requested for VA Medical Care in 2026 and 2027 and estimated medical care collections. All amounts are prior to transfer to the VA-DoD joint health care accounts.

Discretionary Appropriations

Dollars in Thousands ($000) Description	2026 Advance Approp. (AA)	2026 Revised Request (RR)	+/- 2026 AA 2026 RR	2027 Advance Approp. (AA)	+/- 2027 AA 2026 RR
Medical Services	$75,039,000	$75,039,000	$0	$59,858,000	($15,181,000)
Medical Support & Compliance	$12,700,000	$12,700,000	$0	$12,000,000	($700,000)
Medical Facilities	$9,700,000	$9,700,000	$0	$11,700,000	$2,000,000
Medical Community Care	$34,000,000	$34,000,000	$0	$38,700,000	$4,700,000
Proposed Cancellation of Advance Appropriations:					
Medical Services	$0	($15,889,000)	($15,889,000)	$0	$15,889,000
Medical Support & Compliance	$0	($610,000)	($610,000)	$0	$610,000
Proposed Transfers Among Medical Care Accounts					
From Medical Services	$0	($2,030,000)	($2,030,000)	$0	$2,030,000
To Medical Facilities	$0	$2,030,000	$2,030,000	$0	($2,030,000)
Discretionary Appropriation [Subtotal]	$131,439,000	$114,940,000	($16,499,000)	$122,258,000	$7,318,000
Discretionary Accounts After Above Proposed Actions:					
Medical Services	*$75,039,000*	*$57,120,000*	*($17,919,000)*	*$59,858,000*	*$2,738,000*
Medical Support & Compliance	*$12,700,000*	*$12,090,000*	*($610,000)*	*$12,000,000*	*($90,000)*
Medical Facilities	*$9,700,000*	*$11,730,000*	*$2,030,000*	*$11,700,000*	*($30,000)*
Medical Community Care	*$34,000,000*	*$34,000,000*	*$0*	*$38,700,000*	*$4,700,000*
Collections 1/	$4,582,049	$4,582,049	$0	$4,754,213	$172,164
Discretionary Appropriations & Collections [Total]	$136,021,049	$119,522,049	($16,499,000)	$127,012,213	$7,490,164

Mandatory Appropriations

Dollars in Thousands ($000) Description	2026 Advance Approp. (AA)	2026 Revised Request (RR)	+/- 2026 AA 2026 RR	2027 Advance Approp. (AA)	+/- 2027 AA 2026 RR
Cost of War Toxic Exposures Fund:					
Medical Services Category	$11,800,000	$35,370,000	$23,570,000	$36,542,000	$1,172,000
Medical Support & Compliance Category	$0	$400,000	$400,000	$700,000	$300,000
Medical Community Care Category	$11,000,000	$14,030,000	$3,030,000	$14,500,000	$470,000
Cost of War Toxic Exposures Fund [Subtotal]	$22,800,000	$49,800,000	$27,000,000	$51,742,000	$1,942,000
Medical Facilities (PACT Act, sec. 707)	$400,000	$400,000	$0	$450,000	$50,000
Mandatory Appropriation [Total]	$23,200,000	$50,200,000	$27,000,000	$52,192,000	$1,992,000

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

Dollars in Thousands ($000) Description	2026 Advance Approp. (AA)	2026 Revised Request (RR)	+/- 2026 AA 2026 RR	2027 Advance Approp. (AA)	+/- 2027 AA 2026 RR
Medical Services Category	$86,839,000	$92,490,000	$5,651,000	$96,400,000	$3,910,000
Medical Support & Compliance Category	$12,700,000	$12,490,000	($210,000)	$12,700,000	$210,000
Medical Facilities Category	$10,100,000	$12,130,000	$2,030,000	$12,150,000	$20,000
Medical Community Care Category	$45,000,000	$48,030,000	$3,030,000	$53,200,000	$5,170,000
Appropriations [Subtotal]	$154,639,000	$165,140,000	$10,501,000	$174,450,000	$9,310,000
Collections 1/	$4,582,049	$4,582,049	$0	$4,754,213	$172,164
Appropriations & Collections [Grand Total]	$159,221,049	$169,722,049	$10,501,000	$179,204,213	$9,482,164

1/ Collections in the 2026 advance appropriation column reflect total collections (including those anticipated to be transferred to the Joint VA-DoD Medical Facility Demonstration Fund in 2026 and 2027) and are set at the current estimate for 2026 rather than the estimate included in the 2025 President's Budget.

Note: Amounts in the table above are prior to transfers to the VA-DoD Health Care Sharing Incentive Fund and to the Joint VA-DoD Medical Facility Demonstration Fund in 2026 and 2027.

Medical Services

- The 2026 Medical Services category estimated total obligations level is $97.0 billion for clinical staff salaries, pharmacy, prosthetics, beneficiary travel and medical equipment. To realign funding among multiple sources, VA proposes a cancellation of $15.9 billion from the 2026 Medical Services advance appropriation and a transfer of $2.0 billion from the 2026 Medical Services advance appropriation to Medical Facilities.

- In 2027 the combination of all funding sources provides for a total estimated obligation level of $99.8 billion, an increase of $2.8 billion over 2026.

Medical Services Category Obligations (Dollars in thousands)	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Obligations by Category					
Medical Services Discretionary	$76,306,543	$61,678,221	$63,290,325	($14,628,322)	$1,612,104
Medical Services Mandatory:					
Cost of War Toxic Exposures Fund	$13,150,227	$35,370,000	$36,542,000	$22,219,773	$1,172,000
VACAA, sec. 801	$2,413	$0	$0	($2,413)	$0
Medical Services Mandatory [Subtotal]	$13,152,640	$35,370,000	$36,542,000	$22,217,360	$1,172,000
Medical Services [Total]	$89,459,183	$97,048,221	$99,832,325	$7,589,038	$2,784,104

Medical Community Care

- The 2026 Medical Community category estimated total obligations level is $48.8 billion for non-VA provided medical claims and grants for state home nursing, domiciliary, and adult day care services.

- In 2027 the combination of all funding sources provides for an overall obligations level of $54.0 billion, an increase of $5.2 billion over 2026.

Medical Community Care Category Obligations (Dollars in thousands)	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Obligations by Category					
Medical Community Care Discretionary	$23,977,662	$34,811,838	$39,537,500	$10,834,176	$4,725,662
Medical Community Care Mandatory:					
Cost of War Toxic Exposures Fund	$17,695,716	$14,030,000	$14,500,000	($3,665,716)	$470,000
Veterans Choice Fund	$304,622	$0	$0	($304,622)	$0
Medical Community Care Mandatory [Subtot	$18,000,338	$14,030,000	$14,500,000	($3,970,338)	$470,000
Medical Community Care [Total]	$41,978,000	$48,841,838	$54,037,500	$6,863,838	$5,195,662

Medical Support and Compliance

- The 2026 Medical Support and Compliance category estimated total obligations level is $12.5 billion for regional and medical facility administrators, including leadership teams; community care claim processing and program management; human capital, contracting, financial, and similar administrative support activities; and police officers. To realign funding among multiple sources, VA proposes a cancellation of $610.0 million from the 2026 Medical Support and Compliance advance appropriation.

- In 2027 the combination of all resources provides for an overall obligations level of $12.7 billion, an increase of $193.8 million over 2026.

Medical Support and Compliance Category Obligations (Dollars in thousands)	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Obligations by Category					
Medical Support and Compliance Discretiona	$12,088,421	$12,104,878	$11,998,662	$16,457	($106,216)
Medical Support and Compliance Mandatory:					
Cost of War Toxic Exposures Fund	$415,998	$400,000	$700,000	($15,998)	$300,000
VACAA, sec. 801	$1,582	$0	$0	($1,582)	$0
Medical Support and Compliance Mandatory	$417,580	$400,000	$700,000	($17,580)	$300,000
Medical Support and Compliance [Total]	$12,506,001	$12,504,878	$12,698,662	($1,123)	$193,784

Medical Facilities

- The 2026 Medical Facilities category estimated total obligations level is $12.8 billion for facility maintenance, leasing, and energy costs. To realign funding among multiple sources, VA proposes to transfer $2.0 billion to Medical Facilities from the 2026 Medical Services advance appropriation.

- In 2027 the combination of all resources provides for an overall obligations level of $12.5 billion, a decrease of $347.7 million from 2026.

Medical Facilities Category Obligations (Dollars in thousands)	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Obligations by Category					
Medical Facilities Discretionary	$9,814,487	$11,948,765	$11,631,970	$2,134,278	($316,795)
Medical Facilities Mandatory:					
PACT Act, sec. 705	$69,710	$13,260	$12,438	($56,450)	($822)
PACT Act, sec. 707	$464,607	$872,380	$842,332	$407,773	($30,048)
VACAA, sec. 801	$12,687	$0	$0	($12,687)	$0
Medical Facilities Mandatory [Subtotal]	$547,004	$885,640	$854,770	$338,636	($30,870)
Medical Facilities [Total]	$10,361,491	$12,834,405	$12,486,740	$2,472,914	($347,665)

Key VA Priorities

VA committed to providing the best possible care and benefits to Veterans, families, caregivers, and survivors. In 2024, VA provided more than 127.5 million health care appointments between direct care and community care, a 6% increase over the previous year's record volume of 119.8

million appointments. VA also decreased wait times while delivering more care to Veterans, caregivers, and survivors. The 2026 request supports the following VA health care priorities that are foundational in every decision supporting The Veterans Health Administration's (VHA) long-term goals.

Pain and Opioid Management Program
The 2026 Budget includes a significant investment to address the disproportionate impacts from opioid-related adverse events faced by Veterans. The Budget includes $231.5 million for the Pain and Opioid Management Program in support of subtitle A, Opioid Therapy and Pain Management, as enacted in the Jason Simcakoski Memorial and Promise Act (Jason's Law). Providing Veterans access to pain management services within VA is crucial as pain is the most frequently identified risk factor for Veteran suicide and remains predictive of suicide even after accounting for psychiatric comorbidities. The Budget reflects the critical need for increased funding to ensure that VHA can continue to provide comprehensive pain management services and supports to Veterans, addressing both increasing demand and expanding service reach.

Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)
VA proposes to expedite access to MH RRTP to enhance access to lifesaving residential treatment through new access standards and improved operational efficiency. This goal is to ensure Veterans have timely access to critical mental health and substance use disorder (SUD) treatment, whether in VA facilities or in the community. The 2026 budget includes $1.5 billion in Medical Community Care funding for MH RRTP care in the community, resulting in higher total 2026 budget request for Medical Community Care. At the same time, VA will increase its internal capacity to deliver high quality residential care, which is supported by the 2026 SUD budget request, which will support the hiring of staff and opening of new beds to allow for efficient utilization of and expedited access to existing VA residential treatment programs. The 2026 SUD budget request also supports full implementation of a regional centralized admissions screening process for MH RRTP to improve overall operational efficiency and the quality of screening procedures. These investments will help get Veterans the care they need when they need it and ultimately save lives.

Substance Use Disorder Initiative
The 2026 budget supports efforts to ensure Veterans have access to the full range of SUD treatment from the least intensive services, such as peer specialists and mutual support, to the most intensive services such as inpatient withdrawal management. This Budget also supports VA's MH RRTP, which provide a significant portion of intensive services for Veterans with SUDs and co-occurring conditions with specialized programs for the treatment of SUD and a requirement that all MH RRTPs address co-occurring SUD. The budget Request of $232.3 million supports key efforts in the Administration, including efforts to reduce the number of overdose fatalities with a focus on fentanyl; increase evidence-based treatment including medications for opioid use disorder; strengthen peer recovery support; expand access to naloxone; increase the availability of drug test strips; and raise awareness about overdose prevention through educational campaigns and evidence-based prevention programs. Combined, the MH RRTP expansion and SUD budget requests support increased access to MH RRTP care in VA or, when needed, in the community, consistent with timeframes expected by Veterans and their families. VA anticipates opening three MH RRTP programs in 2026 and two in 2027 to provide Veterans with more access to comprehensive treatment and rehabilitation services.

Mental Health and Preventing Veteran Suicide
Funding for mental health treatment, including suicide prevention treatment, is estimated to be $18.9 billion in 2026, and the Budget includes $697.8 million for suicide prevention outreach programs. Suicide is a complex issue with no single cause or solution. Addressing suicide requires a comprehensive approach that focuses on community and clinical interventions, beyond individual care, that focuses exclusively on mental health. Maintaining the integrity of VA's mental health care system is vitally important, but it is not enough. We know some Veterans may not receive any health care services from VA, which highlights VA alone cannot end Veteran suicide. This requires a Nationwide effort.

The Budget proposes to extend and expand the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP) to enable an anticipated 125 grantees in 45 states, Washington, DC, American Samoa, Guam, and Puerto Rico to provide suicide prevention outreach and education across the Nation to targeted at-risk populations with a projection of serving 14,000 eligible individuals and their family members with direct services.

In alignment with VA's National Strategy for Preventing Veteran Suicide, SSG Fox SPGP assists in further implementing a public health approach that blends community-based prevention with evidence-based clinical strategies through community efforts. VHA's national strategy provides a framework for coordinating lanes of effort across the Nation and ensures coordination of efforts with other Federal agencies, state and local governments, health care systems, academic affiliates, and community organizations with the shared goal to reduce suicide rates among Veterans, and all U.S. citizens. In this mission, VHA's untiring and relentless efforts to engage needs, innovate strategies, and serve the welfare of others will continue to serve as a model and central foundation for the nation as to how to best address suicide as a national public health issue.

Rural Health
The Budget includes robust investment of $342.0 million in funding to support the VHA Office of Rural Health, which conducts, coordinates, promotes, and disseminates research on issues that affect Veterans who reside in rural communities. The funding also supports operation of five Veterans Rural Health Resource Centers that identify, formulate, and develop best practices to enhance the delivery of health care to Veterans living in rural areas. These efforts support rural Veterans, who receive more of their health care from VHA. Of the 4.4 million rural Veterans, 61% are enrolled in VHA, compared to 41% of 13.8 million urban Veterans.

Veterans Homeless Programs
The Budget request of $3.5 billion for Veterans Homeless Programs is a decisive step forward in fulfilling the President's commitment to end and prevent Veteran homelessness. It reflects best practices informed by years of measurable outcomes and empowers VA to meet today's urgent needs with proven, community-based solutions. By sustaining over 850 grantee partnerships Nationwide, supporting more than 11,000 transitional beds, serving Veterans in every state, and integrating housing with health, legal, and employment services, this Budget ensures no Veteran is left behind. Additionally, VA efforts to end Veteran homeless will include a new appropriation account, the Bridging Rental Assistance for Veteran Empowerment Program, described in a separate chapter in Volume 2.

The Budget strengthens the full continuum of VA's homeless response across critical operational pillars: effective outreach, immediate interim housing, permanent housing, clinical treatment, legal services, employment, long-term housing stability, upstream prevention, ongoing optimization, transparency, and accountability. Importantly, some services are inclusive of Veteran families, ensuring that spouses, children, and other dependents are supported as full participants in the housing journey.

The request reflects both long-standing commitments and evolving realities, ensuring that VA is prepared to address increasing demand in homelessness assistance resources, reach more unsheltered and vulnerable Veterans, and sustain the remarkable 52% decline in Veteran homelessness over the past 15 years. Notably, Veterans are the only homeless subpopulation that have achieved such a significant reduction, and VA will continue its efforts to prevent and end Veteran homelessness.

Women's Health
The Budget requests $252.6 million for women's health programs to proactively and strategically expand women's specific services for the fastest growing cohort of users of VA health care. The women Veteran population is the fastest growing demographic within the VA and is anticipated to grow from 800,000 women Veterans enrolled in VA health care in 2020, to over 1.2 million by 2030. The Budget supports implementation of high-quality, comprehensive women's health care at all sites of care across VA to provide services to meet the unique needs of women Veterans. The Budget includes funding support for frontline women's health providers and staff, clinical equipment needs, hands-on training in clinical skills, and maternity care coordination.

Access to Care
Since the enactment of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 (P.L. 15-182), VA significantly expanded Veteran access to health care. The Veterans Community Care Program, launched on June 6, 2019, is a cornerstone of this effort. As of March 2025, VHA provided over 39.6 million community care referrals to more than 5.4 million Veterans since its launch.

In addition, the enactment of the PACT Act enabled VA to expand its reach and provide health care to even more Veterans. Since the PACT Act was signed into law in August 2022, nearly 900,000 additional Veterans enrolled in VA health care. The combined results of empowering Veterans to choose providers authorized by the MISSION Act, in conjunction with the expanded enrollment following enactment of the PACT Act, resulted in VA delivering 78.8 million appointments in VA facilities along with 53.6 million appointments in the community since August of 2022. This unprecedented enrollment and care delivery growth resulted in the greatest number of Veterans receiving the world-class health experiences they earned.

Quality of Care
VA is a trusted Veteran health care provider, furnishing high-quality care that surpasses our private sector counterparts. Veterans notice the difference. In 2024, VA internal survey data showed an unprecedented trust rate of 92% in the Department's health service delivery, surpassing our private sector counterparts. Nearly 70% of VA hospitals received 4 or 5 stars in the Overall Hospital Quality Star Ratings by the Centers for Medicare and Medicaid Services (CMS), compared to 41%

of non-VA hospitals. This achievement highlights VHA's opportunity to further enhance care for Veterans, including through close collaboration with community providers.

Methods Used to Formulate the Budget Request

The VA uses three actuarial models to support formulation of much 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 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 (SB), Foreign Medical Program (FMP), and Children of Women Vietnam Veterans (CWVV)), and some components for the PCAFC program (caregiver travel, VA oversight, administrative salaries, and contracts). Detailed information on the three actuarial models can be found in the Actuarial Model Projections Chapter.

The EHCPM supports approximately 86% of the VA medical care budget. The EHCPM, which was first developed in 1998, is a sophisticated health care demand projection model that uses actuarial methods and approaches to project Veteran demand for VA health care. The EHCPM projects enrollment, utilization, and expenditures for the enrolled Veteran population in more than 140 categories of health care services 20 years into the future.

Key Drivers of Growth in Projected Resource Requirements

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

Historically, growth in cost requirements to provide care to enrolled Veterans is 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 cost growth; however, their impact varies significantly by the type of health care service. An assumption that VA's level of management of health care delivery will improve over time reduces the cost of providing care to enrollees.

PACT Act became Public Law No 117-168 in August of 2022, expanding benefits for Veterans exposed to certain toxins in the course of their military service, with a focus on Gulf War era Veterans as well as new groups of Vietnam Veterans who were exposed to Agent Orange. The 2024 EHCPM projects enrollment and workload for title 1 of the PACT Act, which changes enrollment eligibility timelines, as well as titles 3 and 4 of the PACT Act, which expand eligibility based on conditions presumed to be associated with hazardous exposures. The PACT Act affects VHA

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

Since the implementation of the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act in June 2019, significant community care growth has been observed for many services, and enrollees with enhanced community care access due to these provisions had been responsible for a larger percentage of that growth. Community care growth from 2022-23, no longer appears to be related to drive-time eligibility status to the same degree that was observed from 2019-22, suggesting that the impact of drive-time provisions on total community care growth was tapering. This data suggests that the implementation of this MISSION Act provision reached a stable level and continuing community care growth is being driven by different factors, such as VA productivity/capacity or VA provider referral patterns. Therefore, no additional MISSION Act drive-time adjustments were included in the 2024 EHCPM.

In 2023, the COVID-19 pandemic largely settled into the endemic stage with relatively little continued impact on changes in health care utilization patterns. For VHA, enrollee health care workload broadly returned to pre-pandemic expected levels or settled at a "new normal" that reflects a longer-term shift in health care workload. For some specific service areas, particularly mental health care, long term services and supports (LTSS), and inpatient rehabilitation care, the effects of COVID-19 deferred care remain and it is expected that there will be continued recovery of health care workload in 2024 and beyond. However, these impacts are no longer considered to be key drivers of costs.

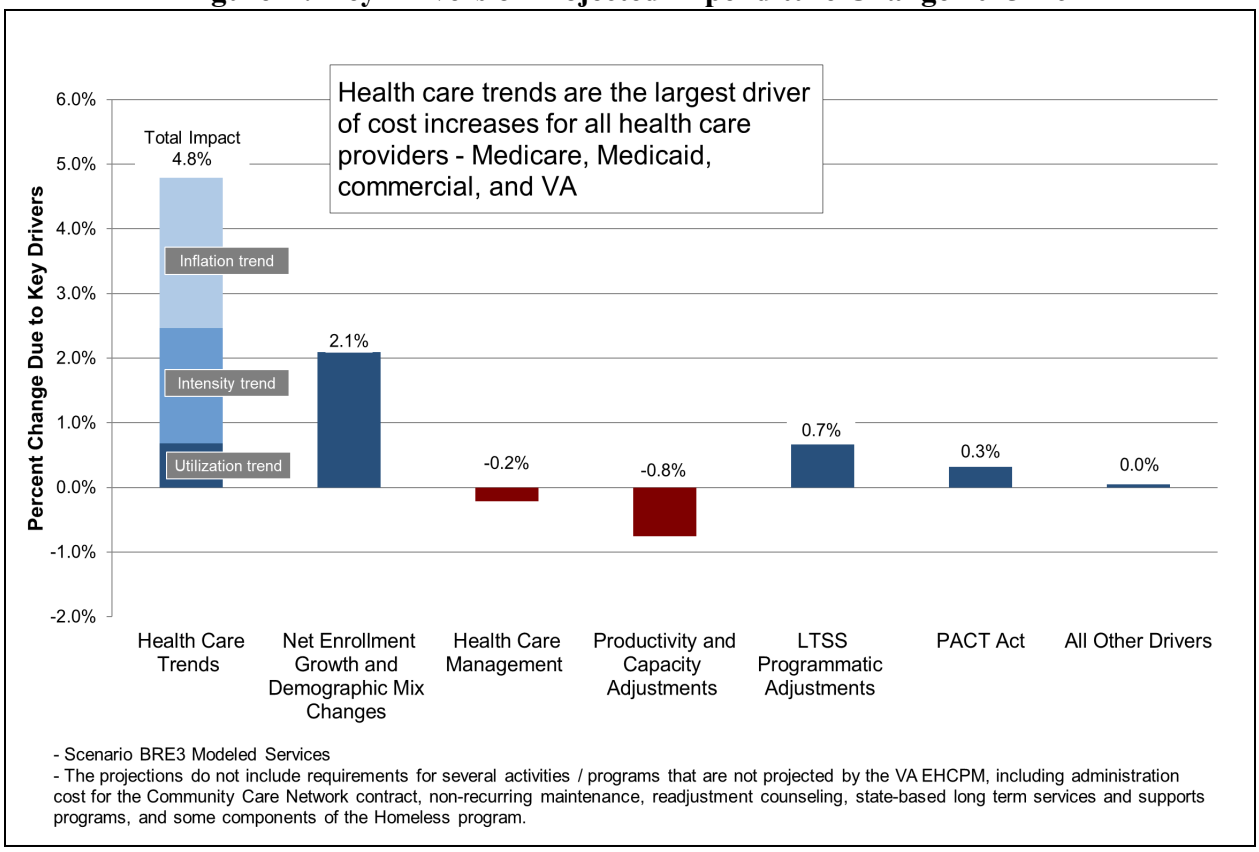
VHA staffing levels continued to increase throughout the COVID-19 pandemic and recovery period, while direct care workload largely remained below 2019 levels through 2022. This led to a significant increase in direct care unit costs over the course of the pandemic. Although the annual growth in unit costs returned much closer to historical levels, the higher costs persisted in 2023. In response to these changes, VHA is assuming that staffing levels will remain flat from 2025-27, which is expected to reduce VHA capacity to provide for the growing demand for VA direct care services. VHA observed an improvement in productivity rates of the direct care system, suggesting that more workload may be provided by the fixed staffing level. Productivity improvements consistent with recent historical experience are assumed to continue through 2027. These changes are assumed to be independent of total enrollee reliance on VA, so that projected changes in VHA capacity are modeled with complementary changes in community care utilization. Only inpatient and ambulatory services available in both VA direct and community care settings are impacted by these staffing-level and productivity changes.

Historical growth for many LTSS programs accelerated in the past few fiscal years and significantly exceeded growth that would be expected based on demographic changes and other factors that would typically be captured in the EHCPM, particularly for Home and Community Based Services. The 2024 EHCPM includes an increased projected workload of certain services beyond demographic trends to continue through the budget years.

Figure A quantifies the key drivers of the projected increase in cost requirements for 2025 for all modeled services. Health care trends, net enrollment growth and demographic mix changes, and

health care management and their impact on the resources required to provide health care to enrolled Veterans are discussed in detail in the following sections. PACT Act, LTSS programmatic adjustments, and all other drivers are discussed throughout the Actuarial Model chapter.

Figure A. Key Drivers of Projected Expenditure Change 2025–26



- Scenario BRE3 Modeled Services
- 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

In March 2025, the VA began its department-wide review of its mission, organization, and structure to identify and eliminate waste, to reduce burdensome processes and bureaucracy, and to ensure that taxpayer dollars will be invested wisely to support our Veterans. While the VA anticipates increased efficiencies, there are no savings assumptions from personnel reductions resulting from the Department-wide review in the 2026 Budget.

Table: Medical Care Appropriations by Account Category

(with Medical Care Collections)
($ in thousands)

		2025		2026	2027		
	2024 Actual	Budget Estimate	Current Estimate	**Revised Request**	**Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Appropriations							
Discretionary Appropriations 1/							
Annual Discretionary Appropriations:							
Medical Services (0160)	$69,018,045	$71,000,000	$71,000,000	$75,039,000	$59,858,000	$4,039,000	($15,181,000)
Medical Support and Compliance (0152)	$10,750,000	$11,800,000	$11,800,000	$12,700,000	$12,000,000	$900,000	($700,000)
Medical Facilities (0162/1124XN)	$8,949,485	$9,400,000	$9,549,485	$9,700,000	$11,700,000	$150,515	$2,000,000
Medical Community Care (0140)	$30,342,023	$20,382,000	$20,382,000	$34,000,000	$38,700,000	$13,618,000	$4,700,000
P.L. 118-158, American Relief Act, 2025 (Hurricane Supplemental)							
Medical Services (0160)	$0	$0	$19,258	$0	$0	($19,258)	$0
Medical Support and Compliance (0152)	$0	$0	$330	$0	$0	($330)	$0
Medical Facilities (0162)	$0	$0	$41,660	$0	$0	($41,660)	$0
Proposed Cancellation of Advance Appropriations							
Medical Services (0160)	$0	$0	$0	($15,889,000)	$0	($15,889,000)	$15,889,000
Medical Support and Compliance (0152)	$0	$0	$0	($610,000)	$0	($610,000)	$610,000
Proposed Transfers Among VA Accounts							
Medical and Prosthetic Research (0161)	$0	$0	$8,318	$0	$0	($8,318)	$0
Board of Veterans' Appeals (1122)	$0	$0	$9,870	$0	$0	($9,870)	$0
General Administration (0142)	$0	$0	$26,901	$0	$0	($26,901)	$0
Information Technology Systems (0167)	$0	$0	$174,034	$0	$0	($174,034)	$0
Discretionary Appropriations [Subtotal]	**$119,059,553**	**$112,582,000**	**$113,011,856**	**$114,940,000**	**$122,258,000**	**$1,928,144**	**$7,318,000**
MCCF Collections 2/	$3,847,492	$4,389,678	$4,389,676	$4,582,049	$4,754,213	$192,372	$172,165
Discretionary Appropriations, Transformational Fund, and Collections [Total]	**$122,907,045**	**$116,971,678**	**$117,401,532**	**$119,522,049**	**$127,012,213**	**$2,120,516**	**$7,490,165**
Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act) for Medical Care 3/							
Section 707:							
Medical Facilities (0162)	$100,000	$200,000	$200,000	$400,000	$450,000	$200,000	$50,000
Section 707 [Subtotal]	**$100,000**	**$200,000**	**$200,000**	**$400,000**	**$450,000**	**$200,000**	**$50,000**
PACT Act Mandatory Appropriations [Subtotal]	**$100,000**	**$200,000**	**$200,000**	**$400,000**	**$450,000**	**$200,000**	**$50,000**
Cost of War Toxic Exposures Fund for Medical Care (1126) 4/							
Medical Services Category	$9,525,428	$11,683,896	$11,883,896	$35,370,000	$36,542,000	$23,486,104	$1,172,000
Medical Support and Compliance Category	$850,000	$0	$0	$400,000	$700,000	$400,000	$300,000
Medical Community Care Category	$6,801,538	$9,770,646	$15,694,178	$14,030,000	$14,500,000	($1,664,178)	$470,000
Appropriations [Subtotal]	**$17,176,966**	**$21,454,542**	**$27,578,074**	**$49,800,000**	**$51,742,000**	**$22,221,926**	**$1,942,000**
Mandatory Appropriations [Total]	**$17,276,966**	**$21,654,542**	**$27,778,074**	**$50,200,000**	**$52,192,000**	**$22,421,926**	**$1,992,000**
Discretionary and Mandatory Appropriations (Including Discretionary Collections and Transformational Fund) [Grand Total]	**$140,184,011**	**$138,626,220**	**$145,179,606**	**$169,722,049**	**$179,204,213**	**$24,542,442**	**$9,482,165**

1/ Amounts are reflected before transfers to the two joint VA-DoD health care accounts. Please see the Table: Funding Crosswalks 2024-2027 later in this chapter for all proposed transfers from the Medical Care discretionary accounts.
2/ Includes the portion of MCCF collections actual, or anticipated to be, transferred to the Joint VA-DoD Medical Facility Demonstration Fund, in support of the Captain James A. Lovell Federal Health Care Center (JALFHCC).
3/ Includes only TEF and PACT Act funding in the four medical care categories. For more information on all VA accounts, please see Volume 1 and the Budget in Brief.

Table: Medical Care Obligations by Discretionary and Mandatory Accounts

($ in thousands)

	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Obligations 1/							
Discretionary Obligations:							
Regular Obligations:							
Medical Services (0160)	$70,654,421	$72,462,629	$76,306,543	$61,678,221	$63,290,325	($14,628,322)	$1,612,104
Medical Support and Compliance (0152)	$10,583,838	$12,073,523	$12,088,421	$12,104,878	$11,998,662	$16,457	($106,216)
Medical Facilities (0162/1124XN)	$8,811,982	$9,159,785	$9,814,487	$11,948,765	$11,631,970	$2,134,278	($316,795)
Medical Community Care (0140)	$31,754,225	$29,634,284	$23,977,662	$34,811,838	$39,537,500	$10,834,176	$4,725,662
Discretionary Obligations [Subtotal]	**$121,804,466**	**$123,330,221**	**$122,187,113**	**$120,543,702**	**$126,458,457**	**($1,643,411)**	**$5,914,755**
Mandatory Obligations:							
Veterans Choice Act Section 801 2/							
Medical Services (0160)	$6,408	$4,980	$2,413	$0	$0	($2,413)	$0
Medical Support and Compliance (0152)	$2,052	$256	$1,582	$0	$0	($1,582)	$0
Medical Facilities (0162)	$709	$0	$12,687	$0	$0	($12,687)	$0
Veterans Choice Act Section 801 [Subtotal]	**$9,169**	**$5,236**	**$16,682**	**$0**	**$0**	**($16,682)**	**$0**
Veterans Choice Fund (0172) [Subtotal] 3/	**$297**	**$304,826**	**$304,622**	**$0**	**$0**	**($304,622)**	**$0**
American Rescue Plan Act Mandatory Obligations for Medical Care 4/							
Section 8007:							
Medical Services (0160)	$5						
Copayment Reimbursement (5287)	$0						
Medical Community Care (0140)	$0						
Section 8007 [Subtotal]	**$5**						
Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act) for Medical Care 5/							
Section 705:							
Medical Facilities (0162)	$28,331	$40,608	$69,710	$13,260	$12,438	($56,450)	($822)
Section 705 [Subtotal]	**$28,331**	$40,608	$69,710	$13,260	$12,438	**($56,450)**	**($822)**
Section 707:							
Medical Facilities (0162)	$70,933	$808,558	$464,607	$872,380	$842,332	$407,773	($30,048)
Section 707 [Subtotal]	**$70,933**	**$808,558**	**$464,607**	**$872,380**	**$842,332**	**$407,773**	**($30,048)**
Cost of War Toxic Exposures Fund for Medical Care (1126):							
Medical Services Category	$11,705,716	$14,029,971	$13,150,227	$35,370,000	$36,542,000	$22,219,773	$1,172,000
Medical Support and Compliance Category	$847,650	$0	$415,998	$400,000	$700,000	($15,998)	$300,000
Medical Community Care Category	$4,800,000	$11,000,000	$17,695,716	$14,030,000	$14,500,000	($3,665,716)	$470,000
Obligations [Subtotal]	**$17,353,366**	**$25,029,971**	**$31,261,941**	**$49,800,000**	**$51,742,000**	**$18,538,059**	**$1,942,000**
Mandatory Obligations [Subtotal]	**$17,462,101**	**$26,189,199**	**$32,117,562**	**$50,685,640**	**$52,596,770**	**$18,568,078**	**$1,911,130**
Discretionary and Mandatory Obligations [Total]	**$139,266,567**	**$149,519,420**	**$154,304,675**	**$171,229,342**	**$179,055,227**	**$16,924,667**	**$7,825,885**

1/ Obligations after transfers, reimbursements, changes in unobligated balances, and lapse.
2/ Includes only 801, Veterans Choice Act, mandatory obligations in the medical care categories.
3/ Includes only 802, Veterans Choice Act, mandatory obligations in the medical care categories.
4/ Includes only ARP obligations in the medical care categories.
5/ Includes only TEF and PACT Act funding in the four medical care categories. For more information on all VA accounts, please see Volume 1 and the Budget in Brief.

Table: Discretionary and Mandatory Obligations and FTE by Account

($ in thousands)

	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary and Mandatory Obligations by Category							
Medical Services	$82,366,550	$86,497,580	$89,459,183	$97,048,221	$99,832,325	$7,589,038	$2,784,104
Medical Support and Compliance	$11,433,540	$12,073,779	$12,506,001	$12,504,878	$12,698,662	($1,123)	$193,784
Medical Facilities	$8,911,955	$10,008,951	$10,361,491	$12,834,405	$12,486,740	$2,472,914	($347,665)
Community Care	$36,554,522	$40,939,110	$41,978,000	$48,841,838	$54,037,500	$6,863,838	$5,195,662
Obligations [Grand Total]	**$139,266,567**	**$149,519,420**	**$154,304,675**	**$171,229,342**	**$179,055,227**	**$16,924,667**	**$7,825,885**
Full-Time Equivalent (FTE)							
Discretionary Funding							
Medical Services	222,328	290,658	236,063	120,858	114,840	(115,205)	(6,018)
Medical Support and Compliance	60,815	66,658	64,326	64,440	62,562	114	(1,878)
Medical Facilities	27,487	25,839	26,523	26,523	26,523	0	0
Discretionary Funding [Subtotal]	**310,630**	**383,155**	**326,912**	**211,821**	**203,925**	**(115,091)**	**(7,896)**
Mandatory Funding							
Cost of War Toxic Exposures Fund - Medical Services	81,717	0	66,400	181,616	187,634	115,216	6,018
Cost of War Toxic Exposures Fund - Medical Support and Compliance	6,846	0	2,666	2,563	4,441		
Veterans Choice Act, Sec. 801, FTE 1/	34	31	22	0	0	(22)	0
Veterans Choice Act, Sec. 802, FTE	0	0	0	0	0	0	0
Mandatory Funding [Subtotal]	**88,597**	**31**	**69,088**	**184,179**	**192,075**	**115,194**	**6,018**
FTE [Total]	**399,227**	**383,186**	**396,000**	**396,000**	**396,000**	**0**	**0**

1/ FTEs previously funded by section 801, Veterans Choice Act, 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.

Medical Care Obligations by Program

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

Table: Medical Care Total Obligations by Program

(Includes All Funding Sources)
($ in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Health Care Services:							
Ambulatory Care 1/	$51,724,145	$57,583,114	$57,801,406	$65,265,003	$65,148,184	$7,463,597	($116,819)
Dental Care	$2,778,552	$2,975,647	$3,072,287	$3,291,314	$3,486,234	$219,027	$194,920
Inpatient Care	$25,019,535	$25,973,867	$26,423,674	$27,630,181	$28,909,124	$1,206,507	$1,278,943
Mental Health Care 2/	$15,689,848	$17,053,718	$16,731,830	$18,886,195	$19,529,518	$2,154,365	$643,323
Pharmacy	$13,749,510	$14,880,740	$16,097,397	$18,283,001	$20,495,385	$2,185,604	$2,212,384
Prosthetic and Sensory Aids Services	$5,011,980	$5,343,218	$5,653,512	$6,241,476	$6,842,716	$587,964	$601,240
Rehabilitation Care	$1,411,181	$1,461,684	$1,452,097	$1,459,454	$1,454,245	$7,357	($5,209)
Health Care Services [Subtotal]	**$115,384,751**	**$125,271,988**	**$127,232,203**	**$141,056,624**	**$145,865,406**	**$13,824,421**	**$4,808,782**
Long-Term Services & Supports (LTSS):							
Institutional LTSS							
VA Community Living Centers (VA CLC)	$5,478,763	$5,470,160	$5,551,534	$5,619,357	$5,718,300	$67,823	$98,943
Community Nursing Home	$2,192,137	$2,078,128	$2,628,921	$2,788,370	$2,954,399	$159,449	$166,029
State Home Nursing	$1,731,909	$1,745,012	$1,945,841	$2,206,275	$2,503,751	$260,434	$297,476
State Home Domiciliary	$48,717	$62,662	$52,784	$57,086	$61,739	$4,302	$4,653
Institutional LTSS [Subtotal]	$9,451,526	$9,355,962	$10,179,080	$10,671,088	$11,238,189	$492,008	$567,101
Non-Institutional LTSS							
State Home Adult Day Care	$3,299	$1,986	$2,816	$3,046	$3,294	$230	$248
Other Non-Institutional LTSS	$8,162,207	$7,678,612	$9,624,333	$11,185,658	$12,647,664	$1,561,325	$1,462,006
Non-Institutional LTSS [Subtotal]	$8,165,506	$7,680,598	$9,627,149	$11,188,704	$12,650,958	$1,561,555	$1,462,254
LTSS [Subtotal]	**$17,617,032**	**$17,036,560**	**$19,806,229**	**$21,859,792**	**$23,889,147**	**$2,053,563**	**$2,029,355**
Other Health Care Programs:							
Camp Lejeune Families (P.L. 112-154)	$2,021	$4,606	$2,088	$2,172	$2,257	$84	$85
Caregiver Support Program 3/	$2,157,001	$2,913,000	$2,676,438	$3,264,938	$3,590,212	$588,500	$325,274
CHAMPVA & Other Dependent Prgs. 4/	$2,516,424	$2,898,351	$3,229,526	$3,726,092	$4,185,941	$496,566	$459,849
Homeless Program Grants 5/	$1,019,462	$983,946	$935,890	$935,890	$1,131,841	$0	$195,951
PACT Act § 705 Enhanced-Use Leases	$25,976	$40,608	$69,710	$13,260	$12,438	($56,450)	($822)
Readjustment Counseling	$324,504	$370,361	$352,591	$370,574	$377,985	$17,983	$7,411
Other Health Care Programs [Subtotal]	**$6,045,388**	**$7,210,872**	**$7,266,243**	**$8,312,926**	**$9,300,674**	**$1,046,683**	**$987,748**
Obligations [Subtotal]	**$139,047,171**	**$149,519,420**	**$154,304,675**	**$171,229,342**	**$179,055,227**	**$16,924,667**	**$7,825,885**
Recoveries of prior year paid & unpaid obligations	$219,396	$0	$0	$0	$0	$0	$0
Obligations [Total]	$139,266,567	$149,519,420	$154,304,675	$171,229,342	$179,055,227	$16,924,667	$7,825,885

1/ The Ambulatory Care category includes cost adjustements made outside of the Enrollee Health Care Projection Model (EHCPM) to account for certain programmatic funding levels. All other service lines projected by the EHCPM are inflated by their respective EHCPM growth rates. (See the Actuarial Models Projections chapter for more information about the EHCPM.)

2/ 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).

3/ Includes stipend costs, respite care, mental health care, CHAMPVA benefits, and program administration for the Caregiver Support Program.

4/ Excludes CHAMPVA benefits provided in the Caregiver Support Program.

5/ Includes projected grant costs for the Grant and Per Diem (GPD) and Supportive Services for Low Income Veterans (SSVF). The 2025 Budget Estimate also includes Legal Services for Veterans (LSV) programs.

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

Table: Programs Included in Medical Care Obligations

(Includes All Funding Sources)
($ in thousands)

Description	2024 Actual	2025 Budget Estimate 1/2/5/	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Medical Care Programs: (Included Above)							
Activations	$507,740	$623,359	$495,427	$653,863	$588,567	$158,436	($65,296)
Artifical Intelligence (Medical Care) 1/	$9,142	N/A	$32,762	$33,209	$33,873	$447	$664
Blind Rehabilitation Treatment	$166,718	$193,232	$180,185	$193,415	$206,909	$13,230	$13,494
Education & Training	$2,825,730	$3,048,609	$2,965,216	$3,132,370	$3,195,017	$167,154	$62,647
Food Security Program Office	$3,180	$16,985	$1,985	$17,526	$17,877	$15,541	$351
Health Professionals Educational Assistance Program 2/	$252,516	$369,277	$277,412	$310,647	$316,860	$33,235	$6,213
Indian Health Service/THP/UIO Reimbursement	$31,571	$37,924	$37,924	$41,717	$44,637	$3,793	$2,920
Intimate Partner Violence program	$29,833	$31,373	$30,862	$31,997	$32,637	$1,135	$640
Leases	$1,248,894	$2,263,759	$1,567,811	$2,490,726	$3,849,195	$922,915	$1,358,469
Mental Health Topics:							
Opioid Prevention:							
Treatment Modalities	$422,673	$458,562	$436,620	$454,086	$471,794	$17,466	$17,708
Pain and Opioid Management Program (includes Jason's Law) 3/	$216,939	$221,518	$200,592	$231,518	$236,148	$30,926	$4,630
Substance Use Disorder Initiative	$151,809	$263,881	$186,439	$232,287	$236,933	$45,848	$4,646
Suicide Prevention:							
Medical Treatment	$2,610,319	$2,667,713	$2,833,552	$2,953,958	$3,091,520	$120,406	$137,562
Outreach Programs	$560,328	$582,554	$579,888	$697,760	$713,418	$117,872	$15,658
National Center for Posttraumatic Stress Disorder 4/	$45,273	$42,000	$41,274	$41,274	$42,099	$0	$825
National Veterans Sports Program	$28,652	$30,542	$28,211	$29,072	$29,653	$861	$581
Neurology Centers of Excellence							
Epilepsy	$21,773	$23,871	$23,047	$25,000	$25,500	$1,953	$500
Headaches	$16,913	$22,092	$22,125	$24,000	$24,480	$1,875	$480
Multiple Sclerosis 2/	$3,080	$5,300	$5,992	$6,500	$6,630	$508	$130
Parkinson's Disease Research, Education and Clinical Centers 4/	$10,926	$10,200	$13,367	$14,500	$14,790	$1,133	$290
Non-Recurring Maintenance (Lands & Structure only) 5/	$2,345,955	$2,027,648	$2,626,563	$4,841,400	$3,040,204	$2,214,837	($1,801,196)
Precision Oncology Initiative	$186,440	$215,433	$214,159	$251,458	$256,487	$37,299	$5,029
Rural Health	$315,090	$337,455	$301,968	$342,455	$349,304	$40,487	$6,849
Spinal Cord Injury Treatment	$853,619	$1,081,569	$919,255	$991,961	$1,073,001	$72,706	$81,040
Supply Chain Management 2/	$88,175	$148,866	$91,840	$121,964	$124,403	$30,124	$2,439
Telehealth:							
Home & Clinic Based Telehealth	$5,136,964	$5,958,100	$5,587,400	$5,894,465	$6,191,287	$307,065	$296,822
Office of Connected Care Program	$331,682	$439,920	$422,409	$461,569	$470,800	$39,160	$9,231
Veterans Childcare Assistance Program 6/	$3,650	$18,619	$2,681	$21,656	$22,089	$18,975	$433
Veterans Homelessness Programs	$3,230,974	$3,210,276	$3,321,338	$3,459,121	$3,801,724	$137,783	$342,603
Whole Health	$86,524	$119,289	$107,271	$116,107	$118,429	$8,836	$2,322

Note: certain program funding levels presented in this table overlap and therefore cannot be added together to determine overall funding amounts.

1/ Information not previously displayed in the 2025 Congressional Justification.

2/ Excludes administrative costs in all years; these costs had been previously displayed in the 2025 Congressional Justification.

3/ Includes the pain management, opioid safety, and prescription drug monitoring program costs of Jason's Law. Excludes Whole Health Patient Centered Care and Patient Advocacy cost components of Jason's Law.

4/ 2024 actuals are represented by allocated amounts rather than obligations.

5/ See the Medical Facilities chapter for the 2024 actual that includes supporting full-time equivalent (FTE) employees and contract-related costs pertaining to non-recurring maintenance, which are not included in this table.

6/ The Veterans Childcare Assistance Program had been previously included in the Women's Health Program Office budget.

The obligations shown in the table below reflect the cost of total health care services provided to each designated Veteran population. However, some programs overlap and therefore cannot be

added together to determine the overall funding amount. For example, the cost of health care services provided to a female Gulf War Veteran would appear in both the Gulf War and Women Veterans Health Care funding lines.

Table: Veteran Population Obligations in Medical Care Obligations

(Includes All Funding Sources)

($ in thousands)

Description	2024 Actual	2025 Budget Estimate 1/	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
AIDS/HIV Program	$2,071,519	$2,062,108	$2,229,162	$2,392,232	$2,565,319	$163,070	$173,087
Health Outcomes Military Exposures (HOME):							
Gulf War Program	$8,303,100	$10,106,231	$9,838,985	$11,629,869	$13,757,280	$1,790,884	$2,127,410
OEF/OIF/OND/OIR	$16,720,576	$19,580,291	$19,676,251	$22,987,809	$26,688,949	$3,311,558	$3,701,139
Program Office	$68,783	$82,838	$75,696	$77,402	$78,950	$1,706	$1,548
Traumatic Brain Injury and Polytrauma System of Care:							
OEF/OIF/OND/OIR	$347,135	$359,553	$389,334	$438,564	$494,258	$49,230	$55,693
All Veteran Care	$1,135,159	$1,285,527	$1,240,863	$1,364,583	$1,498,219	$123,720	$133,635
Women Veterans Health Care:							
Program Office & Initiative Budget 1/	$98,130	$245,041	$177,583	$252,626	$257,679	$75,043	$5,053
Women Veterans-Specific Care	$986,081	$1,059,784	$1,145,627	$1,322,781	$1,529,716	$177,154	$206,935
All Care	$12,999,081	$13,657,684	$15,111,958	$17,641,692	$20,602,823	$2,529,734	$2,961,131

1/ The Women's Health Program Office budget no longer includes the Veterans Childcare Assistance Program.

Medical Care Collections Fund

VA estimates medical care collections of $4.6 billion in 2026 and $4.8 billion in 2027.

Medical Care Collections Fund[1]
($ in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2024-2025	+/- 2025-2026
Medical Care Collections Fund:							
First Party Payments:							
1st Party Other Co-payments	$137,053	$117,873	$117,873	$114,352	$113,508	($3,521)	($844)
Community Care Collections 1st Party	$17,104	$33,520	$33,520	$32,253	$32,015	($1,267)	($238)
Long-Term Care Co-Payments	$1,582	$1,712	$1,712	$1,705	$1,745	($7)	$40
Pharmacy Co-payments	$362,998	$376,251	$376,251	$412,993	$438,359	$36,742	$25,367
First Party Payments [Subtotal]	**$518,737**	**$529,356**	**$529,355**	**$561,302**	**$585,626**	**$31,947**	**$24,324**
Third Party Payments:							
3rd Party Insurance Collections	$2,543,920	$2,778,378	$2,778,379	$2,886,787	$2,982,420	$108,408	$95,633
3rd Party RX Insurance	$149,020	$183,717	$183,717	$220,500	$238,806	$36,783	$18,306
Community Care Collections 3rd Party	$580,686	$868,227	$868,227	$881,747	$915,985	$13,520	$34,238
Third Party Payments [Subtotal]	**$3,273,626**	**$3,830,322**	**$3,830,322**	**$3,989,034**	**$4,137,211**	**$158,712**	**$148,177**
Other MCCF:							
Comp. & Pension Living Expenses	$2,442	$1,506	$1,506	$1,506	$1,506	$0	$0
Comp. Work Therapy Collections	$47,575	$24,622	$24,622	$24,622	$24,622	$0	$0
Enhanced-Use Revenue	$822	$672	$672	$672	$672	$0	$0
Parking Fees	$4,290	$3,200	$3,200	$3,200	$3,200	($0)	$0
Other MCCF [Subtotal]	**$55,129**	**$30,000**	**$30,000**	**$30,000**	**$30,000**	**$0**	**$0**
Total Collections	**$3,847,492**	**$4,389,678**	**$4,389,676**	**$4,580,336**	**$4,752,837**	**$190,659**	**$172,502**
JALFHCC amount (included above)	$10,957	$17,336	$16,860	$17,336	$17,837	$476	$501

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

VA Staffing

The Budget assumes an FTE level of 396,000 in both 2026 and 2027. The 2026 Budget assumes there will be no pay increase for civilian employees in calendar years 2026 and 2027, and 2026 and 2027 FTE levels are consistent with the levels as of March 2025 by account and type. In March 2025, VA began its Department-wide review of its mission, organization, and structure to identify and eliminate waste, to reduce burdensome processes and bureaucracy, and to ensure that taxpayer dollars will be invested wisely to support Veterans. While VA anticipates increased efficiencies, there are no savings assumptions in the 2026 Budget.

Table: Employment Summary (FTE)

Account	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Medical Services	222,328	290,658	236,063	120,858	114,840	(115,205)	(6,018)
Medical Community Care	0	0	0	0	0	0	0
Medical Support and Compliance	60,815	66,658	64,326	64,440	62,562	114	(1,878)
Medical Facilities	27,487	25,839	26,523	26,523	26,523	0	0
Total Discretionary Medical Care	310,630	383,155	326,912	211,821	203,925	(115,091)	(7,896)

	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Cost of War Toxic Exposures Fund - Medical Services	81,717	0	66,400	181,616	187,634	115,216	6,018
Cost of War Toxic Exposures Fund - Medical Support and Compliance	6,846	0	2,666	2,563	4,441	(103)	1,878
Veterans Choice Act, Sec. 801, FTE 1/	34	31	22	0	0	(22)	0
Veterans Choice Act, Sec. 802, FTE	0	0	0	0	0	0	0
Total Mandatory Medical Care	88,597	31	69,088	184,179	192,075	115,091	7,896

1/ 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.

Grand Total Medical Care FTE	**399,227**	**383,186**	**396,000**	**396,000**	**396,000**	**0**	**0**

Table: FTE by Type Medical Care

Account	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary:							
Physicians	13,467	25,099	19,762	10,548	10,066	(9,214)	(482)
Dentists	1,438	1,402	1,140	590	561	(550)	(29)
Registered Nurses	44,007	76,302	62,562	33,705	32,198	(28,857)	(1,507)
LP Nurse/LV Nurse/Nurse Assistant	15,044	28,281	21,460	11,020	10,475	(10,440)	(545)
Non-Physician Providers	13,272	20,391	17,050	8,935	8,511	(8,115)	(424)
Health Technicians/Allied Health	82,226	89,281	73,639	38,346	36,502	(35,293)	(1,844)
Wage Board/Purchase and Hire	29,287	27,920	27,085	24,987	24,877	(2,098)	(110)
All Other 1/	111,889	114,479	104,214	83,690	80,734	(20,524)	(2,956)
SubTotal	310,630	383,155	326,912	211,821	203,924	(115,091)	(7,897)
Mandatory:							
Physicians	11,734	14	5,317	14,531	15,013	9,214	482
Dentists	0	0	317	867	896	550	29
Registered Nurses	37,089	0	17,630	46,487	47,994	28,857	1,507
LP Nurse/LV Nurse/Nurse Assistant	13,365	0	6,017	16,457	17,002	10,440	545
Non-Physician Providers	8,017	2	4,676	12,791	13,215	8,115	424
Health Technicians/Allied Health	11,643	2	20,339	55,632	57,476	35,293	1,844
Wage Board/Purchase and Hire	0	0	1,210	3,308	3,418	2,098	110
All Other 1/	6,749	13	13,582	34,106	37,062	20,524	2,956
Subtotal	88,597	31	69,088	184,179	192,076	115,091	7,897
Total:							
Physicians	25,201	25,113	25,079	25,079	25,079	0	0
Dentists	1,438	1,402	1,457	1,457	1,457	0	0
Registered Nurses	81,096	76,302	80,192	80,192	80,192	0	0
LP Nurse/LV Nurse/Nurse Assistant	28,409	28,281	27,477	27,477	27,477	0	0
Non-Physician Providers	21,289	20,393	21,726	21,726	21,726	0	0
Health Technicians/Allied Health	93,869	89,283	93,978	93,978	93,978	0	0
Wage Board/Purchase and Hire	29,287	27,920	28,295	28,295	28,295	0	0
All Other 1/	118,638	114,492	117,796	117,796	117,796	0	0
Total	399,227	383,186	396,000	396,000	396,000	0	0

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

Table: FTE by Type Medical Services

Account	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary:							
Physicians	12,634	24,309	18,884	9,670	9,188	(9,214)	(482)
Dentists	1,428	1,390	1,127	577	548	(550)	(29)
Registered Nurses	39,658	72,253	59,127	30,270	28,763	(28,857)	(1,507)
LP Nurse/LV Nurse/Nurse Assistant	14,964	28,195	21,391	10,951	10,406	(10,440)	(545)
Non-Physician Providers	12,837	20,053	16,627	8,512	8,088	(8,115)	(424)
Health Technicians/Allied Health	80,836	87,961	72,314	37,021	35,177	(35,293)	(1,844)
Wage Board/Purchase and Hire	5,685	5,655	4,300	2,202	2,092	(2,098)	(110)
All Other 1/	54,286	50,842	42,293	21,655	20,577	(20,638)	(1,078)
Subtotal	222,328	290,658	236,063	120,858	114,839	(115,205)	(6,019)
Mandatory:							
Physicians	11,710	14	5,317	14,531	15,013	9,214	482
Dentists	0	0	317	867	896	550	29
Registered Nurses	36,996	0	16,630	45,487	46,994	28,857	1,507
LP Nurse/LV Nurse/Nurse Assistant	13,365	0	6,017	16,457	17,002	10,440	545
Non-Physician Providers	8,017	2	4,676	12,791	13,215	8,115	424
Health Technicians/Allied Health	11,643	2	20,339	55,632	57,476	35,293	1,844
Wage Board/Purchase and Hire	0	0	1,210	3,308	3,418	2,098	110
All Other 1/	7	13	11,905	32,543	33,621	20,638	1,078
Subtotal	81,738	31	66,411	181,616	187,635	115,205	6,019
Total:							
Physicians	24,344	24,323	24,201	24,201	24,201	0	0
Dentists	1,428	1,390	1,444	1,444	1,444	0	0
Registered Nurses	76,654	72,253	75,757	75,757	75,757	0	0
LP Nurse/LV Nurse/Nurse Assistant	28,329	28,195	27,408	27,408	27,408	0	0
Non-Physician Providers	20,854	20,055	21,303	21,303	21,303	0	0
Health Technicians/Allied Health	92,479	87,963	92,653	92,653	92,653	0	0
Wage Board/Purchase and Hire	5,685	5,655	5,510	5,510	5,510	0	0
All Other 1/	54,293	50,855	54,198	54,198	54,198	0	0
Total	304,066	290,689	302,474	302,474	302,474	0	0

1/ The All Other FTE occupation types include chaplains, medical support assistants, biomedical equipment support specialists, privacy officers, and so forth.

Table: FTE by Type Medical Support and Compliance

Account	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary:							
Physicians	833	790	878	878	878	0	0
Dentists	10	12	13	13	13	0	0
Registered Nurses	4,344	4,049	3,435	3,435	3,435	0	0
LP Nurse/LV Nurse/Nurse Assistant	80	86	69	69	69	0	0
Non-Physician Providers	435	338	423	423	423	0	0
Health Technicians/Allied Health	1,248	1,166	1,192	1,192	1,192	0	0
Wage Board/Purchase and Hire	1,347	1,305	1,363	1,363	1,363	0	0
All Other 1/	52,518	58,912	56,953	57,067	55,189	114	(1,878)
SubTotal	60,815	66,658	64,326	64,440	62,562	114	(1,878)
Mandatory:							
Physicians	24	0	0	0	0	0	0
Dentists	0	0	0	0	0	0	0
Registered Nurses	93	0	1,000	1,000	1,000	0	0
LP Nurse/LV Nurse/Nurse Assistant	0	0	0	0	0	0	0
Non-Physician Providers	0	0	0	0	0	0	0
Health Technicians/Allied Health	0	0	0	0	0	0	0
Wage Board/Purchase and Hire	0	0	0	0	0	0	0
All Other 1/	6,742	0	1,677	1,563	3,441	(114)	1,878
Subtotal	6,859	0	2,677	2,563	4,441	(114)	1,878
Total:							
Physicians	857	790	878	878	878	0	0
Dentists	10	12	13	13	13	0	0
Registered Nurses	4,437	4,049	4,435	4,435	4,435	0	0
LP Nurse/LV Nurse/Nurse Assistant	80	86	69	69	69	0	0
Non-Physician Providers	435	338	423	423	423	0	0
Health Technicians/Allied Health	1,248	1,166	1,192	1,192	1,192	0	0
Wage Board/Purchase and Hire	1,347	1,305	1,363	1,363	1,363	0	0
All Other 1/	59,260	58,912	58,630	58,630	58,630	0	0
Total	67,674	66,658	67,003	67,003	67,003	0	0

1/ The All Other category includes administrative support clerks, administrative specialists, police, personnel management specialists, management and program analysts, medical records clerks and technicians, budget and fiscal staff, contract administrators, supply technicians, medical support assistants, and other staff that are necessary for the effective operations of VHA Medical Support and Compliance.

Table: FTE by Type Medical Facilities

Account	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary:							
Physicians	0	0	0	0	0	0	0
Dentists	0	0	0	0	0	0	0
Registered Nurses	5	0	0	0	0	0	0
LP Nurse/LV Nurse/Nurse Assistant	0	0	0	0	0	0	0
Non-Physician Providers	0	0	0	0	0	0	0
Health Technicians/Allied Health	142	154	133	133	133	0	0
Wage Board/Purchase and Hire	22,255	20,960	21,422	21,422	21,422	0	0
All Other 1/	5,085	4,725	4,968	4,968	4,968	0	0
SubTotal	27,487	25,839	26,523	26,523	26,523	0	0
Veterans Choice Act, Sec. 801, FTE	0	0	0	0	0	0	0
Total	27,487	25,839	26,523	26,523	26,523	0	0

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

Table: Medical Care FTE by Grade 2024 Actuals
(Includes All Funding Sources)

	2024			
General Schedule Grade or Title 38	Medical Services Category	Medical Support & Compliance Category	Medical Facilities Category	Medical Care
Senior Executive Service	0	193	0	193
Title 38	118,404	5,654	4	124,062
15 or Higher	352	726	3	1,081
14	2,372	2,772	161	5,305
13	16,355	6,638	622	23,615
12	24,608	8,915	1,299	34,822
11	21,957	7,694	1,227	30,878
10	2,344	297	72	2,713
9	13,205	8,567	656	22,428
8	7,826	2,628	57	10,511
7	16,573	9,111	576	26,260
6	50,131	7,357	393	57,881
5	21,027	4,088	224	25,339
4	2,046	1,487	34	3,567
3	905	144	81	1,130
2	32	22	1	55
1	4	1	1	6
Wage Board	5,925	1,380	22,076	29,381
FTE Total	304,066	67,674	27,487	399,227

Table: Medical Care FTE by OPM Occupational Groups 2024 Actual

(Includes All Funding Sources)

Office of Personnel Management (OPM) Occupational Groups and Families	2024 Medical Services Category	2024 Medical Support & Compliance Category	2024 Medical Facilities Category	2024 Total Medical Care
0000 –Miscellaneous Occupations Group	929	6,444	1,085	8,458
0100 – Social Science, Psychology, And Welfare Group	34,043	642	4	34,689
0200 – Human Resources Management Group	5	9,641	0	9,646
0300 – General Administrative, Clerical, And Office Services Group	12,681	15,141	1,073	28,895
0500 – Accounting And Budget Group	379	5,707	43	6,129
0600 –Medical, Hospital, Dental, And Public Health Group	244,792	16,245	602	261,639
0800 – Engineering And Architecture Group	538	223	1,804	2,565
0900 – Legal And Kindred Group	233	1,154	0	1,387
1000 – Information And Arts Group	237	681	227	1,145
1100 – Business And Industry Group	1,113	3,853	52	5,018
1300 – Physical Sciences Group	31	63	29	123
1400 – Library And Archives Group	70	54	0	124
1500 –Mathematical Sciences Group	41	84	0	125
1600 – Equipment, Facilities, And Services Group	1,479	30	211	1,720
1700 – Education Group	850	996	39	1,885
1800 – Inspection, Investigation, Enforcement, And Compliance Group	1	123	0	124
2000 – Supply Group	359	4,291	49	4,699
2100 – Transportation Group	258	893	188	1,339
2600 – Electronic Equipment Installation And Maintenance Family	13	0	289	302
2800 – Electrical Installation And Maintenance Family	41	2	885	928
3500 – General Services And Support Work Family	109	11	11,648	11,768
4100 – Painting And Paperhanging Family	12	5	482	499
4200 – Plumbing And Pipefitting Family	7	2	714	723
4600 –Wood Work Family	13	4	509	526
4700 – General Maintenance And Operations Work Family	11	9	2,560	2,580
4800 – General Equipment Maintenance Family	38	17	139	194
5000 – Plant And Animal Work Family	8	3	261	272
5300 – Industrial Equipment Maintenance Family1	18	1	963	982
5400 – Industrial Equipment Operation Family	5	0	764	769
5700 – Transportation/Mobile Equipment Operation Family	99	287	1,730	2,116
6900 –Warehousing And Stock Handling Family	33	1,020	91	1,144
7300 – Laundry, Dry Cleaning, And Pressing Family	0	0	795	795
7400 – Food Preparation And Serving Family	5,417	0	1	5,418
OPM Occupational Groups and Families Not Covered Above1/	203	48	250	501
Grand Total	304,066	67,674	27,487	399,227

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

Veteran Patient Workload

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

The Budget expands health care services for the Nation's Veterans while building an integrated system of care that both strengthens services within the VA and improves VA's and Veterans' relationships with community providers, consistent with the MISSION Act. The 2026 request supports the treatment of 7.7 million patients and 162.6 million outpatient visits.

Table: Unique Patients and Enrollees

Unique Patients 1/

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Priority Levels							
1-6	5,642,274	5,556,227	5,903,603	6,095,978	6,279,362	192,375	183,384
7-8	815,805	788,930	736,222	675,290	619,818	(60,932)	(55,472)
Veterans [Subtotal]	6,458,079	6,345,157	6,639,825	**6,771,268**	**6,899,180**	131,443	127,912
Non-Veterans [Subtotal] 2/	868,682	949,871	894,344	930,648	950,443	36,304	19,795
Unique Patients [Total]	**7,326,761**	**7,295,028**	**7,534,168**	**7,701,915**	**7,849,623**	**167,747**	**147,707**

Unique Enrollees 3/

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Priority Levels							
1-6	7,678,263	7,678,671	7,833,911	7,942,175	8,034,857	108,264	92,682
7-8	1,474,241	1,415,360	1,370,567	1,290,454	1,226,502	(80,113)	(63,952)
Unique Enrollees [Total]	**9,152,504**	**9,094,031**	**9,204,479**	**9,232,629**	**9,261,360**	**28,151**	**28,730**

Users as a Percent of Enrollees

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Priority Levels							
1-6	73.5%	72.4%	75.4%	**76.8%**	**78.2%**	1.4%	1.4%
7-8	55.3%	55.7%	53.7%	**52.3%**	**50.5%**	-1.4%	-1.8%
Unique Enrollees [Total]	**70.6%**	**69.8%**	**72.1%**	**73.3%**	**74.5%**	1.2%	1.2%

1/ Unique patients are uniquely identified individuals treated by VA, or whose treatment is paid for by VA, during the year. The count of projected unique patients for 2025-2027 are primarily based on trends from fiscal years 2022 through 2024.

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 and flu vaccinations.

3/ Like unique patients, the count of unique enrollees represents the count of Veterans enrolled for Veteran's health care sometime during the year, regardless of whether they received VA care as patients during that year. The source for the count of unique enrollees is the EHCPM and is based primarily on the ADUSH Enrollment File. It represents a calibrated count of enrollees that includes Veterans who are officially enrolled in VHA and also Veterans who received care in the last two years but are not officially enrolled. The unique count includes Veterans defined, based on the above, as an enrollee at any time during the year and may include Veterans who were not enrolled for the full year due to timing of new enrollment or mortality. The unique enrollment counts do not include Veterans in Priority Group 8, sub-priorities (e) and (g).

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

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Outpatient Visits (000):							
Ambulatory Care:							
Staff	94,008	89,078	95,601	97,081	98,384	1,480	1,303
Community Care	49,906	52,125	57,123	64,147	70,862	7,024	6,715
Subtotal	143,914	141,203	152,724	161,228	169,246	8,504	8,018
Readjustment Counseling:							
Visits	1,262	1,412	1,299	1,338	1,378	39	40
Grand Total	145,176	142,615	154,023	162,566	170,624	8,543	8,058
Patients Treated:							
Inpatient Care	879,848	800,720	889,126	910,618	935,233	21,492	24,615
Rehabilitation Care	12,326	13,850	12,827	13,265	13,125	438	(140)
Mental Health Care Total	177,316	207,158	185,693	195,419	204,771	9,726	9,352
Acute Psychiatry	*60,386*	*56,003*	*57,027*	*56,501*	*55,374*	*(526)*	*(1,127)*
Community Care Hospital (Psych)	*82,907*	*112,568*	*90,944*	*97,657*	*106,681*	*6,713*	*9,024*
Residential Recovery Programs	*34,023*	*38,587*	*37,722*	*41,261*	*42,716*	*3,539*	*1,455*
Long-Term Care: Institutional	139,262	130,713	165,382	183,171	201,585	17,789	18,414
Subacute Care	1,273	1,048	1,288	1,387	1,438	99	51
Inpatient Facilities, Total	1,210,025	1,153,489	1,254,316	1,303,860	1,356,152	49,544	52,292
Average Daily Census:							
Inpatient Care	14,309	13,932	14,452	14,673	14,898	221	225
Rehabilitation Care	966	1,007	992	1,008	995	16	(13)
Mental Health Care Total	7,311	8,333	7,871	8,047	8,223	176	176
Acute Psychiatry	*1,654*	*1,530*	*1,562*	*1,491*	*1,425*	*(71)*	*(66)*
Community Care Hospital (Psych)	*1,435*	*1,966*	*1,628*	*1,798*	*1,959*	*170*	*161*
Residential Recovery Programs	*4,222*	*4,837*	*4,681*	*4,758*	*4,839*	*77*	*81*
Long-Term Care: Institutional	38,198	41,208	42,713	44,357	46,155	1,644	1,798
Subacute Care	44	44	46	48	51	2	3
Inpatient Facilities, Total	60,828	64,524	66,074	68,133	70,322	2,059	2,189
Length of Stay:							
Inpatient Care	6.0	6.4	5.9	5.9	5.8	0.0	(0.1)
Rehabilitation Care	28.7	26.5	28.2	27.7	27.7	(0.5)	0.0
Mental Health Care	15.1	14.7	15.5	15.0	14.7	(0.5)	(0.3)
Long-Term Care: Institutional	100.4	115.1	94.3	88.4	83.6	(5.9)	(4.8)
Subacute Care	12.7	15.3	13.0	12.6	12.9	(0.4)	0.3
Dental Procedures (000)	8,551	8,407	9,086	9,485	9,802	399	317
CHAMPVA/FMP/Spina Bifida:							
Unique Patients	534,278	546,041	566,843	59,902	631,518	(506,941)	571,616

The following table provides the VA EHCPM workload output used to support this Budget Request categorized by health care setting. Global RVUs are defined in the narrative following this table. Note: Home-based LTSS care workload is in All Other Workload in this table whereas in the preceding table, home-based LTSS visits are included in Outpatient Visits.

Table: Global Relative Value Units (RVU) for VA and Non-VA Facilities

Description	2024 Projection	2025 Projection	2026 Projection	2027 Projection	+/- 2025-2026	+/- 2026-2027
VA System Delivered:						
Outpatient	439,211,826	446,507,565	453,512,966	459,657,584	7,005,401	6,144,618
Inpatient	195,173,164	194,018,220	193,607,051	193,251,653	(411,169)	(355,398)
All other workload	413,881,821	455,677,817	492,187,943	528,119,780	36,510,126	35,931,837
VA System Delivered [Subtotal]	**1,048,266,811**	**1,096,203,602**	**1,139,307,960**	**1,181,029,017**	43,104,358	41,721,057
Community Delivered:						
Outpatient	293,256,114	326,704,108	355,396,145	385,443,947	28,692,037	30,047,802
Inpatient	244,703,772	260,424,216	274,439,167	289,486,992	14,014,951	15,047,825
All other workload	177,258,573	206,004,323	226,919,421	245,934,008	20,915,098	19,014,587
Community Delivered [Subtotal]	**715,218,459**	**793,132,647**	**856,754,733**	**920,864,947**	63,622,086	64,110,214
Total VA Delivered:						
Outpatient	732,467,940	773,211,673	808,909,111	845,101,531	35,697,438	36,192,420
Inpatient	439,876,936	454,442,436	468,046,218	482,738,645	13,603,782	14,692,427
All other workload	591,140,394	661,682,140	719,107,364	774,053,788	57,425,224	54,946,424
Total Delivered [Subtotal]	**1,763,485,270**	**1,889,336,249**	**1,996,062,693**	**2,101,893,964**	106,726,444	105,831,271

The EHCPM Global RVUs encompass both the VA EHCPM Global Total RVUs and VA EHCPM Global Work RVUs. They build on the CMS Resource-Based Relative Value Scale (RBRVS) to cover services and resources that are not assigned CMS RBRVS RVUs. The EHCPM Global Work and Practice RVUs are equal to the CMS RBRVS RVUs for services paid under the CMS RBRVS. The EHCPM Global RVUs produce RVUs consistent with the CMS RBRVS RVUs for other medical services where CMS does not assign RVUs.

The EHCPM Global Total RVUs cover all workload and costs associated with VA health care, including professional services, inpatient and outpatient facility care, lab services, prescription drugs and other pharmacy costs, prosthetics and other medical devices, services not covered by Medicare, VA's special programs, and LTSS.

Veteran Enrollment Priority Group Definitions[1/]

Priority Group	Eligibility Criteria is defined based on 38 C.F.R. § 17.36(b)/2
1	Veterans with a singular or combined rating of 50% or greater based on one or more service-connected disabilities or unemployability and Veterans awarded the Medal of Honor.
2	Veterans with a singular or combined rating of 30% or 40% based on one or more service-connected disabilities.
3	Veterans who are former prisoners of war.
	Veterans awarded the Purple Heart.

Priority Group	Eligibility Criteria is defined based on 38 C.F.R. § 17.36(b)/2
	Veterans with a singular or combined disability rating of 10% or 20% based on one or more service-connected disabilities.
	Veterans who were discharged or released from active military service for a disability incurred or aggravated in the line of duty.
	Veterans who receive disability compensation under 38 U.S.C. § 1151.
	Veterans whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. § 1151, but only to the extent that such Veterans' continuing eligibility for that care is provided for in the judgment or settlement described in 38 U.S.C. § 1151.
	Veterans whose entitlement to disability compensation is suspended because of the receipt of military retired pay.
	Veterans receiving compensation at the 10% rating level based on multiple non-compensable service-connected disabilities that clearly interfere with normal employability.
4	Veterans who receive increased pension based on their need for regular aid and attendance or by reason of being permanently housebound.
	Veterans who are determined to be catastrophically disabled by the Chief of Staff (or equivalent clinical official) at the VA facility where they were examined.
5	Veterans not covered by Priority Groups 1-4 who are determined to be unable to defray the expenses of necessary care under 38 U.S.C. § 1722(a).
6	Veterans of World War II.
	Veterans solely seeking care for a disorder associated with exposure to a toxic substance or radiation, for a disorder associated with service in the Southwest Asia theater of operations during the Gulf War (the period between August 2, 1990, and November 11, 1998), or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as provided and limited in 38 U.S.C. § 1710(e).
	Camp Lejeune Veterans pursuant to 38 C.F.R. § 17.400.
	Veterans with 0% service-connected disabilities who are nevertheless compensated, including Veterans receiving compensation for inactive tuberculosis.

Priority Group	Eligibility Criteria is defined based on 38 C.F.R. § 17.36(b)/2
7	Veterans who agree to pay to the United States the applicable copayment determined under 38 U.S.C. § 1710(f) and 1710(g) if their income for the previous year constitutes low income under the geographical income limits established by the Department of Housing and Urban Development for the FY that ended on September 30 of the previous calendar year.
8	Veterans not included in Priority Groups 4 or 7, who are eligible for care only if they agree to pay to the United States the applicable copayment determined under 38 U.S.C. § 1710(f) and 1710(g). Specifically, the following subcategories are eligible to be enrolled:
	(i) Non-compensable 0% service-connected Veterans who were in an enrolled status on January 17, 2003, or who are moved from a higher Priority Group or subcategory due to no longer being eligible for inclusion in such Priority Group or subcategory and who subsequently do not request disenrollment.
	(ii) Non-compensable 0% service-connected Veterans not included in clause (i) of this section and whose income is not greater than 10% more than the income that would permit their enrollment in Priority Group 5 or Priority Group 7, whichever is higher.
	(iii) Nonservice-connected Veterans who were in an enrolled status on January 17, 2003, or who are moved from a higher Priority Group or subcategory due to no longer being eligible for inclusion in such Priority Group or subcategory and who subsequently do not request disenrollment.
	(iv) Nonservice-connected Veterans not included in clause (iii) of this section and whose income is not greater than 10% more than the income that would permit their enrollment in Priority Group 5 or Priority Group 7, whichever is higher.

1/ Data Source: **eCFR :: 38 CFR Part 17 - Enrollment Provisions and Medical Benefits Package**

Non-Veteran Definitions

Most of the individuals who receive medical attention from the VA health care system are individuals who have completed military service and are considered to hold Veteran status. However, a small number of patients who are treated within the VA health care system are not Veterans. This non-Veteran population consists of individuals such as VA employees, the widows and family of Veterans, or active military. Their patient records indicate a non-Veteran status. These non-Veteran categories include the CHAMPVA, FMP, SB and CWVV. NOTE: For additional information on CHAMPVA, FMP, SB and CWVV, please see the Medical Community Care chapter.

VHA Facility Non-Veterans

Non-Veteran	Includes all non-Veterans who are seen only in a VA inpatient setting.
Non-Veteran: Catastrophic Disability	A 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 U.S. 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 with the DoD.
Non-Veteran: TRICARE/CHAMPUS	TRICARE is a program for Active-Duty personnel and certain other DoD beneficiaries.

Note: For additional information on CHAMPVA, FMP, SB and CWVV, see the Medical Community Care Chapter in Volume II.

Table: Unique Patients /1

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Priority Levels							
Priority 1	3,302,159	3,323,484	3,663,437	3,927,737	4,179,595	264,300	251,858
Priority 2	438,558	426,691	428,569	419,879	411,840	(8,690)	(8,039)
Priority 3	756,509	756,615	739,113	728,956	720,285	(10,157)	(8,671)
Priority 4	110,883	102,086	100,273	90,891	82,092	(9,382)	(8,799)
Priority 5	773,059	698,083	704,176	648,458	595,182	(55,717)	(53,277)
Priority 6	261,106	249,268	268,036	280,057	290,369	12,021	10,312
Priority 7	208,341	217,779	198,993	193,184	188,525	(5,809)	(4,660)
Priority 8	607,464	571,151	537,228	482,105	431,293	(55,123)	(50,813)
Veterans [Subtotal]	6,458,079	6,345,157	6,639,825	**6,771,268**	**6,899,180**	131,443	127,912
Non-Veterans 2/							
CHAMPVA/SB/FMP/CW Non-Vet (less CITI)	523,774	535,209	556,529	589,251	622,291	32,722	33,040
N : Non-Veteran	3,096	3,586	2,933	2,441	1,981	(492)	(460)
N0: Non-Vet, Catastro Disab	2,568	36	2,884	3,990	5,064	1,106	1,074
N1: Non-Vet, CHAMPVA Ben	10,504	10,832	10,314	9,751	9,227	(563)	(524)
N2: Non-Vet, Collaterals	130,208	125,881	134,321	146,539	157,911	12,218	11,372
N3: Non-Vet, VA Employee	126,301	143,299	112,230	101,087	73,874	(11,143)	(27,213)
N4: Non-Vet, Other Federal	2,346	22,099	2,340	2,340	2,340	0	0
N5: Non-Vet, Allied Veterans	1,353	1,565	1,352	1,331	1,307	(21)	(24)
N6: Non-Vet, Humanitarian	35,523	35,827	35,612	35,898	36,170	286	272
N7: Non-Vet, Sharing Agreement	7,958	8,224	7,691	6,869	6,096	(822)	(773)
N9: Non-Vet, TRICARE/CHAMPUS	2,045	2,701	1,925	1,539	1,171	(386)	(368)
NF : FHC Active Duty 3/	23,006	60,612	26,213	29,612	33,011	3,399	3,399
Non-Veterans [Subtotal]	868,682	949,871	894,344	930,648	950,443	36,304	19,795
Unique Patients [Total]	**7,326,761**	**7,295,028**	**7,534,168**	**7,701,915**	**7,849,623**	167,747	147,707
OEF/OIF/OND/OIR (Incl. Above)	1,411,447	1,440,372	1,500,043	**1,589,273**	**1,680,251**	89,230	90,978

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 and flu vaccinations.

3/ Active-duty non-Veterans at the JALFHCC. 2024 actual and projections for 2025-2027 reflect data limitations.

Tables: Funding Crosswalks 2024-2027

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

2024 Actual Discretionary

($ in thousands)

Description	Discretionary				
	Medical Services 0160	Medical Support and Compliance 0152	Medical Facilities 0162/1124XN	Medical Community Care 0140	Medical Care Total
APPROPRIATION					
Advance Appropriation	$74,004,000	$12,300,000	$8,800,000	$33,000,000	$128,104,000
Annual Appropriation Adjustment	$0	$0	$149,485	$0	$149,485
Advance Appropriation Rescission (P.L. 118-42)	($3,034,205)	($1,550,000)	$0	($2,657,977)	($7,242,182)
Unobligated Balances Rescission (P.L. 118-42, sec. 259)	($1,951,750)	$0	$0	$0	($1,951,750)
Appropriation [sub-total]	$69,018,045	$10,750,000	$8,949,485	$30,342,023	$119,059,553
TRANSFERS TO (-)					
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
JALFHCC (0169)	($397,454)	($30,996)	($40,570)	($51,291)	($520,311)
Transfers to [sub-total]	($412,454)	($30,996)	($40,570)	($51,291)	($535,311)
TRANSFERS FROM (+)					
Medical Care Collections Fund (5287)	$3,236,812	$0	$0	$599,722	$3,836,534
Transfers from [sub-total]	$3,236,812	$0	$0	$599,722	$3,836,534
REIMBURSEMENTS	$138,025	$62,697	$19,653	$0	$220,375
UNOBLIGATED BALANCE (SOY)					
P.L. 117-328 § 252 (EO 14507 no-year, RETF [1124XN]) /1	$0	$0	$75,000	$0	$75,000
P.L. 117-103 § 253 (Infrastructure no-year)	$0	$0	$85,871	$0	$85,871
P.L. 115-244 § 248 (NRM no-year)	$0	$0	$58,366	$0	$58,366
P.L. 115-141 § 255 (NRM no-year)	$0	$0	$3,932	$0	$3,932
P.L. 111-32 (H1N1 no-year)	$7	$111	$5	$0	$123
P.L. 110-28 (Emergency Supplemental no-year)	$136	$0	$5,800	$0	$5,936
No-Year (all other)	$2,663,890	$0	$8,252	$182,096	$2,854,238
2-Year	$1,050,837	$150,689	$267,385	$1,213,957	$2,682,868
Unobligated Balance (SOY) [sub-total]	$3,714,870	$150,800	$504,611	$1,396,053	$5,766,334
UNOBLIGATED BALANCE (EOY)					
P.L. 117-328 § 252 (EO 14507 no-year, RETF [1124XN]) /1	$0	$0	($75,000)	$0	($75,000)
P.L. 117-103 § 253 (Infrastructure no-year)	$0	$0	($65,029)	$0	($65,029)
P.L. 115-244 § 248 (NRM no-year)	$0	$0	($12,748)	$0	($12,748)
P.L. 115-141 § 255 (NRM no-year)	$0	$0	($76)	$0	($76)
P.L. 111-32 (H1N1 no-year)	($7)	($111)	($5)	$0	($123)
P.L. 110-28 (Emergency Supplemental no-year)	($136)	$0	($5,800)	$0	($5,936)
No-Year (all other)	($4,826,827)	$0	($8,468)	($264,898)	($5,100,193)
2-Year	($324,646)	($348,679)	($472,274)	($351,438)	($1,497,037)
Unobligated Balance (EOY) [sub-total]	($5,151,616)	($348,790)	($639,400)	($616,336)	($6,756,142)
Lapse	($128)	($430)	($168)	($83)	($809)
OBLIGATIONS [sub total]	$70,543,554	$10,583,281	$8,793,611	$31,670,088	$121,590,534
PRIOR YEAR RECOVERIES	$110,867	$557	$18,371	$84,137	$213,932
OBLIGATIONS [total]	$70,654,421	$10,583,838	$8,811,982	$31,754,225	$121,804,466
FTE	222,328	60,815	27,487	0	310,630

1/ P.L. 117-328, the Consolidated Appropriations Act, 2023, made $75.0 million in the Recurring Expenses Transformational Fund available for NRM.

2024 Actual American Rescue Plan

($ in thousands)

Description	Medical Services	Medical Community Care	Copay Refunds	Medical Care Total
UNOBLIGATED BALANCE (SOY)				
ARP Act § 8004 (no-year).....	$0	$0	$0	$0
ARP Act § 8007 (no-year).....	$2,850	$176	$16,861	$19,887
Unobligated Balance (SOY) [Subtotal].....	$2,850	$176	$16,861	$19,887
UNOBLIGATED BALANCE (EOY)				
ARP Act § 8004 (no-year).....	$0	$0	$0	$0
ARP Act § 8007 (no-year).....	($2,850)	($176)	($16,861)	($19,887)
Unobligated Balance (EOY) [Subtotal].....	($2,850)	($176)	($16,861)	($19,887)
PRIOR YEAR RECOVERIES.....	$5	$0	$0	$5
OBLIGATIONS [Total]	$5	$0	$0	$5
FTE ARP Act.....	0	0	0	0

2024 Actual PACT Act / TEF

($ in thousands)

Description	Mandatory					
	Cost of War Toxic Exposures Fund (TEF)					Medical Care Total
	Medical Services	Medical Suppor and Compliance	Medical Facilities	Community Care	Medical Facilities	
MANDATORY APPROPRIATION						
PACT Act § 707 (no-year, base year 2024+).....	$0	$0	$0	$0	$100,000	$100,000
P.L. 118-5 (2024/2028, TEF).....	$9,525,428	$850,000	$0	$6,801,538	$0	$17,176,966
**Mandatory Appropriation [Subtotal]..... **	$9,525,428	$850,000	$0	$6,801,538	$100,000	$17,276,966
UNOBLIGATED BALANCE (SOY)						
PACT Act § 705 (no-year).....	$0	$0	$0	$0	$229,656	$229,656
PACT Act § 707 (no-year, base year 2023).....	$0	$0	$0	$0	$1,855,998	$1,855,998
PACT Act § 806 (2022/2024, TEF).....	$0	$26,049	$0	$0	$0	$26,049
P.L. 117-328 (2023/2027, TEF).....	$3,815,453	$0	$0	$0	$0	$3,815,453
**Unobligated Balance (EOY) [Subtotal]..... **	$3,815,453	$26,049	$0	$0	$2,085,654	$5,927,156
REALIGNMENT						
PACT Act § 705 (no-year).....	$0	$0	$0	$0	$0	$0
PACT Act § 806 (2022/2024, TEF).....	$0	$0	$0	$0	$0	$0
P.L. 117-328 (2023/2027, TEF).....	$18,765	$0	$0	$0	$0	$18,765
UNOBLIGATED BALANCE (EOY)						
PACT Act § 705 (no-year).....	$0	$0	$0	$0	($203,680)	($203,680)
PACT Act § 707 (no-year, base year 2023).....	$0	$0	$0	$0	($1,790,100)	($1,790,100)
PACT Act § 707 (no-year, base year 2024+).....	$0	$0	$0	$0	($94,965)	($94,965)
P.L. 117-328 (2023/2028, TEF).....	($22,504)	$0	$0	$0	$0	($22,504)
P.L. 118-5 (2024/2028, TEF).....	($1,631,426)	($28,399)	$0	($2,001,538)	$0	($3,661,363)
**Unobligated Balance (EOY) [Subtotal]..... **	($1,653,930)	($28,399)	$0	($2,001,538)	($2,088,745)	($5,772,612)
**PRIOR YEAR RECOVERIES..... **	$0	$0	$0	$0	$2,355	$2,355
**OBLIGATIONS..... **	$11,705,716	$847,650	$0	$4,800,000	$99,264	$17,452,630
**Mandatory FTE PACT Act..... **	81,717	6,846	0	0	0	88,563

2024 Actual Veterans Access, Choice and Accountability Act of 2014, Section 801

($ in thousands)

Description	Mandatory			
	Medical Services 0160XA	Medical Support and Compliance 0152XA	Medical Facilities 0162XA	Medical Care Total (continued)
UNOBLIGATED BALANCE (SOY)				
No-Year.....	$8,817	$3,629	$10,394	$22,840
UNOBLIGATED BALANCE (EOY)				
No-Year.....	($2,413)	($1,582)	($12,687)	($16,682)
**OBLIGATIONS [Subtotal]..... **	$6,404	$2,047	($2,293)	$6,158
**PRIOR YEAR RECOVERIES [Subtotal]..... **	$4	$5	$3,002	$3,011
**OBLIGATIONS [Total] ..... **	$6,408	$2,052	$709	$9,169
**FTE..... **	21	13	0	34

2024 Actual Veterans Access, Choice and Accountability Act of 2014, Section 802

($ in thousands)

Description	Mandatory					Medical Care Total (continued)
	Administrative 0172XA	Medical Care 0172XB	Emergency Hepatitis C 0172XC	Emergency Community Care 0172XE	Community Care (MISSION) 0172XG	
UNOBLIGATED BALANCE (SOY)						
No-Year	$1,000	$36,056	$0	$101	$267,669	$304,826
UNOBLIGATED BALANCE (EOY)						
No-Year	($1,000)	($35,842)	$0	($111)	($267,669)	($304,622)
OBLIGATIONS [Subtotal]	$0	$214	$0	($10)	$0	$204
PRIOR YEAR RECOVERIES [Subtotal]	$0	$82	$0	$11	$0	$93
OBLIGATIONS [Total]	$0	$296	$0	$1	$0	$297
FTE [Total]	0	0	0	0	0	0

Medical Care Obligations, Discretionary	**$121,804,466**
Medical Care Obligations, ARP Act	**$5**
Medical Care Obligations, TEF and PACT Act	**$17,452,630**
Medical Care Obligations, VACAA, Section 801	**$9,169**
Medical Care Obligations, VACAA, Section 802	**$297**
Medical Care Obligations [Grand Total]	**$139,266,567**
Medical Care FTE, Regular	**310,630**
Medical Care FTE, ARP	**0**
Medical Care Obligations, TEF and PACT Act	**88,563**
Medical Care FTE, VACAA, Section 801	**34**
Medical Care FTE, VACAA, Section 802	**0**
Medical Care FTE [Grand Total]	**399,227**

2025 Budget Estimate Discretionary

($ in thousands)

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

1/ P.L. 117-328, the Consolidated Appropriations Act, 2023, made $75.0 million in the Recurring Expenses Transformational Fund available for NRM.

2025 Budget Estimate American Rescue Plan
($ in thousands)

Description	Medical Services	Medical Community Care	Copay Refunds	Medical Care Total
UNOBLIGATED BALANCE (SOY)				
ARP Act § 8004 (no-year).....	$0	$0	$0	$0
ARP Act § 8007 (no-year).....	$2,850	$176	$16,861	$19,887
Unobligated Balance (SOY) [Subtotal].....	$2,850	$176	$16,861	$19,887
UNOBLIGATED BALANCE (EOY)				
ARP Act § 8004 (no-year).....	$0	$0	$0	$0
ARP Act § 8007 (no-year).....	($2,850)	($176)	($16,861)	($19,887)
Unobligated Balance (EOY) [Subtotal].....	($2,850)	($176)	($16,861)	($19,887)
OBLIGATIONS [Total]	$0	$0	$0	$0
FTE ARP Act.....	0	0	0	0

2025 Budget Estimate PACT Act / TEF

($ in thousands)

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

2025 Budget Estimate Veterans Access, Choice and Accountability Act of 2014, Section 801

($ in thousands)

Description	Mandatory			
	Medical Services 0160XA	Medical Support and Compliance 0152XA	Medical Facilities 0162XA	Medical Care Total (continued)
UNOBLIGATED BALANCE (SOY)				
No-Year	$4,980	$256	$0	$5,236
UNOBLIGATED BALANCE (EOY)				
No-Year	$0	$0	$0	$0
OBLIGATIONS [Total]	$4,980	$256	$0	$5,236
FTE	31	0	0	31

2025 Budget Estimate Veterans Access, Choice and Accountability Act of 2014, Section 802

($ in thousands)

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

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

2025 Current Estimate Discretionary

($ in thousands)

Description	Discretionary				
	Medical Services 0160	Medical Support and Compliance 0152	Medical Facilities 0162/1124XN	Medical Community Care 0140	Medical Care Total
APPROPRIATION					
Advance Appropriation	$71,000,000	$11,800,000	$9,400,000	$20,382,000	$112,582,000
Annual Appropriation Adjustment	$0	$0	$149,485	$0	$149,485
P.L. 118-158, American Relief Act, 2025 (Hurricane Supplemental)	$19,258	$330	$41,660	$0	$61,248
Appropriation [sub-total]	$71,019,258	$11,800,330	$9,591,145	$20,382,000	$112,792,733
TRANSFERS TO (-)					
Medical Community Care (0140)	($2,090,089)	($81,092)	($1,983)	$0	($2,173,164)
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
JALFHCC (0169)	($384,926)	($42,193)	($66,021)	($93,500)	($586,640)
Transfers to [sub-total]	($2,490,015)	($123,285)	($68,004)	($93,500)	($2,774,804)
TRANSFERS FROM (+)					
Medical Services (0160)	$0	$0	$0	$2,090,089	$2,090,089
Medical Support and Compliance (0152)	$0	$0	$0	$81,092	$81,092
Medical Facilities (0162)	$0	$0	$0	$1,983	$1,983
Medical and Prosthetic Research (0161)	$8,318	$0	$0	$0	$8,318
Board of Veterans' Appeals (1122)	$9,870	$0	$0	$0	$9,870
General Administration (0142)	$26,901	$0	$0	$0	$26,901
Information Technology Systems (0167)	$174,034	$0	$0	$0	$174,034
Medical Care Collections Fund (5287)	$3,471,000	$0	$0	$901,000	$4,372,000
Transfers from [sub-total]	$3,690,123	$0	$0	$3,074,164	$6,764,287
REIMBURSEMENTS	$138,025	$62,697	$19,653	$0	$220,375
UNOBLIGATED BALANCE (SOY)					
P.L. 117-328 § 252 (EO 14507 no-year, RETF [1124XN]) /1	$0	$0	$75,000	$0	$75,000
P.L. 117-103 § 253 (Infrastructure no-year)	$0	$0	$65,029	$0	$65,029
P.L. 115-244 § 248 (NRM no-year)	$0	$0	$12,748	$0	$12,748
P.L. 115-141 § 255 (NRM no-year)	$0	$0	$76	$0	$76
P.L. 111-32 (H1N1 no-year)	$7	$111	$5	$0	$123
P.L. 110-28 (Emergency Supplemental no-year)	$136	$0	$5,800	$0	$5,936
No-Year (all other)	$4,826,827	$0	$8,468	$264,898	$5,100,193
2-Year	$324,646	$348,679	$472,274	$351,438	$1,497,037
Unobligated Balance (SOY) [sub-total]	$5,151,616	$348,790	$639,400	$616,336	$6,756,142
UNOBLIGATED BALANCE (EOY)					
P.L. 118-158, American Relief Act, 2025 (Hurricane Supplemental)	($16,766)	$0	($28,434)	$0	($45,200)
P.L. 117-328 § 252 (EO 14507 no-year, RETF [1124XN]) /1	$0	$0	($75,000)	$0	($75,000)
P.L. 117-103 § 253 (Infrastructure no-year)	$0	$0	$0	$0	$0
P.L. 115-244 § 248 (NRM no-year)	$0	$0	$0	$0	$0
P.L. 115-141 § 255 (NRM no-year)	$0	$0	$0	$0	$0
P.L. 111-32 (H1N1 no-year)	($7)	($111)	($5)	$0	($123)
P.L. 110-28 (Emergency Supplemental no-year)	($136)	$0	($5,800)	$0	($5,936)
No-Year (all other)	$0	$0	($8,468)	($1,338)	($9,806)
2-Year	($1,185,555)	$0	($250,000)	$0	($1,435,555)
Unobligated Balance (EOY) [sub-total]	($1,202,464)	($111)	($367,707)	($1,338)	($1,571,620)
OBLIGATIONS [total]	$76,306,543	$12,088,421	$9,814,487	$23,977,662	$122,187,113
FTE	236,063	64,326	26,523	0	326,912

1/ P.L. 117-328, the Consolidated Appropriations Act, 2023, made $75.0 million in the Recurring Expenses Transformational Fund available for NRM.

2025 Current Estimate American Rescue Plan
($ in thousands)

Description	Medical Services	Medical Community Care	Copay Refunds	Medical Care Total
UNOBLIGATED BALANCE (SOY)				
ARP Act § 8004 (no-year).....	$0	$0	$0	$0
ARP Act § 8007 (no-year).....	$2,850	$176	$16,861	$19,887
Unobligated Balance (SOY) [Subtotal]....	$2,850	$176	$16,861	$19,887
UNOBLIGATED BALANCE (EOY)				
ARP Act § 8004 (no-year).....	$0	$0	$0	$0
ARP Act § 8007 (no-year).....	($2,850)	($176)	($16,861)	($19,887)
Unobligated Balance (EOY) [Subtotal]....	($2,850)	($176)	($16,861)	($19,887)
OBLIGATIONS [Total]	$0	$0	$0	$0
FTE ARP Act.....	0	0	0	0

2025 Current Estimate PACT Act / TEF

($ in thousands)

Description	Mandatory					
	Cost of War Toxic Exposures Fund (TEF)					
	Medical Services	Medical Support and Compliance	Medical Facilities	Community Care	Medical Facilities	Medical Care Total
MANDATORY APPROPRIATION						
PACT Act § 707 (no-year, base year 2024+).....	$0	$0	$0	$0	$200,000	$200,000
P.L. 118-5 (2025/2029, TEF).....	$11,683,896	$0	$0	$9,894,178	$0	$21,578,074
P.L. 119-4 (no-year, TEF).....	$200,000	$0	$0	$5,800,000	$0	$6,000,000
**Mandatory Appropriation [Subtotal]..... **	$11,883,896	$0	$0	$15,694,178	$200,000	$27,778,074
UNOBLIGATED BALANCE (SOY)						
PACT Act § 705 (no-year).....	$0	$0	$0	$0	$203,680	$203,680
PACT Act § 707 (base year 2023).....	$0	$0	$0	$0	$1,790,100	$1,790,100
PACT Act § 707 (base year 2024+).....	$0	$0	$0	$0	$94,965	$94,965
P.L. 117-328 (2023/2027, TEF).....	$22,504	$0	$0	$0	$0	$22,504
P.L. 118-5 (2024/2028, TEF).....	$1,631,426	$28,399	$0	$2,001,538	$0	$3,661,363
**Unobligated Balance (EOY) [Subtotal]..... **	$1,653,930	$28,399	$0	$2,001,538	$2,088,745	$5,772,612
REALIGNMENT						
P.L. 118-5 (2024/2028, TEF).....	($387,599)	$387,599	$0	$0	$0	$0
UNOBLIGATED BALANCE (EOY)						
PACT Act § 705 (no-year).....	$0	$0	$0	$0	($133,970)	($133,970)
PACT Act § 707 (base year 2023).....	$0	$0	$0	$0	($1,326,553)	($1,326,553)
PACT Act § 707 (base year 2024+).....	$0	$0	$0	$0	($293,905)	($293,905)
P.L. 117-328 (2023/2027, TEF).....	$0	$0	$0	$0	$0	$0
P.L. 118-5 (2025/2029, TEF).....	$0	$0	$0	$0	$0	$0
P.L. 119-4 (no-year, TEF).....	$0	$0	$0	$0	$0	$0
**Unobligated Balance (EOY) [Subtotal]..... **	$0	$0	$0	$0	($1,754,428)	($1,754,428)
**OBLIGATIONS..... **	$13,150,227	$415,998	$0	$17,695,716	$534,317	$31,796,258
**Mandatory FTE PACT Act..... **	66,400	2,666	0	0	0	69,066

2025 Current Estimate Veterans Access, Choice and Accountability Act of 2014, Section 801
($ in thousands)

Description	Mandatory			
	Medical Services 0160XA	Medical Support and Compliance 0152XA	Medical Facilities 0162XA	Medical Care Total (continued)
UNOBLIGATED BALANCE (SOY)				
No-Year	$2,413	$1,582	$12,687	$16,682
UNOBLIGATED BALANCE (EOY)				
No-Year	$0	$0	$0	$0
OBLIGATIONS [Total]	$2,413	$1,582	$12,687	$16,682
FTE	11	11	0	22

2025 Current Estimate Veterans Access, Choice and Accountability Act of 2014, Section 802

($ in thousands)

Description	Mandatory					Medical Care Total (continued)
	Admin. 0172XA	Medical Care 0172XB	Emergency Hepatitis C 0172XC	Emergency Com. Care 0172XE	Community Care (MISSION) 0172XG	
UNOBLIGATED BALANCE (SOY)						
No-Year	$1,000	$35,842	$0	$111	$267,669	$304,622
REALIGNMENT						
No-Year	($1,000)	($35,542)	$0	($111)	$36,653	$0
UNOBLIGATED BALANCE (EOY)						
No-Year	$0	$0	$0	$0	$0	$0
OBLIGATIONS [Total]	$0	$300	$0	$0	$304,322	$304,622
FTE [Total]	0	0	0	0	0	0

Medical Care Obligations, Discretionary	**$122,187,113**
Medical Care Obligations, ARP Act	**$0**
Medical Care Obligations, TEF and PACT Act	**$31,796,258**
Medical Care Obligations, VACAA, Section 801	**$16,682**
Medical Care Obligations, VACAA, Section 802	**$304,622**
Medical Care Obligations [Grand Total]	**$154,304,675**
Medical Care FTE, Regular	**326,912**
Medical Care FTE, ARP	**0**
Medical Care Obligations, TEF and PACT Act	**69,066**
Medical Care FTE, VACAA, Section 801	**22**
Medical Care FTE, VACAA, Section 802	**0**
Medical Care FTE [Grand Total]	**396,000**

2026 Revised Request Discretionary

($ in thousands)

Description	Discretionary				
	Medical Services 0160	Medical Support and Compliance 0152	Medical Facilities 0162/1124XN	Medical Community Care 0140	Medical Care Total
APPROPRIATION					
Advance Appropriation	$75,039,000	$12,700,000	$9,700,000	$34,000,000	$131,439,000
Annual Appropriation Adjustment	$0	$0	$0	$3,000,000	$3,000,000
Proposed Cancellation 1/	($15,889,000)	($610,000)	$0	($3,000,000)	($19,499,000)
Appropriation [sub-total]	$59,150,000	$12,090,000	$9,700,000	$34,000,000	$114,940,000
TRANSFERS TO (-)					
Medical Facilities (0162)	($2,030,000)	$0	$0	$0	($2,030,000)
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
JALFHCC (0169)	($416,125)	($47,819)	($79,322)	($103,500)	($646,766)
Transfers to [sub-total]	($2,461,125)	($47,819)	($79,322)	($103,500)	($2,691,766)
TRANSFERS FROM (+)					
Medical Services (0160)	$0	$0	$2,030,000	$0	$2,030,000
Medical Care Collections Fund (5287)	$3,649,000	$0	$0	$914,000	$4,563,000
Transfers from [sub-total]	$3,649,000	$0	$2,030,000	$914,000	$6,593,000
REIMBURSEMENTS	$138,025	$62,697	$19,653	$0	$220,375
UNOBLIGATED BALANCE (SOY)					
P.L. 118-158, American Relief Act, 2025 (Hurricane Supplemental)	$16,766	$0	$28,434	$0	$45,200
P.L. 117-328 § 252 (EO 14507 no-year, RETF [1124XN]) 1/	$0	$0	$75,000	$0	$75,000
P.L. 111-32 (H1N1 no-year)	$7	$111	$5	$0	$123
P.L. 110-28 (Emergency Supplemental no-year)	$136	$0	$5,800	$0	$5,936
No-Year (all other)	$0	$0	$8,468	$1,338	$9,806
2-Year	$1,185,555	$0	$250,000	$0	$1,435,555
Unobligated Balance (SOY) [sub-total]	$1,202,464	$111	$367,707	$1,338	$1,571,620
UNOBLIGATED BALANCE (EOY)					
P.L. 118-158, American Relief Act, 2025 (Hurricane Supplemental)	$0	$0	$0	$0	$0
P.L. 117-328 § 252 (EO 14507 no-year, RETF [1124XN]) 1/	$0	$0	($75,000)	$0	($75,000)
P.L. 111-32 (H1N1 no-year)	($7)	($111)	($5)	$0	($123)
P.L. 110-28 (Emergency Supplemental no-year)	($136)	$0	($5,800)	$0	($5,936)
No-Year (all other)	$0	$0	($8,468)	$0	($8,468)
2-Year	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [sub-total]	($143)	($111)	($89,273)	$0	($89,527)
OBLIGATIONS [total]	$61,678,221	$12,104,878	$11,948,765	$34,811,838	$120,543,702
FTE	120,858	64,440	26,523	0	211,821

1/ P.L. 117-328, the Consolidated Appropriations Act, 2023, made $75.0 million in the Recurring Expenses Transformational Fund available for NRM.

2026 Revised Request American Rescue Plan
($ in thousands)

Description	Medical Services	Medical Community Care	Copay Refunds	Medical Care Total
UNOBLIGATED BALANCE (SOY)				
ARP Act § 8004 (no-year).....	$0	$0	$0	$0
ARP Act § 8007 (no-year).....	$2,850	$176	$16,861	$19,887
Unobligated Balance (SOY) [Subtotal].....	$2,850	$176	$16,861	$19,887
UNOBLIGATED BALANCE (EOY)				
ARP Act § 8004 (no-year).....	$0	$0	$0	$0
ARP Act § 8007 (no-year).....	($2,850)	($176)	($16,861)	($19,887)
Unobligated Balance (EOY) [Subtotal].....	($2,850)	($176)	($16,861)	($19,887)
OBLIGATIONS [Total]	$0	$0	$0	$0
FTE ARP Act.....	0	0	0	0

2026 Revised Request PACT Act / TEF

($ in thousands)

Description	Mandatory					
	Cost of War Toxic Exposures Fund (TEF)					
	Medical Services	Medical Support and Compliance	Medical Facilities	Community Care	Medical Facilities	Medical Care Total
MANDATORY APPROPRIATION						
PACT Act § 707 (no-year, base year 2024+).....	$0	$0	$0	$0	$400,000	$400,000
Request (no-year, TEF).....	$35,370,000	$400,000	$0	$14,030,000	$0	$49,800,000
Mandatory Appropriation [Subtotal].....	$35,370,000	$400,000	$0	$14,030,000	$400,000	$50,200,000
UNOBLIGATED BALANCE (SOY)						
PACT Act § 705 (no-year).....	$0	$0	$0	$0	$133,970	$133,970
PACT Act § 707 (base year 2023).....	$0	$0	$0	$0	$1,326,553	$1,326,553
PACT Act § 707 (base year 2024+).....	$0	$0	$0	$0	$293,905	$293,905
Unobligated Balance (EOY) [Subtotal].....	$0	$0	$0	$0	$1,754,428	$1,754,428
UNOBLIGATED BALANCE (EOY)						
PACT Act § 705 (no-year).....	$0	$0	$0	$0	($120,710)	($120,710)
PACT Act § 707 (base year 2023).....	$0	$0	$0	$0	($774,268)	($774,268)
PACT Act § 707 (base year 2024+).....	$0	$0	$0	$0	($373,810)	($373,810)
Unobligated Balance (EOY) [Subtotal].....	$0	$0	$0	$0	($1,268,788)	($1,268,788)
OBLIGATIONS.....	$35,370,000	$400,000	$0	$14,030,000	$885,640	$50,685,640
Mandatory FTE PACT Act.....	181,616	2,563	0	0	0	184,179

Medical Care Obligations, Discretionary	**$120,543,702**
Medical Care Obligations, ARP Act	**$0**
Medical Care Obligations, TEF and PACT Act	**$50,685,640**
Medical Care Obligations [Grand Total]	**$171,229,342**
Medical Care FTE, Regular	**211,821**
Medical Care FTE, ARP	**0**
Medical Care Obligations, TEF and PACT Act	**184,179**
Medical Care FTE [Grand Total]	**396,000**

2027 Advance Appropriation Discretionary

($ in thousands)

Description	Discretionary				
	Medical Services 0160	Medical Support and Compliance 0152	Medical Facilities 0162/1124XN	Medical Community Care 0140	Medical Care Total
APPROPRIATION					
Advance Appropriation	$59,858,000	$12,000,000	$11,700,000	$38,700,000	$122,258,000
Appropriation [sub-total]	$59,858,000	$12,000,000	$11,700,000	$38,700,000	$122,258,000
TRANSFERS TO (-)					
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
JALFHCC (0169)	($477,700)	($64,035)	($87,683)	($110,500)	($739,918)
Transfers to [sub-total]	($492,700)	($64,035)	($87,683)	($110,500)	($754,918)
TRANSFERS FROM (+)					
Medical Care Collections Fund (5287)	$3,787,000	$0	$0	$948,000	$4,735,000
Transfers from [sub-total]	$3,787,000	$0	$0	$948,000	$4,735,000
REIMBURSEMENTS	$138,025	$62,697	$19,653	$0	$220,375
UNOBLIGATED BALANCE (SOY)					
P.L. 118-158, American Relief Act, 2025 (Hurricane Supplemental)	$0	$0	$0	$0	$0
P.L. 117-328 § 252 (EO 14507 no-year, RETF [1124XN]) /1	$0	$0	$75,000	$0	$75,000
P.L. 111-32 (H1N1 no-year)	$7	$111	$5	$0	$123
P.L. 110-28 (Emergency Supplemental no-year)	$136	$0	$5,800	$0	$5,936
No-Year (all other)	$0	$0	$8,468	$0	$8,468
2-Year	$0	$0	$0	$0	$0
Unobligated Balance (SOY) [sub-total]	$143	$111	$89,273	$0	$89,527
UNOBLIGATED BALANCE (EOY)					
P.L. 118-158, American Relief Act, 2025 (Hurricane Supplemental)	$0	$0	$0	$0	$0
P.L. 117-328 § 252 (EO 14507 no-year, RETF [1124XN]) /1	$0	$0	($75,000)	$0	($75,000)
P.L. 111-32 (H1N1 no-year)	($7)	($111)	($5)	$0	($123)
P.L. 110-28 (Emergency Supplemental no-year)	($136)	$0	($5,800)	$0	($5,936)
No-Year (all other)	$0	$0	($8,468)	$0	($8,468)
2-Year	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [sub-total]	($143)	($111)	($89,273)	$0	($89,527)
OBLIGATIONS [total]	$63,290,325	$11,998,662	$11,631,970	$39,537,500	$126,458,457
FTE	114,840	62,562	26,523	0	203,925

1/ P.L. 117-328, the Consolidated Appropriations Act, 2023, made $75.0 million in the Recurring Expenses Transformational Fund available for NRM.

2027 Advance Appropriation American Rescue Plan

($ in thousands)

Description	Medical Services	Medical Community Care	Copay Refunds	Medical Care Total
UNOBLIGATED BALANCE (SOY)				
ARP Act § 8007 (no-year).....	$2,850	$176	$16,861	$19,887
Unobligated Balance (SOY) [Subtotal].....	$2,850	$176	$16,861	$19,887
UNOBLIGATED BALANCE (EOY)				
ARP Act § 8007 (no-year).....	($2,850)	($176)	($16,861)	($19,887)
Unobligated Balance (EOY) [Subtotal].....	($2,850)	($176)	($16,861)	($19,887)
OBLIGATIONS [Total]	$0	$0	$0	$0
FTE ARP Act.....	0	0	0	0

2027 Advanced Appropriation PACT Act / TEF

($ in thousands)

Description	Mandatory					
	Cost of War Toxic Exposures Fund (TEF)					
	Medical Services	Medical Support and Compliance	Medical Facilities	Community Care	Medical Facilities	Medical Care Total
MANDATORY APPROPRIATION						
PACT Act § 707 (no-year, base year 2024+).....	$0	$0	$0	$0	$450,000	$450,000
Request (no-year, TEF).....	$36,542,000	$700,000	$0	$14,500,000	$0	$51,742,000
**Mandatory Appropriation [Subtotal]..... **	$36,542,000	$700,000	$0	$14,500,000	$450,000	$52,192,000
UNOBLIGATED BALANCE (SOY)						
PACT Act § 705 (no-year).....	$0	$0	$0	$0	$120,710	$120,710
PACT Act § 707 (base year 2023).....	$0	$0	$0	$0	$774,268	$774,268
PACT Act § 707 (base year 2024+).....	$0	$0	$0	$0	$373,810	$373,810
**Unobligated Balance (EOY) [Subtotal]..... **	$0	$0	$0	$0	$1,268,788	$1,268,788
UNOBLIGATED BALANCE (EOY)						
PACT Act § 705 (no-year).....	$0	$0	$0	$0	($108,272)	($108,272)
PACT Act § 707 (base year 2023).....	$0	$0	$0	$0	($755,746)	($755,746)
PACT Act § 707 (base year 2024+).....	$0	$0	$0	$0	$0	$0
**Unobligated Balance (EOY) [Subtotal]..... **	$0	$0	$0	$0	($864,018)	($864,018)
**OBLIGATIONS..... **	$36,542,000	$700,000	$0	$14,500,000	$854,770	$52,596,770
**Mandatory FTE PACT Act..... **	187,634	4,441	0	0	0	192,075

Medical Care Obligations, Discretionary	**$126,458,457**
Medical Care Obligations, ARP Act	**$0**
Medical Care Obligations, TEF and PACT Act	**$52,596,770**
Medical Care Obligations [Grand Total]	**$179,055,227**
Medical Care FTE, Regular	**203,925**
Medical Care FTE, ARP	**0**
Medical Care Obligations, TEF and PACT Act	**192,075**
Medical Care FTE [Grand Total]	**396,000**

Tables: Obligations by Object Class by Medical Care Category

The tables that follow in the remainder of this chapter show Medical Care obligations by object class. Obligations include only obligations in the Medical Care categories (Medical Services, Medical Support and Compliance, Medical Facilities, and Medical Community Care). They exclude obligations from VACAA section 801 for information technology and minor construction, Grants for Construction of State Extended Care Facilities, Medical and Prosthetics Research, and the two joint VA-DoD health care accounts. The tables include obligations from TEF funding in the Medical Services, Medical Support and Compliance, and Medical Community Care categories.

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

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

(dollars in thousands)

Description	Discretionary Appropriations – Medical Services				Mandatory Appropriations – Veterans Access, Choice, and Accountability Act (VACAA)			
	FY 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027
10 Personnel Compensation and Benefits:								
Physicians	$8,243,128	$7,969,252	$4,315,793	$4,309,771	$4,338	$1,475	$0	$0
Dentists	$426,282	$350,415	$186,546	$182,429	$0	$0	$0	$0
Registered Nurses	$9,823,991	$11,045,092	$5,609,354	$5,147,077	$0	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$2,327,756	$2,335,062	$1,342,484	$1,439,392	$35	$0	$0	$0
Non-Physician Providers	$3,564,149	$3,914,689	$2,091,330	$2,056,325	$280	$0	$0	$0
Health Technicians/Allied Health	$12,220,445	$10,795,708	$6,023,811	$6,245,963	$440	$0	$0	$0
Wage Board/Purchase & Hire	$469,113	$367,883	$187,592	$173,064	$0	$0	$0	$0
All Other	$4,895,796	$3,998,255	$2,108,503	$2,085,217	$810	$826	$0	$0
Permanent Change of Station	$4,749	$4,845	$4,943	$5,043	$0	$0	$0	$0
Employee Compensation Pay	$301,223	$307,338	$313,577	$319,943	$0	$0	$0	$0
Subtotal	$42,276,632	$41,088,539	$22,183,933	$21,964,224	$5,903	$2,301	$0	$0
21 Travel & Transportation of Persons:					$12	$0	$0	$0
Employee	$57,257	$66,787	$69,458	$72,167	$0	$0	$0	$0
Beneficiary	$1,317,233	$1,730,378	$1,066,716	$1,142,666	$0	$0	$0	$0
Other	$49,601	$84,074	$89,126	$92,602	$12	$0	$0	$0
Subtotal	$1,424,091	$1,881,239	$1,225,300	$1,307,435	$12	$0	$0	$0
22 Transportation of Things	$38,388	$42,682	$46,975	$48,807	$0	$0	$0	$0
23 Rent, Communications, and Utilities:								
Rental of Equipment	$429,124	$557,813	$686,502	$713,276	$0	$0	$0	$0
Communications	$592,401	$682,926	$762,789	$792,538	$0	$0	$0	$0
Utilities	$1,603	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental (Including GSA)	$9,059	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,032,187	$1,240,739	$1,449,291	$1,505,814	$0	$0	$0	$0
24 Printing & Reproduction:	$10,860	$11,294	$11,734	$12,192	$0	$0	$0	$0
25 Other Contractual Services:								
Care in the Community Outpatient Dental Care	$6,425	$6,637	$6,902	$7,171	$0	$0	$0	$0
Medical and Nursing Care in the Community	$335,725	$346,804	$360,676	$374,742	$0	$0	$0	$0
Repairs to Furniture/Equipment	$407,872	$421,332	$438,185	$455,274	$0	$0	$0	$0
Maintenance & Repair Contract Services	$78,502	$81,093	$84,337	$87,626	$0	$0	$0	$0
Care in the Community Hospital Care	$0	$0	$0	$0	$0	$0	$0	$0
Community Nursing Homes	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$401,375	$453,126	$500,946	$549,750	$0	$0	$0	$0
Home Oxygen	$216,811	$244,765	$270,596	$296,959	$0	$0	$0	$0
Organ Procurement	$13,969	$14,430	$15,007	$15,592	$0	$0	$0	$0
Personal Services Contracts	$74,777	$77,245	$80,335	$83,468	$0	$0	$0	$0
House Staff Disbursing Agreement	$866,797	$895,401	$931,217	$967,534	$228	$0	$0	$0
Scarce Medical Specialists	$238,816	$246,697	$256,565	$266,571	$30	$0	$0	$0
Other Medical Contract Services	$1,904,409	$2,195,712	$4,427,771	$2,892,811	-$3	$112	$0	$0
Administrative Contract Services	$1,446,394	$1,494,125	$1,553,890	$1,614,492	$41	$0	$0	$0
Training Contract Services	$119,638	$123,586	$128,529	$133,542	$5	$0	$0	$0
Caregiver Stipends	$1,565,048	$1,919,844	$2,372,254	$2,656,451	$0	$0	$0	$0
CHAMPVA	$0	$20,000	$21,000	$22,000	$0	$0	$0	$0
Subtotal	$7,676,558	$8,540,797	$11,448,210	$10,423,983	$301	$112	$0	$0

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

(dollars in thousands)

Description	Discretionary Appropriations Medical Services FY 2024	FY 2025	FY 2026	FY 2027	Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA) FY 2024	FY 2025	FY 2026	FY 2027
26 Supplies & Materials:								
Provisions	$148,996	$153,913	$160,070	$166,313	$0	$0	$0	$0
Drugs & Medicines	$8,169,700	$11,792,465	$12,058,988	$13,760,626	$0	$0	$0	$0
Blood & Blood Products	$53,818	$55,594	$57,818	$60,073	$0	$0	$0	$0
Medical/Dental Supplies	$2,392,226	$3,111,550	$3,763,731	$3,910,517	$33	$0	$0	$0
Operating Supplies	$319,510	$330,054	$343,256	$356,643	$0	$0	$0	$0
Maintenance & Repair Supplies	$42,022	$0	$0	$0	$0	$0	$0	$0
Other Supplies	$284,424	$293,810	$305,562	$317,479	$0	$0	$0	$0
Prosthetic Appliances	$3,807,241	$4,298,122	$4,751,723	$5,214,656	$0	$0	$0	$0
Home Respiratory Therapy	$439,361	$496,009	$548,355	$601,779	$0	$0	$0	$0
Subtotal	$15,657,298	$20,531,517	$21,989,503	$24,388,086	$33	$0	$0	$0
31 Equipment	$1,211,037	$1,811,122	$2,088,230	$2,191,985	$85	$0	$0	$0
32 Lands & Structures:								
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$2,683	$2,864	$2,975	$3,091	$70	$0	$0	$0
Subtotal	$2,683	$2,864	$2,975	$3,091	$70	$0	$0	$0
41 Grants, Subsidies & Contributions:								
State Home	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$1,201,622	$1,143,064	$1,218,890	$1,431,014	$0	$0	$0	$0
Veteran Adoption Reimbursement	$8	$8	$8	$8	$0	$0	$0	$0
Subtotal	$1,201,630	$1,143,072	$1,218,898	$1,431,022	$0	$0	$0	$0
42 - Insurance Claims and Indemnities	$12,190	$12,678	$13,172	$13,686	$0	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$70,543,554	$76,306,543	$61,678,221	$63,290,325	$6,404	$2,413	$0	$0
Prior Year Recoveries	$110,867	$0	$0	$0	$4	$0	$0	$0
Obligations [Total]	**$70,654,421**	**$76,306,543**	**$61,678,221**	**$63,290,325**	**$6,408**	**$2,413**	**$0**	**$0**

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

(dollars in thousands)

	Mandatory Appropriations				Discretionary and Mandatory Grand Total			
	Cost of War Toxic Exposures Fund				Medical Services Category			
Description	FY 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027
10 Personnel Compensation and Benefits:								
Physicians	$1,589,643	$2,242,081	$6,132,067	$6,335,256	$9,837,109	$10,212,808	$10,447,860	$10,645,027
Dentists	$0	$98,564	$269,574	$278,506	$426,282	$448,979	$456,120	$460,935
Registered Nurses	$3,988,639	$3,106,534	$8,497,108	$8,778,663	$13,812,630	$14,151,626	$14,106,462	$13,925,740
LP Nurse/LV Nurse/Nurse Assistant	$554,430	$656,822	$1,796,463	$1,855,990	$2,882,221	$2,991,884	$3,138,947	$3,295,382
Non-Physician Providers	$1,103,719	$1,100,927	$3,011,539	$3,111,328	$4,668,148	$5,015,616	$5,102,869	$5,167,653
Health Technicians/Allied Health	$757,692	$3,036,389	$8,305,246	$8,580,444	$12,978,577	$13,832,097	$14,329,057	$14,826,407
Wage Board/Purchase & Hire	$0	$103,520	$283,013	$292,391	$469,113	$471,403	$470,605	$465,455
All Other	$0	$1,142,488	$3,134,089	$3,237,938	$4,896,606	$5,141,569	$5,242,592	$5,323,155
Permanent Change of Station	$0	$0	$0	$0	$4,749	$4,845	$4,943	$5,043
Employee Compensation Pay	$0	$0	$0	$0	$301,223	$307,338	$313,577	$319,943
Subtotal	$7,994,123	$11,487,325	$31,429,099	$32,470,516	$50,276,658	$52,578,165	$53,613,032	$54,434,740
21 Travel & Transportation of Persons:								
Employee	$0	$0	$0	$0	$57,257	$66,787	$69,458	$72,167
Beneficiary	$748,985	$409,090	$1,182,270	$1,221,445	$2,066,218	$2,139,468	$2,248,986	$2,364,111
Other	$0	$0	$0	$0	$49,613	$84,074	$89,126	$92,602
Subtotal	$748,985	$409,090	$1,182,270	$1,221,445	$2,173,088	$2,290,329	$2,407,570	$2,528,880
22 Transportation of Things	$0	$0	$0	$0	$38,388	$42,682	$46,975	$48,807
23 Rent, Communications, and Utilities:								
Rental of Equipment	$0	$0	$0	$0	$429,124	$557,813	$686,502	$713,276
Communications	$0	$0	$0	$0	$592,401	$682,926	$762,789	$792,538
Utilities	$0	$0	$0	$0	$1,603	$0	$0	$0
Other Real Property Rental (Including GSA)	$0	$0	$0	$0	$9,059	$0	$0	$0
Subtotal	$0	$0	$0	$0	$1,032,187	$1,240,739	$1,449,291	$1,505,814
24 Printing & Reproduction:	$0	$0	$0	$0	$10,860	$11,294	$11,734	$12,192
25 Other Contractual Services:								
Care in the Community Outpatient Dental Care	$0	$0	$0	$0	$6,425	$6,637	$6,902	$7,171
Medical and Nursing Care in the Community	$0	$0	$0	$0	$335,725	$346,804	$360,676	$374,742
Repairs to Furniture/Equipment	$0	$0	$0	$0	$407,872	$421,332	$438,185	$455,274
Maintenance & Repair Contract Services	$0	$0	$0	$0	$78,502	$81,093	$84,337	$87,626
Care in the Community Hospital Care	$0	$0	$0	$0	$0	$0	$0	$0
Community Nursing Homes	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$0	$0	$0	$0	$401,375	$453,126	$500,946	$549,750
Home Oxygen	$0	$0	$0	$0	$216,811	$244,765	$270,596	$296,959
Organ Procurement	$0	$0	$0	$0	$13,969	$14,430	$15,007	$15,592
Personal Services Contracts	$0	$0	$0	$0	$74,777	$77,245	$80,335	$83,468
House Staff Disbursing Agreement	$0	$0	$0	$0	$867,025	$895,401	$931,217	$967,534
Scarce Medical Specialists	$0	$0	$0	$0	$238,846	$246,697	$256,565	$266,571
Other Medical Contract Services	$0	$0	$0	$0	$1,904,406	$2,195,824	$4,427,771	$2,892,811
Administrative Contract Services	$0	$0	$0	$0	$1,446,435	$1,494,125	$1,553,890	$1,614,492
Training Contract Services	$0	$0	$0	$0	$119,643	$123,586	$128,529	$133,542
Caregiver Stipends	$0	$0	$0	$0	$1,565,048	$1,919,844	$2,372,254	$2,656,451
CHAMPVA	$0	$0	$0	$0	$0	$20,000	$21,000	$22,000
Subtotal	$0	$0	$0	$0	$7,676,859	$8,540,909	$11,448,210	$10,423,983

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

(dollars in thousands)

Description	Mandatory Appropriations Cost of War Toxic Exposures Fund FY 2024	FY 2025	FY 2026	FY 2027	Discretionary and Mandatory Grand Total Medical Services Category FY 2024	FY 2025	FY 2026	FY 2027
26 Supplies & Materials:								
Provisions	$0	$0	$0	$0	$148,996	$153,913	$160,070	$166,313
Drugs & Medicines	$2,962,608	$1,253,812	$2,758,631	$2,850,039	$11,132,308	$13,046,277	$14,817,619	$16,610,665
Blood & Blood Products	$0	$0	$0	$0	$53,818	$55,594	$57,818	$60,073
Medical/Dental Supplies	$0	$0	$0	$0	$2,392,259	$3,111,550	$3,763,731	$3,910,517
Operating Supplies	$0	$0	$0	$0	$319,510	$330,054	$343,256	$356,643
Maintenance & Repair Supplies	$0	$0	$0	$0	$42,022	$0	$0	$0
Other Supplies	$0	$0	$0	$0	$284,424	$293,810	$305,562	$317,479
Prosthetic Appliances	$0	$0	$0	$0	$3,807,241	$4,298,122	$4,751,723	$5,214,656
Home Respiratory Therapy	$0	$0	$0	$0	$439,361	$496,009	$548,355	$601,779
Subtotal	$2,962,608	$1,253,812	$2,758,631	$2,850,039	$18,619,939	$21,785,329	$24,748,134	$27,238,125
31 Equipment	$0	$0	$0	$0	$1,211,122	$1,811,122	$2,088,230	$2,191,985
32 Lands & Structures:								
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$0	$0	$0	$0	$2,753	$2,864	$2,975	$3,091
Subtotal	$0	$0	$0	$0	$2,753	$2,864	$2,975	$3,091
41 Grants, Subsidies & Contributions:								
State Home	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$0	$0	$0	$0	$1,201,622	$1,143,064	$1,218,890	$1,431,014
Veteran Adoption Reimbursement	$0	$0	$0	$0	$8	$8	$8	$8
Subtotal	$0	$0	$0	$0	$1,201,630	$1,143,072	$1,218,898	$1,431,022
42 - Insurance Claims and Indemnities	$0	$0	$0	$0	$12,190	$12,678	$13,172	$13,686
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$11,705,716	$13,150,227	$35,370,000	$36,542,000	$82,255,674	$89,459,183	$97,048,221	$99,832,325
ARP 8007 Prior Year Recoveries	$0	$0	$0	$0	$5	$0	$0	$0
Prior Year Recoveries	$0	$0	$0	$0	$110,871	$0	$0	$0
Obligations [Total]	**$11,705,716**	**$13,150,227**	**$35,370,000**	**$36,542,000**	**$82,366,550**	**$89,459,183**	**$97,048,221**	**$99,832,325**

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

(dollars in thousands)

Description	Discretionary Appropriations Medical Support And Compliance				Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA)			
	FY 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027
10 Personnel Compensation and Benefits:								
Physicians	$368,066	$400,734	$405,247	$407,465	$544	$0	$0	$0
Dentists	$4,188	$5,581	$5,750	$5,895	$0	$0	$0	$0
Registered Nurses	$830,033	$689,164	$694,739	$693,294	$21	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$7,955	$7,382	$7,732	$8,095	$0	$0	$0	$0
Non-Physician Providers	$98,284	$101,314	$104,205	$106,751	$0	$0	$0	$0
Health Technicians/Allied Health	$219,961	$224,106	$231,824	$238,737	$27	$0	$0	$0
Wage Board/Purchase & Hire	$120,135	$127,487	$129,265	$130,002	$0	$0	$0	$0
All Other	$6,410,431	$7,245,778	$7,399,154	$7,180,346	$1,179	$1,203	$0	$0
Permanent Change of Station	$8,562	$8,737	$8,914	$9,095	$0	$0	$0	$0
Employee Compensation Pay	$36,827	$37,576	$38,339	$39,117	$0	$0	$0	$0
Subtotal	$8,104,442	$8,847,859	$9,025,169	$8,818,797	$1,771	$1,203	$0	$0
21 Travel & Transportation of Persons:								
Employee	$65,686	$67,656	$67,656	$67,656	$5	$0	$0	$0
Beneficiary	$61	$0	$0	$0	$0	$0	$0	$0
Other	$8,083	$7,471	$7,471	$7,471	$0	$0	$0	$0
Subtotal	$73,830	$75,127	$75,127	$75,127	$5	$0	$0	$0
22 Transportation of Things	$17,132	$20,109	$20,109	$20,109	$0	$0	$0	$0
23 Rent, Communications, and Utilities:								
Rental of Equipment	$95,881	$102,574	$99,018	$102,880	$0	$0	$0	$0
Communications	$86,068	$88,908	$92,464	$96,070	$0	$0	$0	$0
Utilities	$15	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental (Including GSA)	$2,153	$0	$0	$0	$0	$0	$0	$0
Subtotal	$184,117	$191,482	$191,482	$198,950	$0	$0	$0	$0
24 Printing & Reproduction:	$25,803	$26,835	$26,835	$27,882	$0	$0	$0	$0
25 Other Contractual Services:								
Care in the Community Outpatient Dental Care	$0	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$1,928	$0	$0	$0	$0	$0	$0	$0
Repairs to Furniture/Equipment	$3,565	$3,683	$3,830	$3,979	$0	$0	$0	$0
Maintenance & Repair Contract Services	$2,210	$0	$0	$0	$138	$0	$0	$0
Care in the Community Hospital Care	$0	$0	$0	$0	$0	$0	$0	$0
Community Nursing Homes	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$0	$0	$0	$0	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$7,078	$7,312	$7,604	$7,901	$5	$0	$0	$0
House Staff Disbursing Agreement	$0	$0	$0	$0	$0	$0	$0	$0
Scarce Medical Specialists	$2	$0	$0	$0	$0	$0	$0	$0
Other Medical Contract Services	$34,796	$35,944	$37,382	$38,840	$0	$0	$0	$0
Administrative Contract Services	$1,888,220	$2,587,536	$2,422,223	$2,502,717	$1	$379	$0	$0
Training Contract Services	$62,524	$64,587	$67,170	$69,790	$34	$0	$0	$0
Caregiver Stipends	$24	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$2,000,347	$2,699,062	$2,538,209	$2,623,227	$178	$379	$0	$0

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

(dollars in thousands)

Description	Discretionary Appropriations Medical Support And Compliance FY 2024	FY 2025	FY 2026	FY 2027	Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA) FY 2024	FY 2025	FY 2026	FY 2027
26 Supplies & Materials:								
Provisions	$3,115	$0	$0	$0	$0	$0	$0	$0
Drugs & Medicines	$1	$0	$0	$0	$0	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$1,441	$0	$0	$0	$0	$0	$0	$0
Operating Supplies	$40,144	$41,469	$41,469	$43,086	$64	$0	$0	$0
Maintenance & Repair Supplies	$450	$0	$0	$0	$0	$0	$0	$0
Other Supplies	$84,112	$92,198	$92,198	$95,794	-$1	$0	$0	$0
Prosthetic Appliances	-$482	$0	$0	$0	$0	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$128,781	$133,667	$133,667	$138,880	$63	$0	$0	$0
31 Equipment	$34,076	$68,006	$68,006	$69,416	$29	$0	$0	$0
32 Lands & Structures:								
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$822	$1,222	$1,222	$1,222	$1	$0	$0	$0
Subtotal	$822	$1,222	$1,222	$1,222	$1	$0	$0	$0
41 Grants, Subsidies & Contributions:								
State Home	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$0	$0	$0	$0	$0	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
42 - Insurance Claims and Indemnities	$13,931	$25,052	$25,052	$25,052	$0	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$10,583,281	$12,088,421	$12,104,878	$11,998,662	$2,047	$1,582	$0	$0
Prior Year Recoveries	$557	$0	$0	$0	$5	$0	$0	$0
Obligations [Total]	**$10,583,838**	**$12,088,421**	**$12,104,878**	**$11,998,662**	**$2,052**	**$1,582**	**$0**	**$0**

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

(dollars in thousands)

Description	Mandatory Appropriations Cost of War Toxic Exposures Fund				Discretionary and Mandatory Grand Total Medical Support And Compliance Category			
	FY 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027
10 Personnel Compensation and Benefits:								
Physicians	$10,394	$0	$0	$0	$379,004	$400,734	$405,247	$407,465
Dentists	$0	$0	$0	$0	$4,188	$5,581	$5,750	$5,895
Registered Nurses	$19,851	$200,630	$202,253	$201,832	$849,905	$889,794	$896,992	$895,126
LP Nurse/LV Nurse/Nurse Assistant	$0	$0	$0	$0	$7,955	$7,382	$7,732	$8,095
Non-Physician Providers	$0	$0	$0	$0	$98,284	$101,314	$104,205	$106,751
Health Technicians/Allied Health	$0	$0	$0	$0	$219,988	$224,106	$231,824	$238,737
Wage Board/Purchase & Hire	$0	$0	$0	$0	$120,135	$127,487	$129,265	$130,002
All Other	$748,580	$215,368	$197,747	$498,168	$7,160,190	$7,462,349	$7,596,901	$7,678,514
Permanent Change of Station	$0	$0	$0	$0	$8,562	$8,737	$8,914	$9,095
Employee Compensation Pay	$0	$0	$0	$0	$36,827	$37,576	$38,339	$39,117
Subtotal	$778,825	$415,998	$400,000	$700,000	$8,885,038	$9,265,060	$9,425,169	$9,518,797
21 Travel & Transportation of Persons:								
Employee	$0	$0	$0	$0	$65,691	$67,656	$67,656	$67,656
Beneficiary	$0	$0	$0	$0	$61	$0	$0	$0
Other	$0	$0	$0	$0	$8,083	$7,471	$7,471	$7,471
Subtotal	$0	$0	$0	$0	$73,835	$75,127	$75,127	$75,127
22 Transportation of Things	$0	$0	$0	$0	$17,132	$20,109	$20,109	$20,109
23 Rent, Communications, and Utilities:								
Rental of Equipment	$0	$0	$0	$0	$95,881	$102,574	$99,018	$102,880
Communications	$0	$0	$0	$0	$86,068	$88,908	$92,464	$96,070
Utilities	$0	$0	$0	$0	$15	$0	$0	$0
Other Real Property Rental (Including GSA)	$0	$0	$0	$0	$2,153	$0	$0	$0
Subtotal	$0	$0	$0	$0	$184,117	$191,482	$191,482	$198,950
24 Printing & Reproduction:	$0	$0	$0	$0	$25,803	$26,835	$26,835	$27,882
25 Other Contractual Services:								
Care in the Community Outpatient Dental Care	$0	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$0	$0	$0	$0	$1,928	$0	$0	$0
Repairs to Furniture/Equipment	$0	$0	$0	$0	$3,565	$3,683	$3,830	$3,979
Maintenance & Repair Contract Services	$0	$0	$0	$0	$2,348	$0	$0	$0
Care in the Community Hospital Care	$0	$0	$0	$0	$0	$0	$0	$0
Community Nursing Homes	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$0	$0	$0	$0	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$0	$0	$0	$0	$7,083	$7,312	$7,604	$7,901
House Staff Disbursing Agreement	$0	$0	$0	$0	$0	$0	$0	$0
Scarce Medical Specialists	$0	$0	$0	$0	$2	$0	$0	$0
Other Medical Contract Services	$0	$0	$0	$0	$34,796	$35,944	$37,382	$38,840
Administrative Contract Services	$68,825	$0	$0	$0	$1,957,046	$2,587,915	$2,422,223	$2,502,717
Training Contract Services	$0	$0	$0	$0	$62,558	$64,587	$67,170	$69,790
Caregiver Stipends	$0	$0	$0	$0	$24	$0	$0	$0
CHAMPVA	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$68,825	$0	$0	$0	$2,069,350	$2,699,441	$2,538,209	$2,623,227

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

(dollars in thousands)

Description	Mandatory Appropriations Cost of War Toxic Exposures Fund FY 2024	FY 2025	FY 2026	FY 2027	Discretionary and Mandatory Grand Total Medical Support And Compliance Category FY 2024	FY 2025	FY 2026	FY 2027
26 Supplies & Materials:								
Provisions	$0	$0	$0	$0	$3,115	$0	$0	$0
Drugs & Medicines	$0	$0	$0	$0	$1	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$0	$0	$0	$0	$1,441	$0	$0	$0
Operating Supplies	$0	$0	$0	$0	$40,208	$41,469	$41,469	$43,086
Maintenance & Repair Supplies	$0	$0	$0	$0	$450	$0	$0	$0
Other Supplies	$0	$0	$0	$0	$84,111	$92,198	$92,198	$95,794
Prosthetic Appliances	$0	$0	$0	$0	-$482	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$128,844	$133,667	$133,667	$138,880
31 Equipment	$0	$0	$0	$0	$34,105	$68,006	$68,006	$69,416
32 Lands & Structures:								
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$0	$0	$0	$0	$823	$1,222	$1,222	$1,222
Subtotal	$0	$0	$0	$0	$823	$1,222	$1,222	$1,222
41 Grants, Subsidies & Contributions:								
State Home	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$0	$0	$0	$0	$0	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
42 - Insurance Claims and Indemnities	$0	$0	$0	$0	$13,931	$25,052	$25,052	$25,052
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$847,650	$415,998	$400,000	$700,000	$11,432,978	$12,506,001	$12,504,878	$12,698,662
Prior Year Recoveries	$0	$0	$0	$0	$562	$0	$0	$0
Obligations [Total]	**$847,650**	**$415,998**	**$400,000**	**$700,000**	**$11,433,540**	**$12,506,001**	**$12,504,878**	**$12,698,662**

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

(dollars in thousands)

Description	Discretionary Appropriations Medical Facilities				Discretionary Appropriations Recurring Expenses Transformational Funding				Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA)			
	FY 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027
10 Personnel Compensation and Benefits:												
Physicians	$176	$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	$882	$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	-$1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Health Technicians/Allied Health	$15,344	$15,143	$15,540	$15,851	$0	$0	$0	$0	$0	$0	$0	$0
Wage Board/Purchase & Hire	$1,981,988	$1,991,793	$2,009,447	$2,008,448	$0	$0	$0	$0	$0	$0	$0	$0
All Other	$694,509	$717,031	$735,267	$749,686	$0	$0	$0	$0	$0	$0	$0	$0
Permanent Change of Station	$1,593	$1,624	$1,657	$1,691	$0	$0	$0	$0	$0	$0	$0	$0
Employee Compensation Pay	$31,307	$31,943	$32,591	$33,253	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$2,725,798	$2,757,534	$2,794,502	$2,808,929	$0	$0	$0	$0	$0	$0	$0	$0
21 Travel & Transportation of Persons:												
Employee	$5,787	$5,978	$6,217	$6,459	$0	$0	$0	$0	$0	$0	$0	$0
Beneficiary	$507	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other	$73,231	$91,214	$112,567	$116,957	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$79,525	$97,192	$118,784	$123,416	$0	$0	$0	$0	$0	$0	$0	$0
22 Transportation of Things	$23,582	$30,489	$39,420	$40,957	$0	$0	$0	$0	$0	$0	$0	$0
23 Rent, Communications, and Utilities:												
Rental of Equipment	$14,732	$15,218	$15,827	$16,444	$0	$0	$0	$0	$19	$0	$0	$0
Communications 1/	$10,882	$11,241	$11,691	$12,147	$0	$0	$0	$0	$0	$0	$0	$0
Utilities	$688,166	$710,398	$738,076	$766,861	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental (Including GSA) 1/	$1,018,639	$1,082,916	$1,215,463	$1,388,936	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,732,419	$1,819,773	$1,981,057	$2,184,388	$0	$0	$0	$0	$19	$0	$0	$0
24 Printing & Reproduction:	$79	$82	$85	$88	$0	$0	$0	$0	$0	$0	$0	$0
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$18	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$976	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Furniture/Equipment	$25,305	$26,140	$27,186	$28,246	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Contract Services	$399,005	$466,038	$415,240	$422,299	$0	$0	$0	$0	$130	$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	$1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$2,698	$2,787	$2,898	$3,011	$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	$21,684	$0	$0	$0	$0	$0	$0	$0	$1	$0	$0	$0
Administrative Contract Services	$660,623	$1,310,780	$591,463	$601,958	$0	$0	$0	$0	$12	$12,687	$0	$0
Training Contract Services	$2,037	$2,104	$2,188	$2,273	$0	$0	$0	$0	$0	$0	$0	$0
Caregiver Stipends	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,112,347	$1,807,849	$1,038,975	$1,057,787	$0	$0	$0	$0	$143	$12,687	$0	$0

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

(dollars in thousands)

Description	Discretionary Appropriations Medical Facilities				Discretionary Appropriations Recurring Expenses Transformational Funding				Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA)			
	FY 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027
26 Supplies & Materials:												
Provisions	$382	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Drugs & Medicines	$325	$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	$4,349	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Operating Supplies	$170,360	$177,174	$184,084	$191,263	$0	$0	$0	$0	$18	$0	$0	$0
Maintenance & Repair Supplies	$213,769	$227,680	$236,559	$245,785	$0	$0	$0	$0	$11	$0	$0	$0
Other Supplies	$90,866	$94,501	$98,187	$102,016	$0	$0	$0	$0	$10	$0	$0	$0
Prosthetic Appliances	$59	$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	$480,110	$499,355	$518,830	$539,064	$0	$0	$0	$0	$39	$0	$0	$0
31 Equipment	$84,945	$143,764	$143,764	$143,764	$0	$0	$0	$0	$382	$0	$0	$0
32 Lands & Structures:												
Non-Recurring Maintenance	$2,315,281	$2,565,853	$4,837,500	$3,037,500	$0	$0	$0	$0	-$2,992	$0	$0	$0
All Other Lands & Structures	$234,543	$87,411	$470,460	$1,690,479	$0	$0	$0	$0	$116	$0	$0	$0
Subtotal	$2,549,824	$2,653,264	$5,307,960	$4,727,979	$0	$0	$0	$0	-$2,876	$0	$0	$0
41 Grants, Subsidies & Contributions:												
State Home	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Grants	-$4	$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	-$4	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
42 - Insurance Claims and Indemnities	$4,986	$5,185	$5,388	$5,598	$0	$0	$0	$0	$0	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$8,793,611	$9,814,487	$11,948,765	$11,631,970	$0	$0	$0	$0	-$2,293	$12,687	$0	$0
Prior Year Recoveries	$18,371	$0	$0	$0	$0	$0	$0	$0	$3,002	$0	$0	$0
Obligations [Total]	**$8,811,982**	**$9,814,487**	**$11,948,765**	**$11,631,970**	**$0**	**$0**	**$0**	**$0**	**$709**	**$12,687**	**$0**	**$0**

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

(dollars in thousands)

Description	Mandatory Appropriations PACT Act, sec. 705				Mandatory Appropriations PACT Act, sec. 707				Discretionary and Mandatory Grand Total Medical Facilities Category			
	FY 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027
10 Personnel Compensation and Benefits:												
Physicians	$0	$0	$0	$0	$0	$0	$0	$0	$176	$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	$882	$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	-$1	$0	$0	$0
Health Technicians/Allied Health	$0	$0	$0	$0	$0	$0	$0	$0	$15,344	$15,143	$15,540	$15,851
Wage Board/Purchase & Hire	$0	$0	$0	$0	$0	$0	$0	$0	$1,981,988	$1,991,793	$2,009,447	$2,008,448
All Other	$0	$0	$0	$0	$0	$0	$0	$0	$694,509	$717,031	$735,267	$749,686
Permanent Change of Station	$0	$0	$0	$0	$0	$0	$0	$0	$1,593	$1,624	$1,657	$1,691
Employee Compensation Pay	$0	$0	$0	$0	$0	$0	$0	$0	$31,307	$31,943	$32,591	$33,253
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$2,725,798	$2,757,534	$2,794,502	$2,808,929
21 Travel & Transportation of Persons:												
Employee	$0	$0	$0	$0	$0	$0	$0	$0	$5,787	$5,978	$6,217	$6,459
Beneficiary	$0	$0	$0	$0	$0	$0	$0	$0	$507	$0	$0	$0
Other	$0	$0	$0	$0	$0	$0	$0	$0	$73,231	$91,214	$112,567	$116,957
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$79,525	$97,192	$118,784	$123,416
22 Transportation of Things	$0	$0	$0	$0	$0	$0	$0	$0	$23,582	$30,489	$39,420	$40,957
23 Rent, Communications, and Utilities:												
Rental of Equipment	$0	$0	$0	$0	$0	$0	$0	$0	$14,751	$15,218	$15,827	$16,444
Communications 1/	$0	$0	$0	$0	$0	$0	$0	$0	$10,882	$11,241	$11,691	$12,147
Utilities	$0	$0	$0	$0	$0	$0	$0	$0	$688,166	$710,398	$738,076	$766,861
Other Real Property Rental (Including GSA) 1/	$0	$0	$0	$0	$0	$0	$3,580	$18,522	$1,018,639	$1,082,916	$1,219,043	$1,407,458
Subtotal	$0	$0	$0	$0	$0	$0	$3,580	$18,522	$1,732,438	$1,819,773	$1,984,637	$2,202,910
24 Printing & Reproduction:	$0	$0	$0	$0	$0	$0	$0	$0	$79	$82	$85	$88
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$0	$0	$0	$0	$0	$0	$0	$0	$18	$0	$0	$0
Medical and Nursing Care in the Community	$0	$0	$0	$0	$0	$0	$0	$0	$976	$0	$0	$0
Repairs to Furniture/Equipment	$0	$0	$0	$0	$0	$0	$0	$0	$25,305	$26,140	$27,186	$28,246
Maintenance & Repair Contract Services	$0	$0	$0	$0	$0	$0	$0	$0	$399,135	$466,038	$415,240	$422,299
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	$1	$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	$2,698	$2,787	$2,898	$3,011
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	$21,685	$0	$0	$0
Administrative Contract Services	$7,969	$9,000	$9,360	$9,734	$338	$1,060	$6,350	$0	$668,942	$1,333,527	$607,173	$611,692
Training Contract Services	$0	$0	$0	$0	$0	$0	$0	$0	$2,037	$2,104	$2,188	$2,273
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	$7,969	$9,000	$9,360	$9,734	$338	$1,060	$6,350	$0	$1,120,797	$1,830,596	$1,054,685	$1,067,521

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

(dollars in thousands)

Description	Mandatory Appropriations PACT Act, sec. 705				Mandatory Appropriations PACT Act, sec. 707				Discretionary and Mandatory Grand Total Medical Facilities Category			
	FY 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027
26 Supplies & Materials:												
Provisions	$0	$0	$0	$0	$0	$0	$0	$0	$382	$0	$0	$0
Drugs & Medicines	$0	$0	$0	$0	$0	$0	$0	$0	$325	$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	$4,349	$0	$0	$0
Operating Supplies	$0	$0	$0	$0	$0	$0	$0	$0	$170,378	$177,174	$184,084	$191,263
Maintenance & Repair Supplies	$0	$0	$0	$0	$0	$0	$0	$0	$213,780	$227,680	$236,559	$245,785
Other Supplies	$0	$0	$0	$0	$0	$0	$0	$0	$90,876	$94,501	$98,187	$102,016
Prosthetic Appliances	$0	$0	$0	$0	$0	$0	$0	$0	$59	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$480,149	$499,355	$518,830	$539,064
31 Equipment	$0	$0	$0	$0	$0	$0	$0	$0	$85,327	$143,764	$143,764	$143,764
32 Lands & Structures:												
Non-Recurring Maintenance	$18,007	$60,710	$3,900	$2,704	$15,660	$0	$0	$0	$2,345,956	$2,626,563	$4,841,400	$3,040,204
All Other Lands & Structures	$0	$0	$0	$0	$54,935	$463,547	$862,450	$823,810	$289,594	$550,958	$1,332,910	$2,514,289
Subtotal	$18,007	$60,710	$3,900	$2,704	$70,595	$463,547	$862,450	$823,810	$2,635,550	$3,177,521	$6,174,310	$5,554,493
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	-$4	$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	-$4	$0	$0	$0
42 - Insurance Claims and Indemnities	$0	$0	$0	$0	$0	$0	$0	$0	$4,986	$5,185	$5,388	$5,598
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$25,976	$69,710	$13,260	$12,438	$70,933	$464,607	$872,380	$842,332	$8,888,227	$10,361,491	$12,834,405	$12,486,740
Prior Year Recoveries	$2,355	$0	$0	$0	$0	$0	$0	$0	$23,728	$0	$0	$0
Obligations [Total]	**$28,331**	**$69,710**	**$13,260**	**$12,438**	**$70,933**	**$464,607**	**$872,380**	**$842,332**	**$8,911,955**	**$10,361,491**	**$12,834,405**	**$12,486,740**

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

(dollars in thousands)

Description	Discretionary Appropriations Medical Community Care FY 2024	FY 2025	FY 2026	FY 2027	Mandatory Appropriations Veterans Choice Fund FY 2024	FY 2025	FY 2026	FY 2027
10 Personnel Compensation and Benefits:								
Physicians	$0	$0	$0	$0	$0	$0	$0	$0
Dentists	$0	$0	$0	$0	$0	$0	$0	$0
Registered Nurses	$0	$0	$0	$0	$0	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$0	$0	$0	$0	$0	$0	$0	$0
Non-Physician Providers	$0	$0	$0	$0	$0	$0	$0	$0
Health Technicians/Allied Health	$0	$0	$0	$0	$0	$0	$0	$0
Wage Board/Purchase & Hire	$0	$0	$0	$0	$0	$0	$0	$0
All Other	$0	$0	$0	$0	$0	$0	$0	$0
Permanent Change of Station	$0	$0	$0	$0	$0	$0	$0	$0
Employee Compensation Pay	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
21 Travel & Transportation of Persons:								
Employee	$0	$0	$0	$0	$0	$0	$0	$0
Beneficiary	$0	$0	$0	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
22 Transportation of Things	$0	$0	$0	$0	$0	$0	$0	$0
23 Rent, Communications, and Utilities:								
Rental of Equipment	$0	$0	$0	$0	$0	$0	$0	$0
Communications	$0	$0	$0	$0	$0	$0	$0	$0
Utilities	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental (Including GSA)	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
24 Printing & Reproduction:	$0	$0	$0	$0	$0	$0	$0	$0
25 Other Contractual Services:								
Care in the Community Outpatient Dental Care	$1,144,490	$1,118,432	$1,386,574	$1,531,126	$51	$0	$0	$0
Medical and Nursing Care in the Community	$8,721,136	$6,271,317	$9,958,391	$11,780,295	($54)	$182,593	$0	$0
Repairs to Furniture/Equipment	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Contract Services	$0	$0	$0	$0	$0	$0	$0	$0
Care in the Community Hospital Care	$9,498,062	$5,683,964	$9,154,634	$9,933,239	$6	$0	$0	$0
Community Nursing Homes	$1,650,940	$1,101,379	$1,589,346	$1,717,884	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$0	$0	$0	$0	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$31,813	$24,086	$34,969	$39,716	$0	$0	$0	$0
House Staff Disbursing Agreement	$0	$0	$0	$0	$0	$0	$0	$0
Scarce Medical Specialists	$0	$0	$0	$0	$0	$0	$0	$0
Other Medical Contract Services	$7,054,919	$5,205,207	$7,441,962	$8,610,200	$97	$122,029	$0	$0
Administrative Contract Services	$3,002	$2,273	$3,300	$3,748	$104	$0	$0	$0
Training Contract Services	$0	$0	$0	$0	$0	$0	$0	$0
Caregiver Stipends	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$1,772,396	$2,547,024	$2,951,384	$3,325,299	$0	$0	$0	$0
Subtotal 2/	$29,876,758	$21,953,682	$32,520,560	$36,941,507	$204	$304,622	$0	$0

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

(dollars in thousands)

Description	Discretionary Appropriations Medical Community Care				Mandatory Appropriations Veterans Choice Fund			
	FY 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027
26 Supplies & Materials:								
Provisions	$0	$0	$0	$0	$0	$0	$0	$0
Drugs & Medicines	$20,137	$22,539	$24,871	$27,209	$0	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$0	$0	$0	$0	$0	$0	$0	$0
Operating Supplies	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Supplies	$0	$0	$0	$0	$0	$0	$0	$0
Other Supplies	$0	$0	$0	$0	$0	$0	$0	$0
Prosthetic Appliances	$0	$0	$0	$0	$0	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$20,137	$22,539	$24,871	$27,209	$0	$0	$0	$0
31 Equipment	$0	$0	$0	$0	$0	$0	$0	$0
32 Lands & Structures:								
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
41 Grants, Subsidies & Contributions:								
State Home	$1,773,193	$2,001,441	$2,266,407	$2,568,784	$0	$0	$0	$0
Grants	$0	$0	$0	$0	$0	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal 2/	$1,773,193	$2,001,441	$2,266,407	$2,568,784	$0	$0	$0	$0
42 - Insurance Claims and Indemnities	$0	$0	$0	$0	$0	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$31,670,088	$23,977,662	$34,811,838	$39,537,500	$204	$304,622	$0	$0
Prior Year Recoveries	$84,137	$0	$0	$0	$93	$0	$0	$0
Obligations [Total]	**$31,754,225**	**$23,977,662**	**$34,811,838**	**$39,537,500**	**$297**	**$304,622**	**$0**	**$0**

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

(dollars in thousands)

Description	Mandatory Appropriations Cost of War Toxic Exposures Fund				Discretionary and Mandatory Grand Total Medical Community Care Category			
	FY 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027
10 Personnel Compensation and Benefits:								
Physicians	$0	$0	$0	$0	$0	$0	$0	$0
Dentists	$0	$0	$0	$0	$0	$0	$0	$0
Registered Nurses	$0	$0	$0	$0	$0	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$0	$0	$0	$0	$0	$0	$0	$0
Non-Physician Providers	$0	$0	$0	$0	$0	$0	$0	$0
Health Technicians/Allied Health	$0	$0	$0	$0	$0	$0	$0	$0
Wage Board/Purchase & Hire	$0	$0	$0	$0	$0	$0	$0	$0
All Other	$0	$0	$0	$0	$0	$0	$0	$0
Permanent Change of Station	$0	$0	$0	$0	$0	$0	$0	$0
Employee Compensation Pay	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
21 Travel & Transportation of Persons:								
Employee	$0	$0	$0	$0	$0	$0	$0	$0
Beneficiary	$0	$0	$0	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
22 Transportation of Things	$0	$0	$0	$0	$0	$0	$0	$0
23 Rent, Communications, and Utilities:								
Rental of Equipment	$0	$0	$0	$0	$0	$0	$0	$0
Communications	$0	$0	$0	$0	$0	$0	$0	$0
Utilities	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental (Including GSA)	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
24 Printing & Reproduction:	$0	$0	$0	$0	$0	$0	$0	$0
25 Other Contractual Services:								
Care in the Community Outpatient Dental Care	$122,144	$428,278	$324,847	$335,729	$1,266,685	$1,546,710	$1,711,421	$1,866,855
Medical and Nursing Care in the Community	$1,602,278	$6,097,055	$5,047,078	$5,216,154	$10,323,360	$12,550,965	$15,005,469	$16,996,449
Repairs to Furniture/Equipment	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Contract Services	$0	$0	$0	$0	$0	$0	$0	$0
Care in the Community Hospital Care	$1,727,464	$6,114,666	$4,677,107	$4,833,788	$11,225,532	$11,798,630	$13,831,741	$14,767,027
Community Nursing Homes	$343,456	$1,335,038	$1,000,962	$1,034,494	$1,994,396	$2,436,417	$2,590,308	$2,752,378
Repairs to Prosthetic Appliances	$0	$0	$0	$0	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$7,049	$25,990	$20,610	$21,290	$38,862	$50,076	$55,579	$61,006
House Staff Disbursing Agreement	$0	$0	$0	$0	$0	$0	$0	$0
Scarce Medical Specialists	$0	$0	$0	$0	$0	$0	$0	$0
Other Medical Contract Services	$997,609	$3,694,689	$2,959,396	$3,058,545	$8,052,625	$9,021,925	$10,401,358	$11,668,745
Administrative Contract Services	$0	$0	$0	$0	$3,106	$2,273	$3,300	$3,748
Training Contract Services	$0	$0	$0	$0	$0	$0	$0	$0
Caregiver Stipends	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$0	$0	$0	$0	$1,772,396	$2,547,024	$2,951,384	$3,325,299
Subtotal 2/	$4,800,000	$17,695,716	$14,030,000	$14,500,000	$34,676,962	$39,954,020	$46,550,560	$51,441,507

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

(dollars in thousands)

Description	Mandatory Appropriations Cost of War Toxic Exposures Fund FY 2024	FY 2025	FY 2026	FY 2027	Discretionary and Mandatory Grand Total Medical Community Care Category FY 2024	FY 2025	FY 2026	FY 2027
26 Supplies & Materials:								
Provisions								
Drugs & Medicines	$0	$0	$0	$0	$20,137	$22,539	$24,871	$27,209
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$0	$0	$0	$0	$0	$0	$0	$0
Operating Supplies	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Supplies	$0	$0	$0	$0	$0	$0	$0	$0
Other Supplies	$0	$0	$0	$0	$0	$0	$0	$0
Prosthetic Appliances	$0	$0	$0	$0	$0	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$20,137	$22,539	$24,871	$27,209
31 Equipment	$0	$0	$0	$0	$0	$0	$0	$0
32 Lands & Structures:								
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
41 Grants, Subsidies & Contributions:								
State Home	$0	$0	$0	$0	$1,773,193	$2,001,441	$2,266,407	$2,568,784
Grants	$0	$0	$0	$0	$0	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal 2/	$0	$0	$0	$0	$1,773,193	$2,001,441	$2,266,407	$2,568,784
42 - Insurance Claims and Indemnities	$0	$0	$0	$0	$0	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$4,800,000	$17,695,716	$14,030,000	$14,500,000	$36,470,292	$41,978,000	$48,841,838	$54,037,500
Prior Year Recoveries	$0	$0	$0	$0	$84,230	$0	$0	$0
Obligations [Total]	**$4,800,000**	**$17,695,716**	**$14,030,000**	**$14,500,000**	**$36,554,522**	**$41,978,000**	**$48,841,838**	**$54,037,500**

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 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027	FY 2024	FY 2025	FY 2026	FY 2027
10 Personnel Compensation and Benefits:												
Physicians	$8,611,370	$8,369,986	$4,721,040	$4,717,236	$1,604,919	$2,243,556	$6,132,067	$6,335,256	$10,216,289	$10,613,542	$10,853,107	$11,052,492
Dentists	$430,470	$355,996	$192,296	$188,324	$0	$98,564	$269,574	$278,506	$430,470	$454,560	$461,870	$466,830
Registered Nurses	$10,654,906	$11,734,256	$6,304,093	$5,840,371	$4,008,511	$3,307,164	$8,699,361	$8,980,495	$14,663,417	$15,041,420	$15,003,454	$14,820,866
LP Nurse/LV Nurse/Nurse Assistant	$2,335,711	$2,342,444	$1,350,216	$1,447,487	$554,465	$656,822	$1,796,463	$1,855,990	$2,890,176	$2,999,266	$3,146,679	$3,303,477
Non-Physician Providers	$3,662,432	$4,016,003	$2,195,535	$2,163,076	$1,103,999	$1,100,927	$3,011,539	$3,111,328	$4,766,431	$5,116,930	$5,207,074	$5,274,404
Health Technicians/Allied Health	$12,455,750	$11,034,957	$6,271,175	$6,500,551	$758,159	$3,036,389	$8,305,246	$8,580,444	$13,213,909	$14,071,346	$14,576,421	$15,080,995
Wage Board/Purchase & Hire	$2,571,236	$2,487,163	$2,326,304	$2,311,514	$0	$103,520	$283,013	$292,391	$2,571,236	$2,590,683	$2,609,317	$2,603,905
All Other	$12,000,736	$11,961,064	$10,242,924	$10,015,249	$750,569	$1,359,885	$3,331,836	$3,736,106	$12,751,305	$13,320,949	$13,574,760	$13,751,355
Permanent Change of Station	$14,904	$15,206	$15,514	$15,829	$0	$0	$0	$0	$14,904	$15,206	$15,514	$15,829
Employee Compensation Pay	$369,357	$376,857	$384,507	$392,313	$0	$0	$0	$0	$369,357	$376,857	$384,507	$392,313
Subtotal	$53,106,872	$52,693,932	$34,003,604	$33,591,950	$8,780,622	$11,906,827	$31,829,099	$33,170,516	$61,887,494	$64,600,759	$65,832,703	$66,762,466
21 Travel & Transportation of Persons:												
Employee	$128,730	$140,421	$143,331	$146,282	$5	$0	$0	$0	$128,735	$140,421	$143,331	$146,282
Beneficiary	$1,317,801	$1,730,378	$1,066,716	$1,142,666	$748,985	$409,090	$1,182,270	$1,221,445	$2,066,786	$2,139,468	$2,248,986	$2,364,111
Other	$130,915	$182,759	$209,164	$217,030	$12	$0	$0	$0	$130,927	$182,759	$209,164	$217,030
Subtotal	$1,577,446	$2,053,558	$1,419,211	$1,505,978	$749,002	$409,090	$1,182,270	$1,221,445	$2,326,448	$2,462,648	$2,601,481	$2,727,423
22 Transportation of Things	$79,102	$93,280	$106,504	$109,873	$0	$0	$0	$0	$79,102	$93,280	$106,504	$109,873
23 Rent, Communications, and Utilities:												
Rental of Equipment	$539,737	$675,605	$801,347	$832,600	$19	$0	$0	$0	$539,756	$675,605	$801,347	$832,600
Communications 1/	$689,351	$783,075	$866,944	$900,755	$0	$0	$0	$0	$689,351	$783,075	$866,944	$900,755
Utilities	$689,784	$710,398	$738,076	$766,861	$0	$0	$0	$0	$689,784	$710,398	$738,076	$766,861
Other Real Property Rental (Including GSA) 1/	$1,029,851	$1,082,916	$1,215,463	$1,388,936	$0	$0	$3,580	$18,522	$1,029,851	$1,082,916	$1,219,043	$1,407,458
Subtotal	$2,948,723	$3,251,994	$3,621,830	$3,889,152	$19	$0	$3,580	$18,522	$2,948,742	$3,251,994	$3,625,410	$3,907,674
24 Printing & Reproduction:	$36,742	$38,211	$38,654	$40,162	$0	$0	$0	$0	$36,742	$38,211	$38,654	$40,162
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$1,150,933	$1,125,069	$1,393,476	$1,538,297	$122,195	$428,278	$324,847	$335,729	$1,273,128	$1,553,347	$1,718,323	$1,874,026
Medical and Nursing Care in the Community	$9,059,765	$6,618,121	$10,319,067	$12,155,037	$1,602,224	$6,279,648	$5,047,078	$5,216,154	$10,661,989	$12,897,769	$15,366,145	$17,371,191
Repairs to Furniture/Equipment	$436,742	$451,155	$469,201	$487,499	$0	$0	$0	$0	$436,742	$451,155	$469,201	$487,499
Maintenance & Repair Contract Services	$479,717	$547,131	$499,577	$509,925	$268	$0	$0	$0	$479,985	$547,131	$499,577	$509,925
Care in the Community Hospital Care	$9,498,062	$5,683,964	$9,154,634	$9,933,239	$1,727,470	$6,114,666	$4,677,107	$4,833,788	$11,225,532	$11,798,630	$13,831,741	$14,767,027
Community Nursing Homes	$1,650,940	$1,101,379	$1,589,346	$1,717,884	$343,456	$1,335,038	$1,000,962	$1,034,494	$1,994,396	$2,436,417	$2,590,308	$2,752,378
Repairs to Prosthetic Appliances	$401,376	$453,126	$500,946	$549,750	$0	$0	$0	$0	$401,376	$453,126	$500,946	$549,750
Home Oxygen	$216,811	$244,765	$270,596	$296,959	$0	$0	$0	$0	$216,811	$244,765	$270,596	$296,959
Organ Procurement	$13,969	$14,430	$15,007	$15,592	$0	$0	$0	$0	$13,969	$14,430	$15,007	$15,592
Personal Services Contracts	$116,366	$111,430	$125,806	$134,096	$7,054	$25,990	$20,610	$21,290	$123,420	$137,420	$146,416	$155,386
House Staff Disbursing Agreement	$866,797	$895,401	$931,217	$967,534	$228	$0	$0	$0	$867,025	$895,401	$931,217	$967,534
Scarce Medical Specialists	$238,818	$246,697	$256,565	$266,571	$30	$0	$0	$0	$238,848	$246,697	$256,565	$266,571
Other Medical Contract Services	$9,015,808	$7,436,863	$11,907,115	$11,541,851	$997,704	$3,816,830	$2,959,396	$3,058,545	$10,013,512	$11,253,693	$14,866,511	$14,600,396
Administrative Contract Services	$3,998,239	$5,394,714	$4,570,876	$4,722,915	$77,290	$23,126	$15,710	$9,734	$4,075,529	$5,417,840	$4,586,586	$4,732,649
Training Contract Services	$184,199	$190,277	$197,887	$205,605	$39	$0	$0	$0	$184,238	$190,277	$197,887	$205,605
Caregiver Stipends	$1,565,072	$1,919,844	$2,372,254	$2,656,451	$0	$0	$0	$0	$1,565,072	$1,919,844	$2,372,254	$2,656,451
CHAMPVA	$1,772,396	$2,567,024	$2,972,384	$3,347,299	$0	$0	$0	$0	$1,772,396	$2,567,024	$2,972,384	$3,347,299
Subtotal 2/	$40,666,010	$35,001,390	$47,545,954	$51,046,504	$4,877,958	$18,023,576	$14,045,710	$14,509,734	$45,543,968	$53,024,966	$61,591,664	$65,556,238

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)			
	FY2024	FY2025	FY2026	FY2027	FY2024	FY2025	FY2026	FY2027	FY2024	FY2025	FY2026	FY2027
26 Supplies & Materials:												
Provisions	$152,493	$153,913	$160,070	$166,313	$0	$0	$0	$0	$152,493	$153,913	$160,070	$166,313
Drugs & Medicines	$8,190,163	$11,815,004	$12,083,859	$13,787,835	$2,962,608	$1,253,812	$2,758,631	$2,850,039	$11,152,771	$13,068,816	$14,842,490	$16,637,874
Blood & Blood Products	$53,818	$55,594	$57,818	$60,073	$0	$0	$0	$0	$53,818	$55,594	$57,818	$60,073
Medical/Dental Supplies	$2,398,016	$3,111,550	$3,763,731	$3,910,517	$33	$0	$0	$0	$2,398,049	$3,111,550	$3,763,731	$3,910,517
Operating Supplies	$530,014	$548,697	$568,809	$590,992	$82	$0	$0	$0	$530,096	$548,697	$568,809	$590,992
Maintenance & Repair Supplies	$256,241	$227,680	$236,559	$245,785	$11	$0	$0	$0	$256,252	$227,680	$236,559	$245,785
Other Supplies	$459,402	$480,509	$495,947	$515,289	$9	$0	$0	$0	$459,411	$480,509	$495,947	$515,289
Prosthetic Appliances	$3,806,818	$4,298,122	$4,751,723	$5,214,656	$0	$0	$0	$0	$3,806,818	$4,298,122	$4,751,723	$5,214,656
Home Respiratory Therapy	$439,361	$496,009	$548,355	$601,779	$0	$0	$0	$0	$439,361	$496,009	$548,355	$601,779
Subtotal	$16,286,326	$21,187,078	$22,666,871	$25,093,239	$2,962,743	$1,253,812	$2,758,631	$2,850,039	$19,249,069	$22,440,890	$25,425,502	$27,943,278
31 Equipment	$1,330,058	$2,022,892	$2,300,000	$2,405,165	$496	$0	$0	$0	$1,330,554	$2,022,892	$2,300,000	$2,405,165
32 Lands & Structures:												
Non-Recurring Maintenance	$2,315,281	$2,565,853	$4,837,500	$3,037,500	$30,675	$60,710	$3,900	$2,704	$2,345,956	$2,626,563	$4,841,400	$3,040,204
All Other Lands & Structures	$238,048	$91,497	$474,657	$1,694,792	$55,122	$463,547	$862,450	$823,810	$293,170	$555,044	$1,337,107	$2,518,602
Subtotal	$2,553,329	$2,657,350	$5,312,157	$4,732,292	$85,797	$524,257	$866,350	$826,514	$2,639,126	$3,181,607	$6,178,507	$5,558,806
41 Grants, Subsidies & Contributions:												
State Home	$1,773,193	$2,001,441	$2,266,407	$2,568,784	$0	$0	$0	$0	$1,773,193	$2,001,441	$2,266,407	$2,568,784
Grants	$1,201,618	$1,143,064	$1,218,890	$1,431,014	$0	$0	$0	$0	$1,201,618	$1,143,064	$1,218,890	$1,431,014
Veteran Adoption Reimbursement	$8	$8	$8	$8	$0	$0	$0	$0	$8	$8	$8	$8
Subtotal 2/	$2,974,819	$3,144,513	$3,485,305	$3,999,806	$0	$0	$0	$0	$2,974,819	$3,144,513	$3,485,305	$3,999,806
42 Insurance Claims and Indemnities	$31,107	$42,915	$43,612	$44,336	$0	$0	$0	$0	$31,107	$42,915	$43,612	$44,336
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$121,590,534	$122,187,113	$120,543,702	$126,458,457	$17,456,637	$32,117,562	$50,685,640	$52,596,770	$139,047,171	$154,304,675	$171,229,342	$179,055,227
ARP 8007 Prior Year Recoveries	$0	$0	$0	$0	$5	$0	$0	$0	$5	$0	$0	$0
Prior Year Recoveries	$213,932	$0	$0	$0	$5,459	$0	$0	$0	$219,391	$0	$0	$0
Obligations [Total]	**$121,804,466**	**$122,187,113**	**$120,543,702**	**$126,458,457**	**$17,462,101**	**$32,117,562**	**$50,685,640**	**$52,596,770**	**$139,266,567**	**$154,304,675**	**$171,229,342**	**$179,055,227**

1/ Amounts from BOC 2311, “Rental Property Rental – GSA”, had been previously mapped to Communications and are now included in Other Real Property Rental (including GSA).
2/ Amounts for Object Class 25 and 41 in the Medical Community Care appropriation differ from the President’s Budget Appendix due to revised State Home cost estimates from subsequently available data.

Medical Care Areas of Focus

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

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

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Health Care Services:							
Ambulatory Care 1/	$51,724,145	$57,583,114	$57,801,406	$65,265,003	$65,148,184	$7,463,597	($116,819)
Dental Care	$2,778,552	$2,975,647	$3,072,287	$3,291,314	$3,486,234	$219,027	$194,920
Inpatient Care	$25,019,535	$25,973,867	$26,423,674	$27,630,181	$28,909,124	$1,206,507	$1,278,943
Mental Health Care 2/	$15,689,848	$17,053,718	$16,731,830	$18,886,195	$19,529,518	$2,154,365	$643,323
Pharmacy	$13,749,510	$14,880,740	$16,097,397	$18,283,001	$20,495,385	$2,185,604	$2,212,384
Prosthetic and Sensory Aids Services	$5,011,980	$5,343,218	$5,653,512	$6,241,476	$6,842,716	$587,964	$601,240
Rehabilitation Care	$1,411,181	$1,461,684	$1,452,097	$1,459,454	$1,454,245	$7,357	($5,209)
Health Care Services [Subtotal]	**$115,384,751**	**$125,271,988**	**$127,232,203**	**$141,056,624**	**$145,865,406**	**$13,824,421**	**$4,808,782**
Long-Term Services & Supports (LTSS):							
Institutional LTSS							
VA Community Living Centers (VA CLC)	$5,478,763	$5,470,160	$5,551,534	$5,619,357	$5,718,300	$67,823	$98,943
Community Nursing Home	$2,192,137	$2,078,128	$2,628,921	$2,788,370	$2,954,399	$159,449	$166,029
State Home Nursing	$1,731,909	$1,745,012	$1,945,841	$2,206,275	$2,503,751	$260,434	$297,476
State Home Domiciliary	$48,717	$62,662	$52,784	$57,086	$61,739	$4,302	$4,653
Institutional LTSS [Subtotal]	$9,451,526	$9,355,962	$10,179,080	$10,671,088	$11,238,189	$492,008	$567,101
Non-Institutional LTSS							
State Home Adult Day Care	$3,299	$1,986	$2,816	$3,046	$3,294	$230	$248
Other Non-Institutional LTSS	$8,162,207	$7,678,612	$9,624,333	$11,185,658	$12,647,664	$1,561,325	$1,462,006
Non-Institutional LTSS [Subtotal]	$8,165,506	$7,680,598	$9,627,149	$11,188,704	$12,650,958	$1,561,555	$1,462,254
LTSS [Subtotal]	**$17,617,032**	**$17,036,560**	**$19,806,229**	**$21,859,792**	**$23,889,147**	**$2,053,563**	**$2,029,355**
Other Health Care Programs:							
Camp Lejeune Families (P.L. 112-154)	$2,021	$4,606	$2,088	$2,172	$2,257	$84	$85
Caregiver Support Program 3/	$2,157,001	$2,913,000	$2,676,438	$3,264,938	$3,590,212	$588,500	$325,274
CHAMPVA & Other Dependent Prgs. 4/	$2,516,424	$2,898,351	$3,229,526	$3,726,092	$4,185,941	$496,566	$459,849
Homeless Program Grants 5/	$1,019,462	$983,946	$935,890	$935,890	$1,131,841	$0	$195,951
PACT Act § 705 Enhanced-Use Leases	$25,976	$40,608	$69,710	$13,260	$12,438	($56,450)	($822)
Readjustment Counseling	$324,504	$370,361	$352,591	$370,574	$377,985	$17,983	$7,411
Other Health Care Programs [Subtotal]	**$6,045,388**	**$7,210,872**	**$7,266,243**	**$8,312,926**	**$9,300,674**	**$1,046,683**	**$987,748**
Obligations [Subtotal]	**$139,047,171**	**$149,519,420**	**$154,304,675**	**$171,229,342**	**$179,055,227**	**$16,924,667**	**$7,825,885**
Recoveries of prior year paid & unpaid obligations	$219,396	$0	$0	$0	$0	$0	$0
Obligations [Total]	$139,266,567	$149,519,420	$154,304,675	$171,229,342	$179,055,227	$16,924,667	$7,825,885

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

[1/] The Ambulatory Care category includes cost adjustements made outside of the Enrollee Health Care Projection Model (EHCPM) to account for certain programmatic funding levels. All other service lines projected by the EHCPM are inflated by their respective EHCPM growth rates. (See the Actuarial Models Projections chapter for more information about the EHCPM.)

[2/] 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).
[3/] Includes stipend costs, respite care, mental health care, Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) benefits, and program administration for the Caregiver Support Program.
[4/] Excludes CHAMPVA benefits provided in the Caregiver Support Program.
[5/] Includes projected grant costs for the Grant and Per Diem (GPD) and Supportive Services for Low Income Veterans (SSVF). The 2025 Budget Estimate includes Legal Services for Veterans (LSV) programs.

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

Description	2024 Actual	2025 Budget Estimate 1/2/5/	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Medical Care Programs: (Included Above)							
Activations	$507,740	$623,359	$495,427	$653,863	$588,567	$158,436	($65,296)
Artifical Intelligence (Medical Care) 1/	$9,142	N/A	$32,762	$33,209	$33,873	$447	$664
Blind Rehabilitation Treatment	$166,718	$193,232	$180,185	$193,415	$206,909	$13,230	$13,494
Education & Training	$2,825,730	$3,048,609	$2,965,216	$3,132,370	$3,195,017	$167,154	$62,647
Food Security Program Office	$3,180	$16,985	$1,985	$17,526	$17,877	$15,541	$351
Health Professionals Educational Assistance Program 2/	$252,516	$369,277	$277,412	$310,647	$316,860	$33,235	$6,213
Indian Health Service/THP/UIO Reimbursement	$31,571	$37,924	$37,924	$41,717	$44,637	$3,793	$2,920
Intimate Partner Violence program	$29,833	$31,373	$30,862	$31,997	$32,637	$1,135	$640
Leases	$1,248,894	$2,263,759	$1,567,811	$2,490,726	$3,849,195	$922,915	$1,358,469
Mental Health Topics:							
Opioid Prevention:							
Treatment Modalities	$422,673	$458,562	$436,620	$454,086	$471,794	$17,466	$17,708
Pain and Opioid Management Program (includes Jason's Law) 3/	$216,939	$221,518	$200,592	$231,518	$236,148	$30,926	$4,630
Substance Use Disorder Initiative	$151,809	$263,881	$186,439	$232,287	$236,933	$45,848	$4,646
Suicide Prevention:							
Medical Treatment	$2,610,319	$2,667,713	$2,833,552	$2,953,958	$3,091,520	$120,406	$137,562
Outreach Programs	$560,328	$582,554	$579,888	$697,760	$713,418	$117,872	$15,658
National Center for Posttraumatic Stress Disorder 4/	$45,273	$42,000	$41,274	$41,274	$42,099	$0	$825
National Veterans Sports Program	$28,652	$30,542	$28,211	$29,072	$29,653	$861	$581
Neurology Centers of Excellence							
Epilepsy	$21,773	$23,871	$23,047	$25,000	$25,500	$1,953	$500
Headaches	$16,913	$22,092	$22,125	$24,000	$24,480	$1,875	$480
Multiple Sclerosis 2/	$3,080	$5,300	$5,992	$6,500	$6,630	$508	$130
Parkinson's Disease Research, Education and Clinical Centers 4/	$10,926	$10,200	$13,367	$14,500	$14,790	$1,133	$290
Non-Recurring Maintenance (Lands & Structure only) 5/	$2,345,955	$2,027,648	$2,626,563	$4,841,400	$3,040,204	$2,214,837	($1,801,196)
Precision Oncology Initiative	$186,440	$215,433	$214,159	$251,458	$256,487	$37,299	$5,029
Rural Health	$315,090	$337,455	$301,968	$342,455	$349,304	$40,487	$6,849
Spinal Cord Injury Treatment	$853,619	$1,081,569	$919,255	$991,961	$1,073,001	$72,706	$81,040
Supply Chain Management 2/	$88,175	$148,866	$91,840	$121,964	$124,403	$30,124	$2,439
Telehealth:							
Home & Clinic Based Telehealth	$5,136,964	$5,958,100	$5,587,400	$5,894,465	$6,191,287	$307,065	$296,822
Office of Connected Care Program	$331,682	$439,920	$422,409	$461,569	$470,800	$39,160	$9,231
Veterans Childcare Assistance Program 6/	$3,650	$18,619	$2,681	$21,656	$22,089	$18,975	$433
Veterans Homelessness Programs	$3,230,974	$3,210,276	$3,321,338	$3,459,121	$3,801,724	$137,783	$342,603
Whole Health	$86,524	$119,289	$107,271	$116,107	$118,429	$8,836	$2,322

Note: certain program funding levels presented in this table overlap and therefore cannot be added together to determine overall funding amounts.

[1/] Information not previously displayed in the 2025 Congressional Justification.

[2/] Excludes administrative costs in all years; these costs had been previously displayed in the 2025 Congressional Justification.

[3/] Includes the pain management, opioid safety, and prescription drug monitoring program costs of Jason's Law. Excludes Whole Health Patient Centered Care and Patient Advocacy cost components of Jason's Law.

[4/] 2024 actuals are represented by allocated amounts rather than obligations.

[5/] See the *Medical Facilities* chapter for the 2024 actual that includes supporting full-time equivalent (FTE) employees and contract-related costs pertaining to non-recurring maintenance, which are not included in this table.

[6/] The Veterans Childcare Assistance Program had been previously included in the Women's Health Program Office budget.

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

Description	2024 Actual	2025 Budget Estimate 1/	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
AIDS/HIV Program	$2,071,519	$2,062,108	$2,229,162	$2,392,232	$2,565,319	$163,070	$173,087
Health Outcomes Military Exposures (HOME):							
Gulf War Program	$8,303,100	$10,106,231	$9,838,985	$11,629,869	$13,757,280	$1,790,884	$2,127,410
OEF/OIF/OND/OIR	$16,720,576	$19,580,291	$19,676,251	$22,987,809	$26,688,949	$3,311,558	$3,701,139
Program Office	$68,783	$82,838	$75,696	$77,402	$78,950	$1,706	$1,548
Traumatic Brain Injury and Polytrauma System of Care:							
OEF/OIF/OND/OIR	$347,135	$359,553	$389,334	$438,564	$494,258	$49,230	$55,693
All Veteran Care	$1,135,159	$1,285,527	$1,240,863	$1,364,583	$1,498,219	$123,720	$133,635
Women Veterans Health Care:							
Program Office & Initiative Budget 1/	$98,130	$245,041	$177,583	$252,626	$257,679	$75,043	$5,053
Women Veterans-Specific Care	$986,081	$1,059,784	$1,145,627	$1,322,781	$1,529,716	$177,154	$206,935
All Care	$12,999,081	$13,657,684	$15,111,958	$17,641,692	$20,602,823	$2,529,734	$2,961,131

1/ The Women's Health Program Office budget no longer includes the Veterans Childcare Assistance Program.

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

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

Ambulatory Care

This health service category includes funding for ambulatory care provided in VA medical centers and community-based clinics, as well as ambulatory care provided in the community by non-VA providers. Estimated obligations in this category are derived primarily by applying the growth in obligations projected by the EHCPM to the most recent year of actual data. This category also includes cost adjustments made outside of the EHCPM to account for certain programmatic funding levels. For additional detail on the EHCPM's ambulatory care projections, see the Actuarial Model Projections chapter.

Table: Ambulatory Care
($ in thousands)

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$25,406,830	$29,988,308	$26,576,895	$20,244,006	$17,670,496	($6,332,889)	($2,573,510)
Medical Community Care (0140):	$10,498,189	$15,144,985	$7,918,667	$11,312,454	$13,085,282	$3,393,787	$1,772,828
Medical Support and Compliance (0152):	$4,985,454	$5,650,426	$5,709,397	$5,709,762	$5,658,048	$365	($51,714)
Medical Facilities (0162):	$4,055,964	$4,206,989	$4,550,922	$5,551,181	$5,401,228	$1,000,259	($149,953)
Discretionary Total	**$44,946,437**	**$54,990,708**	**$44,755,881**	**$42,817,403**	**$41,815,054**	**($1,938,478)**	**($1,002,349)**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$4,571,568	$1,928,186	$6,169,907	$16,913,423	$17,473,856	$10,743,516	$560,433
VACAA, Section 801 (0160)	$2,765	$4,980	$2,413	$0	$0	($2,413)	$0
Mandatory Obligations [Subtotal]	**$4,574,333**	**$1,933,166**	**$6,172,320**	**$16,913,423**	**$17,473,856**	**$10,741,103**	**$560,433**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$1,671,201	$0	$6,081,809	$4,871,109	$5,034,288	($1,210,700)	$163,179
Veterans Choice Fund (0172)	$59	$304,826	$304,622	$0	$0	($304,622)	$0
Mandatory Obligations [Subtotal]	**$1,671,260**	**$304,826**	**$6,386,431**	**$4,871,109**	**$5,034,288**	**($1,515,322)**	**$163,179**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$498,605	$0	$244,698	$235,288	$411,754	($9,410)	$176,466
VACAA, Section 801 (0152)	$1,019	$256	$1,582	$0	$0	($1,582)	$0
Mandatory Obligations [Subtotal]	**$499,624**	**$256**	**$246,280**	**$235,288**	**$411,754**	**($10,992)**	**$176,466**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$34,784	$354,158	$227,807	$427,780	$413,232	$199,973	($14,548)
VACAA, Section 801 (0162)	($2,293)	$0	$12,687	$0	$0	($12,687)	$0
Mandatory Obligations [Subtotal]	**$32,491**	**$354,158**	**$240,494**	**$427,780**	**$413,232**	**$187,286**	**($14,548)**
Mandatory Total	**$6,777,708**	**$2,592,406**	**$13,045,525**	**$22,447,600**	**$23,333,130**	**$9,402,075**	**$885,530**
Combined Discretionary and Mandatory by Category							
Medical Services	$29,981,163	$31,921,474	$32,749,215	$37,157,429	$35,144,352	$4,408,214	($2,013,077)
Medical Community Care	$12,169,449	$15,449,811	$14,305,098	$16,183,563	$18,119,570	$1,878,465	$1,936,007
Medical Support and Compliance	$5,485,078	$5,650,682	$5,955,677	$5,945,050	$6,069,802	($10,627)	$124,752
Medical Facilities	$4,088,455	$4,561,147	$4,791,416	$5,978,961	$5,814,460	$1,187,545	($164,501)
Obligations [Grand Total]	**$51,724,145**	**$57,583,114**	**$57,801,406**	**$65,265,003**	**$65,148,184**	**$7,463,597**	**($116,819)**

Notes:

- Ambulatory Care excludes all pharmacy costs, which had been included in this health care service category in prior years' Congressional Justifications, to align with the data in the Medical Services chapter. The Ambulatory Care category includes cost adjustments made outside of the EHCPM to account for certain programmatic funding levels.
- Obligations from PACT Act section 707 are allocated to the health care service category without specificity of project type.

Authority for Action:

- Title 38, United States Code (USC), Chapter 17
- 38 CFR §17.38: Medical Benefits Package
- 38 U.S.C. §1784A
- 38 U.S.C. §7301(b)
- P.L. 94-581, Veterans Omnibus Health Care Act of 1976
- P.L. 93-82, Veterans Health Care Expansion Act of 1973

Types of Services Provided

Primary Care: Patient Aligned Care (PACT) team is a customized patient-centered medical home model of care adopted and branded by VHA. PACT staff includes primary care providers (physicians, advanced practice nurses and physician assistants), registered nurses, clinical associates, licensed practical nurses, licensed vocational nurses, medical assistants, health technicians, intermediate care technicians, and clerical associates. The extended PACT team staff includes, but is not limited to dieticians, clinical pharmacist practitioners, and Primary Care Mental Health Integration staff (psychologists, psychiatrists, licensed clinical social workers, registered nurses, peer support specialists and care managers.) The PACT model has remained the foundational model for team-based primary care and over the years has incorporated virtual primary care modalities (for example, synchronous telehealth including video and telephone visits, clinical video telehealth visits to clinic or non-VA site of care, secure messaging, and patient generated health data via VA mobile apps.

Specialty Care Services: Specialty care is an area of health care focused on either a specific area of medicine or specific types of symptoms and conditions. Specialty care providers, also known as specialists, include doctors as well as nurses and physical therapists. Specialty care providers address chronic (ongoing) conditions like heart disease and osteoporosis as well as acute (sudden) conditions like a heart attack or a broken bone. Patients may also see a specialist for certain preventive care exams and screenings, such as a mammogram or colonoscopy, ideally coordinated with a patient's primary care provider. Specialty care delivery can be categorized at a high level by: 1) procedural outpatient care including: cardiology, dialysis, gastroenterology, ophthalmology, Mohs surgery (dermatology), and podiatry; 2) outpatient virtual care, where a significant amount of the care provided can be provided virtually, including: sleep medicine, dermatology, eye care and genomic medicine; and 3) outpatient brick and mortar, which would include specialties such as allergy, endocrinology, infectious diseases, kidney medicine (nephrology), and rheumatology.

VA Registered Dietitian Nutritionists (RDN): VA RDNs provide Veterans medical nutrition therapy, nutrition counseling, and nutrition education through multiple modalities (telehealth, one-to-one encounters, group classes in VHA ambulatory and outpatient clinics in each VA medical center.

Emergency Medicine: VA provides access to a wide range of ambulatory care services to Veterans, including access to on-demand, immediate care through 36 Urgent Care centers and 110 Emergency Departments.

Dental Care

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$1,036,280	$966,347	$1,090,276	$1,084,020	$1,131,394	($6,256)	$47,374
Medical Community Care (0140):	$1,240,425	$1,576,100	$1,118,432	$1,386,574	$1,531,126	$268,142	$144,552
Medical Support and Compliance (0152):	$202,166	$218,600	$230,900	$231,200	$229,200	$300	($2,000)
Medical Facilities (0162):	$170,789	$194,300	$189,800	$231,100	$225,000	$41,300	($6,100)
Discretionary Total	**$2,649,660**	**$2,955,347**	**$2,629,408**	**$2,932,894**	**$3,116,720**	**$303,486**	**$183,826**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$5,351	$0	$7,222	$19,797	$20,453	$12,575	$656
VACAA, Section 801 (0160)	$91	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$5,442**	**$0**	**$7,222**	**$19,797**	**$20,453**	**$12,575**	**$656**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$122,144	$0	$428,278	$324,847	$335,729	($103,431)	$10,882
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$122,144**	**$0**	**$428,278**	**$324,847**	**$335,729**	**($103,431)**	**$10,882**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$160	$0	$79	$76	$132	($3)	$56
VACAA, Section 801 (0152)	$38	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$198**	**$0**	**$79**	**$76**	**$132**	**($3)**	**$56**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$1,108	$20,300	$7,300	$13,700	$13,200	$6,400	($500)
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,108**	**$20,300**	**$7,300**	**$13,700**	**$13,200**	**$6,400**	**($500)**
Mandatory Total	**$128,892**	**$20,300**	**$442,879**	**$358,420**	**$369,514**	**($84,459)**	**$11,094**
Combined Discretionary and Mandatory by Category							
Medical Services	$1,041,722	$966,347	$1,097,498	$1,103,817	$1,151,847	$6,319	$48,030
Medical Community Care	$1,362,569	$1,576,100	$1,546,710	$1,711,421	$1,866,855	$164,711	$155,434
Medical Support and Compliance	$202,364	$218,600	$230,979	$231,276	$229,332	$297	($1,944)
Medical Facilities	$171,897	$214,600	$197,100	$244,800	$238,200	$47,700	($6,600)
Obligations [Grand Total]	**$2,778,552**	**$2,975,647**	**$3,072,287**	**$3,291,314**	**$3,486,234**	**$219,027**	**$194,920**

Note: obligations from PACT Act section 707 are allocated to the health care service category without specificity of project type.

This health service category includes funding for dental care provided in VA medical centers and community-based clinics, as well as dental care provided in the community by non-VA providers. Estimated obligations in this category are derived by applying the growth in obligations projected by the EHCPM to the most recent year of actual data. For additional detail on the EHCPM's dental care projections, see Actuarial Model Projections in Volume II. 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. The statutory authority limits dental eligibility for comprehensive (routine) dental care to certain qualifying Veterans.

Authority for Action:

- 38 USC §1710(c)
- 38 USC §1712
- 38 CFR §17.160 – 17.166.

Population Covered:
There are over 8.3 million Veterans enrolled in VA health. At the end of 2024 there were approximately 2.0 million enrolled Veterans eligible for comprehensive dental care (24.3% of all enrolled Veterans). During 2024, VA dental services managed the care of 679,000 Veterans eligible for comprehensive dental care. An additional 125,000 were eligible and provided dental care due to medical necessity, totaling 797,000 Veterans. 627,000 received care within the VA, 172,000 exclusively through community care, and 342,000 accessed dental care through a combination of care within the VA and through community providers. Some Veterans eligible for limited care become eligible for comprehensive dental care during the year due to a change in their disability rating.

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

Inpatient Care

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$9,832,274	$9,234,518	$9,340,101	$4,662,789	$4,783,280	($4,677,312)	$120,491
Medical Community Care (0140):	$8,206,279	$0	$5,035,356	$7,205,018	$8,004,342	$2,169,662	$799,324
Medical Support and Compliance (0152):	$1,812,102	$2,124,700	$2,069,800	$2,072,600	$2,054,400	$2,800	($18,200)
Medical Facilities (0162):	$1,506,623	$1,624,500	$1,674,500	$2,038,600	$1,984,600	$364,100	($54,000)
Discretionary Total	**$21,357,278**	**$12,983,718**	**$18,119,757**	**$15,979,007**	**$16,826,622**	**($2,140,750)**	**$847,615**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$1,931,097	$1,883,338	$2,606,258	$7,144,476	$7,381,212	$4,538,218	$236,736
VACAA, Section 801 (0160)	$1,013	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,932,110**	**$1,883,338**	**$2,606,258**	**$7,144,476**	**$7,381,212**	**$4,538,218**	**$236,736**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$1,535,289	$10,943,411	$5,488,068	$4,192,121	$4,332,556	($1,295,947)	$140,435
Veterans Choice Fund (0172)	$16	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,535,305**	**$10,943,411**	**$5,488,068**	**$4,192,121**	**$4,332,556**	**($1,295,947)**	**$140,435**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$175,626	$0	$86,191	$82,877	$145,034	($3,314)	$62,157
VACAA, Section 801 (0152)	$371	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$175,997**	**$0**	**$86,191**	**$82,877**	**$145,034**	**($3,314)**	**$62,157**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$18,845	$163,400	$123,400	$231,700	$223,700	$108,300	($8,000)
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$18,845**	**$163,400**	**$123,400**	**$231,700**	**$223,700**	**$108,300**	**($8,000)**
Mandatory Total	**$3,662,257**	**$12,990,149**	**$8,303,917**	**$11,651,174**	**$12,082,502**	**$3,347,257**	**$431,328**
Combined Discretionary and Mandatory by Category							
Medical Services	$11,764,384	$11,117,856	$11,946,359	$11,807,265	$12,164,492	($139,094)	$357,227
Medical Community Care	$9,741,584	$10,943,411	$10,523,424	$11,397,139	$12,336,898	$873,715	$939,759
Medical Support and Compliance	$1,988,099	$2,124,700	$2,155,991	$2,155,477	$2,199,434	($514)	$43,957
Medical Facilities	$1,525,468	$1,787,900	$1,797,900	$2,270,300	$2,208,300	$472,400	($62,000)
Obligations [Grand Total]	**$25,019,535**	**$25,973,867**	**$26,423,674**	**$27,630,181**	**$28,909,124**	**$1,206,507**	**$1,278,943**

Note: obligations from PACT Act section 707 are allocated to the health care service category without specificity of project type.

This health service category includes funding for inpatient care provided in VA medical centers and community-based clinics, as well as inpatient care provided in the community by non-VA providers. Estimated obligations in this category are derived by applying the growth in obligations projected by the EHCPM to the most recent year of actual data. For additional detail on the EHCPM's inpatient care projections, see the Actuarial Model Projections chapter.

Authority for Action:

- Title 38, USC, Chapter 17

Types of Services Provided

Inpatient care in VHA includes critical care, hospital medicine, emergency medicine, inpatient dialysis, critical care, and infection control and prevention. The VHA provides an array of inpatient anesthesia care services, including general anesthesia for major surgeries, regional anesthesia like epidurals and nerve blocks, and various levels of sedation for minor procedures. Comprehensive preoperative evaluations, continuous intraoperative monitoring, and postoperative care in the post-anesthesia care unit are also key components. Critical Care Intensivists provide inpatient care to

patients in the Intensive Care Units (ICUs) of 112 VHA facilities. Procedures include intubation, central venous and arterial catheter insertion, chest tube placement, thoracentesis, and various forms of bronchoscopy. Most of these intensivists are pulmonologists also providing consultative services to inpatients with lung disease. There are over 700 physicians that perform these services across the enterprise. Respiratory Therapists provide multiple services for hospitalized patients, including assessments, treatments, and interventions in the ICU and in-patient wards.

Hospital Medicine Physicians 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 care providers and educators, supervising thousands of medical students and residents each year. The National Hospital Medicine (HM) Program supports the field through a network of 18 Veterans Integrated Service Network (VISN) HM Consultants, direct guidance, policy development, and ongoing advancement of the HM community of practice. Tele-hospital medicine has been implemented at multiple sites, now supported by an Office of Rural Health Enterprise-Wide Initiative and represents an area of growth and opportunity to expand access to Hospital Medicine specialty care especially to rural VA Medical Centers.

Kidney Medicine provides consultative care for acute and chronic kidney disease for hospitalized Veterans across the enterprise. The Kidney Medicine program provided acute hemodialysis for 8,900 hospitalized Veterans with acute kidney injury or end-stage kidney disease in 2023. Availability of inpatient dialysis services supports the VA's ability to provide complex vascular and cardiovascular surgery, and kidney and non-kidney (heart, liver, lung and bone marrow) transplantation.

VHA Nutrition and Food Services (NFS) provides all the inpatient/residential food operations (i.e., meal services) to Veterans admitted to VA medical centers. VA RDNs provide Veterans in the VHA medical nutrition therapy, nutrition counseling, and nutrition education to Veterans admitted to VA medical centers.

VA's Inpatient Evaluation Center works closely with the Centers for Medicare and Medicaid Services (CMS) Center for Clinical Standards and Quality 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), and health care associated infections. 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.

Mental Health

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$9,608,173	$11,329,959	$9,862,150	$6,979,554	$7,518,127	($2,882,596)	$538,573
Medical Community Care (0140):	$1,644,400	$1,973,128	$968,071	$2,909,874	$2,878,951	$1,941,803	($30,923)
Medical Support and Compliance (0152):	$1,346,458	$1,561,100	$1,537,900	$1,540,000	$1,526,500	$2,100	($13,500)
Medical Facilities (0162):	$1,500,806	$1,516,000	$1,668,100	$2,030,800	$1,977,000	$362,700	($53,800)
Discretionary Total	**$14,099,837**	**$16,380,187**	**$14,036,221**	**$13,460,228**	**$13,900,578**	**($575,993)**	**$440,350**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$1,232,252	$505,942	$1,663,079	$4,558,961	$4,710,024	$2,895,882	$151,063
VACAA, Section 801 (0160)	$834	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,233,086**	**$505,942**	**$1,663,079**	**$4,558,961**	**$4,710,024**	**$2,895,882**	**$151,063**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$260,359	$56,589	$935,221	$723,859	$748,108	($211,362)	$24,249
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$260,359**	**$56,589**	**$935,221**	**$723,859**	**$748,108**	**($211,362)**	**$24,249**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$88,044	$0	$43,209	$41,547	$72,708	($1,662)	$31,161
VACAA, Section 801 (0152)	$267	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$88,311**	**$0**	**$43,209**	**$41,547**	**$72,708**	**($1,662)**	**$31,161**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$8,255	$111,000	$54,100	$101,600	$98,100	$47,500	($3,500)
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$8,255**	**$111,000**	**$54,100**	**$101,600**	**$98,100**	**$47,500**	**($3,500)**
Mandatory Total	**$1,590,011**	**$673,531**	**$2,695,609**	**$5,425,967**	**$5,628,940**	**$2,730,358**	**$202,973**
Combined Discretionary and Mandatory by Category							
Medical Services	$10,841,259	$11,835,901	$11,525,229	$11,538,515	$12,228,151	$13,286	$689,636
Medical Community Care	$1,904,759	$2,029,717	$1,903,292	$3,633,733	$3,627,059	$1,730,441	($6,674)
Medical Support and Compliance	$1,434,769	$1,561,100	$1,581,109	$1,581,547	$1,599,208	$438	$17,661
Medical Facilities	$1,509,061	$1,627,000	$1,722,200	$2,132,400	$2,075,100	$410,200	($57,300)
Obligations [Grand Total]	**$15,689,848**	**$17,053,718**	**$16,731,830**	**$18,886,195**	**$19,529,518**	**$2,154,365**	**$643,323**

Note: obligations from PACT Act section 707 are allocated to the health care service category without specificity of project type.

This health service category includes funding for mental health care provided in VA medical centers and community-based clinics, as well as mental health care provided in the community by non-VA providers. Estimated obligations in this category are derived by applying the growth in obligations projected by the EHCPM to the most recent year of actual data. For additional detail on the EHCPM's mental health care projections, see Section H – Actuarial Model Projections, in Volume II.

Treatment Modality (Continuum of Care)

- **VA Inpatient Hospital**. VA inpatient bed-based acute mental health care.
- **Non-VA Inpatient Hospital.** Purchased community inpatient bed-based acute mental health care.
- **Compensated Work Therapy - Transitional Residence.** Staffed structured residential environment in the community providing some mental health services augmented by use of other VA outpatient services.

- **VA Domiciliary Residential Rehabilitation Treatment**. Staffed structured residential environment in a VA medical center providing intensive mental health and substance use treatment services augmented by use of other VA outpatient services.
- **Non-VA Domiciliary Residential Rehabilitation Treatment**. Purchased community residential mental health and substance use care.
- **VA Outpatient Clinics.** The full range of VA outpatient medical health clinics, providing mental health services from Psychiatrists, Psychologists, Licensed Professional Counselors, Marriage and Family Therapists, and Social Workers as well as others with mental health expertise including Clinical Pharmacists, Physician Assistants, Advanced Practice Nurses, and Peer Support Specialists. The encounters may be individual or group sessions. The issue may be general mental health or care with special emphasis on posttraumatic stress disorder (PTSD), substance use disorder and homelessness.
- **Non-VA Outpatient.** General mental health services purchased from the community.

Suicide Prevention Outreach. VA Suicide Prevention services include the Veteran Crisis Line, Suicide Coordinators, comprehensive suicide risk assessment at VA facilities, and the cost of other national efforts to improve awareness of the risk of suicide and improve the care to those Veterans.

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

Major Characteristics of Mental Health Services for Veterans with Serious Mental Illness. The major characteristics in this section break out care provided to Veterans with serious mental illness (SMI) by sub-specialty such as PTSD, Substance Use, and General Mental Health Services. In addition, it shows the care associated with Suicide Prevention efforts and a default category which contains all the other mental health specialty care not provided to the SMI population, all community care mental health, and all mental health provided in a non-Mental Health specialty setting, such as a primary care clinic.

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

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Treatment Modality ($000):							
VA Inpatient Hospital	$2,275,965	$2,308,491	$2,268,731	$2,244,745	$2,218,894	($23,986)	($25,851)
Contract Inpatient Hospital	$1,241,455	$2,025,261	$1,363,165	$2,972,186	$2,833,220	$1,609,021	($138,966)
Psychiatric and VA Dom Res. Rehab. Trmt	$1,183,987	$1,426,272	$1,312,559	$1,363,302	$1,410,867	$50,743	$47,565
VA Outpatient Clinics	$8,800,753	$8,905,637	$9,358,330	$9,548,667	$10,103,768	$190,337	$555,101
Non-VA Outpatient	$402,945	$565,569	$540,127	$661,547	$793,839	$121,420	$132,292
Subtotal Direct Mental Health	$13,905,104	$15,231,230	$14,842,912	$16,790,447	$17,360,588	$1,947,535	$570,141
Non-Add included above:							
Suicide Prevention Treatment in MH setting	*$2,003,488*	*$2,046,921*	$2,174,826	$2,267,241	$2,372,823	*$92,415*	*$105,582*
Suicide Prevention Outreach 1/:							
Suicide Prevention Direct Program, SP	$476,906	$493,713	$493,713	$608,138	$620,301	$114,425	$12,163
Suicide Prevention Coordinators, GP	$83,422	$88,841	$86,175	$89,622	$93,117	$3,447	$3,495
Subtotal Suicide Prevention Program Subtotal	$560,328	$582,554	$579,888	$697,760	$713,418	$117,872	$15,658
Suicide Prevention Treatment in Non MH Setting	$606,830	$620,792	$658,726	$686,717	$718,697	$27,991	$31,980
Contract Homeless	$248,299	$242,153	$256,493	$266,753	$277,156	$10,260	$10,403
VA - Mental Health in non MH Setting	$369,286	$376,989	$393,811	$444,518	$459,659	$50,707	$15,141
Total Mental Health 2/	**$15,689,848**	**$17,053,718**	**$16,731,830**	**$18,886,195**	**$19,529,518**	**$2,154,365**	**$643,323**
Major Characteristics of Program ($000):							
SMI - PTSD	$412,561	$460,034	$464,746	$523,350	$588,971	$58,604	$65,621
SMI - Substance Abuse	$958,364	$1,023,402	$1,124,300	$1,319,589	$1,561,142	$195,289	$241,553
SMI - Other Than PTSD & SA	$8,080,000	$8,777,079	$9,168,014	$10,416,309	$11,561,639	$1,248,295	$1,145,330
Subtotal, SMI	$9,450,925	$10,260,515	$10,757,060	$12,259,248	$13,711,752	$1,502,188	$1,452,504
Suicide Prevention Outreach	$560,328	$582,554	$579,888	$697,760	$713,418	$117,872	$15,658
Other Mental Health (Non-SMI)	$5,678,595	$6,210,649	$5,394,882	$5,929,187	$5,104,348	$534,305	($824,839)
Total Mental Health 2/	**$15,689,848**	**$17,053,718**	**$16,731,830**	**$18,886,195**	**$19,529,518**	**$2,154,365**	**$643,323**
Included Above:							
OEF/OIF/OND POPULATION *ONLY*:							
SMI - PTSD	$188,413	$231,614	$209,289	$223,312	$236,830	$14,023	$13,518
SMI - Substance Abuse	$285,957	$302,754	$317,641	$338,925	$359,441	$21,284	$20,516
SMI - Other Than PTSD & SA	$1,781,563	$1,935,435	$1,978,966	$2,111,565	$2,239,382	$132,599	$127,817
Subtotal, SMI	$2,255,932	$2,469,803	$2,505,896	$2,673,802	$2,835,653	$167,906	$161,851
Other Mental Health (Non-SMI)	$1,513,948	$1,803,007	$1,681,697	$1,794,379	$1,902,996	$112,682	$108,617
Total OEF/OIF/OND	$3,769,880	$4,272,810	$4,187,593	$4,468,181	$4,738,649	$280,588	$270,468
Average Daily Census:							
Acute Psychiatry	1,654	1,530	1,562	1,491	1,425	(71)	(66)
Contract Hospital (Psych)	1,435	1,966	1,628	1,798	1,959	170	161
Psy Residential Rehab	4,222	4,837	4,681	4,758	4,839	77	81
Total	7,311	8,333	7,871	8,047	8,223	176	176
Outpatient Visits:							
VA Care - Mental Health	17,376,649	16,836,046	17,751,764	17,975,770	18,187,398	224,006	211,628
Non-VA Care - Mental Health	2,193,623	2,872,826	2,784,157	3,272,366	3,786,025	488,209	513,659
Not Included Above:							
VA - Mental Health in non MH Setting	683,697	697,025	706,540	725,200	721,619	18,660	(3,581)

1/ Suicide Prevention and Outreach program costs are depicted in these two rows. Please see the Suicide Prevention narrative later in this chapter for additional detail.
2/ Includes obligations at the Federal Health Care Center in the mental health care service category, which are offset in the ambulatory care health care service category to align with total medical care obligations.

Authority for Action:

- 38 United States Code (U.S.C.), Chapter 17
- 38 U.S.C. §1712A: Eligibility for readjustment counseling and related mental health services
- 38 U.S.C. §1720A: Treatment and rehabilitative services for persons with drug or alcohol dependency

- 38 U.S.C. §1720F: Comprehensive program for suicide prevention among Veterans and members of the reserve components of the Armed Forces
- 38 U.S.C. §1720H: Mental health treatment for Veterans and members of the reserve components of the Armed Forces who served in classified missions
- 38 U.S.C. §1720I: Mental and behavioral health care for certain former members of the Armed Forces
- 38 U.S.C. §1720J: Emergent Suicide Care
- P.L. 117-328, Division V, STRONG Veterans Act of 2022, Section 401: Expansion of Peer Specialist Support Program of Department of Veterans Affairs
- P.L. 116-315, Title V, Deborah Sampson Act, Sec. 5206: Staffing Improvement Plan for Peer Specialists of Department of Veterans Affairs Who are Women
- P.L. 116-171, Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019
- P.L. 115-182, VA MISSION Act of 2018, Section 506: Program on Establishment of Peer Specialists in Patient Aligned Care Team Settings Within VA Medical Centers
- P.L. 114-198, Jason Simcakoski Memorial and Promise Act, Secs. 901-933
- P.L. 114-2, Clay Hunt Suicide Prevention for American Veterans Act
- 38 CFR 17.38: Medical Benefits Package
- 38 CFR 17.80: Alcohol and drug dependence or abuse treatment and rehabilitation in residential and nonresidential facilities by contract
- 38 CFR 17.98: Mental Health Services

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 2 million Veterans (33% of all VHA patients) receiving mental health services in a VHA specialty mental health setting in 2024, defined as individual or group treatment provided by a mental health professional.

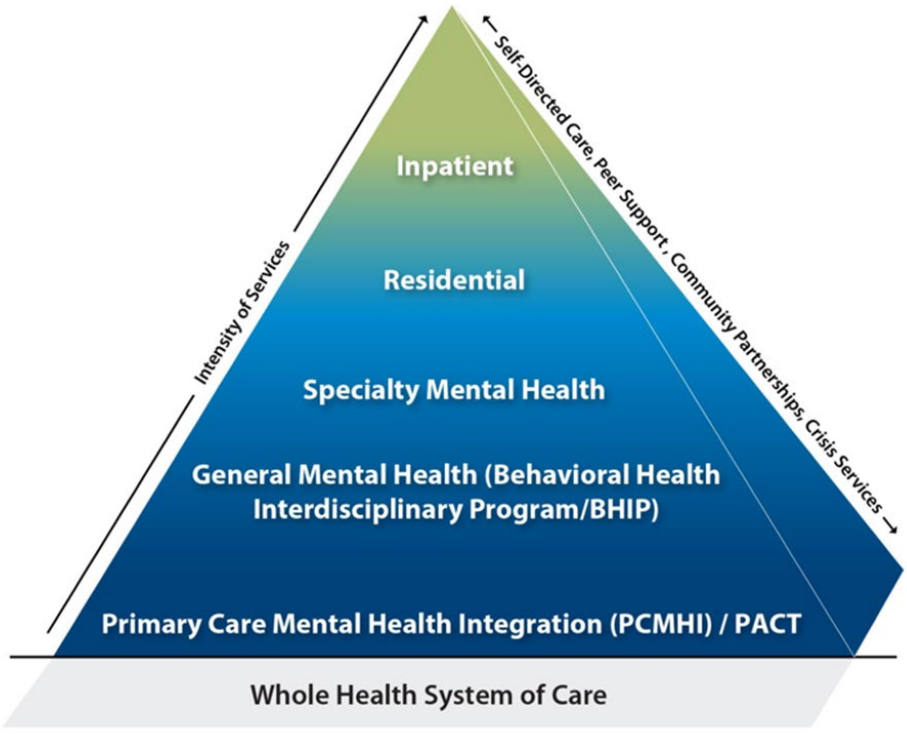
Across VA settings of care, more than 590,000 VHA eligible patients were seen in 2024 for a substance use disorder diagnosis. The proportions of VHA health-service users who receive mental health treatment vary across age groups. The proportions of VHA health-service users who receive mental health treatment are highest among younger Veterans and decline with age, but women in the older age groups are more likely to access mental health treatment compared to men. Among women, 51% of Veterans using VHA care in 2024 were under age 50, whereas among men, the comparable figure was 23%.

In 2024, the rate of all VHA users under age 50 who use VA mental health services was 45% while the rate for Veterans over age 50 was 24%. However, given the size of the older cohort of male Veterans, 52% of all users of VHA mental health services in 2024 were men over age 50, many of whom are over 65.

Types of Services Provided

The mission of the VHA mental health services is to promote, protect, and restore Veterans' mental health and overall well-being; to empower and equip them to achieve their life goals; and to provide quality, state-of-the-art care in a timely manner. 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, Veterans, their families (as appropriate), and their mental health treatment teams collaborate in developing and modifying the treatment plan to ensure care is responsive to the individual Veteran's needs. Consistent with VHA's Whole Health approach to care, VHA mental health care rests on the principle that it is an essential component of overall health, and it requires the availability of a continuum of services, including self-help resources, telephone crisis intervention services, outpatient care, residential care, and acute inpatient care. The program requirements for the full range of mental health services that VHA delivers are specified in the Uniform Mental Health Services in VHA Medical Points of Service (VHA Directive 1160.01).

VHA offers the largest continuum of mental health care in the U.S., providing innovative, evidence-based outpatient, residential, and acute inpatient services. Please see Figure 1 for a visualization and brief description of the full range of services available on the mental health continuum of care.



Opioid Prevention, Treatment and Program

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Treatment Modality ($000):							
MH Inpatient	$109,104	$128,204	$112,704	$117,212	$121,783	$4,508	$4,571
MH Clinics	$162,944	$161,711	$168,321	$175,054	$181,881	$6,733	$6,827
MH Dom/RRT	$65,187	$66,220	$67,338	$70,032	$72,763	$2,694	$2,731
Methadone	$28,767	$40,591	$29,716	$30,905	$32,110	$1,189	$1,205
Other Inpatient	$13,773	$15,651	$14,228	$14,797	$15,374	$569	$577
Other OPC	$19,643	$22,853	$20,291	$21,103	$21,926	$812	$823
Subtotal Treatment	**$399,418**	**$435,230**	**$412,598**	**$429,103**	**$445,837**	**$16,505**	**$16,734**
Pharmacy	$23,255	$23,332	$24,022	$24,983	$25,957	$961	$974
Total Treatment	**$422,673**	**$458,562**	**$436,620**	**$454,086**	**$471,794**	**$17,466**	**$17,708**
Jason Simcakoski Memorial and Promise Act (*Jason's Law*) 1/ 2/ 3/:							
Pain and Opioid Management Program Services	$212,250	$211,158	$193,261	$221,158	$225,581	$27,897	$4,423
Pain and Opioid Management Program Administration	$4,689	$10,360	$7,331	$10,360	$10,567	$3,029	$207
Program [Subtotal]	**$216,939**	**$221,518**	**$200,592**	**$231,518**	**$236,148**	**$30,926**	**$4,630**

[1/] P.L. 114-198, Comprehensive Addiction and Recovery Act of 2016 (CARA), Title IX, Jason Simcakoski Memorial and Promise Act. Funding shown supports subtitle A (Opioid Therapy and Pain Management) of Jason's Law.
[2/] The components of Patient Advocacy supporting subtitle B (Patient Advocacy) and Whole Health Patient Centered Care Services and Administration supporting subtitle C (Complementary and Integrative Health) of Jason's Law are excluded. For further information on Whole Health, see the section on Whole Health later in the chapter.

Authority for action

- 38 U.S.C. §1730B. Access to State prescription drug monitoring programs
- 38 U.S.C. §5701. Confidential nature of claims
- P.L. 114-198, Comprehensive Addiction and Recovery Act of 2016 (CARA), Title IX, Jason Simcakoski Memorial and Promise Act, §§ 901-933
    - Secs. 911-915: Opioid Therapy and Pain Management
        - § 911(a). Expansion of Opioid Safety Initiative
        - § 911(c). Pain Management Teams

Purpose

Veterans face disproportionate impacts from opioid-related adverse events due to high rates of chronic pain and risk factors for substance use disorders (SUD), overdose, and suicide, with up to 50% of Veterans experiencing chronic pain, significantly increasing their risk for suicide and opioid-related adverse events. In 2009, VA developed the Stepped-Care Model for Pain Management (SCM-PM) to expand access to pain care. In 2013, VA implemented the Opioid Safety Initiative at all VHA facilities to address opioid use in pain management. VA has become a leader in addressing the opioid epidemic. Since the Opioid Safety Initiative was implemented through March 2025, VHA reduced opioid prescriptions by 68% and implemented effective nonpharmacological treatments, such as Cognitive Behavioral Therapy for Chronic Pain (CBT-CP), to enhance Veterans' quality of life. VHA employs a comprehensive, interdisciplinary, biopsychosocial approach to reduce suffering from chronic pain, especially in Veterans affected by mental health and physical injuries related to military service. This approach aligns with VHA's mission to provide exceptional health care that improves Veterans' health and well-being.

Additionally, in November 2020, the VA launched a prescription drug monitoring program integrated with the Electronic Health Record (EHR) system to guide treatment decisions regarding controlled substances. The National Pain Management, Opioid Safety, and Prescription Drug Monitoring Program (PMOP) within VHA's Specialty Care Program Office (SCPO) oversees these initiatives to support VISNs and facilities enterprise-wide.

The National PMOP Program implements enterprise-wide initiatives, establishes direct care system programs, particularly at the facility level with national program support, and increases access to safe controlled substance prescribing and pain specialty care across the enterprise, especially in rural areas. This will continue the excellent work already completed and assist with improved care and enhanced solutions to reduce suicide risk for our Veterans. Further, this funding will ensure legislative and regulatory compliance. The 2026 request includes salary support for Pain Management Teams (PMTs) at all facilities, including board-certified pain medicine specialists, addiction medicine providers, behavioral medicine providers, rehabilitation medicine providers, pharmacists, nurses, and health and wellness coaches. By law, PMTs must provide consultation to healthcare providers without expertise in prescribing pain medications, subsequent prescriptions, and related therapy. PMTs improve VA's compliance with the Opioid Safety Initiative (OSI), provide opioid risk mitigation activities at each VA facility, and ensure field-based personnel have the education, resources, and clinical decision support tools needed to provide safe and effective pain care. This focus on establishing and expanding interdisciplinary pain care at all VHA facilities ensures every Veteran has the option to receive clinical care through VHA in-person or telehealth visits. Additionally, the 2026 request will support key opioid safety initiatives in 2026, such as developing and coordinating Opioid Risk Mitigation Guidance at all VISNs and facilities, purchasing Naloxone for the Naloxone Free to Facilities Initiative and the Rapid Naloxone Initiative, and developing and disseminating the Buprenorphine for Chronic Pain Educational Campaign. The National PMOP Program will continue to collaborate with the Office of Information Technology (OIT) and the Electronic Health Record Modernization Integration Office (EHRMIO) to review and advise on opioid safety, pain management, and controlled substance prescribing priorities for the Oracle Health transition. They will also integrate individual state, regional, and Department of Defense (DoD) Prescription Drug Monitoring Programs (PDMPs) into VHA's EHR systems, as recommended by the National Drug Control Strategy of the Office of National Drug Control Policy (ONDCP).

2025 Planned Accomplishments

- The unprecedent growth in encounters and unique Veterans continues in 2025. In Q1 and Q2 of 2025, VHA clinicians completed 774,709 encounters and served 229,622 unique Veterans. In comparison, 2024 Q1 and Q2 had 671,848 encounters and 207,635 unique Veterans, which represents an increase of 15.3% in encounters and 10.6% in unique Veterans.
- The Acute Pain Service Expansion Program was launched as a pilot with funding for up to 10 facilities. This program focuses on comprehensive inpatient and transitional pain management services (including perioperative care and inpatient consultation), by purchasing equipment and supporting 40 full-time equivalent (FTE) clinical care providers dedicated to the Acute Pain Service to ensure high-quality pain care.

- PMOP plans to release formal Opioid Risk Mitigation Guidance in 2025 to standardize and facilitate compliance with required opioid safety activities.
- PMOP developed and piloted a national controlled substances note template to streamline the completion of required opioid risk mitigation activities at the point of care. This template allows providers to focus on caring for Veterans while remaining compliant with policy.
- Developed new clinical guidance on buprenorphine use for chronic pain and provided educational materials for Veterans and providers.

2026 Budget Request

The 2026 Budget request is $231.5 million for the Pain and Opioid Management Program, supporting Jason's Law subtitle A, which represents an increase of $30.9 million (15.4%) above the 2025 Current Estimate. (This amount excludes Patient Centered Care Services and Administration, which also fall under Jason's Law.) Providing Veterans access to pain management services within VA is crucial as pain is the most frequently identified risk factor for Veteran suicide and remains predictive of suicide even after accounting for psychiatric comorbidities. These projections underline the critical need for sustained and increased funding to ensure that PMOP can continue to provide comprehensive pain management services and support to our Veterans, addressing both increasing demand and expanding outreach services.

The 2026 budget request includes $221.1 million in medical services funding that will support the current staffing infrastructure for basic pain leadership roles at the facility and VISN levels, and fund specific field-based initiatives to facilitate pain care consistent with the Comprehensive Addiction and Recovery Act (CARA) of 2016. There is a clear need for additional support to facilities to achieve the legislatively required PMT at every VA facility, as defined in VA's 2017 memo, despite making significant progress. Many facilities still do not provide the required pain-related services resulting in Veterans suffering from chronic severe pain potentially treatable with better access to specialty care. Currently, only 66.9% of VA medical facilities have fully compliant interdisciplinary PMTs. Additionally, about 70.0% of VA facilities report lacking an acute pain service, and many do not have inpatient pain consultation services as required by the Joint Commission. PMOP will use the 2026 funding to support hiring staffing to fill missing key PMT roles. Currently, 5 facilities lack a medical provider, 30 facilities need an addiction provider, 14 facilities lack a behavioral provider, and 14 facilities lack a rehabilitation provider. In order to maintain the current pain management staff and fill identified staffing gaps for pain management field personnel, VA projects a funding requirement of $200.7 million for staffing at VA medical facilities in 2026.

Additionally, the 2026 Budget will support the purchase of Naloxone (which directly supports VHA's Naloxone Free to Facilities program), VHA's Overdose Education and Naloxone Distribution Program (OEND), and VHA's Rapid Naloxone Initiative. The 2026 Budget includes $15.2 million in supplies and materials to maintain VHAs Naloxone programming. Finally, $4.6 million is projected for equipment needs in pain clinics and to support the field's interventional needs as well as Applied Virtual Reality (VR) headset purchases. VR headsets provide Veterans an innovative, immersive solution that reduces pain perception and improves quality of life. This approach, which is completed at home, empowers Veterans to manage pain with less reliance on

medication. By increasing the use of adaptive self-management skills, VHA promotes a path to greater Veteran independence and well-being. Additionally, the funding request supports the provision of Opioid Safety educational materials to advance the Opioid Safety Transformation.

The 2026 Budget request includes $10.4 million in Medical Support and Compliance funding, of which $5.6 million supports the National PMOP program, as well as VISN-level field funded staff. The National Program provides required oversight, monitoring, and enterprise-wide implementation of congressional mandates listed above. Of the $10.4 million, $4.6 million is planned to support contractual services for a data and quality contract; website development; core metric database development, maintenance, automation, and implementation; as well as an automated process for patient-reported outcomes in the EHR for pain management.

2026 Planned Accomplishments

- Through direct targeted outreach, PMOP intends to offer funding opportunities and track associated action plans and hiring actions for the 46 medical facilities currently missing a total of 63 primary role clinical care providers in VHA PMTs, defined as medical, addiction, behavioral, and rehabilitation providers.
- PMOP Opioid Risk Mitigation Guidance will implement solutions developed in 2025 to improve CARA mandated compliance with the following required activities: 1) data-based risk reviews will increase from 43.6% to 85.0% nationally; 2) Opioid and benzodiazepine combinations will have justifications documented in the EHR increasing from 63.0% to 90.0% compliance; and 3) Communication of unexpected urine drug test (UDT) results will improve from 40.0% to 75.0%.
- PMOP projects an additional 50.0% increase in rural patient access with expansion to new spoke sites and prioritizing rurality within current active CRH TelePain programs. VHA continues to enhance telehealth access for complex pain care at facilities through VISN-based CHRs, providing care for complex pain to Veterans nationwide, including those in rural settings, aligned with VA goals to address the opioid epidemic and reduce suffering associated with service-related injuries. Projections indicate that PMOP will achieve a total of 1,926,243 encounters in 2026, reflecting a 33.9% increase compared to the previous year. Additionally, VA anticipates closing 2026 with 384,381 unique patients, maintaining a steady increase of 19.9% annually. Finally, PMOP projects an additional 50.0% increase in rural patient access with expansion to new spoke sites and prioritizing rurality within the active CRH TelePain programs funded by PMOP.
- PMOP projects approximately 75,800 Veteran encounters for TelePain, representing an 40% increase over 2024 volumes and sustained expansion in rural and urban service reach. In 2023, providers completed 25,446 Veteran encounters, representing a fivefold increase since services launched in 2022, (4,417 Veteran encounters). In 2024, 54,144 encounters were completed.
- PMOP will work directly with PMOP-funded clinical staff at the 6 existing Oracle Health sites and 13 sites planning to go live in 2026. PMOP will continue to support clinicians in the field through education, real-time responsiveness to field inquiries, troubleshooting to identify root causes, and solution development in the EHR transition to support pain

management, opioid safety, and controlled substance prescribing at VA's legacy and Oracle Health sites.

Evidence

Chronic pain affects over 20% of U.S. adults, with Veterans at even greater risk. Up to 50% of Veterans within VHA experience chronic pain, with similar prevalence among men and women (Kerns et al., 2003; Gironda et al., 2006). Chronic pain often leads to increased risks of suicidal ideation and behavior. Data show a lifetime prevalence of suicidal ideation in people with chronic pain at about 20%, and up to 15% for suicide attempts (Racine, 2018; Tang & Crane, 2006). Approximately 9% of Americans who died by suicide had chronic pain (Petrosky et al., 2018). Veterans with chronic pain often face additional challenges such as limb loss, musculoskeletal injuries, and the polytrauma clinical trial, complicating their pain management (Lew et al., 2009).

VHA documented that Veterans with chronic pain have a high prevalence of mental health conditions and are vulnerable to suicide and overdose deaths. Specialized pain care and risk mitigation strategies can prevent suffering and mental health crises related to poor pain care and inappropriate opioid prescribing. The U.S. Food and Drug Administration (FDA) approved opioid risk evaluation and mitigation strategies that decrease the rates of intentional misuse and adverse medical outcomes and hospitalizations (Bucher Bartelson et al., 2017). These strategies are outlined in the "VA/DoD Clinical Practice Guidelines: The Use of Opioids in the Management of Chronic Pain" as well as the "CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022" based on comprehensive, evidence-based recommendations (VA/DOD 2022; CDC, 2022). Multiple Office of the Inspector General (OIG) reports have demonstrated that VHA standards for opioid prescribing and completion of risk mitigation strategies are superior to those provided in the community (OIG 2017, OIG 2023). These strategies include risk assessments, urine drug screens, PDMP queries and analysis, and naloxone education and distribution.

- VHA has wide variability in opioid prescribing in urban versus rural settings including access to pain management teams, services, and opioid safety implementation which is demonstrated by 35% higher opioid prescribing in rural settings, mostly among those on long-term opioid therapy (Courtney et al., 2025).
- VHA mandated case reviews are associated with lower probability of all-cause mortality for high-risk patients receiving Long-Term Opioid Therapy (LTOT) (Li et al., 2023).
- Urine drug tests measure medication compliance and opioid safety screening via the most well-studied medium for monitoring drug and medication use (Pesce et al., 2012).
- Among Veterans enrolled in both VA and Medicare Part D, dual receipt of opioids was associated with two to three times the risk of high-dose opioid exposure (Gellad et al., 2018). Per a 2020 Government Accountability Office (GAO) report, PDMPs were reported useful by physicians, most of whom reported that PDMP information assisted with the identification of inappropriate medication seeking and prevention of prescribing that would lead to excessive and dangerous cumulative amounts and drug combinations (GAO 2020). Prior to launch of the integrated solution, VA providers had to manually access external PDMP sites and enter the required Veteran information to query PDMP data. Providing direct access to information through integration in the EHR saves clinician time and

increased queries by clinicians when compared to querying in clinics with non-integrated access (Neprash et al., 2022).

- Literature supports the life-saving potential of naloxone (Aziz et al., 2024; Bird et al., 2016; McDonald & Strang, 2016; Wheeler et al., 2015). Studies on Opioid Overdose Education and Naloxone Distribution (OEND) programs have noted outcomes including improved naloxone knowledge, positive attitudes, and overdose reversals (Rawal et al., 2022; Knudsen et al., 2024). Increasing naloxone availability is a part of the ONDCP's 2022 National Drug Control Strategy (ONDCP 2022).

Proper pain management plays a critical role in reducing suicide risk and improving the quality of life for Veterans. Nonpharmacological treatments like CBT-CP are effective in improving overall quality of life and reducing pain intensity, interference, and catastrophizing (Murphy et al., 2020). Studies highlight those nonpharmacological treatments result in fewer self-inflicted injuries and cases of suicidal ideation among Veterans diagnosed with chronic pain (Meerwijk et al., 2019). Comprehensive pain management strategies and ongoing support for both nonpharmacological and pharmacological treatments are essential to protect against suicide risk. Increasing opioid doses does not improve pain symptoms but rather associates with increased risks of suicide and overdose (Hayes et al., 2020a, 2020b). VHA reduced opioid prescriptions by 64% and promoted safer, evidence-based pain management practices, which impacted both overdose and suicide risks (U.S. Department of Veterans Affairs, 2020). These initiatives are supported through further funding and resources to continue safeguarding Veterans' health and well-being.

Specialized pain care, provided by an interdisciplinary, multimodal, and biopsychosocial approach, delivers the best outcomes, including reduced pain and pain-related disability (U.S. Department of Health and Human Services, 2019; Golden, 2022; Connell et al., 2022; McGeary et al., 2022; Breugelmans et al., 2024). Introducing interdisciplinary pain rehabilitation programs at VHA medical centers improved patient-reported outcomes, including pain intensity, interference, catastrophizing, and sleep (Murphy et al., 2021). Behavioral interventions, physical therapy, exercise, neurofeedback, neuromodulation, and non-opioid pharmacological therapies have shown evidence of improved pain and associated outcomes (Murphy et al., 2022; Ledesma et al., 2024).

Substance Use Disorder Program Initiative

		2025		**2026**	**2027**		
Description (dollars in thousands)	2024 Actual	Budget Estimate	Current Estimate	**Revised Request**	**Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations							
Medical Services (0160):	$150,105	$260,504	$184,219	$229,446	$234,035	$45,227	$4,589
Medical Support and Compliance (0152):	$1,704	$3,377	$2,220	$2,841	$2,898	$621	$57
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$151,809**	**$263,881**	**$186,439**	**$232,287**	**$236,933**	**$45,848**	**$4,646**

Authority for action

- 38 U.S.C. §1710.
- 38 U.S.C. §1720A: Outlines the expectation that the VA provide Veterans with substance use disorder diagnoses treatment services.
- 38 U.S.C. §7301(b): Highlights that the primary function of the VA is to provide complete medical and hospital service for the medical care and treatment of Veterans.
- 38 U.S.C. §8110*:* Outlines requirements for the operation of VA facilities including expectations for the establishment of the total number of beds, maintaining capacity to support operation of these beds, and requirements for the annual analysis of access, staffing, and admission policies.
- P.L. 117-328, Division V, Supporting The Resiliency of Our Nation's Greatest (STRONG) Veterans Act of 2022
- P.L. 115-271, SUPPORT for Patients and Communities Act
- P.L. 115-182, VA MISSION Act of 2018, Subtitle V, Sec. 506: Program on Establishment of Peer Specialists in Patient Aligned Care Team Settings within Medical Centers of Department of Veterans Affairs.
- P.L. 114-198, Comprehensive Addiction and Recovery Act of 2016, Title IX, Jason Simcakoski Memorial and Promise Act
    - Subtitle A, Secs. 911-915: Opioid Therapy and Pain Management
    - Subtitle B, Secs. 921-924: Patient Advocacy
    - Subtitle C, Secs. 931-933: Complementary and Integrative Health
    - Subtitle D, Secs. 941-943: Fitness of Health Care Providers
- 38 C.F.R. 17.38
- 38 C.F.R. 17.46
- 38 C.F.R. 17.47
- 38 C.F.R. 17.80

Purpose

Funding for SUD services allow VA to provide evidence-based treatment and harm reduction interventions for Veterans with SUD throughout the enterprise. These evidence-based treatment and harm reduction initiatives serve to reduce Veteran overdose fatalities, mitigate suicide risk, and improve Veteran quality of life. SUD commonly involves the use of multiple substances, co-occurring mental health and medical conditions, and psychosocial challenges such as housing instability, unstable employment, and justice involvement. The number of Veterans with SUD, including alcohol use disorder, served within VHA is rising. For example, from 2023 to 2024, the number of VA-eligible patients with SUD treated in VHA facilities rose by more than 33,000 from 559,600 to 592,906. Further, this Budget supports efforts to ensure Veterans have access to the full

range of SUD treatment from the least intensive services, such as peer specialists and mutual support, to the most intensive services such as inpatient withdrawal management.

VA's Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) provide a significant portion of intensive services for Veterans with SUDs and co-occurring conditions with specialized programs for treatment and a requirement that all MH RRTPs address co-occurring SUD. The percent of Veterans with a SUD served by the MH RRTPs continues to rise with more than 97% of Veterans served during 2024 experiencing substance use concerns. Funding is specifically designated to ensure Veterans have timely access to residential treatment within VA or, if needed, in the community. The requested Budget supports ongoing efforts to remove barriers to accessing care and to ensure sufficient capacity is available to meet the needs of Veterans experiencing substance use concerns.

2025 Planned Accomplishments

- Offered a web-based SUD education course for Veterans, their loved ones, and the general public in November 2024. Between January and March 2025, more than 600 new users accessed the course.
- Purchase and begin operations of a mobile methadone unit in one VA OTP site.
- Continue to support implementation of a central funding process to support VA healthcare systems with the purchase of patient self-testing supplies for provision of contingency management. Provided funding requests from 47 facilities the week of May 5- 9, 2025.
- Implement centralized screening teams (CST) at the level of the VISN to support improved access to residential treatment for Veterans experiencing substance use and mental health concerns. Preliminary data indicate that CST will further reduce wait times, support more timely screening, and remove barriers to accessing care. For example, within VISNs utilizing CSTs, acceptance rates at initial screening are up to 97% and more than 50% of Veterans are screened within two days.
- Implement new access standards for MH RRTP care to ensure Veterans requiring priority admission are admitted for residential treatment either within VA or in the community within 48 hours and no more than 20 days for all other Veterans.

2026 Budget Request

The 2026 Budget request is $232.3 million for SUD, an increase of $45.9 million (24.6%) above the 2025 Current Estimate. The program growth in large part reflects increased dedicated funding for MH RRTP to ensure Veterans have timely access to residential treatment. Resources will address two leading drivers of overdose fatalities among Veterans: OUD and stimulant use disorder (a vector of exposure to potentially fatal, synthetic opioids). VA's SUD priorities support fulfillment of the Trump Administration's Statement of Drug Policy Priorities including efforts to reduce the number of overdose fatalities with a focus on fentanyl; increase evidence-based treatment including medications for OUD; strengthen peer recovery support; expand access to naloxone; increase the availability of drug test strips; and raise awareness about overdose prevention through educational campaigns and evidence-based prevention programs. For 2026, $178.1 million funds overall operations of SUD Care which includes responding to emerging drug

threats; enhancing employment opportunities for Veterans in recovery; supporting education, training, and consolation services; and supporting ongoing operations of the SUD Program Office, Centers of Excellence in Substance Addition Treatment and Education (CESATE), Stepped Care for Opioid Use disorder Train-the-Trainer (SCOUTT), Program Evaluation Research Center (PERC), and Northeast Program Evaluation Center (NEPEC). In 2026, $30.0 million will be used to support access to life-saving residential treatment with an additional $24.2 million to support enterprise implementation of centralized screening for residential care.

This request incorporates:

- Costs to support sustainment of initiatives initially funded in 2022 (including sustainment of the SUD Peer Specialist workforce and related initiatives funded in subsequent years) and expansion of opioid overdose education, naloxone distribution, and purchase and distribution of drug test strips.
- Expansion of access to MOUD among Veterans with OUD including increasing the number of mobile methadone unit pilots and MOUD access to Veterans with OUD treated in hospital and emergency medicine settings.
- CM patient self-testing supplies, Veterans Canteen Service coupon books for use as CM incentives, and remote rewards system for telehealth CM.
- Continued development of a Veteran-centric, SUD application intended to offer the full range of VHA SUD treatment services in a mobile platform.
- Funds to sustain improved and timely access to MH RRTP care.
- Enterprise implementation of centralized screening for residential treatment with a focus on ensuring seamless access to residential treatment in VA or, when needed, in the community.

2026 Planned Accomplishments

- Planned expansion of access to MOUD among Veterans with OUD treated in hospital medicine and emergency medicine settings. VA anticipates that at least 500 Veterans with OUD seen in its emergency medicine settings will have MOUD initiated in 2026. This is a 100% increase from 2024.
- Provide CM to at least 2,000 Veterans with SUD, an anticipated increase of over 17% in the number of Veterans who received CM in 2025.
- Planned expansion of evidence-based harm reduction services.
- Seamless integration between withdrawal management and follow-up residential treatment for Veterans with all Veterans offered same-day admission to residential treatment, when indicated, following inpatient withdrawal management.
- Decrease in the average time to admission for Veterans requiring priority admission to less than 2 days and a 5% increase in overall acceptance rates for MH RRTP care. The estimated increase in community care costs associated with the change in access standards is included in the Medical Community Care budget request, while the SUD initiative

funding request is focused on direct care support for MH RRTP access and regional-centralized screening for residential care.

Evidence

The peer-reviewed, published literature has repeatedly demonstrated that OUD is a significant risk factor for fatal overdose[1, 2] and suicide;[3, 4] and treatment with MOUD (methadone, buprenorphine and its combination products, and injectable, extended-release naltrexone) dramatically reduces the risk of overdose mortality and suicide.[4, 5] Furthermore, the Trump Administration's Statement of Drug Policy Priorities includes expanding access to medications for OUD (White House, 2025, pages 3-5).

Support for a national OEND program was prompted by seminal peer-reviewed publications that underscored the potential for OEND to save lives.[6] The Trump Administration's Statement of Drug Policy Priorities sustains an emphasis on OEND as a strategy to reduce overdose fatalities with an emphasis on addressing fentanyl-related overdose risks (White House, 2025, page 3).

Published, peer-reviewed literature suggests that non-fatal overdoses are predictive of subsequent overdose mortality. Based on observations of treatment utilization patterns of patients identified as very high risk per the Stratification Tool for Opioid Risk Mitigation (STORM) predictive model, VHA developed a novel intervention to reduce risk in high-risk patients exposed to opioid drugs. Here, patients prescribed opioid analgesics and identified as "very high" risk per an algorithm based on past-year medical record data were flagged for review by an interdisciplinary team consisting of at least clinicians with expertise in pain, addiction, and rehabilitative treatments. This team reviewed cases to develop a set of recommendations for a consolidated and harmonized treatment plan including risk mitigation interventions to address suicide, overdose, addiction, and other risks. These factors were documented in the patient's medical record and shared across treating providers. This case review program reduced all-cause mortality in this population by 22% over the next four months.[7] Based on these results, the case review program was expanded to

[1] Burns, M., Tang, L., Chang, C. H., Kim, J. Y., Ahrens, K., Allen, L., Cunningham, P., Gordon, A. J., Jarlenski, M. P., Lanier, P., Mauk, R., McDuffie, M. J., Mohamoud, S., Talbert, J., Zivin, K., & Donohue, J. (2022). Duration of medication treatment for opioid-use disorder and risk of overdose among Medicaid enrollees in 11 states: a retrospective cohort study. *Addiction* (Abingdon, England), 117(12), 3079–3088. https://doi.org/10.1111/add.15959

[2] Morgan, J. R., Barocas, J. A., Murphy, S. M., Epstein, R. L., Stein, M. D., Schackman, B. R., Walley, A. Y., & Linas, B. P. (2020). Comparison of Rates of Overdose and Hospitalization After Initiation of Medication for Opioid Use Disorder in the Inpatient vs Outpatient Setting. *JAMA network open*, 3(12), e2029676. https://doi.org/10.1001/jamanetworkopen.2020.29676

[3] Bohnert KM, Ilgen MA, Louzon S, McCarthy JF, Katz IR. Substance use disorders and the risk of suicide mortality among men and women in the US Veterans Health Administration. *Addiction*. 2017;112(7):1193-1201.

[4] Mooney, L. (2022). Medication Treatment for Opioid Use Disorder Reduces Suicide Risk. American Journal of Psychiatry, 179, 4.

[5] Wakeman, S. E., Larochelle, M. R., Ameli, O., Chaisson, C. E., McPheeters, J. T., Crown, W. H., Azocar, F., & Sanghavi, D. M. (2020). Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. *JAMA network open*, *3*(2), e1920622. https://doi.org/10.1001/jamanetworkopen.2019.20622

[6] Coffin, P. O., & Sullivan, S. D. (2013). Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal. *Annals of internal medicine*, 158(1), 1–9. https://doi.org/10.7326/0003-4819-158-1-201301010-00003

[7] Strombotne, K. L., Legler, A., Minegishi, T., Trafton, J. A., Oliva, E. M., Lewis, E. T., Sohoni, P., Garrido, M. M., Pizer, S. D., & Frakt, A. B. (2023). Effect of a Predictive Analytics-Targeted Program in Patients on Opioids: a

include patients experiencing non-fatal overdoses. Preliminary evaluation of the interdisciplinary case review program for patients experiencing a non-fatal overdose suggests that those receiving case review within 1 month of the overdose are 38% less likely to have a subsequent overdose in the next year as compared to those reviewed later.

CM is an evidence-based treatment for SUD that applies operant conditioning principles to assist patients with initiating and maintaining recovery behaviors such as abstinence from substances. A large and growing body of peer-reviewed published studies has repeatedly found that CM is the most effective treatment for stimulant use disorder.[8,] [9] CM effectively treats stimulant use disorder with enduring benefits after incentives are discontinued.[10] Furthermore, stimulants are the second leading driver of fatal overdoses. These drugs are not only toxic but serve as a vector of exposure to fentanyl. Therefore, VA's expansion of CM is consistent with and helps fulfill the Trump Administration's Statement of Drug Policy Priorities (White House, 2025, page 3-4).

VHA is committed to ensuring timely access to high-quality residential treatment for mental health and SUD for Veterans. Recent findings evaluating the impact of residential treatment for Veterans experiencing SUD demonstrated significantly lower mortality rates for Veterans who participated in residential treatment when indicated and overall significant improvement in symptoms in the 12 months following screening.[11] VA has been actively working to ensure Veterans have access to residential treatment, their family members, and external stakeholders. Implementation of centralized screening is meant to streamline the admission process by addressing identified barriers to accessing this critical part of the broader SUD and mental health continuum, ultimately resulting in reduced wait times. Preliminary data suggest more than 10% improvement in acceptance rates and more than 50% of Veterans being screened for residential treatment within 2 days.

Stepped-Wedge Cluster Randomized Controlled Trial. *Journal of general internal medicine*, 38(2), 375–381. https://doi.org/10.1007/s11606-022-07617-y

[8] The ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder. Journal of Addiction Medicine 18(1S):p 1-56, May/June 2024. | DOI: 10.1097/ADM.0000000000001299

[9] DePhilippis, D., Khazanov, G., Christofferson, D. E., Wesley, C. W., Burden, J. L., Liberto, J., & McKay, J. R. (2023). History and current status of contingency management programs in the Department of Veterans Affairs. *Preventive medicine*, 176, 107704.

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Suicide Prevention
($ in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Treatment Modality ($000):							
Suicide Diagnosis 1/	$1,662,296	$1,634,786	$1,804,455	$1,785,050	$1,872,713	($19,405)	$87,663
MH care in the Emergency Room	$137,217	$151,043	$148,952	$170,927	$176,411	$21,975	$5,484
Reach Veteran in Crisis	$1,559	$2,486	$1,692	$2,813	$2,004	$1,121	($809)
Suicide Safety Plan	$338,850	$403,661	$367,828	$456,802	$435,635	$88,974	($21,167)
High Risk of Suicide	$466,145	$471,428	$506,009	$533,490	$599,290	$27,481	$65,800
MH Suicide Prevention PACT	$4,252	$4,309	$4,616	$4,876	$5,467	$260	$591
Total Treatment	**$2,610,319**	**$2,667,713**	**$2,833,552**	**$2,953,958**	**$3,091,520**	**$120,406**	**$137,562**
Suicide Prevention Outreach Program:							
Veterans Crisis Line	$249,375	$306,683	$290,572	$312,817	$319,073	$22,245	$6,256
National Suicide Prevention Strategy Implementation	$56,272	$48,792	$47,883	$51,985	$53,025	$4,102	$1,040
Demonstration Projects 1/	$13,734	$7,703	$0	$0	$0	$0	$0
Suicide Prevention 2.0 Initiative	$86,947	$58,907	$84,580	$95,856	$97,773	$11,276	$1,917
VA Governors Challenge Program	$0	$10,000	$10,000	$0	$0	($10,000)	$0
Centers of Excellence (includes MIRECC and SMITREC) 1/	$11,389	$6,059	$34,383	$34,792	$35,488	$409	$696
Local Facility and Community Outreach Activities	$829	$750	$757	$750	$765	($7)	$15
Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program	$58,361	$54,819	$25,537	$111,938	$114,177	$86,401	$2,239
Specific Purpose [Subtotal]	**$476,907**	**$493,713**	**$493,712**	**$608,138**	**$620,301**	$114,426	$12,163
Suicide Prevention Coordinators and Teams	$83,421	$88,841	$86,176	$89,622	$93,117	$3,446	$3,495
Total Suicide Prevention Outreach Program	**$560,328**	**$582,554**	**$579,888**	**$697,760**	**$713,418**	**$117,872**	**$15,658**

1/ Demonstration Projects' funding is merged with the Centers of Excellence beginning in 2025.

Authority for action

- 38 U.S.C. §1709B: Evaluations of mental health care and suicide prevention programs.
- 38 U.S.C. §§1710(e)(1), (G), (H), (I): Eligibility for VA medical care, including mental health services and counseling due to toxic exposure, service in specified locations on specific dates, and deployed in support of a specified contingency operation.
- 38 U.S.C. §1710(e)(3)
- 38 U.S.C. §1712A. Eligibility for readjustment counseling and related mental health services.
- 38 U.S.C. §1720F. Comprehensive program for suicide prevention among Veterans and members of the reserve components of the Armed Forces
- 38 U.S.C. §1720J. Emergent suicide care
- 42 U.S.C. §290bb-36c(b)(3): National Suicide Prevention Lifeline Program
- 42 U.S.C. §290bb-37: Mental health crisis response partnership pilot program
- 47 U.S.C. §251(e)(4): Universal telephone number for national suicide prevention and mental health crisis hotline system.
- P.L. 117-328, Division V, Strong Veterans Act of 2022
    - Title 1, Training to support veterans' mental health, Sec. 101: Mental health and suicide prevention outreach to minority veterans and American Indian and Alaska Native veterans.
    - Title II, Veterans Crisis Line:

        - Sec. 212: Quality Review and Management
        - Sec. 231 – Feedback on transition of crisis line number.
    - Title III, Outreach to Veterans, Sec. 303: Department of Veterans Affairs Governors Challenge Program.
    - Title V, Research:
        - Sec. 505: Study on workload of Suicide Prevention teams of Department of Veterans Affairs.
        - Sec. 506: Expansion of Suicide Prevention and Mental Health Research.

- P.L. 117-168, The Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act of 2022, Title V, Research Matters, Sec. 507 – Study on toxic exposure and mental health outcomes

- P.L. 116-214, The Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act of 2020, Title II, Suicide Prevention, Sec. 205: Police crisis intervention training of Department of Veterans Affairs.

- P.L. 116-171, Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019:
    - Sec. 102: Review of records of former members of the Armed Forces who die by suicide within one year of separation from the Armed Forces.
    - Title II, Suicide Prevention:
        - Sec. 201 – Established the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program.
        - Sec. 204 – Department of Veterans Affairs study of all-cause mortality of Veterans, including by suicide, and review of staffing levels of mental health professionals.
    - Title III, Programs, Studies, and Guidelines on Mental Health, Sec. 303 – Update of clinical practice guidelines for assessment and management of patients at risk for suicide.
    - Title IV, Oversight of Mental Health Care and Related Services:
        - Sec. 401 – Study on effectiveness of suicide prevention and mental health outreach programs of Department of Veterans Affairs.
        - Sec. 402 – Oversight of mental health and suicide prevention media outreach conducted by Department of Veterans Affairs.
    - Title V, Improvement of Mental Health Medical Workforce:

        - Sec. 501 – Staffing improvement plan for mental health providers of Department of Veterans Affairs
        - Sec. 506 – Suicide Prevention Coordinators
        - Sec. 507 – Report to efforts by Department of Veterans Affairs to implement safety planning in emergency departments.
- P.L.114-247, No Veterans Crisis Line Call Should Go Unanswered Act
    - Sec. 2 – Improvements to Veterans Crisis Line
- P.L. 114-2, Clay Hunt SAV Act
    - Sec. 3 – Publication of internet website to provide information regarding mental health care services.
    - Sec. 5 – Pilot program on community outreach.
    - Sec. 6 – Collaboration on suicide prevention efforts between department of Veterans affairs and nonprofit mental health organizations.

Purpose

Suicide is preventable, it is not an inevitable outcome, and preventing suicide requires a public health approach that incorporates everyone's unique contributions to save lives. As the highest priority within the VA, suicide prevention priorities are derived from the VA 2018 – 2028 National Strategy for Preventing Veteran Suicide, United States Code (U.S.C.) authorities, enacted legislation, and national suicide prevention strategic priorities (The National Strategy for Suicide Prevention – Federal Action Plan).

The Office of Suicide Prevention (OSP) is the primary coordinating office for the VHA suicide prevention strategic efforts. VHA's comprehensive public health approach includes coordination of community-based engagements; collaborations across federal, state, community, and academic affiliates; research; training; crisis care; and national activation strategies. Each of these lanes of effort are supported by resources provided within the Presidential Suicide Prevention Outreach Program budget line-items.

2025 Planned Accomplishments

- The SSG Fox SPGP supports 93 grantees across 41 states, the District of Columbia, American Samoa, Guam, and Puerto Rico to provide suicide prevention outreach and education across the Nation to targeted at-risk populations with grantees projected to serve 9,000 eligible individuals and their family members with direct services.
- SP 2.0 programs will continue to expand State level Governor's Challenge work on congressionally funded Suicide Mortality Reviews with Native American Veteran projects and is slated to reach saturation (over 85% population coverage).
- Clinical Interventions will expand Suicide Risk Identification screening and evaluation adherence (focus of a current broad sweeping OIG report). SP 2.0 Clinical Telehealth will continue to expand the range of services offered to improve reach and access for Veterans

across the country. This program will continue to provide direct novel services (not available at VA medical centers) to more than 10,000 Veterans.

2026 Budget Request

The 2026 budget request is $608.1 million for the Suicide Prevention Program Office, which represents an increase of $114.4 million (23.2%) above the 2025 Current Estimate.
The budget includes:

- $312.8 million to support the Veterans Crisis Line (VCL), including nearly 2,570 authorized FTE and the line's operational costs.
- $95.9 million for SP 2.0 efforts, to support suicide prevention evidence-based treatments provided directly to Veterans through VISN CRHs, Community Engagement and Partnership Coordinators, and VISN Suicide Prevention Coordinator Leads across the nation, as well as paid media outreach. These collaboration, outreach, education, and direct service offerings are a core component of VHA's Public Health strategy for suicide prevention and are aligned to requirements in the Joshua Omvig Veterans Suicide Prevention Act (P.L. 110-110), Veterans COMPACT Act of 2020 (P.L. 116-214), and STRONG Veterans Act of 2022 (P.L. 117-328, Division V).
- $52.0 million to support National Suicide Prevention Strategy implementation and oversight, including support for White House, Congressional, VISN, VA medical center (VAMC), and Program Office suicide prevention priorities (including the National Suicide Strategic Plan tracking, grants management, Lethal Means Safety resources, and active VHA suicide prevention contracts).
- $34.8 million for suicide prevention innovations and research through the Centers of Excellence. The Centers of Excellence for Veterans suicide prevention (COE-SP) encompass a broad range of nationwide suicide prevention research, clinical consultation services (for VA and non-VA providers), education, and program evaluation. This funding level supports the coordination and realignment of operational costs for the Rocky Mountain Mental Illness Research, Education, and Clinical Center (RM MIRECC) for Suicide Prevention; the VISN2 COE-SP; Program Evaluation and Resource Center projects; and VISN 16 Community Program Evaluation for COMPACT related services. The 2026 budget also consolidates the Demonstration Projects budget into the Suicide Prevention Research and Innovation (PREV) budget and supports the Serious Mental Illness Treatment Resource and Evaluation Center. This funding will facilitate the coordination of VHA suicide prevention lanes of effort across the enterprise.
- $750,000 for local facility and community outreach travel and transportation to support Suicide Prevention Coordinators in conducting outreach, training, and support of community-based Veteran suicide prevention.

2026 Planned Accomplishments

- Both 2.0 programs provide direct novel clinical and community interventions to thousands of Veterans across the nation. Successful implementation of the programs and new legislatively mandated initiatives will be VA's priority (STRONG Veterans Act of 2022, COMPACT Act of 2020, and VCL 9-8-8 expansion) through 2026.

- OSP engages a public health approach to suicide prevention, integrating evidence-based community and clinical interventions, strategic planning, program operations, program evaluation, and crisis services. OSP consistently moves forward key suicide prevention initiatives using this approach and will continue to evaluate each throughout the year.

Evidence

In 2022, there were 6,407 suicides among Veterans and 41,484 among non-Veteran U.S. adults. The number of Veteran suicides in 2022 was lower than 12 of the prior 14 years. Age-adjusted death by suicide rates for male Veterans rose more slowly than the rate among non-Veteran U.S. males, and the age-adjusted rates among female Veterans decreased 24.1% while the rate among female non-Veterans increased 5.2%.

- Firearm involvement in female Veteran suicide deaths fell from 51.6% to 45.4%.
- Firearm and suffocation suicide rates among female Veterans fell by over 30.0%.
- Female Veterans in VHA care: Age-adjusted suicide rates declined by 29.6%.
- From 2021 to 2022: Veteran deaths by suicide among Veterans aged 18 – 34: decreased by 3.8%, decreased in female Veterans (18-34) by 31.2%.
- From 2001 to 2022: Death by suicide among Veterans with a high-risk mental health diagnosis decreased by 36.1% among those with a diagnosis of Anxiety, by 34.5% among those diagnosed with depression, by 31.6% among those with a diagnosis of posttraumatic stress, and by 13.7% among those with a diagnosis of Alcohol Use challenges.
- From 2021 to 2022: Death by suicide among Veterans with Cancer Diagnoses decreased by 16.7% and by 26% among Veterans with a COVID-19 infection diagnosis.
- From 2021 to 2022: death by suicide among Veterans experiencing homelessness decreased by 19.1%.
- The death by suicide rate in the first month following a VCL contact was 22.5% lower than in 2019.

VHA's National Strategy provides a framework for coordinating lanes of effort across the nation and ensures coordination of efforts with other federal agencies, state and local governments, health care systems, academic affiliates, and community organizations with the shared goal to reduce suicide rates among Veterans, and all U.S. citizens. In this mission, our untiring and relentless efforts to engage needs, innovate strategies, and serve the welfare of others will continue to serve as a model and central foundation for the Nation as to how to best address suicide as a national public health issue.

Pharmacy

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$9,891,303	$4,813,044	$13,735,234	$14,355,352	$16,491,314	$620,118	$2,135,962
Medical Community Care (0140):	$0	$6,596	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$769,406	$839,500	$878,800	$880,000	$872,300	$1,200	($7,700)
Medical Facilities (0162):	$192,433	$198,300	$213,900	$260,400	$253,500	$46,500	($6,900)
Discretionary Total	**$10,853,142**	**$5,857,440**	**$14,827,934**	**$15,495,752**	**$17,617,114**	**$667,818**	**$2,121,362**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$2,891,114	$9,000,000	$1,253,812	$2,758,631	$2,850,039	$1,504,819	$91,408
VACAA, Section 801 (0160)	$1,119	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$2,892,233**	**$9,000,000**	**$1,253,812**	**$2,758,631**	**$2,850,039**	**$1,504,819**	**$91,408**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$1,734	$0	$851	$818	$1,432	($33)	$614
VACAA, Section 801 (0152)	$144	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,878**	**$0**	**$851**	**$818**	**$1,432**	**($33)**	**$614**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$2,257	$23,300	$14,800	$27,800	$26,800	$13,000	($1,000)
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$2,257**	**$23,300**	**$14,800**	**$27,800**	**$26,800**	**$13,000**	**($1,000)**
Mandatory Total	**$2,896,368**	**$9,023,300**	**$1,269,463**	**$2,787,249**	**$2,878,271**	**$1,517,786**	**$91,022**
Combined Discretionary and Mandatory by Category							
Medical Services	$12,783,536	$13,813,044	$14,989,046	$17,113,983	$19,341,353	$2,124,937	$2,227,370
Medical Community Care	$0	$6,596	$0	$0	$0	$0	$0
Medical Support and Compliance	$771,284	$839,500	$879,651	$880,818	$873,732	$1,167	($7,086)
Medical Facilities	$194,690	$221,600	$228,700	$288,200	$280,300	$59,500	($7,900)
Obligations [Grand Total]	**$13,749,510**	**$14,880,740**	**$16,097,397**	**$18,283,001**	**$20,495,385**	**$2,185,604**	**$2,212,384**

Note: obligations from PACT Act section 707 are allocated to the health care service category without specificity of project type.

This health service category includes funding for pharmacy in VAMCs and community-based clinics, as well as pharmacy in the community by non-VA providers. Estimated obligations in this category are derived primarily by applying the growth in obligations projected by the EHCPM to the most recent year of actual data. For additional detail on the EHCPM's pharmacy projections, see Section H – Actuarial Model Projections, in Volume II.

Authority for Action:

- 38 U.S.C., Chapter 17, Hospital, Nursing Home, Domiciliary, and Medical Care

Types of Services Provided:

VHA provides a comprehensive range of pharmacy services both in-house at VA medical facilities and through community providers. In-house, VHA pharmacies offer prescription dispensing (including refills and new prescriptions), inpatient pharmacy, mailed medication, medication counseling, safe medication disposal, and clinical pharmacy services such as comprehensive medication management, therapeutic monitoring, and participation in interdisciplinary care teams. Clinical pharmacists are involved in direct patient care, designing and monitoring medication plans, ordering necessary lab tests, and educating patients, often through face-to-face, virtual, or group visits.

For community care, VHA partners with in-network retail pharmacies and other providers through the Community Care Network (CCN). Veterans can fill urgent prescriptions at community or VHA pharmacies, while routine or maintenance prescriptions are typically managed by VA facility pharmacies and VHA's Consolidated Mail Outpatient Pharmacy (CMOP). Additional services, such as immunizations and mail-order medication delivery, are also available to eligible Veterans and certain family members through programs like Meds by Mail.

Prosthetic and Sensory Aids Services

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$5,011,980	$5,343,218	$5,653,512	$6,241,476	$6,842,716	$587,964	$601,240
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	**$5,011,980**	**$5,343,218**	**$5,653,512**	**$6,241,476**	**$6,842,716**	**$587,964**	**$601,240**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
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	$5,011,980	$5,343,218	$5,653,512	$6,241,476	$6,842,716	$587,964	$601,240
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]	**$5,011,980**	**$5,343,218**	**$5,653,512**	**$6,241,476**	**$6,842,716**	**$587,964**	**$601,240**

This health service category includes funding for prosthetics and sensory aids services provided in VAMCs and community-based clinics. Estimated obligations in this category are derived by applying the growth in obligations projected by the EHCPM to the most recent year of actual data. For additional detail on the EHCPM's prosthetics and sensory aids services projections, see Section H – Actuarial Model Projections, in Volume II.

Authority for Action:

- 38 CFR §17.150, sec. 1701(6)(F) and 1710, Program Accessibility; Existing Facilities
- 38 CFR §17.3200-3250, Prosthetic and Rehabilitative Items and Services
- 38 CFR 3.810, Clothing Allowance
- 38 CFR 17.148, Service and Guide Dog Benefits

- 38 CFR 17.149, Sensori-neural Aids
- 38 CFR 17.151, Patient Lifts and Other Rehabilitative Devices.
- 38 CFR 17.152, Devices for deaf Veterans
- 38 CFR 17.154, Equipment for Blind Veterans
- 38 CFR 17.155 – 159, Automobile Adaptive Equipment
- 38 CFR 17.3100 – 3130, Home Improvements and Structural Alterations

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

Population 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 a wide variety of Veterans' needs. All Veterans enrolled for healthcare within VA are eligible for PSAS services if there is a valid clinical prescription.

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

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

Rehabilitative Care

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$914,176	$995,138	$855,281	$423,189	$402,101	($432,092)	($21,088)
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$146,144	$174,800	$166,900	$167,100	$165,600	$200	($1,500)
Medical Facilities (0162):	$172,593	$198,000	$191,800	$233,500	$227,300	$41,700	($6,200)
Discretionary Total	**$1,232,913**	**$1,367,938**	**$1,213,981**	**$823,789**	**$795,001**	**($390,192)**	**($28,788)**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$165,975	$84,546	$224,004	$614,057	$634,405	$390,053	$20,348
VACAA, Section 801 (0160)	$95	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$166,070**	**$84,546**	**$224,004**	**$614,057**	**$634,405**	**$390,053**	**$20,348**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$10,824	$0	$5,312	$5,108	$8,939	($204)	$3,831
VACAA, Section 801 (0152)	$29	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$10,853**	**$0**	**$5,312**	**$5,108**	**$8,939**	**($204)**	**$3,831**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$1,345	$9,200	$8,800	$16,500	$15,900	$7,700	($600)
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,345**	**$9,200**	**$8,800**	**$16,500**	**$15,900**	**$7,700**	**($600)**
Mandatory Total	**$178,268**	**$93,746**	**$238,116**	**$635,665**	**$659,244**	**$397,549**	**$23,579**
Combined Discretionary and Mandatory by Category							
Medical Services	$1,080,246	$1,079,684	$1,079,285	$1,037,246	$1,036,506	($42,039)	($740)
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$156,997	$174,800	$172,212	$172,208	$174,539	($4)	$2,331
Medical Facilities	$173,938	$207,200	$200,600	$250,000	$243,200	$49,400	($6,800)
Obligations [Grand Total]	**$1,411,181**	**$1,461,684**	**$1,452,097**	**$1,459,454**	**$1,454,245**	**$7,357**	**($5,209)**

Note: obligations from PACT Act section 707 are allocated to the health care service category without specificity of project type.

This health service category includes funding for rehabilitative care provided in VA medical centers and community-based clinics. Estimated obligations in this category are derived by applying the growth in obligations projected by the EHCPM to the most recent year of actual data. For additional detail on the EHCPM's rehabilitative care projections, see Section H – Actuarial Model Projections, in Volume II.

Authority for Action:

38 U.S.C.

- §1706: Management of health care: other requirements
- §1710: Eligibility for hospital, nursing home, and domiciliary care
- §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
- §1710F: Wheelchairs, artificial limbs, trusses, and similar items

- §1710 Note: Chiropractic Treatment
- §3104 Note: Blind Rehabilitation Outpatient Specialists
- §3903: Limitations on assistance; special training courses
- §7327: Centers for research, education, and clinical activities on complex multi-trauma
- §8111: Sharing of VA and DoD health care resources
- §8153: Sharing of health-care resources
- §3903A-E: Automobile Adaptive Equipment and Driver Training
- Chapter 75. Visual Impairment and Orientation and Mobility Professionals Educational Assistance Program

Population Covered:
Rehabilitative Care oversees program and policy development for medical rehabilitation services for VHA, coordinating the provision of the full continuum of medical rehabilitative and prosthetic services to promote the health, independence, and quality of life for Veterans with disabilities. This includes administering program and policy development for eight national programs with 11 different medical rehabilitation disciplines, aligning clinical expertise, clinical and practice guidance, and specialized procurement resources to provide comprehensive rehabilitation, prosthetic and orthotic services across the VHA health care. All rehabilitative care services are interdisciplinary team based and include life-long follow up and care. Programs administered include polytrauma/ TBI system of care, blind rehabilitation continuum of care, amputation system of care, driver rehabilitation training, and advanced technology labs.

Types of Services Provided
Services provided include audiology and speech pathology services, blind rehabilitation, chiropractic care, recreation and creative arts therapy, orthotic, prosthetic and pedorthic services and physical medicine and rehabilitation services (polytrauma system of care (PSC), amputation system of care, driver rehabilitation, wheelchair mobility, physical therapy (PT), and occupational therapy). Serves eligible Veterans and Active Duty Service members, including Special Operations Forces, who experience service-related health problems. VA has a long-standing memorandum of agreement with DoD for the "medical treatment provided to Active-Duty Service members with spinal cord injury, TBI, blindness and polytraumatic injuries." Care for Active-Duty Service members is provided under Defense Health Agency or Tricare authorization.

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

The following 22 tables display obligations, workload and appropriation details in the following order:

- Obligations by Program and overall Average Daily Census and Per Diem
- Institutional Programs:
  - Average Daily Census by Long and Short Stay

        - Patients Treated by Long and Short Stay
        - Obligations by Long and Short Stay
        - Per Diem by Long and Short Stay
    - Non-Institutional Obligations and Clinic Stops/Procedures
    - Obligations by Appropriation for the following VA System Provided
        - VA Community Living Centers
        - Community Residential Care
        - Home Telehealth
        - Home-Based Primary Care
        - Spinal Cord Injury and Disability Home Care
        - VA Adult Day Health Care
    - Obligations by Appropriation for the following Non-VA Providers
        - Community Nursing Home
        - State Home Nursing
        - State Home Domiciliary
        - State Home Adult Day Health Care
        - Community Adult Day Health Care
        - Home Hospice Care
        - Home Respite Care
        - Homemaker/Home Health Aide Programs
        - Purchased Skilled Care
    - 2024 Unique Patients using Non-Institutional Long-Term Supportive Services by Fund

Obligations by Program and Overall Average Daily Census and Per Diem

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Obligations ($000)							
Institutional							
Community Nursing Home	$2,192,137	$2,078,128	$2,628,921	$2,788,370	$2,954,399	$159,449	$166,029
State Home Domiciliary	$48,717	$62,662	$52,784	$57,086	$61,739	$4,302	$4,653
State Home Nursing	$1,731,909	$1,745,012	$1,945,841	$2,206,275	$2,503,751	$260,434	$297,476
VA Community Living Centers	$5,478,763	$5,470,160	$5,551,534	$5,619,357	$5,718,300	$67,823	$98,943
Institutional Obligations [Total]	**$9,451,526**	**$9,355,962**	**$10,179,080**	**$10,671,088**	**$11,238,189**	$492,008	$567,101
Non-Institutional							
Community Adult Day Health Care	$331,193	$307,035	$351,891	$369,657	$388,784	$17,766	$19,127
Community Residential Care	$214,783	$170,993	$217,812	$216,223	$213,698	($1,589)	($2,525)
Home Hospice Care	$175,743	$179,656	$182,388	$188,036	$195,332	$5,648	$7,296
Home Respite Care	$423,704	$283,769	$521,551	$634,715	$743,563	$113,164	$108,848
Home Telehealth	$422,153	$524,103	$447,612	$462,105	$474,187	$14,493	$12,082
Home-Based Primary Care	$1,542,956	$1,633,316	$1,716,592	$1,833,361	$1,923,352	$116,769	$89,991
Homemaker/Home Health Aide Prgs.	$3,356,372	$2,766,522	$4,082,778	$4,906,706	$5,689,478	$823,928	$782,772
Purchased Skilled Home Care	$1,666,166	$1,785,368	$2,073,046	$2,543,457	$2,987,307	$470,411	$443,850
Spinal Cord Injury & Disability Home Care	$19,494	$19,824	$20,382	$20,737	$20,917	$355	$180
State Home Adult Day Health Care	$3,299	$1,986	$2,816	$3,046	$3,294	$230	$248
VA Adult Day Health Care	$9,643	$8,026	$10,281	$10,661	$11,046	$380	$385
Non-Institutional Obligations [Total]	$8,165,506	$7,680,598	$9,627,149	$11,188,704	$12,650,958	$1,561,555	$1,462,254
Long-Term Services & Supports Obligations [Total]	**$17,617,032**	**$17,036,560**	**$19,806,229**	**$21,859,792**	**$23,889,147**	**$2,053,563**	**$2,029,355**
Institutional Average Daily Census							
Community Nursing Home	13,110	13,130	15,125	15,735	16,349	610	614
State Home Domiciliary	2,147	2,839	2,325	2,395	2,467	70	72
State Home Nursing	15,562	17,368	17,660	18,681	19,781	1,021	1,100
VA Community Living Centers	7,379	7,871	7,603	7,547	7,559	(56)	12
Institutional Average Daily Census [Total]	38,198	41,208	42,713	44,357	46,155	1,644	1,798
Institutional Per Diem							
Community Nursing Home	$456.86	$433.63	$476.20	$485.50	$495.09	$9.30	$9.59
State Home Domiciliary	$62.00	$60.47	$62.20	$65.31	$68.58	$3.11	$3.27
State Home Nursing	$304.07	$275.27	$301.87	$323.58	$346.78	$21.71	$23.20
VA Community Living Centers	$2,028.64	$1,904.05	$2,000.48	$2,039.95	$2,072.57	$39.47	$32.62
Institutional Per Diem [Total]	$676.05	$622.03	$652.91	$659.10	$667.09	$6.19	$7.99

Average Daily Census

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Nursing Home Average Daily Census, Long & Short Stay							
Community Nursing Home							
Long Stay	9,068	10,020	10,461	10,883	11,308	422	425
Short Stay	4,042	3,110	4,664	4,852	5,041	188	189
Community Nursing Home Stays [Total]	13,110	13,130	15,125	15,735	16,349	610	614
State Home Nursing							
Long Stay	15,052	16,783	17,081	18,069	19,133	988	1,064
Short Stay	510	585	579	612	648	33	36
State Nursing Home Stays [Total]	15,562	17,368	17,660	18,681	19,781	1,021	1,100
VA Community Living Centers							
Long Stay	5,761	6,219	5,935	5,892	5,901	(43)	9
Short Stay	1,618	1,652	1,668	1,655	1,658	(13)	3
VA Community Living Centers Stays [Total]	7,379	7,871	7,603	7,547	7,559	(56)	12
All Nursing Home Average Daily Census, Long & Short Stay [Grand Total]	36,051	38,369	40,388	41,963	43,689	1,575	1,726
Nursing Home Average Daily Census by Age							
Community Nursing Home							
< 65	1,139	1,335	1,314	1,367	1,420	53	53
65 to 84	9,709	9,313	11,201	11,653	12,108	452	455
> 84	2,262	2,482	2,610	2,715	2,821	105	106
Community Nursing Home Stays [Total]	13,110	13,130	15,125	15,735	16,349	610	614
State Home Nursing							
<65	649	944	682	721	764	39	43
65 to 84	10,049	10,412	11,251	11,902	12,603	651	701
> 84	4,864	6,012	5,727	6,058	6,414	331	356
State Home Nursing Stays [Total]	15,562	17,368	17,660	18,681	19,781	1,021	1,100
VA Community Living Centers							
< 65	777	952	801	795	796	(6)	1
65 to 84	5,391	5,704	5,554	5,513	5,522	(41)	9
> 84	1,211	1,215	1,248	1,239	1,241	(9)	2
VA Community Living Centers Stays [Total]	7,379	7,871	7,603	7,547	7,559	(56)	12
All Nursing Home Average Daily Census by Age [Grand Total]	36,051	38,369	40,388	41,963	43,689	1,575	1,726
Nursing Home Average Daily Census by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	10,783	10,524	12,440	12,942	13,447	502	505
Non-Service Connected	1,441	1,624	1,663	1,729	1,797	66	68
Service-Connected	886	982	1,022	1,064	1,105	42	41
Community Nursing Home Stays [Total]	13,110	13,130	15,125	15,735	16,349	610	614
State Home Nursing							
Priority 1A	5,904	5,629	6,700	7,087	7,505	387	417
Non-Service Connected	7,051	8,917	8,002	8,464	8,962	462	498
Service-Connected	2,607	2,822	2,958	3,129	3,314	171	185
State Home Nursing Stays [Total]	15,562	17,368	17,660	18,681	19,781	1,021	1,100
VA Community Living Centers							
Priority 1A	4,500	4,724	4,636	4,602	4,610	(34)	7
Non-Service Connected	1,822	2,046	1,877	1,863	1,866	(14)	4
Service-Connected	1,057	1,101	1,090	1,082	1,083	(8)	1
VA Community Living Centers Stays [Total]	7,379	7,871	7,603	7,547	7,559	(56)	12
All Nursing Home Stays by Priority 1A, SC & Non-SC [Total]	36,051	38,369	40,388	41,963	43,689	1,575	1,726

Patients Treated

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Patients Treated by Long & Short Stay							
Community Nursing Home							
Long Stay	14,795	15,246	18,608	21,342	24,194	2,734	2,852
Short Stay	65,230	47,096	82,039	94,096	106,667	12,057	12,572
Community Nursing Home Patients Trtd., [Total]	80,025	62,342	100,647	115,438	130,861	14,791	15,424
State Home Nursing							
Long Stay	19,410	23,991	22,016	23,575	25,037	1,559	1,462
Short Stay	4,338	5,632	4,920	5,269	5,596	349	327
State Home Nursing Patients Trtd., [Total]	23,748	29,623	26,936	28,844	30,633	1,908	1,789
VA Community Living Centers							
Long Stay	8,065	8,879	8,592	8,867	9,175	275	308
Short Stay	24,565	25,589	26,171	27,006	27,948	836	942
VA Community Living Centers Patients Trtd., [Total]	32,630	34,468	34,763	35,873	37,123	1,111	1,250
Grand Total Patients Treated by Long & Short Stay	136,403	126,433	162,345	180,155	198,617	17,810	18,462
Patients Treated by Age							
Community Nursing Home							
< 65	8,160	6,922	10,263	11,771	13,344	1,508	1,573
65 to 84	58,383	43,587	73,428	84,219	95,470	10,791	11,252
> 84	13,482	11,833	16,956	19,448	22,047	2,492	2,599
Community Nursing Home Stays [Total]	80,025	62,342	100,647	115,438	130,861	14,791	15,424
State Home Nursing							
< 65	917	1,216	1,040	1,114	1,183	74	69
65 to 84	15,130	17,916	17,161	18,376	19,516	1,215	1,140
> 84	7,701	10,491	8,735	9,354	9,934	619	580
State Home Nursing Stays [Total]	23,748	29,623	26,936	28,844	30,633	1,908	1,789
VA Community Living Centers							
< 65	3,834	5,215	4,085	4,215	4,362	130	147
65 to 84	22,956	23,207	24,456	25,238	26,117	783	879
> 84	5,840	6,046	6,222	6,420	6,644	198	224
VA Community Living Centers Stays [Total]	32,630	34,468	34,763	35,873	37,123	1,111	1,250
All Patients Treated by Age [Grand Total]	136,403	126,433	162,345	180,155	198,617	17,810	18,462
Patients Treated by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	54,829	38,859	68,958	79,092	89,660	10,134	10,568
Non-Service Connected	23,237	20,815	29,608	34,280	39,168	4,672	4,889
Service-Connected	1,959	2,668	2,081	2,066	2,033	(15)	(33)
Community Nursing Home Stays [Total]	80,025	62,342	100,647	115,438	130,861	14,791	15,424
State Home Nursing							
Priority 1A	8,937	9,911	10,137	10,855	11,528	718	673
Non-Service Connected	10,820	14,528	12,272	13,142	13,957	870	815
Service-Connected	3,991	5,184	4,527	4,847	5,148	320	301
State Home Nursing Stays [Total]	23,748	29,623	26,936	28,844	30,633	1,908	1,789
VA Community Living Centers							
Priority 1A	14,813	15,057	15,781	16,285	16,853	504	568
Non-Service Connected	11,391	12,694	12,136	12,523	12,959	388	436
Service-Connected	6,426	6,717	6,846	7,065	7,311	219	246
VA Community Living Centers Stays [Total]	32,630	34,468	34,763	35,873	37,123	1,111	1,250
All Patients Treated by Priority 1A, SC & Non-SC [Total]	136,403	126,433	162,345	180,155	198,617	17,810	18,462

Length of Stay

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Length of Stay by Long & Short Stay							
Community Nursing Home							
Long Stay	224.3	239.9	205.2	186.1	170.6	(19.1)	(15.5)
Short Stay	22.7	24.1	20.8	18.8	17.2	(2.0)	(1.6)
Community Nursing Home Length of Stay	60.0	76.9	54.9	49.8	45.6	(5.1)	(4.2)
State Home Nursing							
Long Stay	283.8	255.3	283.2	279.7	278.9	(3.5)	(0.8)
Short Stay	43.0	37.9	43.0	42.4	42.3	(0.6)	(0.1)
State Home Nursing Length of Stay	239.8	214.0	239.3	236.4	235.7	(2.9)	(0.7)
VA Community Living Centers							
Long Stay	261.4	255.7	252.1	242.5	234.8	(9.6)	(7.7)
Short Stay	24.1	23.6	23.3	22.4	21.7	(0.9)	(0.7)
VA Community Living Centers Length of Stay	82.8	83.4	79.8	76.8	74.3	(3.0)	(2.5)
Grand Total Length of Stay by Long & Short Stay	96.7	110.8	90.8	85.0	80.3	(5.8)	(4.7)
Length of Stay by Age							
Community Nursing Home							
< 65	51.1	70.4	46.7	42.4	38.8	(4.3)	(3.6)
65 to 84	60.9	78.0	55.7	50.5	46.3	(5.2)	(4.2)
> 84	61.4	76.6	56.2	51.0	46.7	(5.2)	(4.3)
Community Nursing Home Length of Stay [Total]	60.0	76.9	54.9	49.8	45.6	(5.1)	(4.2)
State Home Nursing							
< 65	259.0	283.4	239.4	236.2	235.7	(3.2)	(0.5)
65 to 84	243.1	212.1	239.3	236.4	235.7	(2.9)	(0.7)
> 84	231.2	209.2	239.3	236.4	235.7	(2.9)	(0.7)
State Home Nursing Length of Stay [Total]	239.8	214.0	239.3	236.4	235.7	(2.9)	(0.7)
VA Community Living Centers							
< 65	74.2	66.6	71.6	68.8	66.6	(2.8)	(2.2)
65 to 84	86.0	89.7	82.9	79.7	77.2	(3.2)	(2.5)
> 84	75.9	73.4	73.2	70.4	68.2	(2.8)	(2.2)
VA Community Living Centers Length of Stay [Total]	82.8	83.4	79.8	76.8	74.3	(3.0)	(2.5)
Grand Total Length of Stay by Age	96.7	110.8	90.8	85.0	80.3	(5.8)	(4.7)
Length of Stay by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	72.0	98.9	65.8	59.7	54.7	(6.1)	(5.0)
Non-Service Connected	22.7	28.5	20.5	18.4	16.7	(2.1)	(1.7)
Service-Connected	165.5	134.3	179.3	188.0	198.4	8.7	10.4
Community Nursing Home Length of Stay [Total]	60.0	76.9	54.9	49.8	45.6	(5.1)	(4.2)
State Home Nursing							
Priority 1A	241.8	207.3	241.3	238.3	237.6	(3.0)	(0.7)
Non-Service Connected	238.5	224.0	238.0	235.1	234.4	(2.9)	(0.7)
Service-Connected	239.1	198.7	238.5	235.6	235.0	(2.9)	(0.6)
State Home Nursing Length of Stay [Total]	239.8	214.0	239.3	236.4	235.7	(2.9)	(0.7)
VA Community Living Centers							
Priority 1A	111.2	114.5	107.2	103.2	99.8	(4.0)	(3.4)
Non-Service Connected	58.5	58.8	56.4	54.3	52.6	(2.1)	(1.7)
Service-Connected	60.2	59.8	58.1	55.9	54.1	(2.2)	(1.8)
VA Community Living Centers Length of Stay [Total]	82.8	83.4	79.8	76.8	74.3	(3.0)	(2.5)
Grand Total Length of Stay by Priority 1A, SC & Non-SC [Total]	96.7	110.8	90.8	85.0	80.3	(5.8)	(4.7)

Obligations

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Obligations by Long & Short Stay							
Community Nursing Home							
Long Stay	$1,404,333	$1,480,542	$1,621,157	$1,650,891	$1,688,028	$29,734	$37,137
Short Stay	$787,804	$597,586	$1,007,764	$1,137,479	$1,266,371	$129,715	$128,892
Community Nursing Home Patients Trtd., [Total]	$2,192,137	$2,078,128	$2,628,921	$2,788,370	$2,954,399	$159,449	$166,029
State Home Nursing							
Long Stay	$1,674,584	$1,687,254	$1,884,214	$2,136,721	$2,426,876	$252,507	$290,155
Short Stay	$57,325	$57,758	$61,627	$69,554	$76,875	$7,927	$7,321
State Home Nursing Patients Trtd., [Total]	$1,731,909	$1,745,012	$1,945,841	$2,206,275	$2,503,751	$260,434	$297,476
VA Community Living Centers							
Long Stay	$4,131,154	$4,124,667	$4,176,235	$4,185,626	$4,239,647	$9,391	$54,021
Short Stay	$1,347,609	$1,345,493	$1,375,299	$1,433,731	$1,478,653	$58,432	$44,922
VA Community Living Centers Patients Trtd., [Total]	$5,478,763	$5,470,160	$5,551,534	$5,619,357	$5,718,300	$67,823	$98,943
Grand Total Obligations by Long & Short Stay [Total]	$9,402,809	$9,293,300	$10,126,296	$10,614,002	$11,176,450	$487,706	$562,448
Obligations by Age							
Community Nursing Home							
< 65	$207,963	$197,148	$242,366	$249,573	$255,175	$7,207	$5,602
65 to 84	$1,627,238	$1,542,608	$1,968,873	$2,104,252	$2,243,616	$135,379	$139,364
> 84	$356,936	$338,372	$417,682	$434,545	$455,608	$16,863	$21,063
Community Nursing Home Obligations [Total]	$2,192,137	$2,078,128	$2,628,921	$2,788,370	$2,954,399	$159,449	$166,029
State Home Nursing							
< 65	$75,096	$75,665	$81,892	$90,940	$100,973	$9,048	$10,033
65 to 84	$1,132,446	$1,141,013	$1,309,554	$1,512,602	$1,744,355	$203,048	$231,753
> 84	$524,367	$528,334	$554,395	$602,733	$658,423	$48,338	$55,690
State Home Nursing Obligations [Total]	$1,731,909	$1,745,012	$1,945,841	$2,206,275	$2,503,751	$260,434	$297,476
VA Community Living Centers							
< 65	$588,594	$670,503	$559,270	$670,503	$694,596	$111,233	$24,093
65 to 84	$3,982,230	$4,031,343	$4,102,376	$4,180,540	$4,229,884	$78,164	$49,344
> 84	$907,939	$768,314	$889,888	$768,314	$793,820	($121,574)	$25,506
VA Community Living Centers Obligations [Total]	$5,478,763	$5,470,160	$5,551,534	$5,619,357	$5,718,300	$67,823	$98,943
Grand Total Obligations by Age	$9,402,809	$9,293,300	$10,126,296	$10,614,002	$11,176,450	$487,706	$562,448
Obligations by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	$1,787,344	$1,694,387	$2,132,410	$2,259,258	$2,402,948	$126,848	$143,690
Non-Service Connected	$251,064	$238,007	$309,989	$331,480	$345,046	$21,492	$13,565
Service-Connected	$153,729	$145,734	$186,522	$197,631	$206,405	$11,109	$8,774
Community Nursing Home Obligations [Total]	$2,192,137	$2,078,128	$2,628,921	$2,788,370	$2,954,399	$159,449	$166,029
State Home Nursing							
Priority 1A	$724,863	$754,997	$865,305	$1,017,496	$1,191,780	$152,191	$174,284
Non-Service Connected	$730,039	$709,195	$773,349	$843,348	$923,373	$69,999	$80,025
Service-Connected	$277,007	$280,820	$307,187	$345,431	$388,598	$38,244	$43,167
State Home Nursing Obligations [Total]	$1,731,909	$1,745,012	$1,945,841	$2,206,275	$2,503,751	$260,434	$297,476
VA Community Living Centers							
Priority 1A	$1,421,400	$1,419,168	$1,501,663	$1,628,105	$1,742,910	$126,442	$114,805
Non-Service Connected	$3,249,726	$3,244,623	$3,223,250	$3,148,576	$3,111,804	($74,674)	($36,772)
Service-Connected	$807,637	$806,368	$826,621	$842,676	$863,586	$16,055	$20,909
VA Community Living Centers Obligations [Total]	$5,478,763	$5,470,160	$5,551,534	$5,619,357	$5,718,300	$67,823	$98,943
Obligations by Priority 1A, SC & Non-SC [Total]	$9,402,809	$9,293,300	$10,126,296	$10,614,002	$11,176,450	$487,706	$562,448

Per Diems

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Per Diems by Long & Short Stay							
Community Nursing Home							
Long Stay	$423.13	$404.82	$424.58	$415.60	$408.98	($8.98)	($6.62)
Short Stay	$532.53	$526.44	$591.98	$642.29	$688.26	$50.31	$45.97
Community Nursing Home Patients Trtd., [Total]	$456.86	$433.63	$476.20	$485.50	$495.09	$9.30	$9.59
State Home Nursing							
Long Stay	$303.97	$275.43	$302.22	$323.99	$347.52	$21.77	$23.53
Short Stay	$307.11	$270.50	$291.61	$311.37	$325.03	$19.76	$13.66
State Home Nursing Patients Trtd., [Total]	$304.07	$275.27	$301.87	$323.58	$346.78	$21.71	$23.20
VA Community Living Centers							
Long Stay	$1,959.26	$1,817.09	$1,927.84	$1,946.28	$1,968.39	$18.44	$22.11
Short Stay	$2,275.64	$2,231.41	$2,258.96	$2,373.43	$2,443.37	$114.47	$69.94
VA Community Living Centers Patients Trtd., [Total]	$2,028.64	$1,904.05	$2,000.48	$2,039.95	$2,072.57	$39.47	$32.62
Overall Per Diem by Long & Short Stay	$712.62	$663.59	$686.92	$692.99	$700.88	$6.07	$7.89
Per Diem by Age							
Community Nursing Home							
< 65	$498.86	$404.59	$505.34	$500.19	$492.33	($5.15)	($7.86)
65 to 84	$457.93	$453.81	$481.58	$494.73	$507.67	$13.15	$12.94
> 84	$431.14	$373.51	$438.44	$438.50	$442.48	$0.06	$3.98
Community Nursing Home Overall Per Diem	$456.86	$433.63	$476.20	$485.50	$495.09	$9.30	$9.59
State Home Nursing							
< 65	$316.15	$219.60	$328.98	$345.56	$362.09	$16.58	$16.53
65 to 84	$307.90	$300.24	$318.89	$348.20	$379.21	$29.31	$31.01
> 84	$294.55	$240.77	$265.22	$272.59	$281.24	$7.37	$8.65
State Home Nursing Overall Per Diem	$304.07	$275.27	$301.87	$323.58	$346.78	$21.71	$23.20
VA Community Living Centers							
< 65	$2,069.73	$1,929.62	$1,912.92	$2,310.68	$2,390.71	$397.76	$80.03
65 to 84	$2,018.25	$1,936.32	$2,023.66	$2,077.55	$2,098.65	$53.89	$21.10
> 84	$2,048.48	$1,732.49	$1,953.57	$1,698.93	$1,752.50	($254.64)	$53.57
VA Community Living Centers Overall Per Diem	$2,028.64	$1,904.05	$2,000.48	$2,039.95	$2,072.57	$39.47	$32.62
Overall Per Diem by Age	$712.62	$663.59	$686.92	$692.99	$700.88	$6.07	$7.89
Per Diem by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	$452.88	$441.10	$469.63	$478.27	$489.58	$8.64	$11.31
Non-Service Connected	$476.04	$401.52	$510.69	$525.25	$526.06	$14.56	$0.81
Service-Connected	$474.07	$406.59	$500.02	$508.89	$511.76	$8.87	$2.87
Community Nursing Home Overall Per Diem	$456.86	$433.63	$476.20	$485.50	$495.09	$9.30	$9.59
State Home Nursing							
Priority 1A	$335.44	$367.47	$353.82	$393.33	$435.07	$39.51	$41.74
Non-Service Connected	$282.90	$217.90	$264.79	$272.98	$282.28	$8.19	$9.30
Service-Connected	$290.31	$272.63	$284.52	$302.46	$321.26	$17.94	$18.80
State Home Nursing Overall Per Diem	$304.07	$275.27	$301.87	$323.58	$346.78	$21.71	$23.20
VA Community Living Centers							
Priority 1A	$863.07	$823.06	$887.37	$969.22	$1,035.92	$81.85	$66.70
Non-Service Connected	$4,872.59	$4,344.76	$4,705.65	$4,630.81	$4,567.70	($74.84)	($63.11)
Service-Connected	$2,087.66	$2,006.57	$2,077.72	$2,133.74	$2,184.66	$56.02	$50.92
VA Community Living Centers Overall Per Diem	$2,028.64	$1,904.05	$2,000.48	$2,039.95	$2,072.57	$39.47	$32.62
Overall Per Diem for Priority 1A, SC & Non-SC	$712.62	$663.59	$686.92	$692.99	$700.88	$6.07	$7.89

Non-Institutional Obligations and Clinic Stops/Procedures

Description	2024 Actual	2025 Budget Estimate 1/	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Non-Institutional Obligations ($000)							
Community Adult Day Health Care	$331,193	$307,035	$351,891	$369,657	$388,784	$17,766	$19,127
Community Residential Care	$214,783	$170,993	$217,812	$216,223	$213,698	($1,589)	($2,525)
Home Hospice Care	$175,743	$179,656	$182,388	$188,036	$195,332	$5,648	$7,296
Home Respite Care	$423,704	$283,769	$521,551	$634,715	$743,563	$113,164	$108,848
Home Telehealth	$422,153	$524,103	$447,612	$462,105	$474,187	$14,493	$12,082
Home-Based Primary Care	$1,542,956	$1,633,316	$1,716,592	$1,833,361	$1,923,352	$116,769	$89,991
Homemaker/Home Health Aide Prgs.	$3,356,372	$2,766,522	$4,082,778	$4,906,706	$5,689,478	$823,928	$782,772
Purchased Skilled Home Care	$1,666,166	$1,785,368	$2,073,046	$2,543,457	$2,987,307	$470,411	$443,850
Spinal Cord Injury & Disability Home Care	$19,494	$19,824	$20,382	$20,737	$20,917	$355	$180
State Home Adult Day Health Care	$3,299	$1,986	$2,816	$3,046	$3,294	$230	$248
VA Adult Day Health Care	$9,643	$8,026	$10,281	$10,661	$11,046	$380	$385
Non-Institutional Obligations [Total]	**$8,165,506**	**$7,680,598**	**$9,627,149**	**$11,188,704**	**$12,650,958**	**$1,561,555**	**$1,462,254**
Non-Institutional Clinic Stops/Procedures							
Community Adult Day Health Care	586,063	613,706	604,420	617,085	631,020	12,665	13,935
Community Residential Care	38,366	39,715	37,229	36,092	34,940	(1,137)	(1,152)
Home Hospice Care	768,885	739,424	774,707	776,113	783,017	1,406	6,904
Home Respite Care	36,024	33,846	43,065	50,979	58,193	7,914	7,214
Home Telehealth	784,314	761,534	799,353	809,573	817,635	10,220	8,062
Home-Based Primary Care	1,663,021	1,605,915	1,778,089	1,863,487	1,927,490	85,398	64,003
Homemaker/Home Health Aide Prgs.	19,936,613	18,398,378	23,266,257	27,151,990	30,550,640	3,885,733	3,398,650
Purchased Skilled Home Care	207,683	209,394	244,398	284,383	317,650	39,985	33,267
Spinal Cord Injury Home Care	18,373	17,658	18,438	18,381	18,222	(57)	(159)
State Adult Day Health Care	12,331	8,898	10,526	11,386	12,313	860	927
VA Adult Day Health Care	31,391	22,439	32,127	32,635	33,282	508	647
Non-Institutional Clinic Stops/Procedures [Total]	**24,083,064**	**22,450,907**	**27,608,609**	**31,652,104**	**35,184,402**	**4,043,495**	**3,532,298**
Non-Institutional Cost Per Clinic Stops/Procedures							
Community Adult Day Health Care	$565.12	$500.30	$582.20	$599.04	$616.12	$16.84	$17.08
Community Residential Care	$5,598.26	$4,305.50	$5,850.60	$5,990.88	$6,116.14	$140.28	$125.26
Home Hospice Care	$228.57	$242.97	$235.43	$242.28	$249.46	$6.85	$7.18
Home Respite Care	$11,761.71	$8,384.12	$12,110.79	$12,450.52	$12,777.53	$339.73	$327.01
Home Telehealth	$538.24	$688.22	$559.97	$570.80	$579.95	$10.83	$9.15
Home-Based Primary Care	$927.80	$1,017.06	$965.41	$983.83	$997.85	$18.42	$14.02
Homemaker/Home Health Aide Prgs.	$168.35	$150.37	$175.48	$180.71	$186.23	$5.23	$5.52
Purchased Skilled Home Care	$8,022.64	$8,526.36	$8,482.25	$8,943.77	$9,404.40	$461.52	$460.63
Spinal Cord Injury Home Care	$1,061.01	$1,122.66	$1,105.43	$1,128.18	$1,147.90	$22.75	$19.72
State Adult Day Health Care	$1.06	$0.89	$1.07	$1.07	$1.07	$0.00	$0.00
VA Adult Day Health Care	$307.19	$357.68	$320.01	$326.67	$331.89	$6.66	$5.22
Non-Institutional Cost Per Clinic Stops/Procedures	**$339.06**	**$342.11**	**$348.70**	**$353.49**	**$359.56**	**$4.79**	**$6.07**

VA Community Living Centers Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$3,192,704	$3,151,325	$2,848,056	$1,003,208	$1,028,131	($1,844,848)	$24,923
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$637,806	$750,700	$728,500	$729,500	$723,100	$1,000	($6,400)
Medical Facilities (0162):	$857,332	$873,800	$952,900	$1,160,100	$1,129,300	$207,200	($30,800)
Discretionary Total	**$4,687,842**	**$4,775,825**	**$4,529,456**	**$2,892,808**	**$2,880,531**	**($1,636,648)**	**($12,277)**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$719,197	$593,035	$970,647	$2,660,812	$2,748,979	$1,690,165	$88,167
VACAA, Section 801 (0160)	$342	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$719,539**	**$593,035**	**$970,647**	**$2,660,812**	**$2,748,979**	**$1,690,165**	**$88,167**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$68,527	$0	$33,631	$32,337	$56,590	($1,294)	$24,253
VACAA, Section 801 (0152)	$132	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$68,659**	**$0**	**$33,631**	**$32,337**	**$56,590**	**($1,294)**	**$24,253**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$2,723	$101,300	$17,800	$33,400	$32,200	$15,600	($1,200)
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$2,723**	**$101,300**	**$17,800**	**$33,400**	**$32,200**	**$15,600**	**($1,200)**
Mandatory Total	**$790,921**	**$694,335**	**$1,022,078**	**$2,726,549**	**$2,837,769**	**$1,704,471**	**$111,220**
Combined Discretionary and Mandatory by Category							
Medical Services	$3,912,243	$3,744,360	$3,818,703	$3,664,020	$3,777,110	($154,683)	$113,090
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$706,465	$750,700	$762,131	$761,837	$779,690	($294)	$17,853
Medical Facilities	$860,055	$975,100	$970,700	$1,193,500	$1,161,500	$222,800	($32,000)
Obligations [Grand Total]	**$5,478,763**	**$5,470,160**	**$5,551,534**	**$5,619,357**	**$5,718,300**	**$67,823**	**$98,943**

Note: obligations from PACT Act section 707 are allocated to the health care service category without specificity of project type.

Community Residential Care Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$162,347	$128,493	$156,541	$137,256	$135,388	($19,285)	($1,868)
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$23,085	$20,400	$26,400	$26,400	$26,200	$0	($200)
Medical Facilities (0162):	$24,679	$20,800	$27,400	$33,400	$32,500	$6,000	($900)
Discretionary Total	**$210,111**	**$169,693**	**$210,341**	**$197,056**	**$194,088**	**($13,285)**	**($2,968)**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$4,424	$0	$5,971	$16,367	$16,910	$10,396	$543
VACAA, Section 801 (0160)	$15	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$4,439**	**$0**	**$5,971**	**$16,367**	**$16,910**	**$10,396**	**$543**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$4	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$4**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$229	$1,300	$1,500	$2,800	$2,700	$1,300	($100)
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$229**	**$1,300**	**$1,500**	**$2,800**	**$2,700**	**$1,300**	**($100)**
Mandatory Total	**$4,672**	**$1,300**	**$7,471**	**$19,167**	**$19,610**	**$11,696**	**$443**
Combined Discretionary and Mandatory by Category							
Medical Services	$166,786	$128,493	$162,512	$153,623	$152,298	($8,889)	($1,325)
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$23,089	$20,400	$26,400	$26,400	$26,200	$0	($200)
Medical Facilities	$24,908	$22,100	$28,900	$36,200	$35,200	$7,300	($1,000)
Obligations [Grand Total]	**$214,783**	**$170,993**	**$217,812**	**$216,223**	**$213,698**	**($1,589)**	**($2,525)**

Note: obligations from PACT Act section 707 are allocated to the health care service category without specificity of project type.

Home Telehealth Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$274,803	$380,203	$274,225	$199,061	$209,545	($75,164)	$10,484
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$54,269	$71,300	$62,000	$62,100	$61,600	$100	($500)
Medical Facilities (0162):	$59,904	$71,300	$66,600	$81,100	$78,900	$14,500	($2,200)
Discretionary Total	**$388,976**	**$522,803**	**$402,825**	**$342,261**	**$350,045**	**($60,564)**	**$7,784**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$31,270	$0	$42,203	$115,690	$119,523	$73,487	$3,833
VACAA, Section 801 (0160)	$25	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$31,295**	**$0**	**$42,203**	**$115,690**	**$119,523**	**$73,487**	**$3,833**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$1,597	$0	$784	$754	$1,319	($30)	$565
VACAA, Section 801 (0152)	$10	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,607**	**$0**	**$784**	**$754**	**$1,319**	**($30)**	**$565**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$275	$1,300	$1,800	$3,400	$3,300	$1,600	($100)
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$275**	**$1,300**	**$1,800**	**$3,400**	**$3,300**	**$1,600**	**($100)**
Mandatory Total	**$33,177**	**$1,300**	**$44,787**	**$119,844**	**$124,142**	**$75,057**	**$4,298**
Combined Discretionary and Mandatory by Category							
Medical Services	$306,098	$380,203	$316,428	$314,751	$329,068	($1,677)	$14,317
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$55,876	$71,300	$62,784	$62,854	$62,919	$70	$65
Medical Facilities	$60,179	$72,600	$68,400	$84,500	$82,200	$16,100	($2,300)
Obligations [Grand Total]	**$422,153**	**$524,103**	**$447,612**	**$462,105**	**$474,187**	**$14,493**	**$12,082**

Note: obligations from PACT Act section 707 are allocated to the health care service category without specificity of project type.

Home Based Primary Care Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$1,028,114	$1,193,792	$1,098,661	$808,231	$887,678	($290,430)	$79,447
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$173,723	$189,500	$198,400	$198,700	$197,000	$300	($1,700)
Medical Facilities (0162):	$186,051	$192,200	$206,800	$251,800	$245,100	$45,000	($6,700)
Discretionary Total	**$1,387,888**	**$1,575,492**	**$1,503,861**	**$1,258,731**	**$1,329,778**	**($245,130)**	**$71,047**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$151,292	$34,924	$204,188	$559,735	$578,282	$355,547	$18,547
VACAA, Section 801 (0160)	$103	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$151,395**	**$34,924**	**$204,188**	**$559,735**	**$578,282**	**$355,547**	**$18,547**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$2,533	$0	$1,243	$1,195	$2,092	($48)	$897
VACAA, Section 801 (0152)	$33	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$2,566**	**$0**	**$1,243**	**$1,195**	**$2,092**	**($48)**	**$897**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$1,107	$22,900	$7,300	$13,700	$13,200	$6,400	($500)
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,107**	**$22,900**	**$7,300**	**$13,700**	**$13,200**	**$6,400**	**($500)**
Mandatory Total	**$155,068**	**$57,824**	**$212,731**	**$574,630**	**$593,574**	**$361,899**	**$18,944**
Combined Discretionary and Mandatory by Category							
Medical Services	$1,179,509	$1,228,716	$1,302,849	$1,367,966	$1,465,960	$65,117	$97,994
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$176,289	$189,500	$199,643	$199,895	$199,092	$252	($803)
Medical Facilities	$187,158	$215,100	$214,100	$265,500	$258,300	$51,400	($7,200)
Obligations [Grand Total]	**$1,542,956**	**$1,633,316**	**$1,716,592**	**$1,833,361**	**$1,923,352**	**$116,769**	**$89,991**

Note: obligations from PACT Act section 707 are allocated to the health care service category without specificity of project type.

Spinal Cord Injury and Disability Home Care Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$15,076	$14,924	$15,291	$13,595	$13,794	($1,696)	$199
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$1,847	$2,300	$2,100	$2,100	$2,100	$0	$0
Medical Facilities (0162):	$1,905	$2,200	$2,100	$2,600	$2,500	$500	($100)
Discretionary Total	**$18,828**	**$19,424**	**$19,491**	**$18,295**	**$18,394**	**($1,196)**	**$99**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$660	$0	$891	$2,442	$2,523	$1,551	$81
VACAA, Section 801 (0160)	$1	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$661**	**$0**	**$891**	**$2,442**	**$2,523**	**$1,551**	**$81**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$5	$400	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$5**	**$400**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$666**	**$400**	**$891**	**$2,442**	**$2,523**	**$1,551**	**$81**
Combined Discretionary and Mandatory by Category							
Medical Services	$15,737	$14,924	$16,182	$16,037	$16,317	($145)	$280
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$1,847	$2,300	$2,100	$2,100	$2,100	$0	$0
Medical Facilities	$1,910	$2,600	$2,100	$2,600	$2,500	$500	($100)
Obligations [Grand Total]	**$19,494**	**$19,824**	**$20,382**	**$20,737**	**$20,917**	**$355**	**$180**

Note: obligations from PACT Act section 707 are allocated to the health care service category without specificity of project type.

VA Adult Day Home Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$6,202	$6,726	$6,301	$5,096	$5,520	($1,205)	$424
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$1,371	$700	$1,600	$1,600	$1,600	$0	$0
Medical Facilities (0162):	$1,565	$600	$1,700	$2,100	$2,000	$400	($100)
Discretionary Total	**$9,138**	**$8,026**	**$9,601**	**$8,796**	**$9,120**	**($805)**	**$324**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$504	$0	$680	$1,865	$1,926	$1,185	$61
VACAA, Section 801 (0160)	$1	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$505**	**$0**	**$680**	**$1,865**	**$1,926**	**$1,185**	**$61**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$505**	**$0**	**$680**	**$1,865**	**$1,926**	**$1,185**	**$61**
Combined Discretionary and Mandatory by Category							
Medical Services	$6,707	$6,726	$6,981	$6,961	$7,446	($20)	$485
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$1,371	$700	$1,600	$1,600	$1,600	$0	$0
Medical Facilities	$1,565	$600	$1,700	$2,100	$2,000	$400	($100)
Obligations [Grand Total]	**$9,643**	**$8,026**	**$10,281**	**$10,661**	**$11,046**	**$380**	**$385**

Community Nursing Home Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$66,795	$57,665	$80,104	$84,962	$90,021	$4,858	$5,059
Medical Community Care (0140):	$1,683,382	$1,893,463	$1,101,379	$1,589,346	$1,717,884	$487,967	$128,538
Medical Support and Compliance (0152):	$96,589	$124,900	$110,300	$110,500	$109,500	$200	($1,000)
Medical Facilities (0162):	$1,915	$2,100	$2,100	$2,600	$2,500	$500	($100)
Discretionary Total	**$1,848,681**	**$2,078,128**	**$1,293,883**	**$1,787,408**	**$1,919,905**	**$493,525**	**$132,497**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$343,456	$0	$1,335,038	$1,000,962	$1,034,494	($334,076)	$33,532
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$343,456**	**$0**	**$1,335,038**	**$1,000,962**	**$1,034,494**	**($334,076)**	**$33,532**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$343,456**	**$0**	**$1,335,038**	**$1,000,962**	**$1,034,494**	**($334,076)**	**$33,532**
Combined Discretionary and Mandatory by Category							
Medical Services	$66,795	$57,665	$80,104	$84,962	$90,021	$4,858	$5,059
Medical Community Care	$2,026,838	$1,893,463	$2,436,417	$2,590,308	$2,752,378	$153,891	$162,070
Medical Support and Compliance	$96,589	$124,900	$110,300	$110,500	$109,500	$200	($1,000)
Medical Facilities	$1,915	$2,100	$2,100	$2,600	$2,500	$500	($100)
Obligations [Grand Total]	**$2,192,137**	**$2,078,128**	**$2,628,921**	**$2,788,370**	**$2,954,399**	**$159,449**	**$166,029**

State Nursing Home Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$0	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$1,731,909	$1,745,012	$1,945,841	$2,206,275	$2,503,751	$260,434	$297,476
Medical Support and Compliance (0152):	$0	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$1,731,909**	**$1,745,012**	**$1,945,841**	**$2,206,275**	**$2,503,751**	**$260,434**	**$297,476**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$0	$0	$0	$0	$0	$0	$0
Medical Community Care	$1,731,909	$1,745,012	$1,945,841	$2,206,275	$2,503,751	$260,434	$297,476
Medical Support and Compliance	$0	$0	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$1,731,909**	**$1,745,012**	**$1,945,841**	**$2,206,275**	**$2,503,751**	**$260,434**	**$297,476**

State Home Domiciliary

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$0	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$48,717	$62,662	$52,784	$57,086	$61,739	$4,302	$4,653
Medical Support and Compliance (0152):	$0	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$48,717**	**$62,662**	**$52,784**	**$57,086**	**$61,739**	**$4,302**	**$4,653**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
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	$48,717	$62,662	$52,784	$57,086	$61,739	$4,302	$4,653
Medical Support and Compliance	$0	$0	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$48,717**	**$62,662**	**$52,784**	**$57,086**	**$61,739**	**$4,302**	**$4,653**

State Home Adult Day Health Care Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$2,754	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$545	$1,986	$2,816	$3,046	$3,294	$230	$248
Medical Support and Compliance (0152):	$0	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$3,299**	**$1,986**	**$2,816**	**$3,046**	**$3,294**	**$230**	**$248**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
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	$2,754	$0	$0	$0	$0	$0	$0
Medical Community Care	$545	$1,986	$2,816	$3,046	$3,294	$230	$248
Medical Support and Compliance	$0	$0	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$3,299**	**$1,986**	**$2,816**	**$3,046**	**$3,294**	**$230**	**$248**

Community Adult Day Health Care Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$7,180	$9,547	$7,629	$8,014	$8,429	$385	$415
Medical Community Care (0140):	$274,445	$279,088	$198,481	$234,442	$249,776	$35,961	$15,334
Medical Support and Compliance (0152):	$17,465	$18,100	$19,900	$19,900	$19,700	$0	($200)
Medical Facilities (0162):	$340	$300	$400	$500	$500	$100	$0
Discretionary Total	**$299,430**	**$307,035**	**$226,410**	**$262,856**	**$278,405**	**$36,446**	**$15,549**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$31,763	$0	$125,481	$106,801	$110,379	($18,680)	$3,578
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$31,763**	**$0**	**$125,481**	**$106,801**	**$110,379**	**($18,680)**	**$3,578**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$31,763**	**$0**	**$125,481**	**$106,801**	**$110,379**	**($18,680)**	**$3,578**
Combined Discretionary and Mandatory by Category							
Medical Services	$7,180	$9,547	$7,629	$8,014	$8,429	$385	$415
Medical Community Care	$306,208	$279,088	$323,962	$341,243	$360,155	$17,281	$18,912
Medical Support and Compliance	$17,465	$18,100	$19,900	$19,900	$19,700	$0	($200)
Medical Facilities	$340	$300	$400	$500	$500	$100	$0
Obligations [Grand Total]	**$331,193**	**$307,035**	**$351,891**	**$369,657**	**$388,784**	**$17,766**	**$19,127**

Home Hospice Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$11,745	$5,743	$13,002	$13,405	$13,925	$403	$520
Medical Community Care (0140):	$130,701	$164,813	$60,344	$80,452	$84,481	$20,108	$4,029
Medical Support and Compliance (0152):	$7,849	$8,900	$9,000	$9,000	$8,900	$0	($100)
Medical Facilities (0162):	$175	$200	$200	$200	$200	$0	$0
Discretionary Total	**$150,470**	**$179,656**	**$82,546**	**$103,057**	**$107,506**	**$20,511**	**$4,449**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$25,273	$0	$99,842	$84,979	$87,826	($14,863)	$2,847
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$25,273**	**$0**	**$99,842**	**$84,979**	**$87,826**	**($14,863)**	**$2,847**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$25,273**	**$0**	**$99,842**	**$84,979**	**$87,826**	**($14,863)**	**$2,847**
Combined Discretionary and Mandatory by Category							
Medical Services	$11,745	$5,743	$13,002	$13,405	$13,925	$403	$520
Medical Community Care	$155,974	$164,813	$160,186	$165,431	$172,307	$5,245	$6,876
Medical Support and Compliance	$7,849	$8,900	$9,000	$9,000	$8,900	$0	($100)
Medical Facilities	$175	$200	$200	$200	$200	$0	$0
Obligations [Grand Total]	**$175,743**	**$179,656**	**$182,388**	**$188,036**	**$195,332**	**$5,648**	**$7,296**

Home Respite Care Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$0	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$409,657	$283,769	$521,551	$634,715	$743,563	$113,164	$108,848
Medical Support and Compliance (0152):	$14,047	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$423,704**	**$283,769**	**$521,551**	**$634,715**	**$743,563**	**$113,164**	**$108,848**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
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	$409,657	$283,769	$521,551	$634,715	$743,563	$113,164	$108,848
Medical Support and Compliance	$14,047	$0	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$423,704**	**$283,769**	**$521,551**	**$634,715**	**$743,563**	**$113,164**	**$108,848**

Homemaker/Home Health Aide Programs Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$69,306	$63,262	$84,306	$101,382	$117,623	$17,076	$16,241
Medical Community Care (0140):	$2,555,388	$2,542,360	$1,610,128	$2,740,279	$3,446,383	$1,130,151	$706,104
Medical Support and Compliance (0152):	$175,426	$158,100	$200,400	$200,700	$198,900	$300	($1,800)
Medical Facilities (0162):	$2,831	$2,800	$3,100	$3,800	$3,700	$700	($100)
Discretionary Total	**$2,802,951**	**$2,766,522**	**$1,897,934**	**$3,046,161**	**$3,766,606**	**$1,148,227**	**$720,445**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$370	$0	$499	$1,369	$1,414	$870	$45
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$370**	**$0**	**$499**	**$1,369**	**$1,414**	**$870**	**$45**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$552,922	$0	$2,184,345	$1,859,176	$1,921,458	($325,169)	$62,282
Veterans Choice Fund (0172)	$129	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$553,051**	**$0**	**$2,184,345**	**$1,859,176**	**$1,921,458**	**($325,169)**	**$62,282**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$553,421**	**$0**	**$2,184,844**	**$1,860,545**	**$1,922,872**	**($324,299)**	**$62,327**
Combined Discretionary and Mandatory by Category							
Medical Services	$69,676	$63,262	$84,805	$102,751	$119,037	$17,946	$16,286
Medical Community Care	$3,108,439	$2,542,360	$3,794,473	$4,599,455	$5,367,841	$804,982	$768,386
Medical Support and Compliance	$175,426	$158,100	$200,400	$200,700	$198,900	$300	($1,800)
Medical Facilities	$2,831	$2,800	$3,100	$3,800	$3,700	$700	($100)
Obligations [Grand Total]	**$3,356,372**	**$2,766,522**	**$4,082,778**	**$4,906,706**	**$5,689,478**	**$823,928**	**$782,772**

Purchased Skilled Home Care Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$55,816	$50,104	$69,446	$85,315	$100,319	$15,869	$15,004
Medical Community Care (0140):	$1,272,977	$1,628,964	$894,700	$1,498,721	$1,899,372	$604,021	$400,651
Medical Support and Compliance (0152):	$77,622	$104,400	$88,700	$88,800	$88,000	$100	($800)
Medical Facilities (0162):	$1,516	$1,900	$1,700	$2,100	$2,000	$400	($100)
Discretionary Total	**$1,407,931**	**$1,785,368**	**$1,054,546**	**$1,674,936**	**$2,089,691**	**$620,390**	**$414,755**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$642	$0	$866	$2,375	$2,454	$1,509	$79
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$642**	**$0**	**$866**	**$2,375**	**$2,454**	**$1,509**	**$79**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$257,593	$0	$1,017,634	$866,146	$895,162	($151,488)	$29,016
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$257,593**	**$0**	**$1,017,634**	**$866,146**	**$895,162**	**($151,488)**	**$29,016**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$258,235**	**$0**	**$1,018,500**	**$868,521**	**$897,616**	**($149,979)**	**$29,095**
Combined Discretionary and Mandatory by Category							
Medical Services	$56,458	$50,104	$70,312	$87,690	$102,773	$17,378	$15,083
Medical Community Care	$1,530,570	$1,628,964	$1,912,334	$2,364,867	$2,794,534	$452,533	$429,667
Medical Support and Compliance	$77,622	$104,400	$88,700	$88,800	$88,000	$100	($800)
Medical Facilities	$1,516	$1,900	$1,700	$2,100	$2,000	$400	($100)
Obligations [Grand Total]	**$1,666,166**	**$1,785,368**	**$2,073,046**	**$2,543,457**	**$2,987,307**	**$470,411**	**$443,850**

2024 Unique Patients using Non-Institutional Long-Term Supportive Services by Fund

FY 2024 Unique Patients using Non-Institutional Long-Term Supportive Services by Fund					
LTCC Category	Medical Services	Medical Support and Compliance	Medical Facilities	Medical Community Care	Joint Demonstration Fund
VA Adult Day Health Care	496	496	496	0	0
Community Adult Day	6,032	6,032	6,032	6,014	18
Home-Based Primary	178,613	178,613	178,613	0	110
Home Respite Care	36,024	36,024	36,024	35,893	134
Purchased Skilled Care	207,683	207,683	207,683	207,683	998
Hospice Care	53,430	53,430	53,430	13,985	132
Homemaker/Home Health Aide	197,101	197,101	197,101	196,317	803
SCI Home Care	2,028	2,028	2,028	0	0
Community Residential	4,358	4,358	4,358	0	1
Home Telehealth	162,691	162,691	162,691	0	695
State Adult Day Health Care	0	154	0	154	0

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

LTSS Programs

Authority for action

- 38 U.S.C. Chapter 17, Hospital, Nursing Home, Domiciliary, and Medical Care
- 38 C.F.R. § 17.38, Medical Benefits Package
- P.L. 106-117, Veterans Millennium Health Care and Benefits Act

Population Covered

VA's health care system provides enrolled Veterans with a broad spectrum of LTSS, which include geriatric outpatient programs, facility-based services, home and community-based services, and end-of-life services. Clinical indicators and Veteran conditions help health care professionals determine whether the service is needed to promote, preserve, or restore the health of the individual in accordance with generally accepted standards of medical practice. Specific eligibility and admission criteria are unique to each of three venues of facility-based services – VA CLCs, community nursing homes (CNHs), state Veterans homes (SVHs), as well as the array of home and community-based services (HCBS). VA provides nursing home care for enrolled Veterans for a service-connected disability, as well as enrolled Veterans who have a single or combined service-connected disability rating of 70% or greater. This includes Veterans with a single disability rated 60% but who have a 100% disability compensation rate based on individual unemployability.

Types of Services Provided

LTSS includes facility-based programs and HCBS. There are six facility-based geriatric and extended care (GEC) programs: VA CLCs; CNHs; SVHs (nursing homes and domiciliaries); inpatient hospice; inpatient respite; and brain injury residential rehabilitation. Some HCBS programs focus on Veterans' skilled care needs that are VA-provided (home-based primary care and adult day health care (ADHC)), purchased through community providers (skilled home health care, home hospice, home infusion, program of all-inclusive care for the elderly) and provided

through SVH ADHC. Four purchased HCBS programs focus on Veterans' personal care service needs: Homemaker/Home Health Aide (HHA), Veteran Directed Care (VDC), Home Respite Care, and Community ADHC. There are two HCBS programs that provide supportive housing: Community Residential Care and Medical Foster Home.

State Home Programs

State Home Per Diem Program

Authority for action

- 38 U.S.C. Chapter 17: Hospital, Nursing Home, Domiciliary, and Medical Care
- 38 CFR §51: Per Diem for Nursing Home, Domiciliary, or Adult Day Health Care of Veterans in State Homes
- P.L. 117-328 § 162b, The Cleland Dole Act

Purpose

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

SHPD supports eligible veterans with a basic rate for nursing home care (NHC), domiciliary (DOM), and ADHC. SHPD provides the prevailing rate for eligible Veterans in the SVH for NHC and ADHC with a service connection of 70% or greater as well as Veterans in the SVH who are adjudicated as totally disabled based on individually unemployability (TDIU).

2025 Planned Accomplishments

- Pilot testing of technology modernization Automated Resident Tracking System (ARTS) that will increase accuracy of reconciliation of invoices and reporting of data information
- Recognize six new SVHs
- Achieve 60% utilization of the online 10-10SH form to determine Veteran's eligibility for medical benefits in SVHs

2026 Budget Request

The 2026 budget requests $2.3 billion for SVH programs, an increase of $265.0 million (13.2%) above the 2025 current estimate. These funds are used to pay states for the care of eligible Veterans living in SVH in three levels of care: DOM, NHC, and ADHC. There are no associated VA FTEs supported in this budget request, however, nurse retention grants to support SVH staffing are included.

SVH occupancy rates are continuing to increase post-COVID pandemic requiring reimbursement for more Veterans, while increases in the per diem rate require more funds per Veteran. The PACT Act increased the number of Veterans eligible for the SHPD program at the higher prevailing per diem rate and required retroactive payments due to increased eligibility. Legislation providing funds for new or replacement SVHs, through VA's Grants for Construction of State Extended Care Facilities, increased the number of beds available for eligible Veterans.

2026 Planned Accomplishments

- Roll-out of Automated Resident Tracking System (ARTS) that will increase accuracy of reconciliation of invoices and reporting of data information.
- Eliminate PACT Act claims backlog.
- Increase nurse retention grant applications funded.
- Achieve 90% utilization of the online 10-10SH form

Evidence

As of May 2025, there are 172 SVHs, 166 recognized NHCs, 47 recognized DOMs, and 3 ADHCs with an average daily census (that is, average daily number of patients) of approximately 21,000 Veterans and 1,600 Veteran spouses and Gold Star Parents. The availability of beds post-pandemic and the passage of new legislation increasing the number of SVHs has increased the number of beds for eligible Veterans. Care and services covered under the SHPD program are not readily available elsewhere in many areas. Basic per diem rates are standardized across states but vary by level of care; and the increase in per diem rates has increased the funds required per eligible Veteran. Prevailing rates vary by location. Recent legislation has also increased the number of Veterans eligible for the SHPD program.

The processes and procedures for determination of Veterans' care eligibility program reimbursement are key outcomes for the SHPD program. By converting the manual completion of the 10-10SH form to an electronic process, the SHPD program has improved customer service by refining process efficiency and minimizing procedural burden for SVH and VAMC staff using the electronic process. Shifting to this new process allowed the program to reduce the amount of time to receive forms from roughly 3-5 days to 1 day. The development and implementation of the ARTS will increase accuracy of the reconciliation of invoices (expected reduction in error rate from 30% to less than 2%) and create automated reporting of data currently unavailable.

The interest in and use of nurse retention grants is evidenced by the continued increase in number of SVHs applying for and receiving funding. In 2024, 63 SVHs received funds versus 47 in 2023 (34% increase).

Camp Lejeune Family Member Program (CLFMP)

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$364	$702	$0	$0	$0	$0	$0
Medical Community Care (0140):	$1,657	$3,904	$2,088	$2,172	$2,257	$84	$85
Medical Support and Compliance (0152):	$0	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$2,021**	**$4,606**	**$2,088**	**$2,172**	**$2,257**	**$84**	**$85**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
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	$364	$702	$0	$0	$0	$0	$0
Medical Community Care	$1,657	$3,904	$2,088	$2,172	$2,257	$84	$85
Medical Support and Compliance	$0	$0	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$2,021**	**$4,606**	**$2,088**	**$2,172**	**$2,257**	**$84**	**$85**

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

CHAMPVA (Excluding Caregivers) Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$544,959	$570,897	$682,454	$774,660	$860,594	$92,206	$85,934
Medical Community Care (0140):	$1,772,437	$2,110,842	$2,305,968	$2,698,273	$3,059,530	$392,305	$361,257
Medical Support and Compliance (0152):	$0	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$2,317,396**	**$2,681,739**	**$2,988,422**	**$3,472,933**	**$3,920,124**	**$484,511**	**$447,191**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
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	$544,959	$570,897	$682,454	$774,660	$860,594	$92,206	$85,934
Medical Community Care	$1,772,437	$2,110,842	$2,305,968	$2,698,273	$3,059,530	$392,305	$361,257
Medical Support and Compliance	$0	$0	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$2,317,396**	**$2,681,739**	**$2,988,422**	**$3,472,933**	**$3,920,124**	**$484,511**	**$447,191**

Foreign Medical Programs Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$3	$0	$3	$3	$3	$0	$0
Medical Community Care (0140):	$127,905	$127,191	$161,997	$170,097	$178,602	$8,100	$8,505
Medical Support and Compliance (0152):	$0	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$127,908**	**$127,191**	**$162,000**	**$170,100**	**$178,605**	**$8,100**	**$8,505**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$3	$0	$3	$3	$3	$0	$0
Medical Community Care	$127,905	$127,191	$161,997	$170,097	$178,602	$8,100	$8,505
Medical Support and Compliance	$0	$0	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$127,908**	**$127,191**	**$162,000**	**$170,100**	**$178,605**	**$8,100**	**$8,505**

Spina Bifida Program Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$45	$0	$45	$45	$45	$0	$0
Medical Community Care (0140):	$71,074	$89,417	$79,055	$83,010	$87,163	$3,955	$4,153
Medical Support and Compliance (0152):	$0	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$71,119**	**$89,417**	**$79,100**	**$83,055**	**$87,208**	**$3,955**	**$4,153**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
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	$45	$0	$45	$45	$45	$0	$0
Medical Community Care	$71,074	$89,417	$79,055	$83,010	$87,163	$3,955	$4,153
Medical Support and Compliance	$0	$0	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$71,119**	**$89,417**	**$79,100**	**$83,055**	**$87,208**	**$3,955**	**$4,153**

Children of Women Vietnam Vets Obligations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$0	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$1	$4	$4	$4	$4	$0	$0
Medical Support and Compliance (0152):	$0	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$1**	**$4**	**$4**	**$4**	**$4**	**$0**	**$0**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$0	$0	$0	$0	$0	$0	$0
Medical Community Care	$1	$4	$4	$4	$4	$0	$0
Medical Support and Compliance	$0	$0	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$1**	**$4**	**$4**	**$4**	**$4**	**$0**	**$0**

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

Caregiver Support Program

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$2,128,907	$2,872,200	$2,644,205	$3,225,345	$3,549,827	$581,140	$324,482
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$28,094	$40,800	$32,233	$39,593	$40,385	$7,360	$792
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$2,157,001**	**$2,913,000**	**$2,676,438**	**$3,264,938**	**$3,590,212**	**$588,500**	**$325,274**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
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	$2,128,907	$2,872,200	$2,644,205	$3,225,345	$3,549,827	$581,140	$324,482
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$28,094	$40,800	$32,233	$39,593	$40,385	$7,360	$792
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$2,157,001**	**$2,913,000**	**$2,676,438**	**$3,264,938**	**$3,590,212**	**$588,500**	**$325,274**

Note: The 2026 budget does not include a separate appropriation account for P.L. 118-210 §122, the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act.

Authority for Action

- 38 U.S.C. § 1720G, Assistance and Support Services for Caregivers
- 38 C.F.R. Part 71, Caregivers Benefits and Certain Medical Benefits Offered to Family Members of Veterans

Purpose

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

Caregivers eligible for participation in PGCSS are caregivers who provide personal care services to covered Veterans. These Veterans are enrolled in VA health care and need personal care services, which include: an inability to perform one or more activities of daily living; necessary supervision or protection based on symptoms or residuals of neurological or other impairment or injury; or a need for regular or extensive instruction or supervision to avoid serious impairments in the

Veteran's ability to function in daily life. Unlike PCAFC, there is no formal application or evaluation required to participate in PGCSS. PGCSS provides resources, education, and support to caregivers of all era Veterans within four core elements. Support services available through PGCSS include a toll-free Caregiver Support Line, the Caregiver Peer Support Mentoring Program, Building Better Caregivers™, Annie Caregiver Text Care Program, Resources for Enhancing All Caregivers Health VA, and Caregiver Self-Care Courses.

As part of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 (P.L. 115-182 § 161), services available under PCAFC have expanded to Veterans of all eras with a serious injury incurred or aggravated in the line of duty, a service-connected disability of 70% or higher, and inability to perform activities of daily living or need for supervision or protection as defined under 38 U.S.C. § 1720G. Additional resources to PCAFC family caregivers include caregiver training, monthly stipends, mental health services, respite care services, patient travel reimbursements, health care benefits under CHAMPVA, and financial and legal services.

2025 Planned Accomplishments

- CSP anticipates an increase in PCAFC participation by 17,000 caregivers over 2024 participation.
- CSP anticipates an increase in respite referrals by 5,257, a 36% increase over the previous year.
- CSP anticipates having VPPC available in all 18 VISNs providing over 22,200 encounters in 2025. That would be an approximate increase of 6,000 encounters, or 37%.

2026 Budget Request

The CSP funding request for 2026 is $3.3 billion, an increase of $588.5 million (22%) above the 2025 Current Estimate. VA expects access to PCAFC would expand based on the changes under consideration, resulting in increases in stipends, health care costs, and staffing. To ensure appropriate case management is provided to the expanded population, CSP staff will need to increase by approximately 260 FTE over the course of 2026, with recruitment and training completed in a phased approach. It is critical that CSP has the projected staff on board by the second half of the year after rulemaking takes effect to meet anticipated projections. Staff will consist of social workers, nurses, and administrative staff in medical centers to handle increased caseload and application processing. FTE will also include additional Centralized Eligibility and Appeals Team staff to review applications and submissions on medical documentation. To support the increase in staffing needs, an additional $38.0 million will be needed in 2026.

The anticipated increase in PCAFC participation will also lead to increases in stipend costs by $452.4 million. Further, the anticipated increase in PCAFC participation will incur an additional $95.3 million in health care costs to cover respite care (for which utilization has experienced notable increases since 2022), mental health services, CHAMPVA, patient travel, and employee travel. Lastly, an increase of $2.8 million is anticipated to cover contracts that are managed by the program office, including a financial and legal services contract and various caregiver trainings whose costs increase with additional participants.

2026 Planned Accomplishments

- CSP anticipates an increase in PCAFC participation by 25,503 caregivers over 2025 participation of 66,430, a 38% increase.
- CSP anticipates an increase in respite referrals by 35% over 2025.
- CSP anticipates increased utilization of mental health services and mental health staff at CRHs in support of VPPC.

Evidence

CSP utilizes an operational dashboard to track the application process, to include application processing, consult workload, in-home visits, and appeals.

Since October 1, 2020, VHA has significantly increased participation in the CSP when it expanded program eligibility to Veterans and their caregivers from all service eras. CSP has evaluated the program requirements and identified a need to adjust certain requirements to be more inclusive of Veterans with moderate to serious conditions. The requested funding will allow the program office to hire additional staff to provide necessary supports and services, stipends payments to eligible PCAFC caregivers, and continued support services to caregivers of Veterans. To date, CSP offers resources and supports to over 168,000 caregivers and Veterans enrolled in the program.

PACT Act Sec. 705 Enhance Use Lease Authority

		2025		**2026**	**2027**		
Description (dollars in thousands)	2024 Actual	Budget Estimate	Current Estimate	**Revised Request**	**Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Mandatory Obligations							
Medical Facilities (0162):	$28,331	$40,608	$69,710	$13,260	$12,438	($56,450)	($822)
Mandatory Obligations [Total]	**$28,331**	**$40,608**	**$69,710**	**$13,260**	**$12,438**	**($56,450)**	**($822)**

Section 705 of the PACT Act modified VA's authority to allow the Secretary to enter into enhanced-use leases that do not adversely affect the mission of the Department or operation of facilities, programs, and services of the Department in the area of the leased property and that enhance the use of leased property by directly or indirectly benefitting Veterans or by providing supportive housing. VA will give priority to enhanced-use leases that provide supportive housing for Veterans, direct services or benefits targeted to Veterans or provide services or benefits that indirectly support Veterans. The funding table above reflects the VHA Medical Facilities portion of estimated obligations in 2025 and 2026 from the total $922 million appropriated to VA in this section of the Act in 2022.

Readjustment Counseling

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$261,049	$302,568	$276,935	$292,367	$298,214	$15,432	$5,847
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$7,265	$14,297	$15,191	$15,323	$15,629	$132	$306
Medical Facilities (0162):	$56,190	$53,496	$60,465	$62,884	$64,142	$2,419	$1,258
Discretionary Total	**$324,504**	**$370,361**	**$352,591**	**$370,574**	**$377,985**	**$17,983**	**$7,411**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
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	$261,049	$302,568	$276,935	$292,367	$298,214	$15,432	$5,847
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$7,265	$14,297	$15,191	$15,323	$15,629	$132	$306
Medical Facilities	$56,190	$53,496	$60,465	$62,884	$64,142	$2,419	$1,258
Obligations [Grand Total]	**$324,504**	**$370,361**	**$352,591**	**$370,574**	**$377,985**	**$17,983**	**$7,411**

Authority for action

- 38 U.S.C §7309 – Readjustment Counseling Service
- 38 U.S.C §1712A – Eligibility for readjustment counseling and related mental health services
- P.L 117-263, James M. Inhofe National Defense Authorization Act for 2023
    - Section 5126: Improvement of Vet Centers at Department of Veterans Affairs

Purpose

Readjustment Counseling Services' (RCS) mission is to welcome home and honor those who served, are still serving, and their families. RCS accomplishes this mission by reaching out to Veterans, Service members, and their families, engaging their communities, and providing a broad range of counseling, outreach, and referral services. At the end of 2024, RCS consisted of 303 Vet Centers nationwide, in both rural and urban areas. These numbers include 3 new Vet Centers approved at the end of 2023. To increase availability of readjustment counseling to those living in communities distant from a Vet Center, RCS services are provided through a variety of venues, such as 88 Mobile Vet Centers, 20 Vet Center Outstations, Vet Center Call Center, RCS Contract Fee program, and over 440 Community Access Points (CAP). Numbers reflect CAP locations with associated workload in 2024 and fluctuate depending on demand. Services for eligible individuals

include individual, group, marriage, and family counseling for challenges such as 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 assistance aids in the readjustment of those who have served or to help cope with the deployment of a loved one. This includes bereavement counseling for families who experience an active-duty service member's death. All services provided are at no cost and are strictly confidential.

2025 Planned Accomplishments

- Vet Center Outstations will be opened in permanent locations in Cumberland County, NJ and Sierra Vista, AZ offering increased services to Veterans, service members, and their families in these communities.
- RCS will complete the pilot of the Vet Center Outreach Application, identify potential improvements and enhancements, as well as work to integrate the application with Vet Center websites.
- Through increased access to care and a focus on effective outreach, RCS will increase unique clients and client encounters by 3% over 2024 results.

2026 Budget Request

The RCS funding request for 2026 is $370.6 million, $18.0 million (5.1%) above the 2025 Current Estimate. This funding level will enable a 3% projected increase of unique clients and client encounters over 2025, full implementation of the Vet Center Outreach Application, and activation of four additional assets. Funding will create increased access to care for Veterans, service members, and their families in the communities of Fredericksburg, VA; Hackettstown, NJ; Leesburg, VA; and Saipan, CNMI. This request includes $4.8 million dollars for projected inflationary impacts and lease operations; and $13.2 million dollars to support sustainment and completion of grade increases resulting from position standardization as required by P.L. 117-263, James M. Inhofe National Defense Authorization Act for 2023, Section 5126 (d). This section required the VA to standardize position descriptions for responsibilities at Vet Centers. The review and standardization resulted in determinations of increased grades for approximately 1,000 positions in RCS Vet Center locations. RCS has implemented grade increases related to standardized positions for approximately 600 positions, resulting in a need of $5.6 million in 2026 for continued support of those positions. Additionally, RCS is requesting $7.6 million dollars in 2026 to support implementation of the remaining approximately 400 standardized positions.

2026 Planned Accomplishments

- RCS will increase access to care by opening a Vet Center in Fredericksburg, VA and Vet Center Outstations in Hackettstown, NJ; Leesburg, VA; and Saipan, CNMI.
- Potential enhancements identified in the pilot phase of the Vet Center Outreach Application will be made with the full implementation anticipated in 2026.
- Through increased access to care and a focus on effective outreach, RCS will increase unique clients and client encounters by 3% over 2025 results.

Evidence

RCS measures unique Veterans, service members, and their families seeking services in Vet Centers based on data available in RCS's proprietary records tracking system. Total counseling visits are also captured from activity documented in the RCS record.

VSignals agreement scores are calculated by using a scale of one to five with one being to a positive agreement score across the VSignals survey types. Five different surveys are administered to capture customer feedback across the spectrum of RCS services at separate and specific stages of engagement including: Initial Engagement, Intake, Ongoing Services, Separation from Services, and Re-engagement Following Separation.

RCS Workload

Readjustment Counseling Workload
(in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Visits	1,262	1,412	1,299	**1,338**	**1,378**	39	40
Uniques	111	126	114	**117**	**121**	3	4

Activations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations							
Medical Services (0160):	$434,929	$411,634	$374,077	$483,378	$438,713	$109,301	($44,665)
Medical Support and Compliance (0152):	$38,124	$94,115	$74,144	$120,787	$106,182	$46,643	($14,605)
Medical Facilities (0162):	$34,687	$117,610	$47,206	$49,698	$43,672	$2,492	($6,026)
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$507,740**	**$623,359**	**$495,427**	**$653,863**	**$588,567**	**$158,436**	**($65,296)**

Authority for action

- 38 U.S.C. Chapter 17, Hospital, Nursing Home, Domiciliary, and Medical Care
- 38 U.S.C. §§ 7301(b), 8104, Congressional Approval of Certain Medical Facility Acquisitions

Purpose

VHA policy states that the Activations Program is used for activation of Major Construction Projects or Major or Mid-Level leases to create or renovate VA medical facilities and other types of spaces to serve VHA functions. Activations costs include non-recurring costs (furniture, fixture, equipment and other non-recurring costs such as equipment and initial supplies) and recurring costs (staffing and operational costs) associated with the activation of completed construction or lease of new or replacement medical care facilities. In addition, VHA executes Initial Outfitting, Transition, and Activation contracts to supplement facility activation resources. VA's activation plans are sensitive to delays in construction schedules and lease awards. VA continuously identifies

and closely monitors activations of new facilities and leases to promote better synchronization of budgetary resources with program needs.

2025 Planned Accomplishments

- Provide activations funding support for 61 projects, of which:
    - 7 projects are anticipated to have a First Patient Day, and
    - 37 projects are anticipated to have activation support contracts in effect.

2026 Budget Request

The Activations funding request for 2026 is $653.9 million, $158.4 million (32.0%) above the 2025 Current Estimate. A portion of this request is due to previous delays in construction schedules and lease awards. From 2024 to 2025, 38 projects experienced lease award or construction delays or cancellation, which shifted all or some of the projected activations funding needs to future years. Twelve projects experienced hiring challenges reducing recurring costs in 2025 that are now included in the 2026 request and could shift to outyears. The increased funding requirement for 2026 is also a result of the increase in projects receiving funding as well as the phase of activation of current projects. In addition, the 2026 request anticipates activations funding for 27 of the PACT Act leases in anticipation of lease space turnover and the First Patient Day. Finally, the request provides activations funding for 14 large major construction projects that anticipate a First Patient Day in 2026, as well as on-going growth in the mid-level and prospectus-level lease programs that require this program's support.

2026 Planned Accomplishments

- Provide activations funding support for 85 projects, of which:
    - 9 projects are anticipated to have a First Patient Day; and
    - 66 projects are anticipated to have activation support contracts in effect.

Evidence

Activations funding in previous years provided much needed execution of furniture, fixtures and equipment through a consistent process which expedited the projects' First Patient Day. This was accomplished by establishing funding plans, executing funding needs and transfers, providing perishable skill support contracts, and providing other essential activation activities.

Artificial Intelligence (Medical Care Funding)

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate 1/	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations							
Medical Services (0160):	$4,517	N/A	$14,223	$6,400	$6,528	($7,823)	$128
Medical Support and Compliance (0152):	$4,625	N/A	$18,539	$26,809	$27,345	$8,270	$536
Medical Facilities (0162):	$0	N/A	$0	$0	$0	$0	$0
Medical Community Care (0140):	$0	N/A	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$9,142**	**N/A**	**$32,762**	**$33,209**	**$33,873**	**$447**	**$664**

1/Information not previously displayed.

Authority for action

- 38 U.S.C. Chapter 17, Hospital, Nursing Home, Domiciliary, and Medical Care
- P.L. 116-283, Division E, National Artificial Intelligence Initiative Act of 2020

Purpose

Funding for Artificial Intelligence (AI) within the Medical Care accounts (AI Medical Care) provides for the development, acquisition, implementation, and monitoring of AI operationally across VHA. Additional emphasis is given to design and implement AI governance (defined as an enabler of effective and safe innovation for AI at VHA), identify emerging AI technologies that improve efficiency and support innovation at VHA, and validate AI technologies for use serving our Nation's Veterans. AI Medical Care consists of the National Artificial Intelligence Institute (NAII) and the AI and Emerging Technology (AIET) program.

2025 Planned Accomplishments

- Design and pilot high-priority AI solutions, including Large Language Models (LLMs); Retrieval Augmented Generation models; and agentic AI tools to streamline and improve efficiency of pre-encounter information gathering and discharge paperwork summary and community care documentation workflows for over 100 staff by at least 50%.
- Reduce clinician documentation burden by several hours per week per clinician through execution of an enterprise contract for AI ambient scribe technology.
- NAII will build upon the success of previous rapid AI development and scaling efforts with an AI Tech Sprint prize challenge designed to identify and deploy innovative enterprise-scale solutions more rapidly than traditional procurement processes.
- Consistent with EO 14179 (*Removing Barriers to American Leadership in Artificial Intelligence*, January 23, 2025), implement the AI Product Operating Model for VHA, de-siloing key components for AI success at VHA by enabling the rapid identification, development, piloting, and scaling of AI solutions for VHA. The expected outcome will guide at least 10 field-based AI solutions to deployment for several hundred VHA staff to improve Veteran care. An emerging technology program will be implemented to design and test a repeatable, standardized process for ordering immersive equipment for asynchronous mental health support.
- In accordance with OMB Guidance M-25-21 (*Accelerating Federal Use of AI through*

Innovation, Governance, and Public Trust, April 3, 2025), ensure that 100% of high-impact AI use cases at VHA implement risk management practices proportionate to anticipated risk, directly protecting all Veterans exposed to sensitive AI-assisted decision-making.

2026 Budget Request

The AI Medical Care Budget request for 2026 is $33.2 million, $0.4 million (1.4 percent) above the 2025 Current Estimate. This funding level will expand AI immersive and other emerging technology; ensure validated AI solutions that improve Veterans' health and the efficiency of VHA are identified, developed, tested, deployed, and monitored to meet VHA's current and future needs; and establish VHA as a national leader in AI-enabled healthcare delivery. Investment in these AI innovations and nationwide deployment efforts are expected to directly improve Veteran care and staff efficiency.

2026 Planned Accomplishments

- Pilot and scale at least 5 best-in-class AI and emerging technologies with uptake by more than 25% of target users to enhance Veteran clinical care or improve operational efficiency allowing more resources for direct Veteran care.
- Conduct an AI Tech Sprint prize challenge designed to identify and deploy innovative enterprise-scale solutions more rapidly than traditional procurement processes.
- Achieve 100% adherence to OMB Guidance M-25-21 AI governance requirements for all high-impact AI use cases across VHA, enabling AI innovation and protecting Veterans exposed to sensitive AI-assisted decision-making.
- Fund an AI Platform-as-a-Service to ensure developed models can be hosted and deployed within the VHA operational environment.
- Reinstitute the VA's International AI Summit which brings industry, government, and academia together to share accomplishments and insights into this emerging technology and establish national partnerships to grow operational AI capacity (National AI Institute Operational Centers Network) and AI Research Translation Capacity (AI Research Translation Centers of Excellence) by bringing VA AI subject-matter experts, practitioners, staff, and industry together to share completed work, collaborate, and identify future opportunities.

Evidence

Research and prior implementations of AI technologies in healthcare settings have demonstrated substantial improvements in operational efficiencies, patient care, and provider satisfaction, cornerstones of the VA program's objectives. The proposed 2026 plans will enable the implementation and governance of these AI capabilities, allowing VHA to realize their benefits.

A novel study published in *Healthcare (Basel)* by the NIH National Library of Medicine in December 2022 provides compelling evidence on the economic benefits of integrating AI technologies within healthcare systems. Amidst rising healthcare costs driven by factors such as population growth, aging demographics, increased disease prevalence, higher utilization rates of healthcare services, and escalating treatment prices implementation of AI is a cost-effective solution. This report analyzed over 200 studies focusing on cost reduction through AI in diagnosis

and treatment contexts and found large cost savings in both diagnosis and treatment using AI tools. These insights directly bolster initiatives focused on enabling AI capabilities by implementing governance as an enabler, piloting promising solutions, and scaling the highest impacts.

Education and Training

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$2,619,520	$2,827,501	$2,748,827	$2,903,782	$2,961,857	$154,955	$58,075
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$85,921	$89,947	$90,162	$95,245	$97,150	$5,083	$1,905
Medical Facilities (0162):	$120,289	$125,925	$126,227	$133,343	$136,010	$7,116	$2,667
Discretionary Total	**$2,825,730**	**$3,043,373**	**$2,965,216**	**$3,132,370**	**$3,195,017**	**$167,154**	**$62,647**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$4,980	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$4,980**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$256	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$256**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$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**	**$5,236**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$2,619,520	$2,832,481	$2,748,827	$2,903,782	$2,961,857	$154,955	$58,075
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$85,921	$90,203	$90,162	$95,245	$97,150	$5,083	$1,905
Medical Facilities	$120,289	$125,925	$126,227	$133,343	$136,010	$7,116	$2,667
Obligations [Grand Total]	**$2,825,730**	**$3,048,609**	**$2,965,216**	**$3,132,370**	**$3,195,017**	**$167,154**	**$62,647**

Graduate Medical Education (GME) Trainees

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$848,582	$937,391	$874,502	$923,227	$941,691	$48,725	$18,464
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	**$848,582**	**$937,391**	**$874,502**	**$923,227**	**$941,691**	**$48,725**	**$18,464**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$4,980	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$4,980**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$256	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$256**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$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**	**$5,236**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$848,582	$942,371	$874,502	$923,227	$941,691	$48,725	$18,464
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$0	$256	$0	$0	$0	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$848,582**	**$942,627**	**$874,502**	**$923,227**	**$941,691**	**$48,725**	**$18,464**

Education and Training Non-GME Trainees

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$258,730	$307,048	$287,470	$304,247	$310,332	$16,777	$6,085
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	**$258,730**	**$307,048**	**$287,470**	**$304,247**	**$310,332**	**$16,777**	**$6,085**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
SFC Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
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	$258,730	$307,048	$287,470	$304,247	$310,332	$16,777	$6,085
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]	**$258,730**	**$307,048**	**$287,470**	**$304,247**	**$310,332**	**$16,777**	**$6,085**

Education and Training Support

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DISCRETIONARY							
Medical Services (0160):	$1,512,208	$1,583,062	$1,586,855	$1,676,308	$1,709,834	$89,453	$33,526
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$85,921	$89,947	$90,162	$95,245	$97,150	$5,083	$1,905
Medical Facilities (0162):	$120,289	$125,925	$126,227	$133,343	$136,010	$7,116	$2,667
Discretionary Total	**$1,718,418**	**$1,798,934**	**$1,803,244**	**$1,904,896**	**$1,942,994**	**$101,652**	**$38,098**
MANDATORY							
Medical Services Category							
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							
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							
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
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	$1,512,208	$1,583,062	$1,586,855	$1,676,308	$1,709,834	$89,453	$33,526
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$85,921	$89,947	$90,162	$95,245	$97,150	$5,083	$1,905
Medical Facilities	$120,289	$125,925	$126,227	$133,343	$136,010	$7,116	$2,667
Obligations [Grand Total]	**$1,718,418**	**$1,798,934**	**$1,803,244**	**$1,904,896**	**$1,942,994**	**$101,652**	**$38,098**

Authority for action

- 38 U.S.C. Section 7302, Functions of Veterans Health Administration: health-care personnel education and training programs
- P.L. 115-182, VA MISSION Act of 2018, Section 403, Pilot program on graduate medical education and residency
- P.L. 117-328, STRONG Veterans Act of 2022, Division V, Title I, Section 103, Expansion of mental health training for Department of Veterans Affairs

Purpose

The purpose of VA's Health Professions Education (HPE) program is to train the next generation of healthcare professionals to meet the needs of Veterans and the Nation, ensuring access to high-quality, timely, and Veteran-centered care across all care settings. This work directly aligns with the Secretary's "Veterans First" strategic priorities, including expanding access to care, particularly in rural and underserved areas, strengthening mental health and suicide prevention services,

modernizing VA's clinical workforce, and improving operational efficiency through streamlined onboarding and training systems. By equipping health professions trainees (HPTs) with the tools and experiences needed to care for Veterans, the HPE program plays a foundational role in advancing these priorities.

VA's HPE program, led by the Office of Academic Affiliations, trains more than 120,000 HPTs annually across over 60 clinical disciplines, in collaboration with 1,450 academic affiliates. These trainees contribute significantly to clinical operations in VAMCs and make up approximately one-third of the VA's clinical workforce. The program also supports long-term recruitment and retention by offering meaningful training opportunities that foster commitment to VA service and promote a Veteran-centric approach to care.

2025 Planned Accomplishments

- In 2025, VA is actively implementing the next phase of the STRONG Veterans Act expansion, with 88 new HPT positions being added across the system. This includes 8 GME positions in psychiatry and primary care, 30 nursing positions focused on mental health and geriatric care, and 50 trainee positions in psychology, social work, and professional mental health counseling. This expansion supports the Secretary's priorities to improve suicide prevention, expand access to mental health care, and strengthen Veteran well-being across the continuum of care.
- VA is evaluating an expansion by 300 new HPT positions through 2025 VHA Mental Health Pipeline Initiative. This includes 25 GME and 275 other trainee positions in key behavioral health disciplines, such as psychology, nursing, social work, rehabilitation counseling, and occupational therapy. These positions directly support the Secretary's focus on timely access to care, mental health system capacity, and addressing critical staffing shortages in high-demand specialties.
- VA will establish 61 new GME residency rotations in underserved and rural areas, including Indian Tribal lands and Indian Health Service (IHS) facilities. These placements support the Secretary's priority to expand care access for rural Veterans, while also addressing long-term provider shortages in high-need regions.
- VA continues to support a national portfolio of more than 120,000 HPTs across 7,700 training programs in collaboration with over 1,450 academic affiliates. These trainees provide essential clinical care in VA facilities, helping ensure timely access to services while building a pipeline of future-ready, Veteran-focused providers.

2026 Budget Request

The 2026 Budget is $1.2 billion, an increase of $65.5 million above the 2025 Current Estimate. This funding level will support VA's statutory mission to educate for VA and the Nation and is critical to maintaining a robust HPE platform that delivers timely, high-quality care to Veterans while building a modern and resilient clinical workforce.

The request includes funding to sustain current HPT positions and expand training capacity in alignment with the Secretary's "Veterans First" strategic priorities. These priorities include improving access to care, particularly in rural and underserved areas, enhancing behavioral health

services, addressing critical workforce shortages, and accelerating clinical onboarding to support timely Veteran care.

For GME, the request includes $919.3 million to maintain existing residency slots and $3.9 million to support 74 new GME positions, with emphasis on psychiatry, primary care, and rural placements. For other trainees (non-GME), most of the request is $254.0 million to maintain existing number of positions and $12.2 million for 184 new FTE across nursing, psychology, social work, and related fields.

This investment will ensure VA continues to operate over 7,700 training programs in partnership with 1,450 academic affiliates, while advancing workforce modernization, increasing care access, and ensuring a pipeline of future-ready providers trained to serve the unique needs of Veterans.

2026 Planned Accomplishments

- In 2026, VA will add 107 new HPT positions through continued implementation of the STRONG Veterans Act. This includes 10 new GME positions in psychiatry and primary care, 30 nursing positions supporting mental health and geriatric care, and 67 other trainee positions in psychology, social work, and professional mental health counseling. This expansion directly supports the Secretary's priorities to strengthen access to behavioral health care and reduce Veteran suicide through a trained, responsive workforce.
- VA is evaluating an expansion by an additional 300 HPT positions under the VHA Mental Health Initiative Staffing Pipeline, including 25 new GME and 275 other trainee positions across high-need behavioral and rehabilitative disciplines. These positions will enhance VA's ability to deliver timely, evidence-based mental health services, advancing the Secretary's goals to increase mental health capacity and modernize clinical workforce.
- VA plans to add the remaining 39 new GME residency rotations in underserved and rural areas, including Indian Tribal lands and IHS facilities. This will bring the total to 100 positions to fulfill the requirements of the MISSION Act pilot.
- VA will continue to support over 120,000 HPTs across more than 7,700 training programs, in collaboration with 1,450 academic affiliates. These trainees will continue to provide one-third of clinical care delivery within VA, playing a critical role in ensuring timely, high-quality care for Veterans across the country.

Evidence

STRONG Veterans Act Expansion and VHA Mental Health Initiative Staffing Pipeline:
Findings from the 2023 HPT Exit Survey, released in 2024, showed that interest in VA employment increased from 54% before training to 73% after training, highlighting the effectiveness of VA-based clinical experiences in shaping long-term workforce engagement. These results are particularly significant for mental health disciplines, where the demand for care is growing and retention is critical to delivering on the Secretary's suicide prevention and behavioral health priorities.

MISSION Act Expansion:
Research consistently shows that clinicians are more likely to practice in the communities where they train. GME rotations launched under the MISSION Act aim to build sustainable workforce capacity in high-need areas such as rural regions and Tribal communities. Early findings from VA pilot programs indicate that trainees placed in underserved areas are more likely to stay and serve those communities, supporting the Secretary's priority to expand access for rural Veterans.

Impact of HPTs Who Train at VA:
While many HPTs who train at the VA go on to pursue careers within the VA system, those who do not stay still play a vital role in fulfilling the VA's mission. Surveys and follow-up studies of former VA HPTs indicate that their training at the VA positively influences their approach to patient care, particularly in understanding Veterans' unique needs. This diffusion of knowledge into the wider healthcare system helps fulfill the VA's broader mission of educating Nation's healthcare professionals.

Cost-Effectiveness and Community Impact:
Training programs, especially those focused on GME, have proven to be cost-effective investments. Studies, such as those by the RAND Corporation, demonstrate that GME programs generate significant returns by reducing future recruitment costs, lowering turnover, and enhancing the quality of care. VA's analysis shows that HPTs significantly contribute to clinical workloads, often at a lower cost compared to hiring additional staff.

Alignment with VA Strategic Priorities:
The expansion of training programs under the STRONG Veterans Act, VHA Mental Health Initiative Staffing Pipeline, and the MISSION Act, aligns with VA's strategic priorities, including modernizing workforce, increasing access to care, and enhancing Veteran experience. The success of previous expansions under VACAA demonstrates tangible benefits, including improved care access, higher retention rates, and enhanced Veteran satisfaction. These outcomes reinforce the long-term value of VA's academic mission as a core strategy in achieving the Secretary's "Veterans First" vision.

Food Security Office

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations							
Food Security Program	$3,180	$16,985	$1,985	$17,526	$17,877	$15,541	$351
Obligations [Grand Total]	**$3,180**	**$16,985**	**$1,985**	**$17,526**	**$17,877**	**$15,541**	**$351**
Account Category:							
Medical Services	*$0*	*$15,000*	*$0*	*$15,000*	*$15,300*	*$15,000*	*$300*
Medical Support & Compliance	*$3,180*	*$1,985*	*$1,985*	*$2,526*	*$2,577*	*$541*	*$51*
Medical Facilities	*$0*	*N/A*	*$0*	*$0*	*$0*	*$0*	*$0*
Medical Care Total	*$3,180*	*$16,985*	*$1,985*	*$17,526*	*$17,877*	*$15,541*	*$351*

Authority for action

- P.L. 117-263, James M. Inhofe National Defense Authorization Act (NDAA) for 2023, Sec. 5126(f), Pilot Program to combat food insecurity among Veterans and family members of Veterans

Purpose

The VHA Food Security Office (FSO) supports Veteran comprehensive health and well-being by providing resources to VA healthcare systems through partnerships, data management, and research and education to support an interdisciplinary approach to ensure Veteran food security, and administration of the pilot program to address food insecurity mandated by Public Law 117-263, James M. Inhofe NDAA for 2023, Sec. 5126(f).

2025 Planned Accomplishments

- Implement a Food Hub pilot program at 13 VA facilities as of January 2025. Food Hubs improve access to nutritious food for Veterans by establishing onsite food pantries with wraparound services that provide immediate food relief, connect to interim support, and facilitate comprehensive assistance. These pilot sites are at various stages of implementation to include a data dashboard for tracking milestones and metrics. Since the implementation of the food hub pilot in January 2025, there have been over 10,000 visits and over 100,000 pounds of food distributed as of May 2025.
- Request for Applications (RFA's) for each proposed pilot program in support of the P.L. 117-263, § 5126(f) have been developed to include evaluation criteria and metrics.
- Establish a Memorandum of Agreement-(MOA) with VHA's Quality Enhancement Research Initiative (QUERI) Center for Evaluation and Implementation Resources (CEIR) to perform pilot launch, management, and evaluations of proposed pilot grant programs that are required by P.L. 117-263, § 5126(f).
- Finalize plans for implementing additional Food is Medicine/Food Security programming in VHA funded through MOAs with the Rockefeller Foundation:
    - In the VA Maryland Health Care System, 250 food-insecure Veterans will be enrolled in the Purposefully Prescribed food delivery program and receive up to 10 pounds of seasonal produce, delivered to their residence or clinic twice per month for 12 months. Veteran participants will receive recipes and nutrition education from registered dietitians aimed at shopping and cooking on a budget. Formal evaluation by VA researchers in Salt Lake City include quality of life and health outcomes, and healthcare costs, utilization data, and data related to farmer suppliers.
    - In the VA Syracuse Health Care System, 250 food-insecure, rural Veterans will receive a $100 subsidy to purchase home-delivered, medically tailored groceries through Instacart Fresh Funds technology for 12 months. Veteran participants will receive nutrition education and nudges to participate in the Healthy Teaching Kitchen and scheduling nutrition appointments with VHA. The pilot will be formally evaluated by researchers at Syracuse University and include metrics

related to implementation and process outcomes, Veteran-reported outcomes, health outcomes, and healthcare utilization.

- Establish a MOA with the Food is Medicine Coalition.

2026 Budget Request

The 2026 Budget request for the Food Security Program is $17.5 million, a $15.5 million increase above the 2025 Current Estimate. This funding will provide $15 million to fully support implementation of P.L. 117-263, James M. Inhofe National Defense Authorization Act for 2023, § 5126(f), at the funding level of $15 million as authorized in the Act. The increase also includes $541,166 to support the MOA with CEIR to serve as the primary coordinating center for the multi-year effort to launch and manage pilot programs. CEIR supported activities will include administrative support, data consolidation and analysis, training and consultation activities for the launch, and delivery and maintenance of pilot programs. The MOA with CEIR will allow VA to establish the pilot programs quickly avoiding delays associated with the recruiting and hiring dedicated FTE. Further, leveraging the CEIR group's in-house expertise will enhance FSO's effectiveness and efficiency without incurring additional contract costs.

VA will award grants to address food insecurity among Veterans and their family members. VA estimates $15 million will support between 19 to 20 grant awards each year for 3 years beginning in 2026. The proposed grant pilots will provide necessary resources to ensure that Veterans and families of Veterans in need have access to nutrient-dense food and will target eligible entities seeking to address Veteran food insecurity through one or more of the enumerated modalities Grantees will be required to submit detailed budget plans in requests for funds. VA estimates between 1,100 to 1,200 Veterans and family members of Veterans will be served by these pilot program grants. The number of Veterans and family members of Veterans served per grant will vary each year; however, VA developed estimates from meeting with experts in each of the programs as provided below.

1. Food Hub programs: support the establishment or expansion of onsite food pantries at VHA healthcare facilities and community-based outpatient clinics (CBOC) to include nutrition education. VA estimates 400 Veterans and family members will be served by each Food Hub pilot grant annually and anticipates awarding 3 of these pilot grants.
2. Medically tailored meals programs: support the establishment or expansion of medically tailored meals (MTM) programs that provide nutrient-dense meals to outpatient Veterans and family members of Veterans in need and in support of their medical nutrition therapy. VA estimates 250 Veterans and family members will be served by each MTM pilot program grant annually and anticipates awarding grant funding to 3 grantees.
3. Medically tailored grocery programs: support the establishment or expansion of grocery delivery programs that provide a variety of food items to Veterans and family members of Veterans in need in conjunction with nutrition education to meet their medical nutrition therapy requirements. VA estimates 250 Veterans and family members will be served annually by each Medically Tailored Grocery pilot grant and anticipates awarding two grantees in this area.
4. Produce prescription programs: support the establishment or expansion of produce prescription programs that provide fresh fruits and vegetables to Veterans and family

members of Veterans in conjunction with nutrition education. VA estimates 250 Veterans and family members will be served by each Produce Prescription pilot grant annually and anticipates awarding eight grantees with funding for this modality.

5. Agriculture programs: support the establishment or expansion of a gardening or agriculture program that grows fresh fruits and vegetables to support Veterans and family members of Veterans, while providing education on how to grow fruits and vegetables. VA estimates 8-12 Veterans per year per grant will be served by Agriculture pilot programs annually and anticipates awarding three grantees funding for this programming.

2026 Planned Accomplishments

- Complete the rule making process for the food insecurity grants mandated by the NDAA for 2023, Sec. 5126(f).
- Increase the number of Medical Center Interdisciplinary Committees dedicated to Food Security enterprise wide.
- Increase the number of Veterans screened for food insecurity and connect them to clinical care.
- Increase the number of facilities with Food Hubs.
- Continue to evaluate and measure pilots supporting Food is Medicine/Food Security initiatives, to include produce prescriptions and medically tailored groceries through VHA's partnership with The Rockefeller Foundation.

Evidence

- Veterans with mental health diagnoses, diabetes, and younger Veterans experience higher rates of food insecurity and require specialized treatment. Since October 2017, the VHA has enhanced food security efforts with screenings, including adding food insecurity screening to inpatient nursing admission notes in August 2023. This addition led to 1,570,244 more screenings in 2024, a 565% increase in consultations with registered dietitians, and a 40% increase in consultations with social workers. Interdisciplinary teams in Primary Care clinics and inpatient settings address these needs using a team-based approach, supporting grant pilot programs established under the NDAA for 2023, Sec. 5126(f).

Veteran Rates of Food Insecurity	
Male Veterans (overall)[a]	6.4%
Male Veterans (aged 50-64)[a]	12%
Male Veterans (aged 65+)[a]	4%
OEF/OIF/OND Veterans[b]	27%
Female Veterans (overall)[c]	27.6%

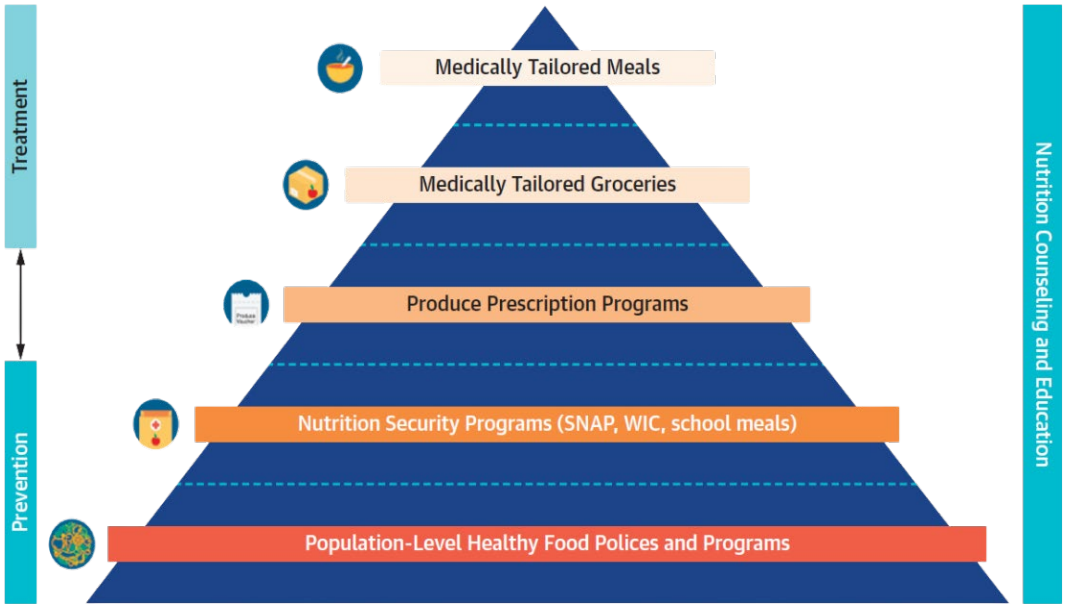
Note: Data from Brostow, et al. (2017)[a]; Widome, et al. (2015)[b]; and Narain et al. (2018)[c].

- Research focused on food insecurity and suicidal ideation indicates Veterans with food insecurity had nearly four times higher suicidal ideations compared to Veterans not

reporting food insecurity (Elbogen et al. 2023). This research showed that Veterans with both food insecurity and Post-Traumatic Stress Disorder are nine times more likely to have suicidal thoughts than those without these challenges, highlighting the combined impact of multiple factors on suicide risk. Depression treatment plans and suicide prevention programs should include addressing food security (Kamdar et al., 2021). This approach emphasizes the importance of collaboration and holistic care, which are key components of the food insecurity pilot programs mandated in the NDAA for 2023, Sec. 5126(f) legislation.

- Veterans of color, women Veterans, and rural Veterans are at higher risk of food insecurity (Cohen et al., 2022). Geographic information systems mapping, and research supported by FSO enable a focused approach to addressing this issue (Bradley et al., 2024). The NDAA for 2023, Sec. 5126(f) pilot grant programs are designed to enhance understanding and implementation to meet the specific needs of Veterans.
- Food is medicine interventions, as outlined in the diagram below (Figure 1), include MTM, groceries, and produce prescriptions to support disease management (Mozaffarian D, et al., 2024). Studies confirm that MTM provide benefits and cost savings by reducing hospitalizations and emergency department visits, improving quality of life, slowing disease progression, and enhancing caregiver well-being (Deng et al., 2025; Berkowitz et al., 2019; Hager et al., 2022). Emerging ideas to use healthcare partners to expand the function and reach of current food banks to support community education (Wetherill et al., 2019) are informing the food hub pilot currently underway within VHA. The NDAA for 2023, Sec. 5126(f) pilot grants program aims to include these interventions and will measure clinical outcomes, utilization management, and implementation science within the VA Enterprise.

Figure 1. Food is Medicine Interventions



Health Care Professionals Educational Assistance Program

Description (Dollars in thousands)	2024 Actual	2025 Budget Estimate 1/	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Obligations [Total]	**$252,516**	**$369,277**	**$277,412**	**$310,647**	**$316,860**	$33,235	$6,213
Education Debt Reduction Program (EDRP)	$158,182	$241,000	$202,333	$241,000	$245,820	$38,667	$4,820
Specialty Education Loan Repayment Program (SELRP)	$4,603	$12,000	$1,948	$1,480	$1,510	($468)	$30
Employee Incentive Scholarship Program (EISP)	$3,393	$7,470	$3,400	$3,400	$3,468	$0	$68
VA National Education for Employees Program (VANEEP)	$16,377	$19,395	$16,400	$16,400	$16,728	$0	$328
Nat'l Nursing Education Initiative (NNEI)	$16,474	$19,707	$19,707	$19,707	$20,101	$0	$394
Health Professional Scholarship Program (HPSP)	$53,291	$69,480	$33,564	$28,495	$29,065	($5,069)	$570
Visual Impairment Education Assistance Program (VIOMPSP)	$196	$225	$60	$165	$168	$105	$3

1/Administrative costs excluded in all years and were previously displayed in the 2025 Congressional Justification.

Awards and Scholarships Description	2024 Actual	2025 Estimate	2026 Estimate	+/- 2025-2026
Education Debt Reduction Program (EDRP)	11,595	12,486	16,500	4,014
Specialty Education Loan Repayment Program (SELRP)	72	51	37	(14)
Employee Incentive Scholarship Program (EISP)	489	518	500	(18)
VA National Education for Employees Program (VANEEP)	742	757	750	(7)
National Nursing Education Initiative (NNEI)	3,362	3,932	4,000	68
Health Professional Scholarship Program (HPSP)	1,126	852	486	(366)
Visual Impairment Education Assistance Program (VIOMPSP)	45	5	14	9

Education Debt Reduction Program (EDRP)

Authority for action

- 38 U.S.C. Chapter 76, Subchapter VII. Education Debt Reduction Program.

Purpose

The Education Debt Reduction Program (EDRP) serves as a critical recruitment and retention tool used by VAMCs to recruit and retain its most difficult-to-fill direct patient care clinical positions. It is a multi-year program that reimburses participant education loan payments up to $40,000 per year, for up to 5 years, for an overall total of $200,000 per participant. EDRP is a principal incentive that allows VHA to remain competitive with the private sector, proving successful in both recruiting and retaining health care providers. EDRP is an education loan payment reimbursement program that repays qualifying student loan debt up to $200,000 ($40,000 per year, tax-free) for up to 5 years for individuals in patient care positions designated as extremely difficult for recruitment and retention by local facilities.

2025 Planned Accomplishments

- The program projects approximately 3,000 new EDRP awards will be issued for clinical providers in hard-to-fill positions for 2025.
- At the conclusion of 2025, the program projects that there will be approximately 12,500 EDRP participants active in the program.
- The program projects that approximately 37% of the new EDRP awardees will be serving in mental health occupations.

2026 Budget Request

The EDRP request for 2026 is $241.0 million, $38.7 million (19.1%) above the 2025 Current Estimate for education loan payment reimbursements to secure nearly 12,500 employees in hard-to-fill patient care provider positions, including 4,000 clinical care providers in hard-to-fill patient care positions. Of the 12,500 employees, 37% are projected to be serving in mental health occupations. Nurses and physicians receive the most EDRP awards. Driven by the MISSION Act's increase in the maximum award amount from $120,000 to $200,000 per participant, the program gained additional strength and continued to grow in demand. EDRP awards for new participants averaged approximately $96,000 for 2022, $99,000 in 2023, $93,000 in 2024, and $101,600 at the mid-year of 2025.

2026 Planned Accomplishments

- The program projects approximately 4,000 new EDRP awards will be issued for clinical providers in hard-to-fill positions for 2026.
- At the conclusion of 2026, the program projects that there will be approximately 16,500 EDRP participants active in the program, providing care to Veterans.
- The program projects that approximately 37% of the new EDRP awardees in 2026 will be serving in mental health occupations.

Evidence

EDRP is an instrumental tool in recruiting and retaining patient care providers in specialties that are nationally scarce. The program has demonstrated remarkable success in retaining hard-to-fill clinical roles, proving essential for VHA to maintain a stable and skilled workforce.

An internal analysis conducted in March 2025 reviewed EDRP's effectiveness in retaining patient care providers. The findings revealed that clinical care providers who receive EDRP stay with the VHA an average of 6.5 years longer than those who do not receive EDRP. The analysis focused on the 10 most common occupational series for which EDRP is awarded, evaluating individuals employed at VHA since October 1, 2003. The impact of EDRP is particularly significant in mental health care. Psychologists who receive EDRP awards remain with the VHA an average of 9.75 years longer than those who do not receive the award.

EDRP's ability to retain clinical care providers for significantly longer periods ensures continuity of care and stability in VA healthcare facilities, directly benefiting Veteran patients through sustained, high-quality care. The program is especially effective in securing mental health providers, addressing a critical and often hardest-to-fill specialty area. This ensures Veterans have consistent access to mental health services, which is vital for their overall well-being.

By retaining providers for longer durations, EDRP reduces the frequent turnover and associated recruitment costs, enhancing operational efficiency and long-term workforce stability. Ensuring the availability of skilled providers in nationally scarce specialties gives VHA a competitive edge in attracting top talent in a competitive healthcare market. Without continued funding for EDRP, the VHA's ability to attract and retain essential clinical talent would be severely compromised, leading to staffing shortages and potentially diminishing the quality of care for Veterans.

Specialty Education Loan Repayment Program (SELRP)

Authority for action

- 38 U.S.C., Chapter 76, Subchapter VIII. Specialty Education Loan Repayment Program.

Purpose

The SELRP provides financial assistance to physicians in the form of a loan repayment to recent graduates of an accredited medical or osteopathic school and who are currently enrolled or matched to a residency identified as a shortage by VA. SELRP participants receive a total of $160,000 (up to $40,000 per year) in education loan repayment assistance. Each SELRP participant agrees to complete a service obligation period of 12 months at a VA facility, for each $40,000 of loan repayment, with a minimum of 24 months of obligated service.

2025 Planned Accomplishments

- VA projects there will be 51 SELRP participants active in the program for 2025. This pipeline of physicians targets family medicine, internal medicine, emergency medicine, psychiatry, and geriatrics.
- VA expects to place approximately 27 physicians in fulltime VHA positions in 2025. Since program inception through July 31, 2024, SELRP has awarded $10.8 million in loan repayments.

2026 Budget Request

The 2026 Budget requests $1.5 million for SELRP, $468,000 (24%) less than the 2025 Current Estimate. VHA will continue to offer SELRP in critical areas of need as defined by the VHA Top Shortage Occupation Report and VA OIG determination of VHA's occupational staffing shortages to align with the shifting environmental climate and administration goals. This funding will allow VA to pay continuing SELRP participant awards and offer new SELRP awards for certain specialties, expanding the health care workforce pipeline at VA facilities where recruitment and retention of qualified health care personnel may be challenging.

2026 Planned Accomplishments

- VA projects there will be 37 SELRP participants active in the program for 2026. This pipeline of physicians will consist of family medicine, internal medicine, emergency medicine, psychiatry and geriatrics.
- VHA expects to place 37 physicians in fulltime VHA positions in 2026.

Evidence

SELRP has proven to be a vital initiative for addressing physician shortages within the VA, especially in rural and highly rural locations; and SELRP remains essential for the VA to strategically enhance its healthcare workforce capacity. VHA will continue to allocate SELRP resources to critical areas of need, as identified by the VHA Top Shortage Occupation Report and the VA OIG's determination of occupational staffing shortages. This alignment ensures that the program adapts to the shifting environmental climate and administration goals, focusing on where it is most needed.

By placing new physicians in areas where they are most needed, SELRP ensures that Veterans, regardless of location, have improved access to essential medical services, directly impacting their health outcomes positively. SELRP supports the VA in forecasting and developing a robust pipeline of physicians, ensuring long-term stability and preparedness in meeting Veterans' evolving healthcare needs of Veterans.

Employee Incentive Scholarship Program (EISP)

Authority for action

- 38 U.S.C., Chapter 76, Subchapter VI. Employee Incentive Scholarship Program

Purpose

The purpose of the Employee Incentive Scholarship Program (EISP) is to assist VA in meeting its need for qualified health care staff in occupations for which recruitment or retention is difficult. EISP helps VA meet its need for qualified health care staff by requiring scholarship recipients to complete a service obligation at a VA health care facility after graduation and licensure or certification. EISP awards cover tuition and related expenses such as registration, fees, and books in return for a one-to-three-year service obligation.

2025 Planned Accomplishments

- As of May 5, 2025, VA has awarded 2,981 scholarships to EISP participants since the program started in 2000.
- As of May 5, 2025, VA awarded 84 new 2025 awards to EISP participants.
- Additionally, during 2025 VA has 256 EISP participants in school and 257 currently serving their service obligation period supporting 166 VA facilities.

2026 Budget Request

The EISP funding request for 2026 is $3.4 million, which is the same as the 2025 Current Estimate. VA is requesting funding to support the VA employee scholarship programs in critical areas of need as defined by the VA OIG determination of VHA's occupational staffing shortages. The requested funding allows VA to continue funding existing scholarship awards, offer new scholarship awards, and sustain the health care provider workforce pipeline at VA facilities where recruitment and retention of qualified health care personnel may be challenging.

2026 Planned Accomplishments

- VA anticipates over 80% of new 2026 awards will continue to support occupations listed on the VA OIG determination of VHA's occupational staffing shortages.
- VA anticipates offering at least 85 new awards to EISP participants
- VA anticipates supporting at least 250 EISP participants in school and 250 EISP participants in their service obligation period.

Evidence

The EISP is crucial in addressing VA's healthcare workforce shortages by requiring scholarship recipients to fulfill service obligations at VA healthcare facilities post-graduation. This ensures a steady influx of skilled professionals into the VA system.

As of September 30, 2024, 1,630 participants completed their degrees and service obligations, with 73.9% completing their academic programs and 94.0% fulfilling their service commitments. The program's success is further highlighted by its high retention rates; 86.2% of participants remain employed as nurses for at least 1 year, and 83.9% stay for 2 years.

VA National Education for Employees Program (VANEEP)

Authority for action

- 38 U.S.C., Chapter 76, Subchapter VI. Employee Incentive Scholarship Program

Purpose

The VANEEP initiative, within EISP, includes a replacement salary component to assist facilities with critical staffing needs while allowing participants to accelerate education completion by attending school full-time.

2025 Planned Accomplishments

- As of May 5, 2025, VA has awarded 3,321 scholarships to VANEEP participants since the program began in 2000.
- As of May 5, 2025, the VA awarded 85 new 2025 awards to VANEEP participants.
- Additionally, during 2025 VA has 290 VANEEP participants in school and 462 currently serving obligations period supporting 166 VA facilities.

2026 Budget Request

The 2026 Budget requests $16.4 million for VANEEP, equal to the 2025 Current Estimate. VA is requesting funding to support the VA employee scholarship programs in critical areas of need as defined by the VA OIG determination of VHA's occupational staffing shortages. The request level would allow VA to sustain continuing participants while adjusting program funding to align with current and future organizational goals. The requested funding allows VA to continue funding existing scholarship awards, offer new scholarship awards, and sustain the health care provider workforce pipeline at VA facilities where recruitment and retention of qualified health care personnel may be challenging.

2026 Planned Accomplishments

- VA anticipates over 80% of new 2026 awards will continue to support occupations listed on the VA OIG determination of VHA's occupational staffing shortages.
- VA anticipates offering at least 85 new awards to VANEEP participants.
- VA anticipates supporting at least 290 VANEEP participants in school and 460 VANEEP participants in their service obligation.

Evidence

VANEEP is a crucial initiative designed to support the educational advancement of VA employees, ultimately enhancing the quality of care for Veterans. Based on the 2024 VA EISP Recipient Exit Survey, which includes VANEEP participants, the VANEEP program has proven to be highly beneficial for its participants.

Participants universally praised the ability to focus entirely on their education, free from the distractions of a traditional work schedule. This opportunity, cited by 60% of respondents, led to better academic performance, reduced stress, and overall improved well-being. The assurance of job placement upon program completion further alleviated anxiety, allowing participants to fully dedicate themselves to their studies.

Another significant advantage was the mentorship received during the program. Participants valued the guidance of mentors who helped them navigate their educational journey and appreciated their advisors' understanding of the VA organization and its patient-focused culture. This mentorship prepared participants to re-enter the VA workforce equipped with enhanced knowledge and skills.

The necessity of VANEEP is clear: it addresses long-term workforce shortages by enabling the current VA workforce to upskill and fill critical roles. The program improves the quality of care for Veterans by ensuring they are treated by highly trained and knowledgeable professionals. By guaranteeing job placement after program completion, VANEEP significantly aids in retaining talented employees within the VA system, reducing turnover and enhancing workforce stability.

Participants' feedback underscores that the ability to focus on education and receive strong mentorship are crucial to their academic and professional success. This support is vital for preparing employees to deliver high-quality, patient-centered care and ensuring a steady pipeline of skilled healthcare providers.

National Nursing Education Initiative (NNEI)

Authority for action

- 38 U.S.C., Chapter 76, Subchapter VI. Employee Incentive Scholarship Program

Purpose

The NNEI initiative, within EISP, is limited to funding registered nurses pursuing associate, baccalaureate, and other advanced degrees.

2025 Planned Accomplishments

- As of May 5, 2025, VA awarded 872 new awards to NNEI participants.
- Additionally, during 2025, VA has 1,842 NNEI participants in school and 2,088 currently serving obligations period supporting 166 VA facilities.
- As of May 5, 2025, VA has awarded 20,856 scholarships to NNEI participants since the program began in 2000.

2026 Budget Request

The NNEI funding request for 2026 is $19.7 million, equal to the 2025 Current Estimate. VA is requesting the same level of funding to continue the VA employee scholarship programs in critical areas of need as defined by the VA OIG determination of VHA's occupational staffing shortages. This funding would allow VA to fund continuing scholarship awards, offer new scholarship awards, and sustain the registered nurse workforce pipeline at VA facilities where recruitment and retention of qualified health care personnel may be challenging.

2026 Planned Accomplishments

- VA anticipates over 80% of new 2026 awards will continue to support the registered nurse occupation, listed on the VA OIG determination of VHA's occupational staffing shortages.
- VA anticipates offering at least 800 new awards to NNEI participants.
- VA anticipates supporting at least 1800 NNEI participants in school and 2000 NNEI participants in their service obligation.

Evidence

The NNEI program has garnered overwhelming praise from its participants for delivering exceptional benefits, notably in financial support, mentorship, and program organization. The 2024 VA EISP Recipient Exit Survey highlights the program's positive attributes, including transformational financial support, empowering mentorship and coordinator guidance, and seamless program organization and flexibility.

Health Professional Scholarship Program (HPSP)

Authority for action

- 38 U.S.C., Chapter 76, Part V, Subchapter II. Scholarship Program
- STRONG Veterans Act of 2022 (P.L. 117-328, Division V), section 104. Expansion of scholarships and loan repayment programs for mental health providers

Purpose

The purpose of the Health Professional Scholarship Program (HPSP) is to elevate VA's mission in supporting our Veterans by delivering tailored healthcare services, world-class healthcare, and securing qualified healthcare talent in critical and hard-to-fill occupations. HPSP improves Veterans access to care with an ongoing pipeline of healthcare providers which results in decreasing appointment times while maximizing the efficiency and effectiveness of services offered. Additionally, HPSP requires scholarship recipients to complete a service obligation at a VA healthcare care facility after graduation, (for example, licensure, certification, and registration) in exchange for covering tuition, required educational expenses, and a monthly stipend.

2025 Planned Accomplishments

- As of May 2025, VA anticipates offering at least 27 new HPSP awards to medical students and at least 73 awards to support mental health disciplines by the end of 25.
- For 2025, VA expects 385 scholarship participants to graduate.
- At the end of 2025, HPSP will have 733 scholarship participants active in school with a forecast of an additional 100 to be awarded by the end of 2025.
- At the end of 2025, HPSP will have 110 currently in their service obligation period.

2026 Budget Request

The HPSP funding request for 2026 is $28.5 million, $5.1 million (15.1%) less than the 2025 Current Estimate. The funding request will allow VA to continue sponsoring VA scholarship programs in critical areas of need as defined by the VHA Top Shortage Occupation Report and the

VA Office of Inspector General (OIG) determination of VHA's occupational staffing shortages. This funding would still enable VA to fund continuing scholarship awards, offer new scholarship awards, cover program associated costs, and strengthen the recruitment and retention efforts for effective and efficient top quality healthcare providers throughout VHA.

2026 Planned Accomplishments

- For 2026, VA anticipates offering at least 50 new HPSP awards to medical students and at least 85 awards to support mental health disciplines.
- VA expects 270 scholarship participants graduating by the end of 2026.
- In 2026, VA expects to have 226 HPSP scholarship participants active in school with a forecast of 309 potentially starting their service obligation period.

Evidence

HPSP is a vital initiative in addressing healthcare workforce shortages at VA healthcare facilities by requiring scholarship recipients to complete a service obligation after graduation. The program ensures a sustained influx of skilled direct patient care professionals in critical and hard-to-fill healthcare positions, that ensure continuity of access and care for Veterans.

Key Statistics and Impact:

- In the 2024 program evaluation, the total number of HPSP participants was 2,078, spread across various programs noted below but this is not an all-inclusive list:
    - Nursing: 892 participants (42.93%), including Bachelor of Science in Nursing (BSN), Licensed Practical Nurse (LPN)/Licensed Vocational Nurse (LVN), Nurse Practitioner (NP), and Certified Nurse Anesthetists (CNA).
    - Allied Health: 405 participants (19.49%).
    - Mental Health: 236 participants (11.36%).
- Among those who completed their obligation a year before the end of 2024 (N=236), 186 (78.81%) were retained as VA employees for at least 1 year, illustrating the program's success in maintaining a dedicated VA workforce.
- HPSP retention rates are impressive:
    - 79% of recipients continue their employment for at least 1 year.
    - 67% continue for at least 2 years.
    - Mental Health participants show an 81% retention rate after 2 years.
    - Allied Health participants show a 72% retention rate after 2 years.
    - Nursing participants show a 76% retention rate after 2 years.

These numbers highlight the program's effectiveness in retaining essential healthcare professionals within the VA system, alleviating workforce shortages, and ensuring continuity of care for Veterans.

Direct Benefits and Strategic Importance:

- The program allows the VHA to place direct patient care providers in its most rural and highly rural locations, addressing acute staffing needs, and improving healthcare access in underserved areas.
- By retaining a high percentage of healthcare professionals post-obligation, the HPSP ensures that Veterans receive consistent care from experienced providers, which enhances the quality of care and operational efficiency of VA facilities.
- The program gives the VHA a significant recruitment advantage in a fiercely competitive and nationally scarce healthcare provider market.

Visual Impairment and Orientation and Mobility Professional Scholarship Program (VIOMPSP)

Authority for action

- 38 U.S.C., Chapter 75. Visual Impairment and Orientation and Mobility Professionals Educational Assistance Program

Purpose

The purpose of the Visual Impairment Orientation & Mobility Professionals Scholarship Program (VIOMPSP) is to elevate VA's mission in supporting our Veterans by delivering tailored healthcare services, world-class healthcare, and increase the supply of qualified blind rehabilitation specialists for VA.

VIOMPSP enhances Veterans access to care with an ongoing pool of talented blind rehabilitation specialists which results in decreasing appointment times while maximizing the efficiency and effectiveness of services offered. Additionally, VIOMPSP requires scholarship recipients to complete a service obligation at a VA healthcare facility after graduation, (for example, licensure, certification, and registration) in exchange for covering tuition, required educational expenses, and a monthly stipend.

2025 Planned Accomplishments

- As of May 2025, VA anticipates offering at least 4 new VIOMPSP awards to blind rehabilitation specialists by the end of 2025.
- For 2025, VA expects 13 VIOMPSP scholarship participant to graduate.
- At the end of 2025, VIOMPSP will have 3 scholarship participants active in school with a forecast of an additional 4 to be awarded by the end of 2025.
- At the end of 2025, VIOMPSP will have 42 currently in their service obligation period.

2026 Budget Request

The 2026 budget requests $165,000 for VIOMPSP, $105,000 (175%) above the 2025 Current Estimate. VA recognizes the need to continue sponsoring VA scholarship programs in critical areas of need as defined by the VHA Top Shortage Occupation Report and the VA OIG determination of VHA's occupational staffing shortages. This request will enable VA to fund continuing scholarship awards, offer new scholarship awards, cover program associated costs, and strengthen the

recruitment and retention efforts for effective and efficient blind rehabilitation specialist providers throughout VHA.

2026 Planned Accomplishments

- For 2026, VA anticipates offering at least 10 new VIOMPSP awards to blind rehabilitation specialists.
- For 2026, VA expects 3 VIOMPSP scholarship participant to graduate by the end of 2026.
- For 2026, VA anticipates 10 VIOMPSP scholarship participants active in school and 43 currently serving in their service obligation period.

Evidence

VIOMPSP is essential in addressing critical workforce shortages within the VA, particularly among Certified Low Vision Therapists (CLVT) and Computer Assistive Technology Instructor Specialists (CATIS). These roles are crucial for meeting the needs of Veterans with visual impairments, but they are difficult to fill due to a limited pool of qualified candidates.

Currently, only 4% of the 679 Blind Rehabilitation Specialists (BRS) are certified to provide assistive technology training, while more than 75% of BRS referrals are technology related. This significant gap illustrates the urgent need for more certified CLVT and CATIS professionals.

In 2024 and 2025, the BRS National Program Office partnered with VHA, Salus University at Drexel, and Northern Illinois University (NIU) to increase the availability and competencies of BRS professionals. This collaboration resulted in 41 BRS clinicians receiving enhanced education, thereby improving the quality of services provided to visually impaired Veterans.

In 2024, 2 scholarship recipients focused on degrees or certificates in orientation and mobility, low vision, assistive technology, and communication and daily living therapy, increasing the supply of qualified blind rehabilitation specialists within the VA. In addition, 13 BRS clinicians completed an assistive technology course at NIU, enhancing their capability to meet Veterans' assistive technology needs. Sixteen (16) BRS clinicians completed Salus coursework, improving their ability to provide low vision assessments and training.

In 2025, 6 recipients are pursuing similar degrees and certifications, ensuring a continued influx of qualified professionals. In addition, 12 BRS clinicians have accepted scholarships for the NIU assistive technology course, further increasing their capacity to serve Veterans with visual impairments.

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

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations							
Medical Services (0160):	$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
Medical Community Care (0140):	$31,571	$37,924	$37,924	$41,717	$44,637	$3,793	$2,920
Obligations [Grand Total]	**$31,571**	**$37,924**	**$37,924**	**$41,717**	**$44,637**	**$3,793**	**$2,920**

Authority for action

- 25 U.S.C. § 1645 Chapter 18, Indian Health Care
- 38 U.S.C. § 8153, Sharing of health-care resources.

Purpose

The Reimbursement Agreement Program (RAP) reimburses participating IHS facilities, THPs, and UIOs for care provided to eligible Native Veterans. VA will reimburse care provided directly, referred to as direct care, and for IHS/THP facilities, care purchased under purchased referred care (PRC) or contracted travel programs.

VA will reimburse for services the Department has the authority to provide or purchase for the Veteran, following special Veteran eligibility rules. Generally, this includes services in the VA medical benefits package, 38 CFR § 17.38, Medical Benefits Package. Examples of these services are basic and preventive care; outpatient; inpatient; ambulatory surgical services; dental; prescription drugs; and the like. These services are provided at IHS,THP, or UIO hospitals, clinics, or facilities, while PRC services are provided away from an IHS or THP facility but paid for by the HIS or THP facility.

2025 Planned Accomplishments

- In 2025, VA is projected to disperse $38.9 million.
- Executed revised agreements will expand the program to include PRC and contracted travel. New and future agreements will continue to adopt the expanded scope of services.
- VA expects to expand by four to six THP and UIO facilities.
- VA expects to reimburse services for over 3,000 unique Veterans.

2026 Budget Request

The budget request for VA reimbursement to IHS, THP, and UIO in 2026 is $ 41.7 million, $3.8 million (10.0%) above the 2025 Current Estimate. Funding is requested to fulfill VA's obligation to reimburse IHS, THP, and UIO facilities for care they provide to eligible Veterans, as required by 25 U.S.C. § 1645. The increase is to reflect annual inflation and program expansion costs.

2026 Planned Accomplishments

- In 2026, VA is projected to disperse $41.7 million.
- VA expects to expand by two to four THP and UIO facilities.
- VA expects to increase utilization by participating facilities.
- VA also plans to maintain relationships with IHS and tribal governments, through outreach, education, and training, which supports Native Veterans.

Evidence

In 2024, RAP dispersed $31.6 million covering over 3,600 unique Veterans. This funding supports services from 73 IHS, 122 THP, and 9 UIO facilities currently participating.

Intimate Partner Violence Assistance Program (IPVAP)

		2025		2026	2027		
Description (dollars in thousands)	2024 Actual	Budget Estimate	Current Estimate	Revised Request	Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations							
Medical Services (0160):	$29,107	$30,101	$30,101	$31,004	$31,624	$903	$620
Medical Support and Compliance (0152):	$726	$1,272	$761	$993	$1,013	$232	$20
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$29,833**	**$31,373**	**$30,862**	**$31,997**	**$32,637**	**$1,135**	**$640**

Authority for action

- 38 U.S.C. § 7301(b), Functions of VHA

Purpose

Intimate partner violence (IPV) can result in long-term consequences for those who experience or use IPV. IPV can impact all Veterans regardless of their demographics and is regarded as a public health epidemic. Veterans have additional risks as identified in the P.L. 116-315 pilot program. IPV, as a health-related social need, recognizes an individual's intimate personal relationships as a significant protective or risk factor that can significantly impact well-being and safety. The presence of IPV increases risk of other detrimental physical, psychological, and social outcomes, including housing insecurity, substance use, suicide, and homicide. The IPVAP strives to prevent and respond to these risks with universal education, provision of resources, safety planning, and intervention.

2025 Planned accomplishments

- Improve efficacy of national program infrastructure for data support by working within both CPRS and Cerner platforms to develop documentation tools and practices to effectively capture IPV-related intervention metrics.
- Develop and deploy process for evaluating facility programs for key success metrics and meet with each VISN IPVAP lead to identify facilities requiring action plans for improvement. This effort includes establishing baseline metric for Relationship Health and Safety Screen for all women Veterans under age 48 to evaluate compliance and

efficacy of using screening to improve access to specialized services for Veterans and their intimate partners to reduce risk.

- Serve as subject-matter expert for Deborah Sampson Act §5305 Task Force.
- Support innovation by supporting the Relationship Health and Safety Veteran Workbook and Anti-Human Trafficking pilots and evaluate results for potential national dissemination.
- Develop products to support staff education regarding IPV and SA prevention and response, informed by Veteran feedback. Products are based on outcomes and recommendations from the P.L. 116-315 pilot program. Education will include a focus on supporting Veterans from all communities.

2026 Budget Request

The IPVAP funding request for 2026 is $32 million. The purpose of this continued funding is to maintain the existing enterprise-wide operation of the IPVAP while also refining the program to better meet the needs of Veterans, their partners, and VA staff impacted by IPV and related issues. The Budget provides continued support for the approved 183 facility IPVAP staff, in compliance with current policy and program needs, as well as support for existing national partnerships established to provide IPV-related program support, intervention, and evaluation for Veterans who experience or use IPV. This includes the development, implementation, and spread of evidence-based clinical interventions for Veterans who experience IPV (Recovering from IPV using Strengths and Empowerment) and those who use IPV (Strength at Home). The Budget also provides continued support for VHA program office staff.

2026 Planned Accomplishments

- Ensure access to all IPV-related clinical interventions for Veterans and couples through expansion of in-person and telehealth services.
- In partnership with the IPV-Center for Implementation, Research and Evaluation (IVP-CIRE), conclude a QUERI-funded, partnered mixed methods evaluation to evaluate the implementation and impact of the Relationship Health and Safety screener for all Veterans.
- Develop staff and Veteran facing materials to support awareness of available programs and services to promote safety and well-being for those who experience or use IPV or have IPV-related concerns.

Evidence

The Reach, Effectiveness, Adoption, Implementation, and Maintenance (Glasgow et al., 1999; Glasgow et al., 2019) evaluation framework is used to assess the reach, effectiveness, adoption, implementation, and maintenance of the program based on the identification of key metrics. For 2026, the priority is to focus specifically on clinical services that directly impact Veterans including screening, safety planning, and interventions. In 2025, a baseline measure screening rate of 32% was established for each facility's mandated screening population of women Veterans under the age of 48. IPVAP will evaluate metrics quarterly for trends and identification of barriers, and an increased screening rate is expected for 2026.

These methods are feasible as they leverage existing infrastructure for evaluation and an ongoing strong partnership with the IPV-CIRE evaluation team. IVPAP will also continue to assess its outcome measures and evaluation tools and procedures through the National IPVAP Advisory Board. This organization was launched by the IPV-CIRE in 2023 with the goal of providing ongoing consultation and feedback on products and procedures developed by the IPV-CIRE to ensure systemic evaluation of IPVAP guidance through evidence and best practice.

National Center for Posttraumatic Stress Disorder (NCPTSD)

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations							
Medical Services (0160):	$32,406	$15,001	$29,507	$29,507	$30,097	$0	$590
Medical Support and Compliance (0152):	$12,709	$26,999	$11,621	$11,621	$11,853	$0	$232
Medical Facilities (0162):	$158	$0	$146	$146	$149	$0	$3
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$45,273**	**$42,000**	**$41,274**	**$41,274**	**$42,099**	**$0**	**$825**

Authority for action

- 38 U.S.C. 1712A note
- Consolidated Appropriations Act, 2024, Division A, H. Comm. Print 56-550, Book 1, pg. 43: National Center for Post-Traumatic Stress Disorder

Purpose

NCPTSD's 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 was also mandated to serve as a resource center for information about PTSD research and education for VA and other Federal and non-Federal organizations. NCPTSD currently consists of six divisions located at VA facilities, with headquarters in White River Junction. NCPTSD is an integral component of the Office of Mental Health.

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 and implementation. Besides its own staff, NCPTSD has built strong collaborative relationships with institutions and agencies from VA, other branches of government, the health care community, and academia. NCPTSD brings current research and clinical knowledge from the field to Veterans, their families, the public, clinicians, military leaders, and others via an award-winning website (www.ptsd.va.gov), publications, online resources, as well as nationwide trainings.

NCPTSD activities are structured around five cross-cutting Operational Priorities across research, education, and consultation: **Biomarkers** to establish reliable and valid biomarkers to aid in predicting who develops PTSD, diagnosing PTSD, predicting treatment outcome, and measuring treatment response; **PTSD and suicide** to investigate the relationship between PTSD and suicide and develop strategies to predict and prevent suicide among individuals with PTSD; **Treatment efficiency, effectiveness, and engagement** to develop strategies to enhance the effectiveness of

existing treatments and engagement in treatment; **Care delivery, models of care, and system factors** to develop strategies to enhance access to treatment, (particularly using telehealth and technology), implement research, education, and consultation activities to enhance the delivery of PTSD care outside of specialty mental health settings and conduct research and education on measurement based care and shared decision-making; and **Implementation** to study and facilitate implementation of evidence-based care for PTSD.

2025 Planned Accomplishments

- The Center will launch a revised version of its online PTSD Decision Aid that incorporates recommendations from the 2023 VA/DoD Clinical Practice Guideline for PTSD and a new user interface to enhance user experience. Decision aids are educational materials that help patients learn about their treatment options for a given condition and make an informed choice about treatment based on their preferences and values. Decision aids improve patient outcomes. For example, a prior study by NCPTSD found that an early version of its decision aid led patients to be 2.2 times more likely to receive evidence-based care, have an almost 200% greater decrease in PTSD symptoms, and experience 75% greater satisfaction compared with usual care.
- The National PTSD Brain Bank (NPBB) is the world's largest brain bank devoted to PTSD. The NPBB provides a unique resource to advance understanding the neurobiology of PTSD and guide the development of novel treatments, especially medications. By the end of 2025, VHA expects to have a total tissue inventory of approximately 390 specimens, with a current rate of about 14 donations per year (which will increase as antemortem programs expands). For the antemortem program, 280 participants are followed and based on prior recruitment rates, the program is expected to have about 330 participants by the end of 2025. In addition to building this tremendous scientific resource, NPBB investigators have published 30 papers on the cutting-edge science produced from this resource, most of which are in extremely high-profile journals such as *Nature*. Particularly important are 2 recent papers that reported sex differences in the patterns of gene expression that may lead to novel pharmacotherapies that may differentiate treatments for males and females. Coordinated research and clinical pipelines in the National PTSD brain bank feed directly into novel drug discovery, companion diagnostic development, personalized medicine approaches, and biomarker validation being used in VA clinical trials to understand the neurobiological basis of PTSD to eventually prevent occurrences as opposed to only treating them.
- Continue work on Written Exposure Therapy (WET), a brief psychotherapy for PTSD. Research demonstrates that WET is as effective as other established psychotherapies, despite requiring only half as many sessions, and reduces treatment dropout by more than half. NCPTSD staff trained VA therapists for an ongoing project in which 452 Veterans with PTSD were enrolled in a multisite clinical trial comparing WET with antidepressant medication. Another accomplishment in 2025 is a study showing that a modified version of WET can reduce PTSD symptoms, suicidal ideation, and the likelihood of rehospitalization among military service members and Veterans hospitalized for suicide risk. Another study examined a combination of ketamine and WET to treat chronic PTSD, which resulted in significant long-term reductions in PTSD. A survey of VA mental health

clinicians using WET with patients found that using WET reduced clinicians' feelings of stress and work-related burnout.

2026 Budget Request

The 2026 Budget request for NCPTSD is $41.3 million, sustaining the 2025 Current Estimate funding level and supporting an FTE level of 110. The 2026 budget will support the following: Executive Division (including the PTSD Consultation and PTSD Mentoring and Implementation Programs), $13.0 million; Behavioral Science, $4.6 million; Clinical Neurosciences, $4.3 million; Women's Health Sciences, $3.5 million; Dissemination & Training, $6.6 million; and PTSD Brain Bank, $9.3 million.

2026 Planned Accomplishments

- **Biomarkers**: As with all brain banks, the primary focus of activities for the NPBB in 2026 will be on maintaining infrastructure and expanding tissue collection. To this end, VA will continue to invest in the staffing, equipment, maintenance contracts, bioinformatics, and tissue collection contracts needed to maintain current levels of excellence and continue adding to existing repository. Based on prior recruitment, VA anticipates enrolling 72-96 new participants into the antemortem program. Conservatively, NPBB expect an additional 14-16 new donations. NPBB will continue to provide tissue and data, to the greatest extent possible, to other investigators in the field; and intramural investigators will continue to report on their findings utilizing the NPBB.
- **PTSD and suicide**: The Center plans to examine suicide among Veterans who are not enrolled in VHA healthcare and identify barriers and facilitators to VHA healthcare enrollment. VA will continue utilizing randomized controlled trials to compare two evidence-based suicide risk interventions, identify predictors of outcome, and identify neurobiological markers of future suicidal behavior. VHA's ORD-funded suicide research resource center will continue to support precision medicine for suicide prevention.
- **Treatment Effectiveness and Engagement**: The Center's emphasis will continue to be on enhancing the effectiveness of existing evidence-based psychotherapies for PTSD. An example of efforts to identify more effective medications for PTSD is a large multisite trial of sleep medication for PTSD, with plans to complete enrollment in 2026. An example of efforts to promote treatment engagement is continuing to support research on WET, which has been shown to increase treatment completion to over 85% (Sloan, Marx, Acierno, et al, 2023), compared to roughly 50% treatment completion with convention therapies (Schnurr, Chard, Ruzek, et al, 2022). The Center will continue to produce the AboutFace website that promotes treatment engagement through Veterans' stories of seeking treatment. VHA previously found that viewing AboutFace doubled treatment initiation. AboutFace has had over 4 million users and additional views on YouTube.
- **Care delivery, models of care, and system factors**: Examples of activities to support this operational priority include plans for a research grant on shared decision-making, continued research to evaluate the Center's portfolio of mobile applications and online delivery of Written Exposure Therapy, and research to explore the use of asynchronous text messaging to deliver evidence-based therapy for PTSD. With support from Office of Rural Health (ORH), NCPTSD will partner with rural primary care clinics to develop best

practices for integrating patient self-management applications into clinics' processes of care for Veterans with PTSD. NCPTSD will release an update of PE Coach, an application that supports delivery of one of the most effective psychotherapies for PTSD. The upgrade will make it easier for patients to complete homework and review content between therapy sessions.

- **Implementation**: The Center's Consultation Program will continue trainings on PTSD assessment, suicide risk management in PTSD, and military culture, along with ongoing lecture series and the provision of individual consultations to VA and community providers who treat Veterans. The PTSD Mentoring Program will continue its facilitation initiative that has significantly increased the delivery of evidence-based treatment in PTSD specialty programs. The Virtual Patient training program will be streamlined to enhance learner experience and will use AI to enhance the virtual patient's responses.

Evidence

- From 2020 through 2024, NCPTSD had an average of 110 competitively awarded research grants and 456 peer-reviewed publications per year. In 2024, NCPTSD investigators led 148 funded studies (totaling $317.6 million); 25 research funding submissions were pending at the end of 2024 and investigators had 356 publications.
- Advanced the assessment of PTSD. The Center has developed all the leading assessment methods for PTSD: (1) Clinician-Administered PTSD Scale (CAPS-5), an interview that is the gold standard around the world, (2) PTSD Checklist (PCL-5), the PTSD measure used in VA's Measurement-Based Care initiative, and (3) Primary Care PTSD Screen, used for mandatory PTSD screening in primary care. The Center continues to refine these measures to optimize performance and is currently testing revised versions of the CAPS-5 and PCL-5, and a new questionnaire based on the CAPS-5.
- Advanced the treatment of PTSD and VA's implementation of evidence-based PTSD treatment. Center research was pivotal in VA's decision to initiate national training for VA clinicians in Prolonged Exposure and Cognitive Processing Therapy. Ongoing trials to test and enhance treatment effectiveness and the Center's Consultation and Mentoring and Implementation Programs are advancing Veteran's access to the most effective treatments.
- Established VA's National PTSD Brain Bank in 2014 as the first brain bank devoted to PTSD. The PTSD Brain Bank is a consortium of five VAMCs and the Uniformed Services University of Health Sciences. The PTSD Brain Bank studies postmortem brain tissue to characterize genes associated with stress, PTSD, and suicide, which may lead to biological markers that could be used to diagnose and monitor treatment response.
- Expanded research on PTSD and suicide. Identified biomarkers of PTSD-related suicidal ideation. Launched a study to determine if PTSD treatment during inpatient hospitalization reduces risk of suicide for service members and Veterans with significant PTSD symptoms. Received funding to (1) evaluate the efficacy of a novel treatment to reduce suicidal thoughts and behaviors in psychiatrically hospitalized active-duty military service members and adult military beneficiaries; and (2) establish a multisite VA clinical resource for precision medicine for suicide prevention.

- Expanded the PTSD Trials Standardized Data Repository (PTSD Repository), a database of nearly 550 published studies on PTSD treatments updated annually to capture new research. Publicly available and free to use, the PTSD Repository helps researchers, clinicians, Veterans, and family members better understand the treatment literature.
- Developed an advanced online training for clinicians to administer the Clinician Administered PTSD Scale for DSM-5. Learners work any of with 3 virtual patients whose presentations, back stories, and responses mimic those of actual Veterans in a clinical interview. By the end of 2024, some 5,400 people took the courses.
- Continued to develop and disseminate online trainings that offer free continuing education credits to VA and community providers. As of 2024, more than 100 hours of continuing education units were available to learners on topics such as assessment, common comorbidities, evidence-based treatment, and provider cultural competence.
- Continued production of AboutFace, a public awareness campaign to motivate Veterans to seek treatment. Includes videos of Veterans, family members, and expert clinicians. Development of a feature on Veterans' experiences of moral injury is underway.
- Developed, updated, and disseminated a suite of 17 mobile applications, including self-help like Beyond MST and applications to support evidence-based treatments for PTSD. These products have been downloaded over 4.2 million times across the U.S. In collaboration with the Office of Connected Care and the Office of Suicide Prevention, the National Center built Safety Plan, designed an application for people with suicidal thoughts to develop a safety plan.
- Promoted the dissemination of evidence-based care for Veterans through the PTSD Consultation and Mentoring Programs, trainings, and educational products. Continuing to study implementation of evidence-based treatments for PTSD and increase awareness and understanding of PTSD and decrease barriers to seeking help.

National Veterans Sports Program

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Direct Programs (Medical Services):							
VA National Rehabilitation Adaptive Sports and Therapeutic Arts Events	$4,908	$3,000	$4,159	$4,870	$4,967	$711	$97
Veteran Monthly Assistance Allowance for Disabled Veterans Training Paralympic & Olympic Sports Program	$2,167	$2,000	$2,200	$2,350	$2,397	$150	$47
Grants for Adaptive Sports Programs for Disabled Veterans & Disabled Members of the Armed Forces Program	$16,000	$14,500	$16,000	$16,000	$16,320	$0	$320
Equine Therapy Grants for Adaptive Sports Programs	$0	$1,500	$0	$0	$0	$0	$0
Program Administration (Medical Support & Compliance)	$5,577	$9,542	$5,852	$5,852	$5,969	$0	$117
Grand Total	**$28,652**	**$30,542**	**$28,211**	**$29,072**	**$29,653**	**$861**	**$581**

Authority for Action

- 38 U.S.C. § 322, Office of National Veterans Sports Programs and Special Events (NVSPSE)
- 38 U.S.C. § 521, Assistance to Certain Rehabilitation Activities

Purpose

VA Adaptive Sports and Therapeutic Arts Rehabilitation events provide opportunities for thousands of Veterans to improve their independence, self-confidence, and quality of life through adaptive sports and therapeutic arts programs in accordance with 38 U.S.C. § 322 and 38 U.S.C. § 521A. The programs complement VA's rehabilitation system of care and encourage Veterans with disabilities to stretch beyond perceived limitations. In service of this mission, VA directs:

1) six national rehabilitation events delivering direct patient care to Veterans eligible for VA health care;
2) $16.0 million for adaptive sports and equine therapy grants to community organizations in support of programming for Veterans; and
3) up to $2.5 million in support of emerging and elite Veteran athletes competing in Olympic and Paralympic sports.

VA also provides the largest coordinated therapeutic arts program for Veterans held in cities across the Nation. Additionally, the events within the program train hundreds of VA rehabilitation providers across more than 100 VAMCs annually. The program primarily includes Veterans with spinal cord injuries, limb loss, traumatic brain injuries, visual impairments, multiple sclerosis, stroke, posttraumatic stress disorder, other musculoskeletal, neurological, and mental health conditions. In addition, VA staff are offered training in adaptive sports and therapeutic arts through in-person, hands-on trainings and online modules for continuing education credits.

2025 Planned Accomplishments

- Develop a communication plan to broaden outreach including: promotional materials intended for national and local use; engagement with media sources for routine distribution of the materials; broadcast and highlight the six national rehabilitation events as well as the adaptive sports and equine therapy grants via traditional and social media platforms; and distribution of content to Veterans, Veterans Service Organizations (VSO), VHA rehabilitation professionals, field public affairs officers, and other identified stakeholders on a quarterly basis.
- Provide seamless arrival and departure experience for Veterans, regardless of disability, attending each of the six national rehabilitation events.
- Provide training in at least one aspect of an adaptive sport activity at the event to spread the treatment modality throughout VHA.

2026 Budget Request

The NVSPSE funding request for 2026 is $29.1 million, $861,000 above the 2025 Current Estimate. This will allow NVSPSE to increase customer outreach 5.0% above the level planned to achieve in 2025 to improve Veteran outcomes, Veteran trust and satisfaction in VHA, and process Veterans payments of increasing cost for the Veterans monthly training allowance program. Of this amount, $16.0 million is for the adaptive sports and equine therapy grants for disabled Veterans and disabled members of the armed forces, and $2.3 million for the Veteran monthly training allowance for disabled Veterans training in Paralympic and Olympic sports programs. The balance of the request is to support full-time equivalents and increasing operational costs (for example,

venue costs to hold national events, transportation costs to facilitate Veteran participation, and technology fees and costs) to operate our six national rehabilitation events annually.

2026 Planned Accomplishments

- Enhance and expand adaptive supplies and equipment in addition to ensuring key staff are trained on use and function of adaptive supplies and equipment.
- Strategically redevelop all six national rehabilitation events to better align resources, ensuring sustainable growth of Veteran attendees and offerings at each event.
- Create a network of resources for VHA rehabilitation therapists to include a user-friendly application for finding VA-sponsored grant organizations by modality throughout the U.S. for ease of referring Veterans.

Evidence

Adaptive sports and therapeutic arts are one factor that can help with the effort to curb Veteran suicide risk. To aid in this effort, there is a need to increase the exposure and access to adaptive sports for all Veterans. Ongoing, systematic tracking of the Veterans served through each of the programs guides the office in identifying areas of improvement for access and exposures for Veterans from underserved populations and Veterans who have not previously been exposed to these activities are enrolled in programming. Partnership initiatives with rehabilitation and prosthetic services program offices will allow for targeted recruitment to fill identified gaps. Initiatives started in the prior year have resulted in increased number of Veteran participants at the six national rehabilitation events in the targeted areas, demonstrating confidence in success of future initiatives. Increasing adaptive sports training and knowledge in VHA rehabilitation staff will also increase the reach of engagement opportunities for Veterans when the staff will bring these skills back to the facility and implement the training into local clinical care practices. Essential support from VSOs, corporate sponsors, individual donors, and community partners helps build the foundation for the six national rehabilitation events which allows VA to extend its care beyond the clinical setting.

Neurology Centers of Excellence

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations							
Epilepsy Centers of Excellence	$21,773	$23,871	$23,047	$25,000	$25,500	$1,953	($500)
Headache Centers of Excellence	$16,913	$22,092	$22,125	$24,000	$24,480	$1,875	($480)
Multiple Sclerosis Centers of Excellence	$3,080	$5,300	$5,992	$6,500	$6,630	$508	($130)
Parkinson's Disease Research, Education and Clinical Centers	$10,926	$10,200	$13,367	$14,500	$14,790	$1,133	($290)
Obligations [Total]	**$52,692**	**$61,463**	**$64,531**	**$70,000**	**$71,400**	**$0**	**$0**
Account Category:							
Medical Services	*$48,443*	*$57,810*	*$61,446*	*$68,500*	*$69,870*	*$7,054*	*$1,370*
Medical Support & Compliance	*$4,249*	*$3,653*	*$3,085*	*$1,500*	*$1,530*	*($1,585)*	*$30*
Medical Care Total	*$52,692*	*$61,463*	*$64,531*	*$70,000*	*$71,400*	*$5,469*	*$1,400*

The National Neurology Program works to continuously enhance Veteran access to quality neurology care. The Neurology Clinical Programs collaborative comprises enterprise-wide, field-based networks with the shared tripartite mission of clinical care innovation, education, and

research. These Neurology COEs are a central mechanism by which Veterans access high quality, subspecialty neurology care.

Epilepsy Centers of Excellence

Authority for action

- 38 U.S.C. §7330A: Epilepsy Centers of Excellence
- Consolidated Appropriations Act, 2024, Division A, H. Comm. Print 56-550, Book 1, pg. 67: Centers of Excellence

Purpose

The Epilepsy Centers of Excellence (ECOE) were established to improve the health and well-being of Veterans with epilepsy and other seizure disorders through integration of clinical care, outreach, research, and education. The ECOE network comprises four regional centers, 19 VA Hospitals, and 66 active Associate sites. The ECOE provides comprehensive epilepsy care for Veterans with seizure disorders, including those with post-traumatic epilepsy. Electroencephalography (EEG) testing is considered the gold standard for diagnosing and treating epilepsy. The National TeleEEG and Epilepsy Program (NTEEG-EP), a National Designated Telehealth Hub, deploys VA Epilepsy and EEG resources to VA sites lacking these services or connections to ECOE network. There are eight regional TeleEEG hubs and 31 spoke site connections along with 17 TeleEpilepsy connected sites.

2025 Planned Accomplishments

- **Acute Seizure Management and Rapid EEG Pilot:** The ECOE launched an education program to improve recognition and management of seizures and status epilepticus in the emergency department and inpatient setting, particularly at non-ECOE sites to improve epilepsy care across the enterprise. They trained staff at three sites in 2025 Q2, with additional trainings planned in Q3 and Q4. Additionally, the NTEEG-EP Rapid EEG Pilot launched in 2024 in partnership with SimVet center resulting in FedRAMP approval for this technology. Seven sites are projected to be connected in 2025 (two are active now) and seven rapid EEG studies have been recorded and interpreted. The connection of an additional 22 VA locations is in the planning phase. This will allow EEG studies to be initiated in critical care and emergency settings when there is concern for status epilepticus even in the absence of EEG technologist coverage 24 hours per day, 7 days each week with interpretation by a coordinated team of epileptologists.
- **Telehealth care expansion**: The NTEEG-EP the tele-epilepsy consultation service is active at 27 sites in 2025 to date, compared to only 2 sites in 2024. This rapid expansion will improve access to virtual epilepsy care for Veterans, particularly those in rural areas very distant from both VA ECOEs and academic non-VA epilepsy centers. Program evaluation in 2024 and 2025 has mapped existing interfacility referral pathways with every VHA facility to ensure Veterans anywhere can receive epilepsy subspecialty care. This network mapping ties directly into the VHA Referral Coordination Initiative (RCI) to streamline referrals and improve access to care.

- **Outreach and caregiver support through collaborations with internal and external stakeholders**: The ECOE is developing partnerships with key stakeholders. The VA CSP collaboration will improve support for caregivers needing to supervise and administer nasal rescue medications for acute seizures. The ECOE will educate CSP staff on these issues, and CSP will educate ECOE providers on resources for caregivers of Veterans with epilepsy. The ECOE has undertaken massive efforts to reach Veterans with epilepsy and their caregivers through newsletters and collaborations with patient advocacy organizations, all resulting in increased awareness of ECOE services, requests for educational materials and self-referrals, and attendance at the Hope in Epilepsy patient and caregiver education series.

2026 Budget Request

The 2026 Budget request for the ECOE is $25.0 million, a $1.9 million increase (8.5%) over the 2025 Current Estimate. The request reflects the resources necessary to maintain operation of the existing ECOEs and NTEEG-EP. These resources will allow ECOE sites to enhance services through resource optimization and staff retention efforts as well as supporting necessary site visits, program evaluations, quality improvement, and outreach. These resources will also allow for efforts to strengthen the ECOE Network beyond its 19 sites to ensure epilepsy care can be accessed by Veterans regardless of geographic location. More than 95% of ECOE funds are used to support field based ECOE sites and operations within existing VAMCs.

NTEEG-EP will be able to continue operational expansion of Store and Forward EEG capacity and extend Tele-EEG access at all VA sites 24 hours per day, 7 days each week. Centralizing and consolidating existing resources will allow this growth in services with less expansion of FTE and hubs compared to the initial budget request. Funding will support synchronous TeleEEG which is anticipated to reduce the costs of unnecessary hospital and ICU transfers by $10 to $100 million annually. Integration and expansion of Rapid EEG technology will further reduce the need for inpatient transfers for EEG monitoring. Further development of Home EEG Community Care partnerships will ensure that Veterans receive same high quality EEG interpretation even when VA cannot perform the study directly.

2026 Planned Accomplishments

- **Strengthening the ECOE Referral Network**: The ECOE will improve access to care by enhancing efforts to strengthen the ECOE referral network and expanding the reach and integration of its related telehealth programs.
- **Program Centralization/Modernization**: Full execution of Synchronous TeleEEG support of ICU and Critical Care and partnership with Tele-ICU Program. Expansion of EMU synchronous Tele-EEG support to offer turnkey remote support for sites needing true continuous video EEG monitoring, either technical monitoring or profession interpretation. Continue operation and expansion of Store and Forward EEGs and on-demand coverage as needed for any VA site.
- **NTEEG-EP Collaborations**: 1) Rapid EEG Technology: 2025 pilot studies demonstrate cost-effectiveness through faster diagnosis and treatment, shorter hospital stays, and fewer transfers for EEG monitoring. 2) Expand VA-DoD partnership to include outpatient

assessments and acute inpatient care for active-duty personnel at military hospitals worldwide. 3) Continue expanding home-based EEG studies.

Evidence

The 2012 Institute of Medicine (IOM) report, *Epilepsy Across the Spectrum: Promoting Health and Understanding*, recommended the creation of criteria and a process of accreditation for epilepsy centers. The VA Hospital Epilepsy Center designations implemented by ECOE are in line with IOM's recommendations and guidelines for specialized epilepsy centers. Many Veterans live in rural areas, far from VA Hospitals that provide specialized epilepsy care. Community neurology care is limited in these areas, and subspecialty epilepsy care is virtually non-existent. As a result, numerous Veterans with epileptic and non-epileptic seizures may remain undiagnosed or misdiagnosed. Mortality rates are significantly higher in U.S. Veterans with DRE compared to the general population. Better utilization of comprehensive epilepsy care, diagnostic services, and medications are each associated with reduced mortality (Haneef et al., 2022). Lack of timely, correct diagnosis leads to treatment delays, unnecessary morbidity, and increased costs due to frequent emergency department visits and hospital admissions. Time to diagnosis for PNES in Veterans was noted to be five times longer than that of civilians in one study (Salinsky, et al., 2011). Seizures dramatically impair Veteran quality of life as 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).

The ECOE can deploy epilepsy care to any Veteran via telehealth. Despite rapid expansion during the COVID-19 pandemic, access and connectivity to epilepsy specialists remains insufficient to meet needs of Veterans with seizures. This shortage has led to increased community care referrals and discontinuity of epilepsy care. Community care hospitalizations including inpatient EEG services cost approximately $30,000 per Veteran between 2020 to 2023 for nearly 60,000 Veterans. (Source: Advanced Medical Cost Management Solution/AMCMS). Repatriating 1% to 10% of these hospitalizations by offering tele-EEG services would save $10 to $100 million dollars annually. Utilizing TeleEEG networks allows EEGs performed in remote VA hospitals or clinics to be interpreted by epilepsy subspecialists and reduces the costs of unnecessary transfers to VA and community hospitals. Community care EEGs are often interpreted by general neurologists without specialized EEG training, resulting in lower quality studies than those interpreted by ECOE and NTEEG-EP providers. The expansion and optimization of telehealth and TeleEEG networks will improve quality of epilepsy care by expediting diagnosis and targeted treatments, reducing Veteran wait times and travel distances, and decreasing the need for outside referrals. Surveys of referring clinicians in 2024 revealed high satisfaction with ECOE services and reduced TeleEEG report times compared with local EEG services.

Headache Centers of Excellence

Authority for action

- Consolidated Appropriations Act, 2024, Division A, H. Comm. Print 56-550, Book 1, pg. 67: Centers of Excellence

Purpose

In 2018, Congress directed VA to create a Headache Centers of Excellence (HCOE) program to better understand and provide the highest quality therapies to Veterans living with chronic and refractory headache, especially headaches associated with military exposures such as brain injury (TBI). HCOEs provide access to team-based care and evidence-based therapies for headache, including pharmacotherapies, injections and infusions, and non-pharmacological options such as cognitive behavioral therapy, physical rehabilitation modalities, and neuro-modulatory devices. The HCOE program provides educational initiatives to clinicians, Veterans, and families; conducts epidemiological work to understand impact of headache on Veterans and the health care system. In 2022, S. Rept. 117-35 accompanying *Military Construction, Veterans Affairs, And Related Agencies Appropriation Bill, 2022*, directed VA to expand the HCOE program to "at least 28" sites, ensure the successful recruitment and retention of healthcare providers with specialty training in headache medicine, and to report on whether an association exists between open burn pit exposure and headaches. Currently the HCOE includes 27 clinical sites (7 Hubs and 13 Associated sites), a Research, Evaluation, Education, Engagement Center for Headache (RE3ACH) with data analytic capacities to monitor and evaluate headache care (including the use of pharmacological and non-pharmacological therapies such as Whole Health modalities), reporting on associations between military exposures and headache, and identifying predictors of access issues as they relate to headache care quality and delivery.

2025 Planned Accomplishments

- **Clinical Care:** VHA increased the number of HCOE Associate sites from 20 to 27 and include those located in: Philadelphia, PA; Baltimore, MD; Miami, FL; Cincinnati, OH; Detroit, MI; San Francisco, CA; and Iowa City, IA. These sites have all been onboarded, oriented to recommended HCOE staffing model, and met with HCOE National Leadership to formulate budget execution plan. In considering growth in the number of new unique patients and new encounters seen in HCOEs and using historical HCOE data from 2021-24 and employing linear regression to extrapolate 2025 and 2026 growth, VHA anticipates an 8.0% and 8.2% increase for each year in the total number of patients and encounters, respectively, seen in the HCOE.
- **Education:** Increase the number of health psychologists trained in non-pharmacologic treatments for headache, including cognitive behavioral therapy for headache, biofeedback, and Acceptance and Commitment Therapy through expansion of the HCOE Behavioral Medicine training program and development of a "train-the-trainer" model. Between 2022-24, the HCOE Behavioral Medicine Council trained 121 psychologists and social workers in delivering non-pharmacologic treatments; 90 VA clinicians have been trained in 2025 to date with 90 more scheduled for training in Q3 of 2025.
- **Research:** Plan to conduct research studies to (1) understand headache healthcare utilization and care quality among Veterans including those with open burn pit exposure, (2) survey Veterans receiving their care by HCOE providers to understand satisfaction levels and identify both best practices and areas for improvement, (3) examine the satisfaction and cost effectiveness of incorporating Clinical Pharmacists into the provision of headache care through a VA QUERI-partnered evaluation, and; (4) develop a Veteran specific headache patient reported outcome measure (PRO) that accurately measures pain,

disability, other headache-related symptoms, such as light and sound sensitivity, and how headache interferes with the ability to meaningfully engage with others.

2026 Budget Request

The 2026 Budget request for the HCOE is $24.0 million, a $1.9 million (8.5%) increase over the 2025 Current Estimate. Veterans are increasingly using both VAMCs and community care for headache care. In 2024, 589,408 Veterans received headache care within a VAMC, which represents a 98.53% increase when compared to the 296,881 Veterans who received headache care in 2016. After the PACT Act was signed into law in 2022, VAMCs saw an increase of 31.1% in headache care utilization between 2022 (449,711) and 2024 (589,408). Research conducted by the HCOE RE3ACH, in partnership with the VA Health Outcomes Military Exposures (HOME) program, demonstrated a dose-dependent relationship between the amount of open burn pit exposure and developing new onset headaches and new onset migraines. While the need for Veterans to have access to high-quality, evidence-based, Veteran-centric headache care continues increasing, the HCOE has partnered with the VA Clinical Pharmacy Practice Office, PSAS, and Office of Patient Centered Care and Cultural Transformation to ensure that Veterans have access to more than a dozen newly approved or cleared therapies for headache. This effort includes ensuring healthcare providers are educated and trained on these treatment modalities.

The 2026 request will be used to support the clinical care across the 27 established HCOEs, such that recommended staffing models are implemented and the use of a highly trained headache healthcare providers, physicians, clinical pharmacists, health psychologists, nursing, and rehabilitation medicine, continues to improve headache care quality, delivery, and access. HCOEs will make widely available the use of a VA Headache Self-Management and Reporting Application (developed in 2024-25) to any Veterans seeking headache care and will widely implement a Veteran Headache Reported Outcome Measure (PRO was developed in 2024-25) to track responses to treatment. Patients will continue to be seen in the host VAMC and additional referral networks within the market and VISN will be established, thereby expanding the reach of a given HCOE. Capitalizing on HCOE infrastructure, care quality using American Academy of Neurology and American Headache Society headache quality measures will be constructed and disseminated along with specific recommendations to improve care quality, as based on the VA/DoD Headache Clinical Practice Guidelines.

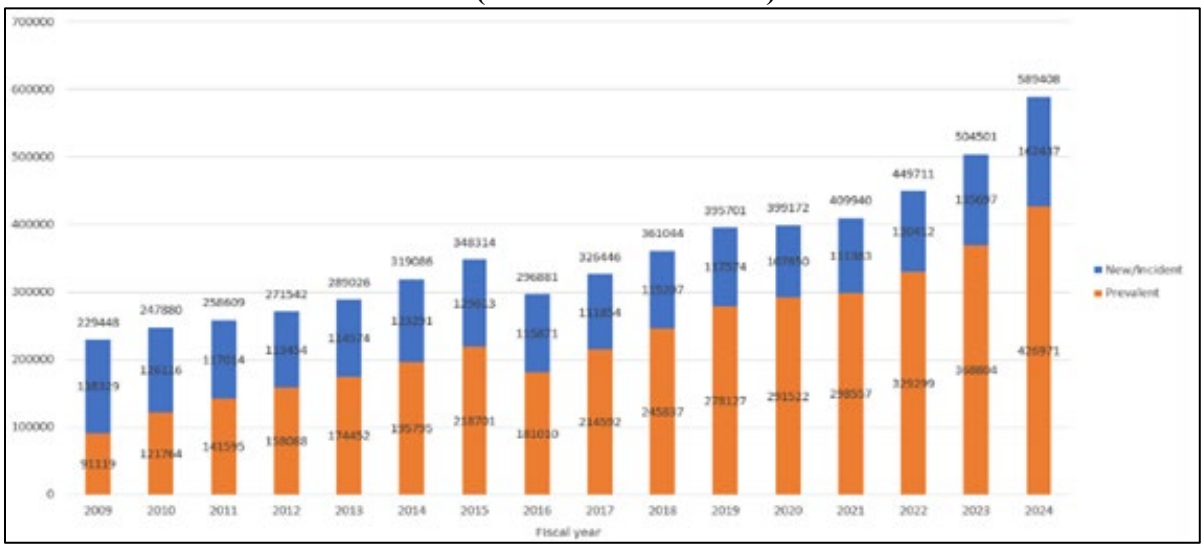
2026 Planned Accomplishments

- **Clinical Care:** Promote routine use of the VA Headache Self-Management and Reporting Application (developed in 2024-25).
- **Education:** Implement hands-on Headache History and Procedure training for Primary Care and Advanced Practice Providers in VAMCs without an HCoE site; this will include history and injection training.
- **Research:** Create a Veteran-specific patient reported outcome for headache and evaluate the impact of the HCoEs on the quality-of-care delivery (via headache quality metrics and patient reported outcomes); conduct administrative data analyses regarding open burn pit associated-headache care quality, delivery, and treatment effectiveness and trial pharmacological and non-pharmacological abortive and preventive treatments for these Veterans; begin a randomized-controlled trial of CBT in Veterans living with migraine.

Evidence

Headache is one of the most common and disabling conditions Veterans experience, and it exacts a heavy toll on Veterans, their families, and loved ones. This condition also taxes healthcare systems charged with providing Veterans access to the highest quality of care. Between 2008-22, VA provided over 10.0 million clinical encounters for headache care to more than 1.8 million Veterans. Approximately 25.0% of Veterans receiving headache care within VHA served in military campaigns during the Post-9/11 Global War on Terror, resulting in a notable increase in headache care utilization. In 2024, over 589,408 Veterans received headache care compared to 296,881 in 2016, representing a 98.5% increase in the use of VHA medical care for headache management (Figure 1).

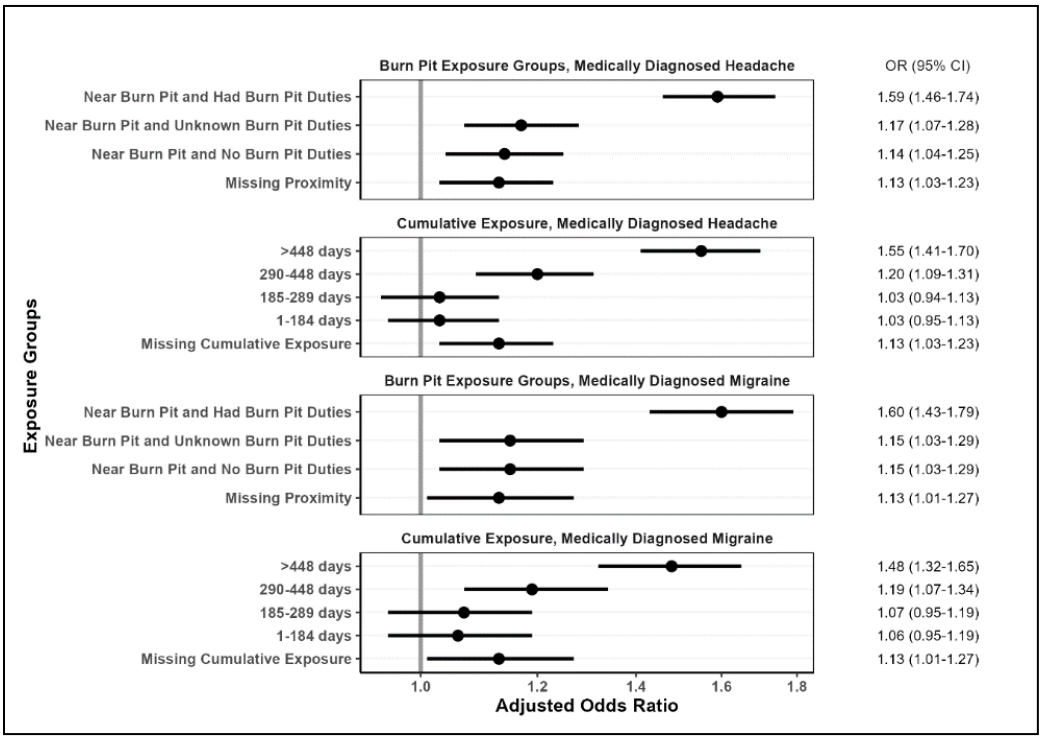
Figure 1. Incident and Prevalent Headache Cases Within VHA by Fiscal Year (VHA Headache CoE)



The link between headache and TBI, especially mild TBI, is well established with 90% of Veterans experiencing headache after TBI and 50% continuing to have headaches more than a year after injury. In 2024, other military exposures have been associated with developing new headache or migraine, including exposure to Agent Orange and to open burn pits. In considering open burn pit exposure, Veterans living near burn pits and having burn pit duties during deployment are 59% more likely to be diagnosed by a healthcare provider with a headache condition and 60% more likely to self-report having severe headache or migraine compared to those without open burn pit exposure. Those living near burn pits and not having burn pit duties during their deployment are 14% more likely to be diagnosed by a healthcare provider with a headache condition and 15% more likely to self-report having severe headache or migraine. Those with more than 290 days of cumulative exposure to open burn pit are more likely to develop either any type of headache or migraine than those without open burn pit exposure, with those having more than 448 days of cumulative open burn pit exposure being 55% to 60% more likely to develop new headache or migraine. In total, the greater amount of open burn pit exposure someone has, the higher likelihood they will develop new onset headache or migraine. (See Figure 2).

Figure 2. Medically diagnosed headache and migraine was assigned by medical providers accordingly in clinical encounters (*ICD-9-CM* and *ICD-10-CM* diagnostic codes). Panel A displays the adjusted odds ratios (and their 95% confidence limits) for medically diagnosed headache by open burn pit exposure levels. Panel B displays the adjusted odds ratios (and their 95% confidence limits) for medically diagnosed headache by the quartiles of days of cumulative exposure to open burn pit. Panel C displays the adjusted odds ratios (and their 95% confidence limits) for medically diagnosed migraine by open burn pit exposure levels. Panel D displays the adjusted odds ratios (and their 95% confidence limits) for medically diagnosed migraine by the quartiles of days of cumulative exposure to open burn pit. 'No open burn pit exposure' was the reference group for Panels A and C. '0 days' of cumulative exposure served as the reference group for Panels B and D. Odds ratios adjusted for age, sex, race and ethnicity, branch of service, and presence of traumatic brain injury.

Figure 2. Burn Pit Exposure Groups, Medically Diagnosed Headache



The use of procedures (including neurotoxin injections) for headache care is both costly and the need is rapidly growing. From 2019-23, community care visits for neurotoxins for migraine increased 46% year over year (cumulative 354% over five years). Over the same time frame, visits to VA neurologists for neurotoxin migraine treatment increased 12% annually (57% cumulative increase over five years). In 2023, 25% of neurotoxin visits for migraine were to community care providers, an increase from only 14% in 2019. Neurotoxin administration therapy with botulinum toxin A is an FDA-approved treatment for chronic migraine. The community care cost of neurotoxin therapy exceeds $1,400 per visit (cost of botulinum toxin A + provider reimbursement for injections, source: Medicare Physician Fee Schedule, www.cms.gov). The therapy is administered every 3 months in patients who respond to treatment. A major goal of the VA

Headache Centers of Excellence is to increase the availability of neurotoxin therapy for migraine with the VA, curbing the growth of costly neurotoxin visits to community care providers. This will be accomplished by leveraging the expertise of HCOE staff for off-site services and training of physicians and mid-level providers at distant VA sites to supply neurotoxin therapy services where needed.

Multiple Sclerosis Centers of Excellence

Authority for action

- 38 U.S.C. §7330: Multiple Sclerosis Centers of Excellence
- Consolidated Appropriations Act, 2024, Division A, H. Comm. Print 56-550, Book 1, pg. 67: Centers of Excellence

Purpose

VA Multiple Sclerosis Centers of Excellence (MSCOE) were established in 2003 to serve Veterans living with Multiple Sclerosis (MS), their families, and care partners by ensuring access to quality healthcare. The MSCOE serves as a resource to VAMCs and healthcare professionals in the functional cores of clinical care/informatics, education, and research, to optimize and coordinate the care of Veterans with MS across the Nation within their local VAMCs. The MS Center of Excellence-East is in the VA Maryland Healthcare System, Baltimore, Maryland and collaborates with Washington, DC VAMC, serving Veteran Integrated Service Networks (VISNs) 1 to 10. MS Center of Excellence-West is in Seattle, Washington and Portland, Oregon, serving VISNs 12 to 23. The MSCOE serve as coordinating sites across the VHA and were made permanent by P.L. 109-461, Veteran's Benefit, Health Care, and Information Technology Act of 2006, to serve Veterans with this disabling and often service-connected condition. Today, there are 35,000 Veterans enrolled in VHA to receive MS care.

2025 Planned Accomplishments

- MS Care Expansion: Secure funding to support 35 MS Regional Specialty Programs (RSP) which will sustain high-quality, patient-centered care for Veterans with MS, reduce community referrals, and ease financial burdens on VA healthcare systems.
- Collect and analyze qualitative and quantitative data (for example, disease modifying therapy (DMT) utilization, type of care) on Veterans with MS receiving care in the community to assess the Veteran experience and costs.
- Expand tele-health services for MS care with standardized protocols and technology to improve access, reduce travel, and ensure consistent support for Veterans.

2026 Budget Request

The 2026 budget request for the MSCOE is $6.5 million, an increase of $507,687 (8.5%) over the 2025 Current Estimate. The 2026 request provides the resources necessary to maintain operation of the existing MSCOE and MS RSP and to enhance services through resource optimization, collaboration, quality improvement and outreach. The expansion will provide at least one MS RSP in every VISN, increasing access to Veterans in rural areas. More than 85% of MSCOE funds are used to support field-based VA MSCOE network sites within existing VAMCs.

2026 Planned Accomplishments

- Increase the number of MS Surveillance Registry (MSSR) entries for Veterans with MS by 10% compared to prior year. This unique registry allows for documentation of key demographic and clinical variables for Veterans with MS and integrates these data with the VA Corporate Data Warehouse.
- Increase MS encounters with Veterans with MS by 10%, compared to the prior year.
- Enhance partnerships with Community Care to ensure that Veterans with MS have improved access and consistent quality care.

Evidence

- **Novel MSCoE informatics tools:** The MSCoE has developed a MS Surveillance Registry since 2014. This unique registry allows for documentation of key demographic and clinical variables for Veterans with MS and integrates these data with the Corporate Data Warehouse (Wallin, Fed Prac 2020). George E. Wahlen VAMC, Salt Lake City, UT investigators have helped develop a Community Care mapping platform for Veterans with MS.
- **Reducing financial burden of MS DMTs**: DMTs are the single most costly item in MS care averaging $86,000 per year in 2019 (Hartung, JAMA Neurol 2019). VHA negotiates DMT contracts with pharmaceutical companies to deliver the optimal price and medication within each class for Veterans with MS. VHA has shown that DMT costs are significantly higher with care in the community. Providing care to Veterans with MS in VHA reduces DMT costs and demonstrates a best practice by following criteria for use protocols.
- **Guideline concordant DMT safety monitoring:** DMTs have risks related to blood counts, liver toxicity, and infections that must be monitored with blood labs and by imaging. In collaboration with VHA radiology, our MSCoE group has developed an MS-MRI protocol (brain and spinal cord) based on the international guidelines (Bagnato, Fed Pract 2022). This protocol has been implemented at our MSCoE Regional Specialty Programs across with US in 2024. VHA has developed criteria for use for MS DMTs with safety monitoring standards in collaboration with VHA Pharmacy Benefits Management.
- **Deficits in the MS workforce:** Recent studies in the US general population have shown geographic access to neurologists is decreased in rural areas, in areas with higher proportions of Hispanics, populations with disabilities, and those that are uninsured. Access is further limited for MS subspecialty care (McGinley, Neurology 2024). There are also deficits in MS provider training programs that provides the pool for replacing the slim neurology population. For example, nearly half of existing fellowship positions go unfilled each year in the U.S. To come closer to meeting the demand for new neurology and allied healthcare professionals, VHA must develop mentoring programs, expand advanced fellowships, and develop an incentivized recruitment feeder system that would attract MS specialists to successfully maintain and strengthen the current MSCOE network.

Parkinson's Disease Research, Education and Clinical Services

Authority for action

- 38 U.S.C. §7329: Parkinson's Disease research, education, and clinical centers.
- Consolidated Appropriations Act, 2024, Division A, H. Comm. Print 56-550, Book 1, pg. 67: Centers of Excellence

Purpose

In 2001, VA launched an expansive campaign to improve services offered to Veterans diagnosed with Parkinson's disease and related disorders (PD/RD), establishing six Parkinson's Disease Research, Education, and Clinical Centers (PADRECCs) The PADRECC's mission is threefold: 1) provide comprehensive, state-of-the-art care to Veterans with PD/RD and support to their caregivers; 2) pursue research leading to improved treatment and a cure; 3) conduct outreach education programs for clinicians, Veterans, and their families. In addition, the PADRECCs are charged with developing a network of clinicians with interest and expertise in the field of movement disorders. The PADRECCs launched the network in 2003 that has expanded Parkinson's disease awareness and education across VA through peer networking, consultative services, education, and training. These PADRECC Associated Sites (PAS) offer specialized Parkinson's disease and movement disorder specialty care to Veterans who cannot travel to a PADRECC. Together, the six PADRECCs and more than 60 PASs provide state-of-the-art movement disorders care to Veterans throughout the country with PD/RD.

2025 Planned Accomplishments

- **Education**: Continue to train the next generation of movement disorders clinicians with clinical rotations, didactic lectures and in person symposia. Collaborate with the ORH CBT to train additional providers to administer CBT for Veterans struggling with PD and depression. Pilot a hospital safety presentation "Caring for Veterans with PD" for VA CLC staff, intended to be disseminated nationally once optimized. Provide Veterans and caregivers high quality education programs and support groups.
- **Research**: Increase Veteran participation in CSP 2015 – Multicenter, Randomized, Double-blind Comparator Study of Antipsychotics Pimavanserin and Quetiapine for Parkinson's Disease Psychosis by utilizing a hub and spoke model of subject recruitment with a goal of enrolling 50 VA Clinicians from around the nation to participate as referring clinicians, referring eligible subjects to Study Sites for completely virtual participation in the trial. This innovative model of subject recruitment is a first within VA.
- **Clinical**: Designate 13 Regional Parkinson's and Movement Disorder Centers to expand multidisciplinary specialized care to Veterans diagnosed with Parkinson's disease and related disorders and initiate bimonthly meetings of these Centers and PADRECC leadership to enhance productivity, identify best practices, and enhance Veteran access to this subspecialty level care. Continue to collect and monitor VSignals data.

2026 Budget Request

The 2026 Budget request for the PADRECC is $14.5 million, a $1.1 million (8.5%) increase over the 2025 Current Budget estimate. The funding request of will support the establishment of at least 13 Regional Parkinson's and Movement Disorder Centers (RPMDC) to increase access to multidisciplinary, specialized care to Veterans diagnosed with Parkinson's disease and related disorders. Each RPMDC will be required to use the PADRECC stop code and clinic set-up to capture workload. In addition, the RPMDCs will provide their services via interfacility consult to at least one other medical center outside of their facility. A review of the established PADRECCs interfacility consults along with community care data will be initiated to ensure clinical access is optimized. A stepped model of care to include the RPMDC and PADRECCs will be developed.

The PADRECC will utilize funds to enter into a Memorandum of Agreement with the Strategic Policy Evidence-based Evaluation Center (SALIENT) group to provide ongoing clinical data utilizing established measures. The data will be used to identify gaps in access, quality of care, where care is provided, co-morbidities, etc. This data will assist in the program making informed decisions about locations for future PADRECCs and or RPMDCs.

2026 Planned Accomplishments

- **Education**: Continue to train the next generation of movement disorders clinicians with clinical rotations, didactic lectures and in person symposia. Collaborate with Epilepsy Centers of Excellence (ECoEs) Mind-Brain Program to train providers on NBT to treat functional movement disorders. Continue to roll out and disseminate nationally the hospital safety presentation "Caring for Veterans with PD" for VA CLC staff. Continue to provide Veterans and caregivers high quality education programs and support groups.
- **Research** Increase Veteran participation in CSP 2015 – Multicenter, Randomized, Double-blind Comparator Study of Antipsychotics Pimavanserin and Quetiapine for Parkinson's Disease Psychosis by utilizing virtual option, and hub and spoke model of subject recruitment.
- **Clinical**: Institute performance measures, staffing models and stepped models of care to include the 13 Regional Parkinson's and Movement Disorder Centers. Continue to collect and monitor VSignals data and include questions about quality-of-life assessment by Veterans. The number of VAMCs with virtual access to specialized care will be increased by 10. PADRECC currently has regular virtual clinics with 25 facilities.

Evidence

- The shifting demographics of the adult population place more individuals at risk for PD than ever before. A recent study revealed that at least 90,000 people are diagnosed with Parkinson's disease in the U.S. each year (Willis et al. 2022), a 50.0% increase from prior annual estimates. In addition, there are multiple known and emerging military service risk factors for parkinsonism and PD, including exposure to herbicides (Ball et al. 2019; Yi et al. 2014), trichloroethylene (Goldman et al. 2023), and traumatic brain injury (Gardner et al. 2018). These service-related factors have been posited to account for up to 30% of PD cases in male servicemen (Payami et al. 2019). Moreover, VHA enrolled Veterans are often successfully treated for military service-related conditions (including epilepsy, headache,

chronic pain, TBI, and PTSD) with medications that have parkinsonism as a drug side effect. These demographic and clinical factors, combined with the PACT Act removal of barriers to care access suggest that Veterans Affairs, one of the largest providers of health care, will continue to see increasing numbers of Veterans needing care for neurological disorders, especially Parkinson Disease and parkinsonism.

- According to a recent report from the SALIENT QUERI report (PADRECC Evaluation 2023), there were 84,644 Veterans with PD in the VA system in 2022, although the total number of Veterans with PD nationwide (including Veterans not in the VA system) has been estimated at over 110,000. Of the Veterans identified in the SALIENT report, 58.0% had no Neurology/PD Specialty Care in the VA or paid for via community care. This suggests an enormous number of Veterans with PD who are not getting specialized care. The accuracy of the diagnosis of Parkinson disease in the VA varies widely depending on who codes the diagnosis. According to a recent publication, (Goldman et al. 2025) that analyzed data from 146,776 Veterans who received care in the VA, 11.9% of Veterans who were diagnosed by a PADRECC-affiliated neurologist or neurosurgeon did not have PD confirmed by a comprehensive sub-specialist chart review, while 31.9% of Veterans diagnosed by non-PADRECC neurologists and neurosurgeons did not have PD or other forms of neurodegenerative parkinsonism. For other types of physicians, the rate of misdiagnosis was between 40 and 73.1%. varies. There are multiple reasons for the exceptionally high inaccurate diagnosis rates among non-PADRECC affiliated providers, including overlapping symptoms with medical conditions that are common in the VA population, the high prevalence of drug induced movement disorders in the VA population, and the relative difficulty accessing expert neurologist diagnosis and care (although the latter, according to forthcoming data, is more difficult in the community as compared to within the VA). Notably, the conditions that are most often mistaken for PD are other movement disorders which are in the expert purview of PADRECC providers, underscoring the need for expanded clinical and educational reach of the PADRECC program.
- There has been increasing recognition that PD involves both motor and non-motor symptoms and that the best care requires a multi-disciplinary approach. Motor symptoms include tremor, stiffness, slowness and gait dysfunction. The most common non-motor symptoms in Veterans from the SALIENT report include falls (20.3%) depression (32.8%), PTSD (20.3%), anxiety (20.1%), dementia (31.4%), sleep disorders (40.3%), constipation (25.8%) and dysphasia (17.9%). PADRECCs have established nationally recognized indicators of quality care (Cheng et al. 2004) and have proven that specialist involvement in care and multidisciplinary care improves outcomes (Carne et al. 2005; Cheng et al. 2007). Implementation of this proposal will allow more Veterans to be treated in multidisciplinary clinics providing state-of-the-art care including movement disorder expertise, specialized rehabilitation, and tailored psychiatric interventions, chemodenervation therapy and DBS therapy.

- The heat map below shows where there is a high prevalence of Veterans with PD/RD. The RPMDCs will be chosen partially based on location to provide increased access to care in higher PD prevalence areas. PADRECC stop codes most likely will not be implemented until mid-2026, therefore a full year of data to establish a baseline will not be available until mid-2027.

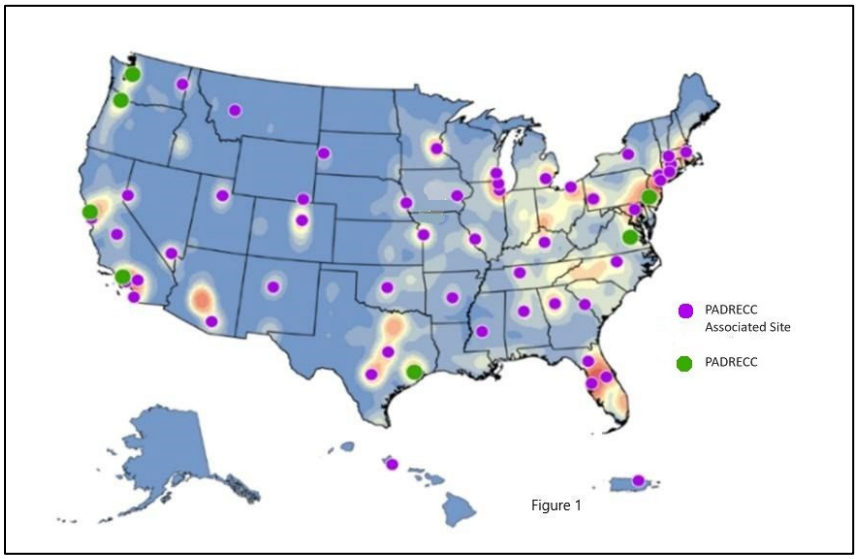


Figure 1

Non-Recurring Maintenance (NRM)

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations - All Other	$2,258,615	$2,000,000	$2,488,000	$4,837,500	$3,037,500	$2,349,500	($1,800,000)
P.L. 117-328 § 252 (EO 14507 no-year, 1124) 1/	$0	$0	$0	$0	$0	$0	$0
P.L. 117-103 § 253 (Infrastructure no-year)	$23,227	$0	$65,029	$0	$0	($65,029)	$0
P.L. 115-244 § 248 (NRM no-year)	$45,577	$0	$12,748	$0	$0	($12,748)	$0
P.L. 115-141 § 255 (NRM no-year)	$3,856	$0	$76	$0	$0	($76)	$0
Discretionary Obligations [Subtotal]	**$2,331,275**	**$2,000,000**	**$2,565,853**	**$4,837,500**	**$3,037,500**	**$2,271,647**	**($1,800,000)**
PACT Act, sec. 705	$18,007	$27,648	$60,710	$3,900	$2,704	($56,810)	($1,196)
PACT Act, sec. 707	$15,661	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	($2,975)	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$30,693**	**$27,648**	**$60,710**	**$3,900**	**$2,704**	**($56,810)**	**($1,196)**
Obligations [Total]	**$2,361,968**	**$2,027,648**	**$2,626,563**	**$4,841,400**	**$3,040,204**	**$2,214,837**	**($1,801,196)**
Non-Add (Included Above):							
Discretionary Obligations - Base NRM	$1,843,979	$1,500,000	$2,065,853	$3,837,500	$2,537,500	$1,771,647	($1,300,000)
Mandatory Obligations - Base NRM	$30,693	$27,648	$60,710	$3,900	$2,704	($56,810)	($1,196)
Discretionary Obligations - EHRM NRM	$487,296	$500,000	$500,000	$1,000,000	$500,000	$500,000	($500,000)
Mandatory Obligations - EHRM NRM	$0	$0	$0	$0	$0	$0	$0
Base NRM/EHRM NRM Obligations [Subtotal]	**$2,361,968**	**$2,027,648**	**$2,626,563**	**$4,841,400**	**$3,040,204**	**$2,214,837**	**($1,801,196)**

Note: The 2024 NRM actual in the above table includes additional object classes than what is displayed in the Budget Overview chapter's Obligations by Object table, such as Personnel Compensation and benefits, Other Contractual Services, Supplies and Materials and Equipment.

NRM funds projects to make additions, alterations and modifications to land, buildings, other structures, nonstructural improvements of land and fixed equipment. NRM can also occur when the equipment is acquired under contract and becomes permanently attached to or part of the building or structure. NRM is utilized to maintain and modernize existing campus facilities, buildings and building systems, replace existing building system components and provide for adequate future functional building system capacity. NRM can also be used for environmental remediation and abatement and building demolition. This is accomplished without constructing any new building square footage for functional program space.

Please see the Medical Facilities Chapter in Volume II and various chapters in Volume IV for additional information.

Precision Oncology

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations							
Medical Services (0160):	$174,279	$194,987	$201,784	$232,180	$236,823	$30,396	$4,643
Medical Support and Compliance (0152):	$11,935	$20,087	$12,044	$18,381	$18,749	$6,337	$368
Medical Facilities (0162):	$226	$359	$331	$897	$915	$566	$18
Pharmacogenomics (Non-add; included in above)	$24,228	$35,616	$35,739	$42,671	$43,524	$6,932	$853
Obligations [Total]	**$186,440**	**$215,433**	**$214,159**	**$251,458**	**$256,487**	**$37,299**	**$5,029**

1/Excludes OI&T

Authority for action

- Title 38 Chapter 17
- 42 U.S.C. §280e(d)(4): National Program of Cancer Registries - Coordination.
- Consolidated Appropriations Act, 2024, Division A, H. Comm. Print 56-550, Book 1, pg. 80: Cancer Registry – Data Sharing with State Cancer Registries.
- P.L. 117-328, Division U, Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022, § 102c: Department of Veterans Affairs Treatment and Research of Prostate Cancer: Development of Comprehensive Prostate Cancer Program and Implementation of the Prostate Cancer Clinical Pathway.
- P.L. 117-135, Making Advances in Mammography and Medical Options for Veterans (MAMMO) Act.
    - Sec. 104. Study on availability of testing for breast cancer gene among Veterans and expansion of availability of such testing.
    - Sec. 106. Report on access to and quality of mammography screenings furnished by Department of Veterans Affairs.

- Sec. 201. Partnerships with National Cancer Institute to expand access of Veterans to cancer care.

Purpose

VA's vision for precision oncology is that Veterans will have access to the highest quality care available anywhere and as close to their homes as possible. Three core activities are used to translate the complexities of cancer care into processes that are deliverable throughout VA. First, the preferred care for each type and stage of cancer is detailed in a clinical pathway for use by any oncologist, both in VA and in community care. Second, subspecialized teleoncology and expanded sites of care are used to deliver access to expert clinicians specific to the patient's needs. Teleoncology can match any patient with a highly skilled clinical team even for patients in rural geographic locations where there is no suitable community oncology care. Additionally, VA developed delivery models establish ambulatory cancer clinics in suburban and rural areas using existing clinic space and support in-home cancer treatments. Approximately 25% of Veterans with cancer live in rural areas but only 3% of medical oncologists work in rural areas. Third, VA providers access industry leading molecular diagnostics through national acquisitions leveraging economies of scale and standardized care delivery. Molecular diagnostics is a central component of oncology practice for most cancer types and is necessary to create personalized treatment plans.

2025 Planned Accomplishments

- Expand teleoncology to 119 VA medical centers with 42% of Veterans residing in rural or highly rural areas to provide full-service coverage, add services, and/or provide oncology care for provider leave and attrition of oncologists across the enterprise.
- Implement cancer services at 30 new ambulatory clinics, giving 2.5 million Veterans access to VA Oncology within an hour of their home, and pilot home cancer treatment service to provide safe and convenient care for Veterans and caregivers who have difficulty traveling to appointments.
- Lead the nation in lung cancer screening quality by achieving high rates of adherence (89% nationwide as of April 25, 2025) to annual lung cancer screening guidelines. VA aims to increase the number of Veterans who have their lung cancer screening eligibility determined by 25% (1.4 million of 2.1 million possibly eligible as of April 25, 2025).
- Increase Mailed Fecal Immunochemical Test (FIT) programs to 80% of all VA facilities and conduct over 200,000 colonoscopies at facilities outfitted with Computer Aided Detection (CADe) devices since their deployment in 2023.
- Expand pharmacogenomics testing and services to 20 new VA sites (15% increase over 2024 baseline of 135 VA sites of care). This expansion will increase access to Veterans being treated for health issues such as depression, cardiovascular disease, or selected cancers to have a seamless and standardized approach to cost-efficient genetic testing services that prevent known medication side effects.

2026 Budget Request

The 2026 Budget request for VA's precision oncology program is $251.5 million, an increase of $37.3 million above the 2025 Current Estimate. Of the $37.3 million increase, $20.0 million will fund 30 new cancer clinics nationwide. Currently, only 10% of oncologists practice outside metro areas, with just 3% in rural regions. To address this, 50% of the new clinics will be in rural communities. Each clinic will have the capacity to care for 300 Veterans annually, thereby increasing VA oncology access for 9,000 additional Veterans each year. The remaining $17.0 million increase will sustain standardized and cost-efficient genetic testing for medications programs which improve treatment response and safety for up to half of all Veterans. Funding to expand this program increases VA's ability to prevent harmful or ineffective medications prescribed to Veterans suffering from health issues such as depression, heart disease, and certain cancers, reduces the burden on their caregivers, and can lower the cost of health care through more efficient medication prescribing. VA is the largest integrated cancer research and healthcare provider in the United States and is committed to delivering high-quality, cost-effective cancer care to Veterans, particularly in rural areas where an estimated 3% of medical oncologists are employed, but 25% of Veterans reside. The 2026 budget is focused on increasing access to care and putting Veterans First by providing cutting edge cancer care and precision medicine treatment.

The number of Veterans receiving cancer care through direct or community care increased by 31% from the start of 2022 through 2024. The funding for cancer and precision medicine established systems of care to support the increase of Veterans with cancer. The funds were first requested in 2019 and approved in 2020. The funding advanced molecular diagnostics for Veterans and provided crucial information for diagnosis, prognosis, and treatment selection for more effective and personalized care. Additionally, because of this dedicated funding for cancer and precision medicine, the VA is now a national leader in colorectal cancer screening and in lung cancer screening with data that suggest VA is bending the lung cancer mortality curve. VA is identifying more instances of early-stage lung cancer when it may be treated more effectively with fewer instances of metastatic lung cancer, which is fatal. The increased funding to cutting-edge, cost-saving cancer programs will expand services that save lives, sustain treatment options, modernize cancer data programs, increase convenient cancer care, and provide effective patient cancer care navigation for Veterans, their caregivers, and families.

2026 Planned Accomplishments

- TeleOncology services will expand to deliver unique cross-state subspecialized cancer services to 100% of VA medical centers, as needed based on demand.
- Establish an additional 30 ambulatory cancer clinics (increase from 60 to 90 ambulatory cancer clinics) and provide cancer treatment homecare service at ten additional VA Healthcare Systems (increase from 1 to 10 programs) resulting in safe clinic and home oncology treatments convenient for Veterans and caregivers.
- Expand seamless and standardized access to cost-efficient genetic testing services at an additional 10 VAMCs to prevent known medication side effects for nearly half of Veterans. This expansion will ensure full access to care regardless of which VAMC the Veteran chooses for his or her health care and will increase the number of medications impacted by genetic testing to nearly 100, a 31% increase over the current baseline of 74 medications.

- Increase Veteran access and participation to cancer clinical trials, with at least 30 Veterans with cancer participating in groundbreaking industry leading decentralized/remote cancer clinical trials and at least 70 Veterans with cancer receiving cancer trial navigation, increasing access to cutting-edge therapy, and contributing to advancements in medical knowledge.
- Expansion of precision medicine-based interventions (pharmacogenomics, somatic and germline comprehensive genomic testing) and high-quality, high-value, and evidence-based cancer care (breast and gynecologic cancer system of excellence, cancer clinical pathways).

Evidence

VA's approach to precision oncology addresses systemic barriers in access found across U.S. oncology care. The American Society of Clinical Oncology's State of Cancer Care in America highlights several of these barriers that particularly impact rural Americans. Only 10% of Oncologists practice in a non-metro area across America with only 3% practicing in rural areas. 70% of US counties lack a single active cancer treatment trial. This means that 26% of residents age 55 and over live more than two hours roundtrip from a site with wide trial offerings and access to the best Cancer care. The American Society of Clinical Oncology, *The State of Cancer Care in America 2023: A Report by the American Society of Clinical Oncology* available at: https://www.asco.org/research-data/reports-studies/state-cancer-care-america.

VA's approach addresses documented deficiencies in rural cancer services from screening to treatment and care after treatment. VA is leveraging proven recommendations to leverage and incentivize the rural cancer care workforce, improve cancer services data quality, timeliness, and accuracy, and increase the number of facilities, providers, and specialists providing rural cancer care. *See* Lent AB, Derksen D, Jacobs ET, Barraza L, Calhoun EA. *Policy recommendations for improving rural cancer services in the United States*. JCO Oncology Practice. 2023;19(5):288-294 available at: https://doi.org/10.1200/op.22.00704.

VA's approach accounts for shifting demographics and advancements in cancer care which are driving a growing demand for oncologists in the United States. Projections indicate the U.S. could see a shortage of more than 2,200 hematologists and oncologists in 2025, reflecting a growing imbalance between supply and demand. Demographic shifts over the next decade will continue to fuel the demand for oncologists. The number of U.S. adults aged 65 and older is expected to double by 2030, with cancer diagnoses among this group projected to increase by 67% between 2010 and 2030. *See* Medicus Healthcare Solutions *Examining the Oncologist Shortage* 2025 available at: https://medicushcs.com/resources/examining-the-oncologist-shortage.

VA's successful Veteran's First approach has leveraged teleoncology and remote chemotherapy services to expand care to Veterans in rural areas who have difficulty accessing oncology services primarily located in more metro areas of America. Patients receiving their chemotherapy on-site vs. remotely via telehealth had no difference in chemotherapy side effects. See Arnold A, Asif S, Shostrom V, Ganti AK. *Outcomes Following Off-Site Remote Chemotherapy Administration*. Journal of Clinical Oncology. 2022; 40(16_suppl): 1516-1516 available at: https://doi.org/10.1200/JCO.2022.40.16_suppl.1516.

VA's integrated solution for implementing pharmacogenomics test results aligns with the approach evaluated in this large, prospective, randomized controlled trial to optimize the prescriptions for over 40 commonly prescribed medications reduces adverse drug reactions by 30% compared to usual care. *See* Swen JJ, et al.. A 12-Gene Pharmacogenetic Panel To Prevent Adverse Drug Reactions: An Open-Label, Multicentre, Controlled, Cluster-Rndomised Crossover Implementation Study. Lancet. 2023 Feb 4;401(10374):347-356. doi: 10.1016/S0140-6736(22)01841-4 available at: https://pubmed.ncbi.nlm.nih.gov/36739136/.

Rural Health

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations							
Medical Services (0160):	$292,307	$305,688	$281,491	$310,688	$316,902	$29,197	$6,214
Medical Support and Compliance (0152):	$10,560	$19,459	$9,130	$19,459	$19,848	$10,329	$389
Medical Facilities (0162):	$12,223	$12,308	$11,347	$12,308	$12,554	$961	$246
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$315,090**	**$337,455**	**$301,968**	**$342,455**	**$349,304**	**$40,487**	**$6,849**

Authority for action

- 38 USC § 7308 – Office of Rural Health
- Consolidated Appropriations Act, 2024, Division A, H. Comm. Print 56-550, Book 1. Rural Health.

Purpose

The ORH conducts, coordinates, promotes, and disseminates research on issues that affect Veterans who reside in rural communities. ORH also operates five Veterans Rural Health Resource Centers that identify, formulate, and develop best practices to enhance the delivery of health care to Veterans living in rural areas.

2025 Planned Accomplishments

- Mobile Prosthetics & Orthotic Care anticipates sustaining 4 sites with third year funding and 9 sites with second year funding for a total of 13 sites.
- Increasing access for rural Veterans by leveraging clinical pharmacist providers to deliver chronic obstructive pulmonary disorder care by serving a projected 14,000 unique Veterans served (72% rural).
- VA Extension for Community Healthcare Outcomes expansion in specialty care projects offering 77,265 continuing medical education/continuing education units in 2025.

2026 Budget Request

The Rural Health funding request for 2026 is $342 million, $40 million above the 2025 Current Estimate to fund programs and projects that conduct, coordinate, promote, and disseminate research on issues that affect Veterans who reside in rural communities. ORH will fund approximately 1,869 FTE in the facilities who work on rural health programs and projects and sustain support for program office operations. ORH will continue to fund five Veterans Rural

Health Resource Centers that identify, formulate, and develop best practices to enhance the delivery of health care to Veterans living in rural areas.

2026 Planned Accomplishments

- The National Tele-Neurology program (NTNP) anticipates conducting 10,000 total encounters and 6,500 rural encounters. NTNP anticipates providing care to 9,500 total unique Veterans and 6,175 rural unique Veterans.
- Rural suicide prevention anticipates having five active communities enrolled in the program that will serve 3,304 rural Veterans and provide 3,304 rural Veteran encounters.
- The National Subspeciality Ophthalmology Network (NSON) anticipates serving 2,950 total Veterans and 2,000 rural Veterans. NSON anticipates providing 6,000 total encounters and 4,500 rural encounters.

Evidence

CRH expects to have a 5% increase in the number of Veterans served by CRHs from 2025 to 2026. Five percent of VISN CRHs will implement at least one additional clinical service by the end of 2026. Physical therapy embedded into Rural PACT projects it will serve 1,400 (1,120 rural and highly rural) Veterans across 8 rural PACT PT sites in 2025 with approximately 3,920 (3,136 rural and highly rural) Veterans across 16 PACT PT sites in 2026.

Evidence supporting the success of current and future projects are recorded in the New Office of Rural Health Management and Analysis Database (NOMAD), which is ORH's program management application. ORH uses NOMAD to collect program management evaluation and measures data. ORH also conducts peer-reviewed publications, presentations, and annual reports.

Supply Chain Management

Medical Care Appropriation Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
VA Logistics Redesign	$45,369	$108,146	$54,415	$82,029	$83,669	$27,614	$1,640
Medical Surgical Prime Vendor (MSPV)	$33,931	$29,187	$26,607	$31,829	$32,466	$5,222	$637
Supply Chain Master Catalog	$4,951	$5,333	$4,916	$5,433	$5,542	$517	$109
Point of Use	$1,351	$3,605	$3,514	$0	$0	($3,514)	$0
Clinical Decision Strategic Sourcing	$2,573	$2,595	$2,388	$2,673	$2,726	$285	$53
Grand Total	$88,175	$148,866	$91,840	$121,964	$124,403	$30,124	$2,439

Authority for action

- 38 U.S.C. Chapter 17, Hospital, Nursing Home, Domiciliary, and Medical Care
- P.L. 109-461, Veterans Benefits, Health Care, and Information Technology Action of 2006
- P.L.115-407 § 703, Veterans Benefits and Transition Act of 2018

Purpose

The VHA Office of Supply Chain (OSC) manages several programs that directly enable the Secretary's "Veterans First" vision by simplifying VA-wide supply chain operations, improving clinical consistency and safety, and delivering savings that can be reinvested in VA needs.

Supply Chain Modernization (SCM). In support of Congressional direction to implement an incremental, scalable approach to modernizing aging, fragmented supply chain management applications and tools, OSC is focused on three modernization priorities: standardizing use of an enterprise asset management system, standardizing and improving an inventory management system, and standardizing SC data and establishing data governance.

Medical/Surgical Prime Vendor (MSPV) Program. Managed by the Medical Supply Program Office (MSPO), MSPV is the mandated source of medical/surgical supplies for VAMCs (VHA Directive 1761). The program provides multi-value by reducing cost and administrative burden for healthcare facilities, streamlining procurement of medical and surgical supplies through standardized, pre-negotiated prices, and ensuring timely delivery of high-quality products tailored to VA's needs.

The Clinical Decision Strategic Sourcing (CDSS) directly supports the MSPV program by leveraging a commercial healthcare best practice that includes physicians and clinicians in the product standardization and sourcing process, achieving cost reduction and cost avoidance by driving purchase order volume toward clinically based best-value contracts, improved clinical outcomes and patient safety, standardized and clinically preferred products, and clinical customer satisfaction.

The Supply Chain Master Catalog (SCMC) provides a searchable, user-friendly authoritative repository for logisticians, clinicians and staff across the VHA to find items and services on a VA contract at best-pricing and availability.

2025 Planned Accomplishments

- **SC Modernization (pre-decisional)**. As the first step towards improving supply chain, the Office of Supply Chain will standardize software and workflows for asset management, reducing the cost of sustaining disparate systems while improving management and oversight.
- **Medical Surgical Prime VendorGenZ.** Complete implementation with a target of approximately $135 million savings achieved through expansion of the product list to achieve optimal pricing, product standardization and availability - ultimately decreasing off-program buys.
- **Sustain investment in data standardization, data quality improvement and data taxonomy** to enhance SC data analytics and system integration supporting business system transformation (SCM, electronic health record, integrated financial management system).
- **Integrate** the SCMC cleansed, enriched, and standardized data into the VA Logistics Integration Platform (VALIP), Supply Chain Master Database (SCMD) project, enabling increased data sharing across VA, VHA, and VA Medical Centers and integration of data into other VA/VHA tools and applications. The migration of LogOp database from CDW to VA Logistics Integration Platform was completed late January 2025, however the additional work required for full development of SCMD within VALIP is still under way.

2026 Budget Request

VA requests $122 million, $30.1 million (32.8%) above the 2025 Current Estimate to support the deployment of VA Supply Chain solutions to modernize systems and focus resources more efficiently to be competitive and to provide world class capabilities to Veterans and employees, as well as to quickly deliver effective solutions that will enable VA to provide improved customer service and provide a secure and seamless experience while decreasing its rate of spend.

- **MSPV.** VA requests $31.8 million to support and improve VHA's program for ordering and distributing medical, surgical, dental, select prosthetic and lab supplies. This includes funding for management and oversight of supply and distribution contracts that facilitate delivery of medical/surgical commodities to VAMCs, with MSPV Gen-Z V1 incorporating MSPV-Next Generation (MSPV-NG) lessons learned and leading practices to help enhance the program by further streamlining procurement processes, increasing item availability, and improving program transparency and visibility. The funding request also supports contract administration support, with activities including proving contractor performance and administration related to performance, support of the reconciliation of outstanding invoices and support for a COR Audit program.
- **CDSS**. VA requests **$**2.7 million. Internal and external reports, including the Commission on Care Assessment J, GAO 18-34, and the Logistics Satisfaction & Time Resource Survey highlighted procedural and structural challenges in VA's supply chain processes resulting in risks to patient care, clinician dissatisfaction, and missed opportunities for cost avoidance. CDSS helps reduce variation of clinically equivalent medical supplies used across VHA, increasing efficiency while reducing time and training requirements for clinicians. VA clinicians benefit by acquiring increased time for patient care.
- **Supply Chain Master Catalog (SCMC)**. VA requests $5.4 million for the VA SCMC to provide a user-friendly, searchable application designed for logisticians, procurement personnel, clinicians, central office, and their support staff nationwide, which serves as an operational enabler for VISN and medical center staff to identify more than 1 million medical products and services available under approximately 7,500 active VA contracts. Additionally, through the SCMC contract, VA receives cleansed, enriched, and standardized data from the Global Health Exchange (GHX) data enrichment service back to VA using industry-tested algorithms. This data is then utilized for reporting, data mining, and analytics to enhance data-driven decision-making.

2026 Planned Accomplishments

- Acquire and deploy an Asset Management / Facility Management solution.
- Acquire and deploy a computerized maintenance management solution.
- Conduct data migration and integration of modernization efforts.
- Leverage strategic partners (HHS, DoD) to enhance supply performance and resilience.
- Increased MSPV program oversight, expansion of the product list and widespread adoption of product list items.
- Reduced government purchase card expenditures and increased utilization of enterprise procurement vehicles through contract analysis.

Evidence

VA SCMC supports the field in actions relating to the collection, data cleansing, organizing and display of VA contracts available for use in procurement of supplies and services. VA personnel utilize this program to ensure they use the appropriate contracts to maximize and leverage VHA funding. The VHA program offices monitors reports daily for usage, statistics reports, and other reports that provides evidence that contract requirements are being met with alignment to overall VA Supply Chain optimization.

Office of Connected Care – Telehealth Services/Connected Health

Description	2024 Actual	2025 Budget Estimate 1/	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Treatment Modality ($000):							
Home Telehealth	$422,153	$524,103	$447,612	$462,105	$474,187	$14,493	$12,082
Clinic Based Telehealth	$4,714,811	$5,433,997	$5,139,788	$5,432,360	$5,717,100	$292,572	$284,740
Total Treatment	**$5,136,964**	**$5,958,100**	**$5,587,400**	**$5,894,465**	**$6,191,287**	**$307,065**	**$296,822**
Connected Care Program Funding by Function 1/							
Home and Community Based Services	$123,812	N/A	$170,842	$181,552	$185,182	$10,710	$3,630
Clinic Based Services	$27,106	N/A	$43,835	$57,793	$58,949	$13,958	$1,156
Hospital and Emergency Services	$41,899	N/A	$48,836	$55,008	$56,108	$6,172	$1,100
Program Foundations	$138,865	N/A	$158,897	$167,217	$170,561	$8,320	$3,344
Connected Care Program Total	**$331,682**	**N/A**	**$422,410**	**$461,570**	**$470,800**	**$39,160**	**$9,230**
Connected Care Program Funding by account:							
Medical Services	$301,924	$396,945	$385,941	$426,748	$435,282	$40,807	$8,534
Medical Support & Compliance	$29,732	$42,975	$36,469	$34,822	$35,518	($1,647)	$696
Medical Facilities	$26	$0	$0	$0	$0	$0	$0
Connected Care Program Total	**$331,682**	**$439,920**	**$422,410**	**$461,570**	**$470,800**	**($1,647)**	**$696**

1/Amounts in Connected Care Program by Function not previously displayed.

Authority for action

- 38 U.S.C.§1730C. Licensure of health care professionals providing treatment via telemedicine
- P.L. 116-171, Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019
    - Sec. 701. Expanded Telehealth from Department of Veterans Affairs
- P.L. 117-328, Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022
    - Sec. 151. Establishment of Strategic Plan Requirement for Office of Connected Care of Department of Veterans Affairs

Purpose

The Office of Connected Care (OCC) and its Telehealth Services/Connected Health program is charged with delivering high-quality Veteran-centered care to optimize individual and population health, advance health care that is personalized and proactive and enhance the health care experience using virtual modalities of care. The Telehealth program supports sustainment and expansion of synchronous, asynchronous, and remote patient monitoring services in VA hospitals, clinics, and Veteran homes. Initiatives supported by the telehealth program include VA Video Connect which is used to deliver video care in the home, clinical resource hubs which fill clinical gaps in rural and other underserved areas, and the connected tablet program which helps Veterans overcome the digital divide. The Connected Health program supports Veteran engagement in health care by developing, deploying, and supporting the use of digital health tools, such as the My Health***e***Vet (MHV) patient portal, mobile health apps and connected devices and wearables.

2025 Planned Accomplishments

- VA anticipates expanding Veteran access through telehealth by delivering an additional million episodes of telehealth care compared to 2024. VA will also advance initiatives that are expected to enhance Veteran trust and satisfaction with telehealth, prioritizing accessibility features (for example, closed captioning, translation) in VA Video Connect, promoting team-based care procedures in virtual environments, and advancing its Provider Connect pilot to provide real time, provider-to-provider consultation.
- VA will pilot enhanced use of digital applications to engage Veterans in 2025 in advance of 2026 deployment, increasing use of a "self-screener" platform that enables Veterans to asynchronously provide health information for review by their care teams in advance of visits and offering a new Patient Engagement Platform to aggregate mobile services and functions for Veterans in a single location
- VA will launch its new MHV portal on VA.gov which will provide a single place for Veterans to manage their healthcare needs in the same location where they manage their own VA benefits and services. Furthermore, VA will transition to the use of modern login credentials for MHV, increasing the security of Veteran information.
- VA anticipates extending Virtual Health Resource Centers to more than 25 additional facilities and maintaining more than 100,000 connected devices in the hands of Veterans to assist them with access to their VA services.

2026 Budget Request

The Connected Care funding request for 2026 is $461.6 million, $39.2 million (9.3 percent) above the 2025 Current Estimate. This increase supports the refresh and replacement of equipment used in the delivery of virtual care that was deferred from 2025 into 2026 ($17.5 million); the needed investment to drive adoption of the patient portal, mobile devices, and software solutions across the enterprise ($6.0 million); and to advance a single digital front door for Veterans with the launch of its new Patient Engagement Platform ($15.7 million). The remainder of the request supports timely delivery of and access to telehealth services and care; furthers telehealth expansion; provides for the launch of the Telehealth Grant Program; modernizes clinic-based telehealth technology; standardizes the availability of select telehealth services; expands the Provider

Connect initiative; enhances the new MHV on VA.gov patient portal; and continues to build on VHA's success and leadership as a provider of digitally enabled health care.

2026 Planned Accomplishments

- VA anticipates further telehealth expansion as it implements standard processes and national tools that support clinical resource sharing through telehealth and Veteran preferences for care delivery across the organization.
- VA anticipates launching its Telehealth Grant Program which will enable new community partners to host Advancing Telehealth through Local Area Station (ATLAS) sites in rural and underserved communities. Additionally, VA anticipates modernizing its clinic-based telehealth technology, standardizing the availability of select telehealth services for Veterans, and expanding its Provider Connect initiative if previous efforts are successful.
- To further enhance Veterans engagement with their digital health, VA anticipates providing Veterans with a single unified view of their data from both VistA and Oracle Health in the new MHV on VA.gov patient portal, introducing three new functions in the Patient Engagement Platform, and expanding opportunities for Veterans to share their personal health data with their VA teams.

Evidence

Telehealth Utilization and Veteran Participation: Telehealth utilization and Veteran participation will be tracked as measures of program success. Telehealth utilization is measured by telehealth episodes of care while Veteran Participation is measured by the percent of VHA unique Veterans receiving a portion of their care through telehealth. Telehealth utilization and Veterans participation data is made available through the VHA Support Service Center. The data is updated daily and based on information captured in the electronic medical record.

Veterans and Health Care Professional Experience with Telehealth: VA tracks Telehealth experience for both Veterans and VA health care professionals. Telehealth experience data is made available in the Medallia Experience Cloud. The data comes directly from Veterans and Health Care Professionals who complete VSignal Surveys asking about their telehealth experience.

My Health*e*Vet on VA.gov Utilization and Veteran Satisfaction: MHV utilization is measured by the number of unique users visiting the website and the number of activities they perform, such as prescription refills, messaging their care team, and viewing their health record. VA also tracks Veteran Satisfaction with their experience. MHV utilization data is captured primarily via Google Analytics 4 and Datadog, MHV experience data, captured through VSignal Surveys, is made available in the Medallia Experience Cloud.

Patient Engagement Platform: VA is investing in a Patient Engagement Platform to enable Veterans and their Caregivers to be active partners in their personal healthcare, regardless of where they choose to receive care. This will be a key driver in reducing costs, securing an effective usage of resources, and improving patient-provider satisfaction. In general, patient engagement seems to be the most conclusive and furthest developed concept in terms of turning patients into active partners in their personal healthcare (Hickmann et al. BMC Health Services Research (2022) 22:1116 https://doi.org/10.1186/s12913-022-08501-5).

Evaluation of Telehealth: Beginning in 2024, OCC collaborated with the Virtual Care Consortium of Research (CORE) and the Telehealth Effectiveness Coordinating Center (TECC; overseen by VA Palo Alto's Center for Innovation to Implementation and the Virtual Care CORE) to develop a comprehensive, 5-phased evaluation of telehealth effectiveness and patient outcomes into which quality metrics will be incorporated. The TECC's evaluation strategy involves building robust evaluation models that consider the relative effect of "hybrid telehealth" scenarios and consider how the proportion of telehealth in overall care impacts effectiveness and downstream outcomes.

To apply key quality and safety metrics for telehealth and virtual care, OCC/TECC have collaborated with VA clinical program offices and external stakeholders to crosswalk quality and safety metrics routinely used for the assessment of in-person care and determine relevance for use in the virtual care context. Applicable metrics have been incorporated into assessment models in the domains of Health Outcomes, Access and Utilization, Experiences of Care, Quality, and Cost.

The TECC's work will be ongoing and span multiple years, resulting in an evidence portfolio that will inform VA on the safety and efficacy of clinical services delivered virtually and shape future expansion of virtual care services.

Veteran Childcare Assistance Program[1]

		2025		**2026**	**2027**		
Description (dollars in thousands)	2024 Actual	Budget Estimate	Current Estimate	**Revised Request**	**Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations							
Medical Services (0160):	$220	$10,500	$1,675	$11,862	$12,099	$10,187	$237
Medical Support and Compliance (0152):	$759	$8,119	$1,006	$2,294	$2,340	$1,288	$46
Medical Facilities (0162):	$2,671	$0	$0	$7,500	$7,650	$7,500	$150
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$3,650**	**$18,619**	**$2,681**	**$21,656**	**$22,089**	**$18,975**	**$433**

1/ The Veterans Childcare Assistance Program had been previously included the Women's Health Program Office budget.

Authority for action

- 38 USC 1709(c): Authority to aid with child care for certain Veterans receiving health care.

Purpose

The purpose of the Veterans Childcare Assistance Program (VCAP) is to implement the 38 U.S.C. 1709(c), authority on assistance for child care for certain Veterans, which requires each VAMC to provide a method of child care assistance to qualified Veterans no later than January 5, 2026.

2025 Planned Accomplishments

- Transitioned the last remaining VA child care pilot site into an official VA Kids Care site on April 1, 2025.
- Complete IT development of a minimum viable product (MVP) and begin beta testing IT infrastructure for Direct Veterans Reimbursement at the end of 2025. OIT received the Authority to Operate (ATO), which authorizes the integration of the new VCAP system with the existing VA IT system.
- Launch VCAP educational awareness campaign for internal and external audiences.
- Distribute an additional $250,000 to American Lake, Fresno, San Francisco, Chillicothe, and Shreveport for their respective child care service contracts.
- Continue to work with 37 VA Health Care Systems on their respective VA Kids Care projects and fund local program managers based on identified need.

2026 Budget Request

In 2026, VA requests $21.7 million for VCAP, an increase of $19.0 million over the 2025 Current Estimate. The request consists of the following components:

Contracted Child Care Services: $4.1 million to support 13 VA medical facilities opening their respective VA Kids Care sites. This estimate is based on the $250,000 child care service contract cost per site, plus an additional amount to account for market variance.

Facilities/Renovation: $7.5 million in NRM funding to support renovations at 10 existing facilities. The renovation costs are estimated at $750,000 per facility. Each site will require between 500 to 1,000 square feet and may face challenges such as lead paint or asbestos abatement that could lead to increased costs. These renovated facilities are expected to begin child care services contracts in 2027, following the completion of construction work in 2026. Additionally, the request includes $1 million to support activation of VA Kids Care sites.

DVR: The request includes $6.8 million to support DVR. Eligible Veterans will be reimbursed for expenses they incur for child care services obtained from a licensed child care provider in the community during the time of their eligible VA medical appointment through DVR. This model of child care support will be implemented and standardized across all VA medical facilities. The functionality of DVR requires the development of dedicated IT infrastructure. DVR will be strategically rolled out and is projected to disburse $250,000 in the first year (2025) and $6.8 million in 2026. Total DVR expenditures may fluctuate and will be dependent on the availability of drop-in child care services in the community, the ability of Veterans to pay for those expenses up front, and the final approval of regulations to authorize the deployment of DVR.

Staffing Support: The remainder of the request supports the staff at the national program office, as well as field-based FTE to assist in the planning, activation, and oversight of the VA Kids Care centers.

2026 Planned Accomplishments

- Activate and open to five additional VA Kids Care centers.
- Meet the legislative deadline with national implementation of Direct Veterans Reimbursement.
- Evaluate the performance of initial VA Kids Care centers.
- Audit the reimbursement and performance measures for VCAP parameters.

Evidence

- Between February 2022 and February 2023, the Veterans Experience Office (VEO) conducted a comprehensive VSignals survey, gathering responses from over 350,000 Veterans specific to their childcare needs.
- In addition, the VA's Quality Enhancement Research Initiative (QUERI) carried out a targeted survey focusing on 2,000 Veterans with dependent children. QUERI's efforts also included qualitative interviews with focus groups and individual Veterans as well as VA health care providers. Recent QUERI interviews led to the published paper titled, "Provider Perspectives on the Need for Child Care," which outlines the need for childcare support during clinical care appointments while simultaneously outlining the negative impact that a child's presence can have on the overall quality of healthcare delivery – further supporting the need for VCAP's enterprise-wide enactment.
- VCAP continues to collaborate closely with VEO and QUERI, utilizing both quantitative and qualitative data, supported by expert analysis.
- Data sources for this evidence include the VA's data warehouse, surveys, and interviews. All research will be conducted by experts independent of the VCAP team.
- The collected data from the VEO survey and QUERI's targeted research supports the demand for child care assistance by demonstrating the utilization of services, measuring impacts on VA facility metrics, and assessing health outcomes. The data reveal how VA-sponsored child care services reduce appointment no-shows and cancellations, increase patient engagement, and improve healthcare outcomes by removing barriers. The surveys and interviews with Veterans and health care providers provide both quantitative and qualitative evidence, showing that child care assistance enhances the patient experience and overall effectiveness of care.

Veterans Homelessness Programs

Description (Dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Appropriation	+/- 2025-2026	+/- 2026-2027
Homeless Veterans Treatment Costs	**$11,461,822**	**$12,007,323**	**$13,057,857**	**$15,068,489**	**$17,655,482**	$2,010,632	$2,586,993
Programs to Assist Homeless Veterans							
Permanent Housing Supportive Services							
HUD-VASH Case Management:							
HUD-VASH Case Management Base (I)	*$606,053*	*$661,535*	*$661,535*	*$702,821*	*$740,000*	$41,286	$37,179
HUD-VASH Case Management [Subtotal]:	**$606,053**	**$661,535**	**$661,535**	**$702,821**	**$740,000**	**$41,286**	**$37,179**
HUD-VASH (S)	$521,526	$445,181	$538,736	$560,286	$582,137	$21,549	$21,851
Perm. Housing Supp. Services [Subtotal]	**$1,127,579**	**$1,106,716**	**$1,200,271**	**$1,263,107**	**$1,322,137**	**$62,835**	**$59,030**
Transitional Housing							
Grant & Per Diem:							
Grant & Per Diem Base (I)	*$219,718*	*$276,841*	*$276,841*	*$276,841*	*$276,841*	$0	$0
Grant & Per Diem [Subtotal]:	**$219,718**	**$276,841**	**$276,841**	**$276,841**	**$276,841**	**$0**	**$0**
Grant & Per Diem Liaisons (I)	$43,364	$42,947	$42,947	$46,264	$48,900	$3,317	$2,636
Other (S)	$17,654	$25,838	$18,237	$18,966	$19,706	$729	$740
Health Care for Homeless Vets:							
Health Care for Homeless Base (I)	*$247,731*	*$283,150*	*$283,150*	*$309,500*	*$337,355*	$26,350	$27,855
Health Care for Homeless Vets [Subtotal]:	**$247,731**	**$283,150**	**$283,150**	**$309,500**	**$337,355**	**$26,350**	**$27,855**
Transitional Housing [Subtotal]	**$528,467**	**$628,776**	**$621,175**	**$651,571**	**$682,802**	**$30,396**	**$31,231**
Prevention Services							
Supportive Svcs Low Income Vets & Families:							
Supportive Svcs Low Income Vets & Families Base (I)	*$799,744*	*$659,049*	*$659,049*	*$659,049*	*$855,000*	$0	$195,951
Supportive Svcs Low Income Vet & Families	**$799,744**	**$659,049**	**$659,049**	**$659,049**	**$855,000**	**$0**	**$195,951**
National Call Center for Homeless Veterans (I)	$10,320	$12,920	$12,111	$12,111	$12,111	$0	$0
Justice Outreach Homeless Prevention Base (I)	$68,945	$74,787	$74,787	$81,787	$99,400	$7,000	$17,613
Legal Services for Veterans (I)	$27,842	$48,056	$48,056	$58,056	$67,800	$10,000	$9,744
Justice Outreach Homeless Prevention (S)	$31,533	$29,950	$32,574	$33,877	$35,198	$1,303	$1,321
Prevention Services [Subtotal]	**$938,384**	**$824,762**	**$826,577**	**$844,880**	**$1,069,509**	**$18,303**	**$224,629**
Treatment							
Domiciliary Care for Homeless Vets (S)	$244,644	$259,321	$252,717	$262,826	$273,076	$10,109	$10,250
Homeless Patient Aligned Care Teams (I)	$11,956	$21,000	$21,000	$21,819	$22,278	$819	$459
Telephone Homeless Chronically Mental Ill (S)	$109,489	$88,646	$113,102	$117,626	$122,214	$4,524	$4,587
Treatment [Subtotal]	**$366,089**	**$368,967**	**$386,819**	**$402,271**	**$417,568**	**$15,452**	**$15,297**
Employment/Job Training							
Homeless Veterans Community Employment Prg (I)	$20,165	$21,772	$21,772	$22,353	$23,000	$581	$647
Homeless. Ther. Empl., CWT & CWT/TR (S)	$224,291	$231,857	$231,693	$240,960	$250,358	$9,268	$9,397
Employment/Job Training [Subtotal]	**$244,456**	**$253,629**	**$253,465**	**$263,313**	**$273,358**	**$9,849**	**$10,044**
Administrative							
Supportive Svces Low Income Vets & Families Adm	$12,459	$11,476	$11,476	$11,924	$13,694	$448	$1,770
CORE Program Office 1/	$4,953	N/A	$5,605	$5,605	$5,605	$0	$0
National Homeless Registry	$2,596	$6,352	$6,352	$6,852	$7,052	$500	$200
National Center on Homelessness among Veterans	$5,991	$9,598	$9,598	$9,598	$10,000	$0	$402
Administrative [Subtotal]	**$25,999**	**$27,426**	**$33,031**	**$33,979**	**$36,351**	**$948**	**$2,372**
Obligations [Total]	**$3,230,974**	**$3,210,276**	**$3,321,338**	**$3,459,121**	**$3,801,724**	**$137,783**	**$342,603**
Breakout by Specific & General Purpose							
(I) Initiative Specific Purpose	$2,081,837	$2,129,483	$2,134,279	$2,224,580	$2,519,036	$90,301	$294,456
(S) Sustainment General Purpose	$1,149,137	$1,080,793	$1,187,059	$1,234,541	$1,282,688	$47,482	$48,147
Obligations [Total]	**$3,230,974**	**$3,210,276**	**$3,321,338**	**$3,459,121**	**$3,801,724**	$137,783	$342,603

Authority for Action: 38 U.S.C. Chapter 20, Benefits for Homeless Veterans

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)

Authority for action

- 38 U.S.C. Chapter 17
- 38 U.S.C §2003(b): VHA Case Managers
- 38 U.S.C §2069: Access to telehealth services
- 42 U.S.C. §1437f(o)(19)(D): Rental vouchers for Veterans Affairs supported housing program
- Consolidated Appropriations Act, 2024, Division A, H. Comm. Print 56-550, Book 1, pg. 68: Homeless Assistance Programs
- P.L. 116-315, Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, Sec. 4207: Contracts relating to Case Managers for homeless Veterans in supported housing program
- P.L. 118-210, Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act

Purpose

HUD-VASH assists Veterans experiencing homelessness and their families in securing permanent housing and maintaining that housing over time. HUD-VASH connects Veterans to care within the VA and/or community and provides case management to assist Veteran meet their treatment plan goals toward independence. HUD-VASH programs predominantly help Veterans move into rental apartments with long-term subsidies that make rent affordable, which directly ends a Veteran's episode of homelessness. HUD-VASH also provides the treatment support including health care, mental health treatment, substance use counseling, and case management supports needed to remain housed. It combines HUD's Housing Choice Voucher rental assistance with VA case management and supportive services. This unique partnership provides Veterans with access to essential healthcare, mental health treatment, and other support services necessary to improve the quality of life for vulnerable Veterans and help them maintain long-term housing stability.

2025 Planned Accomplishments

- Place 46,000 unique individuals in permanent housing by September 30, 2025 (VA Agency Priority Goal).
- Design and development of expanded services for aging and disabled Veterans, a growing need and area of focus for the HUD-VASH program, which will include expanding access to telehealth through implementation of P.L. 118-210, Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, Sec. 404.
- Support the transition of Veterans from HUD-VASH case management to independence. Transitioning stable Veterans from HUD-VASH case management will strengthen the system by freeing up capacity for Veterans with higher case management needs, making the system work more effectively and efficiently.
- Continue to enhance integration between HUD-VASH and Supportive Services for Veteran Families programs to increase voucher use and accelerate housing placements through intentional collaborative strategies to bolster housing search and placement efforts, decrease barriers and increasing access to care.
- HUD-VASH will support surge efforts at every medical center which has a goal of supporting at least 20,000 Veterans living on the street, in their cars, or in encampments enter permanent or transitional housing.

2026 Budget Request

The 2026 budget request is $702.8 million for HUD-VASH, an increase of $41.3 million (6.2%) above the 2025 Current Estimate. VA is required by statute to ensure that the number of case managers is sufficient to assure that every Veteran in receipt of a HUD-VASH voucher "is assigned to, and seen as needed by, a case manager" (38 U.S. Code § 2003(b)). Further, Joint Explanatory Statement accompanying the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2024 directed VA to increase funding for case managers commensurate with increases in HUD's budget for new HUD-VASH vouchers. Through Notice PIH 2024-18, HUD made $78.0 million in funding available to support up to 7,800 new HUD-VASH vouchers in 2025. Of these, approximately 3,500 were awarded to communities across the nation.

The 2026 budget will maintain funding for the current FTE and contract staff who provide case management and supportive services to Veterans receiving HUD-VASH subsidies. Currently, HUD-VASH funds over 4,600 VA FTE, along with approximately $70 million in contract services. This request includes funding for additional case management and supportive services for the 3,500 new vouchers awarded in 2025.

2026 Planned Accomplishments

HPO will increase prioritization strategies by SSVF and HUD-VASH as they partner to ensure each Veteran has the right level of resources to exit homelessness. This strategy will allow Veterans to increase independence, thus prioritizing the most intensive resources for the most vulnerable Veterans.

- Improve outcomes for vulnerable Veterans, including aging and disabled Veterans and rural including those living in tribal communities. HUD-VASH will support staff and

services to accommodate the award of new HUD-VASH vouchers in 2024 and 2025.

- Support initiatives designed to increase access to care through telehealth to support the implementation of section 404 of the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act.
- Ensure best-in-class care and adhere to the case management staffing requirements outlined in P.L. 116-315, Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, Sec. 4207.

Evidence

Between 2008 and 2017, researchers estimate that the number of permanent supportive housing units per 100,000 people increased by 45%, and the data suggest that up to 60% of this increase can be attributed to HUD-VASH vouchers (Evans, et al. 2019). Data modeling indicate each additional voucher decreased the number of homeless Veterans by one and was especially effective for unsheltered Veterans, as 55% of the program's reduction in homelessness came from those who were unsheltered. These data strongly support the effectiveness of the HUD-VASH program. Additionally, research has demonstrated that the population of individuals over age 65 experiencing homelessness will double or even triple 2017 levels in some locations before peaking around 2030 (Culhane, et al. 2019). Congruently, more than 60% of Veterans served in HUD-VASH are over 60 years old, requiring a growing focus on identifying and appropriately responding to the needs of these Veterans within the program.

Citations:

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- Culhane, D., Doran, K., Schretzman, M., Johns, E., Treglia, D., Byrne, T., … Kuhn, R. (2019). The Emerging Crisis of Aged Homelessness in the US: Could Cost Avoidance in Health Care Fund Housing Solutions? International Journal of Population Data Science, 4(3). https://doi.org/10.23889/ijpds.v4i3.1185

Grant & Per Diem (GPD)

Authority for action

- 38 U.S. Code (U.S.C.) Chapter 17
- 38 U.S.C §2011 – Grants
- 38 U.S.C §2012 – Per Diem payments
- 38 U.S.C §2013 – Program to improve retention of housing by formerly homeless Veterans and Veterans at risk of becoming homeless
- 38 U.S.C §2061 – Grant program for homeless Veterans with special needs.

- P.L. 118-210, Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act

Purpose

The purpose of the GPD Program is to promote the development and provision of interim housing and supportive services to help homeless Veterans achieve residential stability, enhance their skill levels to improve their income, and attain greater self-determination. GPD grants offer an efficient and cost-effective approach to addressing the urgent housing needs of Veterans experiencing homelessness through time-limited housing assistance combined with comprehensive supportive services aimed at facilitating their transition to permanent housing.

Interim housing programs provide a safe environment for Veterans who cannot transition directly into permanent housing. These programs are crucial as communities across the nation address the public health and safety concerns associated with unsheltered homelessness. VA's interim housing infrastructure plays a pivotal role in providing low-barrier housing with grantees offering timely same-day access to safe housing coupled with supportive services.

Currently, the GPD program supports over 10,000 transitional housing beds for Veterans nationwide. These grants enable community-based organizations to receive per diem payments from the VA to offset the operational costs associated with serving these Veterans. The per diem rates are statutorily linked to the per diem rates for State Homes providing domiciliary care and may be adjusted annually to account for inflation. Additionally, GPD Case Management grantees facilitate housing navigation and support efforts to ensure long-term housing stability for formerly homeless Veterans who have transitioned to permanent housing.

2025 Planned Accomplishments

- GPD will bolster unsheltered surge efforts nationwide at every medical center, with a goal of helping at least 20,000 Veterans living on the street, in their cars, or in encampments to enter permanent or transitional housing.
- Maximize opportunities for GPD transitional housing providers to successfully assist Veterans in securing permanent housing, aiming for more than 65% of Veterans transitioning to permanent housing.
- Facilitate access to grant resources supporting Veterans experiencing homelessness, including approximately 10,500 transitional housing beds, 11 independent service centers, and 100 dedicated case managers.

2026 Budget Request

The 2026 budget request for GPD program is $323.1 million, which represent a $3.3 million (or 1.0 %) increase over the 2025 Current Estimate. This increase will ensure continued support for more than 10,000 transitional housing beds and approximately 11 independent service centers that are expected to remain operational in 2026. Approximately $276.8 million will support about 400 grants nationwide. This funding will ensure the continuation of Case Management, Per Diem Only, and Transition in Place grants. The per diem rates are statutorily tied to the State Home domiciliary care rate and are subject to annual increases as funding permits. The requested funds also include

provisions for essential fiscal and programmatic oversight, such as a service-level agreement for fiscal oversight and monitoring, and the development of a modernized grants management system. Further, funds will be used to implement P.L. 118-210, Senator Elizabeth Dole Act.21st Century Veterans Healthcare and Benefits Improvement Act, § 402.

The 2026 budget includes $46.3 million, an increase of $3.3 million, to sustain current levels of about 290 GPD liaison positions, located at VAMCs nationwide, which provide local oversight and monitoring of these grants. These staff members are responsible for the oversight, monitoring, and ensuring compliance of all active GPD grants, as well as providing direct engagement with Veteran participants.

The 2026 budget request also includes $5.4 million to support fiscal oversight, a grants management system, and program office staff.

2026 Planned Accomplishments

- Continue supporting more than 10,000 transitional housing beds, 11 independent service centers, and 100 case managers expected to remain operational in 2026.
- Implement P.L. 118-210, Senator Elizabeth Dole Act.21st Century Veterans Healthcare and Benefits Improvement Act, Sec. 402, ensuring grantees have access to sufficient resources to provide high-quality housing and supportive services for Veterans as they transition to permanent housing.
- Provide support to approximately 400 grants nationwide, including the continuation of Case Management, Per Diem Only, and Transition in Place grants, as well as approximately 290 GPD liaison positions.

Evidence

The GPD program has effectively served as a resource for communities to assist 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 vulnerable Veterans nationwide. GPD-funded projects offer communities a structured approach to provide time-limited housing and services tailored to homeless Veterans. Research has demonstrated that GPD programs are effective in helping a diverse range of homeless Veterans achieve housing stability (Tsai, Rosenheck, and McGuire, 2012; Schinka, et al., 2011).

The impact of the GPD program in 2024 is highlighted by several key accomplishments, including but not limited to the following:

- VA's largest transitional housing program with over 10,500 beds authorized nationwide.
- More than 19,700 Veterans entered GPD transitional housing, a rise of 1,230 Veterans from 2023.
- Over 10,500 homeless Veterans exited GPD transitional housing to permanent housing.
- Nearly 25,000 homeless Veterans were served by GPD transitional housing grants.
- The average length of stay in a GPD transitional housing facility was 152 days.

The following GPD grant types were active in 2024:

- Per Diem Only grants: 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. Over 300 grants were awarded to organizations to provide over 10,500 beds and 12 service centers.
- Transition in Place grants: Provides 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. Over 30 grants to organizations were awarded to provide approximately 590 beds.
- Case Management grants: Supports case manager positions within community organizations. These positions provide services to help Veterans retain housing stability, adequate income support, and self-sufficiency. Funding supports approximately 90 grants to organizations to support over 100 case managers.
- Special Need: VA provides funding to approximately 15 organizations to help Veterans with special needs who are experiencing homelessness, including women, individuals with chronic mental illnesses, and elderly Veterans. Funding supports over 100 beds for these Veteran populations.

Citation:

- Tsai J, Rosenheck RA, McGuire JF. Comparison of outcomes of homeless female and male Veterans in transitional housing. Community Ment Health J. 2012 Dec;48(6):705-10. doi: 10.1007/s10597-012-9482-5. PMID: 22294507.
- Schinka, J. A., Casey, R. J., Kasprow, W., & Rosenheck, R. A. (2011). Requiring Sobriety at Program Entry: Impact on Outcomes in Supported Transitional Housing for Homeless Veterans. Psychiatric Services, 62(11), 1325–1330.

Health Care for Homeless Veterans (HCHV)

Authority for action

- 38 U.S.C. § 2031: General treatment
- 38 U.S.C. § 2033: Additional services at certain locations
- 38 CFR Part 63.3
- P.L. 117-328, Division U, Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022, Sec. 311
- P.L. 118-210, Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act

Purpose

The purpose of HCHV is to effectively provide outreach services to the most vulnerable Veterans in the nation and serve as a valuable resource for communities in assisting homeless Veterans to transition out of homelessness. HCHV outreach teams continue to serve as VA's front door to homeless services. These teams meet Veterans literally where they are at, routinely engaging unsheltered Veterans and connecting them to immediate care and housing. They are comprised of social workers, peer specialists, and clinicians and are essential for conducting on-the-spot assessments and reducing barriers to access. Since its authorization in 1987, the HCHV program has been dedicated to reducing homelessness among Veterans by actively engaging and connecting them with essential healthcare and other necessary services. HCHV interim housing in the form of Contract Residential Services (CRS) programs. Interim housing programs provide immediate safe shelter to Veterans who cannot transition directly into permanent housing. As communities nationwide respond to the public health and safety concerns of unsheltered homelessness and encampment closures, VA's interim housing infrastructure is critical to providing low-barrier, dignified alternatives. HCHV CRS interim housing programs are specifically designed to ensure that homeless Veterans, particularly those who are chronically homeless and may have serious mental health diagnoses and/or substance use disorders, can access the necessary support from both the VA and community partners. The aim is to provide quality housing and services that cater to the unique needs of these special populations.

Planned Accomplishments

Goals for 2025 include four main initiatives and projects:

- HCHV outreach staff and CRS liaisons that will provide oversight to more than 3600 HCHV CRS beds (including newly established medical respite beds), which offer residential treatment for Veterans experiencing homelessness.
- Coordinated Entry Specialists, who work with local Continuums of Care to identify and coordinate services for homeless Veterans in their communities.
- Stand Down support for VAMCs, with over 105 Stand Downs through March 2025 serving approximately 19,000 Veterans.
- Providing support to National Surge events across each VA Medical Center.
- 33 Community Resource and Referral Centers (CRRCs), which are a collaborative effort of VA, the community, service providers and agency partners that provide an open door, one-stop hub for homeless Veterans, providing a central location to engage homeless Veterans in VA and community.

2026 Budget Request

The 2026 budget requests $309.5 million for HCHV, which represents an increase of $26.4 million (9.3%) above the 2025 Current Estimate. This budget reflects the commitment to staffing, transitional treatment beds, event support, and the development of new shelter-like services. By investing in these areas, the goal is to ensure the provision of comprehensive care, outreach, and resources to homeless Veterans, ultimately working towards the objective of ending Veteran homelessness. The budget supports the following:

- Nearly $310 million to support HCHV outreach staff, Coordinated Entry Specialists, and CRS liaisons, who play a crucial role in providing outreach services and coordinating care for homeless Veterans. This budget supports over 900 HCHV and CRRC staff, to include support for:
- More than 3,766 HCHV CRS beds, including 19 newly established medical respite beds. These beds offer residential treatment and temporary housing assistance for Veterans experiencing homelessness. 2026 contracts are projected to have a 12.5% growth rate over 2025 requirements.
- 33 CRRCs, which serve as central locations for homeless Veterans to access VA and community services. These centers are a collaborative effort involving VA, community organizations, service providers, and agency partners.
- Stand Down events for VAMCs, which offer essential services and resources to homeless Veterans.
- Implementation of new Rideshare and Goods and Services programming in support of homeless Veterans authorized under P.L. 118-210, Sec. 403.
- The budget request will also support HCHV and CRRC Program Office and operating costs, including support for regular site-specific reviews of HCHV contract compliance for clinical and fiscal oversight needs, program office staff, and implementation of a pilot program for new grants specifically for Veterans with substance use disorders mandated by P.L. 117-328, § 311.

2026 Planned Accomplishments

- Provide essential outreach services to Veterans facing literal street homelessness, Coordinated Entry specialist who work with local Continuums of Care to identify and coordinate services, 33 CRRCs, which collaborate with VA and community partners to identify, engage, and provide services with the lowest barriers possible to enhance access for Veterans experiencing or at risk of homelessness, and Stand Downs, which serve as an effective outreach strategy.
- Maintain accountability and measure program effectiveness, performance standards are established for all HCHV CRS programs. These standards serve as benchmarks to track progress and outcomes.
- Implementation of key legislation aimed at increasing access to care for vulnerable Veterans including P.L. 118-210, Sec. 403 that provides lifesaving goods and services to homeless Veterans and P.L. 117-328, Sec. 311 that requires the development of a grant program to identify and provide treatment to Veterans that are homeless and/or have a history of homelessness with active substance use disorder diagnoses.

Evidence

The Point-in-Time (PIT) Count is an annual effort to estimate the number of Americans, including Veterans, without permanent housing on a single night in January. The PIT Count is administered by HUD and carried out by nearly 400 Continuum of Care organizations. Nationally, the total number of Veterans who experienced homelessness on a single night in January 2023 was 35,573 – an increase of 2,444 Veterans, or 7.4%, over January 2022. Breaking this down further, 20,105 Veterans experienced sheltered homelessness, a rise of 540 Veterans (2.8%), and 15,468 Veterans experienced unsheltered homelessness, an increase of 1,904 Veterans (14.0%). Unsheltered Veterans represented 77.9% of the overall increase, demonstrating an increased demand for services for this population. HCHV projects an increase in the number of Veterans needing outreach services in the coming years to be approximately 29,000 in 2025 and 31,000 in 2026 based on average unique Veterans engaged per year since 2021 through Q2 of 2024. This highlights the program's recognition of the ongoing need for its services and its commitment to meeting the growing demand.

Supportive Services for Low Income Veterans & Families (SSVF)

Authority for action

- 38 U.S. Code (U.S.C.) Chapter 17
- 38 U.S.C. §2044: Financial assistance for supportive services for very low-income Veteran families in permanent housing
- 38 U.S.C. §2069: Access to telehealth services
- 38 CFR part 62: Supportive Services for Veteran Families Program

Purpose

The Supportive Services for Veterans Families (SSVF) program is a critical program designed to help reach the goal of ending homelessness among Veterans and Veteran families. 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. Rapid re-housing services connect homeless Veterans to permanent housing—predominantly rental apartments with short-term subsidies that make rent affordable, which directly ends a Veteran's episode of homelessness—as quickly as possible and are a vital component of VA's homeless system. In addition, SSVF prevention services are also a critical component of VA's overall homeless system because they prevent Veterans from becoming homeless in the first place and provide immediate interventions to preserve housing stability. Funds are granted to private non-profit organizations and consumer cooperatives that will assist very low-income Veteran families by providing a range of outreach, supportive services, and temporary financial assistance designed to promote housing stability.

In 2024, SSVF served over 90,000 Veterans and over 140,000 people. Through health care navigation services, SSVF outreaches to Veterans and Veteran families to assist them with accessing VA and non-VA care including telehealth which increases their ability to sustain

permanent housing. SSVF grantees are also skilled in serving in rural areas and have deep knowledge of local and state resources. In 2025, SSVF has 239 grants that provide services to all 50 states, District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands.

2025 Planned Accomplishments

- Place 76,000 unique individuals in permanent housing by September 30, 2025 (VA Agency Priority Goal).
- Sustain shallow subsidies, which provide up to two years of continuous rental assistance for Veteran families who do not need intensive clinical supports provided by HUD-VASH but are struggling to meet growing housing cost burdens and are working toward self-sufficiency.
- Upgrade health care supports, such as the health care navigators, offered by all SSVF grantees, to help homeless and at-risk Veteran families access critically needed health and mental health resources including access to telehealth services to support the implementation P.L. 118-210, Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, section 404 and improve access to health care services.
- Further enhance integration between HUD-VASH and SSVF to increase voucher use and accelerate permanent housing placements through intentional collaborative strategies to bolster housing search and placement efforts, decrease barriers, and increase access to care.

2026 Budget Request

The 2026 budget request is $670.9 million for the SSVF program, an increase of $448,000 (0.1%) above the 2025 Current Estimate. The budget request reflects the ongoing commitment to provide sustainment of essential services while continuing to support permanent housing placements and reduce the number of Veterans and Veteran families becoming homeless. The majority of the SSVF budget request ($659.0 million) will be awarded in grants to non-profit organizations and consumer cooperatives, including a focus on rural communities. The remainder of the budget request (almost $12.0 million) provides support at the National SSVF Program Office level including for staff, contract services, and other expenses that are essential to program implementation, including grantee and community technical assistance, implementation of oversight fiscal audits and an automated grants management system, Homeless Management Information System (HMIS) and data integration, validation, and education. The SSVF services supported by the 2026 SSVF budget aim to address outreach, supportive services, and housing for Veterans and Veteran families as well as enhance access to critical health care and telehealth resources for Veterans and Veteran families in need.

2026 Planned Accomplishments

- Services supported by the 2026 SSVF budget aim to address outreach and housing for Veterans and Veteran families in need including additional emphasis on rural communities and homelessness prevention.
- Increase access to services and health care through increased outreach to vulnerable Veterans and Veteran families and the provision of telehealth to support implementation

of P.L. 118-210, Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, section 404.

- Sustain over 200 grants for community partners to provide outreach and supportive services to very low-income Veteran families that are currently in or transitioning to permanent housing, rapidly re-house homeless Veteran families and prevent homelessness for those at imminent risk due to a housing crisis.
- Increase prioritization strategies by SSVF and HUD-VASH as they partner to ensure each Veteran has the right level of resources to exit homelessness. This strategy will allow Veterans to increase independence, thus prioritizing the most intensive resources for the most vulnerable Veterans.

Evidence

SSVF's success has significantly contributed to decreasing the number of Veterans and Veteran families experiencing homelessness since 2011. Annual reports published since the inception of the SSVF program continue to demonstrate the efficiency and effectiveness of the SSVF program (reports and additional research is available at https://www.va.gov/homeless/ssvf/research-library). For example, research conducted by the National Center on Homelessness Among Veterans found that for those Veterans exiting SSVF and placed in permanent housing, only 6% to 13% of families and 7% to 15% of individuals re-enter the homeless system one year after discharge from SSVF (Research Library n.d.). As a point of comparison, these return rates were comparable to the 7% to 10% of Veterans in poverty who are estimated to experience homelessness on an annual basis, according to the best available data from 2012 through 2019. This is a particularly important finding as it is well-established that those who have previously been homeless are at higher risk of future homelessness. SSVF's ability to maintain these strong outcomes depends on recourses to support its grantees for effective program implementation coupled with a robust oversight program.

Furthermore, housing affordability remains a crisis. According to the National Low Income Housing Coalition's The Gap report for 2022, only 36 rental homes are affordable and available for every 100 extremely low-income renter households in the U.S (The National Low Income Housing Coalition, 2022). Although the national pandemic crisis has ended, HUD's 2023 Worst Case Housing Needs Executive Summary to Congress states that housing needs have risen across demographic groups, household types, and regions across the U.S. Needs have continued to expand while affordable housing has declined.

These trends evidence the increase demand in services. Furthermore, the rise in Veteran homelessness would have been worse if not for the significant actions taken and this will entail the need to continue to enhance upstream prevention and rapid rehousing efforts in 2026. Program outcomes include an increased performance of placing Veterans into permanent housing and service to Veterans and their families.

National Call Center for Homeless Veterans (NCCHV)

Authority for action

- 38 U.S.C. 2031: General treatment
- 38 U.S.C. 7301: Functions of the Veterans Health Administration: in general

Purpose

The National Call Center for Homeless Veterans (NCCHV) was established in March 2010 to provide accessible, no-cost support to Veterans experiencing homelessness and those at risk of homelessness. It functions as a crucial entry point to homeless services for hundreds of thousands of Veterans annually and serves VA's primary resource for assistance outside of traditional business hours. NCCHV aims to enhance homeless support services by improving operational efficiency and integrating advanced technological solutions. By expanding communication channels and leveraging the latest technologies, NCCHV seeks to strengthen the transition from active duty to civilian life, allowing leadership and responders to more effectively identify, understand, and address Veteran needs, while proactively implementing improvements for future interactions.

2025 Planned Accomplishments

- In preparation for the 2026 implementation of the Genesys communication platform, NCCHV is actively engaging in technical assessment, defining business requirements, and coordinating access and training logistics. NCCHV is collaborating closely with the Office of Information & Technology (OIT) partners to ensure system readiness, data security, and smooth integration with existing VA systems. NCCHV currently manages an average of 540 calls and 75 chat interactions daily. The new platform will enable Team Members to handle multiple chat sessions concurrently, thereby enhancing service capacity through technological improvements without the need for additional staffing resources. These enhancements will facilitate more effective engagement with younger, tech-savvy Veterans who prefer digital communication channels, while maintaining efficient traditional phone services. This integrated approach ensures all Veterans can access support in a convenient, efficient, and aligned manner with their preferred communication methods.
- Enhancing automation and optimizing the Interactive Voice Response (IVR) system are essential components in advancing NCCHV's dedication to delivering a Veteran-centered service experience. By refining call flows and increasing first-call resolution rates, these improvements enable Veterans to access information and support more efficiently and effectively. Improved IVR automation facilitates quicker routing to appropriate resources, reduces obstacles, and offers a more intuitive, user-friendly interface for callers.
- In 2025, NCCHV expanded outreach efforts by participating in four Veteran-focused events. These engagements provided valuable opportunities to enhance awareness of available services, fostered collaboration with partner organizations, and connected Veterans directly with resources and programs. Throughout these events, NCCHV engaged with approximately 30 to 50 internal and external stakeholders and served between 75 to 150 Veterans at each event, facilitating impactful interactions and widespread dissemination of essential information.

- Successfully meeting or exceeding the established Service Level target of 85% or higher, maintaining a Quality standard of 98% or above, and achieving a Customer Satisfaction rating of at least 80%.

2026 Budget Request

The 2026 Budget request for the NCCHV is $12.1 million, equal to the 2025 current estimate budget levels. The 2026 Budget will support approximately 120 FTE, which are critical for maintaining established service level benchmarks and delivering future state enhancements designed to expand communication modalities for Veterans to access NCCHV and subsequent VA Homeless Programs services.

Investing in the NCCHV offers significant value by directly supporting Veterans who are experiencing or at risk of homelessness. It connects them to essential services, thereby improving health outcomes for this vulnerable population. NCCHV plays a key role in responding to Veterans' needs at the front line and provides critical resources to one of the VA's most vulnerable groups. This approach also contributes to reducing long-term costs through preventive measures, while enhancing public safety and community well-being. Furthermore, it advances the VA Secretary's mission to reduce Veteran homelessness and facilitates successful reintegration into society.

2026 Planned Accomplishments

- Continue collaboration with VHA's HPO to optimize the process for Veterans contacting the facility regarding escalated or unresolved issues. Upon identifying repeat or dissatisfied callers from NCCHV, who meet these criteria, NCCHV will forward the Veteran's details and the local facility's Homeless Program concerns to the Health Resource Center (HRC) Veteran Experience team for appropriate follow-up, to include submitting a PATS-R service recovery request to facilitate resolution of the escalation.
- NCCHV plans to deploy the Genesys text communication platform in 2026 to facilitate accessible and convenient engagement opportunities for Veterans seeking resources and support services. Considering a 23% rise in chat interactions over the past two years and the prevalent use of mobile devices among Veterans experiencing homelessness, the need for robust digital communication channels is increasingly evident. Research demonstrates text messaging improves patient engagement, minimizes missed care opportunities, and contributes to better health outcomes. Integrating text messaging capabilities will enhance NCCHV outreach efforts, optimize call volume management, and connect Veterans through their preferred communication method.
- NCCHV is committed to supporting DoD and VHA during the transition of care process by strengthening outbound outreach efforts. This initiative focuses on engaging Service Members identified through predictive analytics who may have an increased risk for homelessness, unemployment, or suicidal behaviors. Upon implementation, this program aims to proactively connect with these individuals within the first 12 months following separation from the military to provide early intervention, critical resources access, and risk mitigation strategies that may prevent potential crises. To prepare for this effort, NCCHV plans to collaborate closely with HPO to improve and maintain a comprehensive knowledge management system and resource guide, ensuring staff have access to current

and relevant information. This proactive approach underscores NCCHV's dedication to delivering timely, Veteran-centered support from the outset of the program.

- Strive to meet or exceed the Service Level goal of 85%, achieve a Quality standard goal of 98% or higher, and attain a Customer Satisfaction rating of 80% or higher.

Evidence

From October 2023 through May 2025, NCCHV's Service Level performance improved from 97% to 99%, with quality scores increasing from 97% to over 98%. These metrics reflect NCCHV leadership's dedication to leveraging innovative technologies and ensuring effective communication channels for Veterans remain fully operational. Text messaging is one of three primary modalities utilized by VCL to connect high-risk Veterans with VA representatives who can assist with their needs. Transitioning to advanced phone and chat technologies is essential for NCCHV's continued growth and effectiveness. Having Team Members skilled in program requirements, system issues, and acting as liaisons between NCCHV and OIT leadership is vital to maintaining seamless operations within the call center.

For the first time in 2023, NCCHV Team Members collaborated proactively with other VA and DoD entities to identify and reach out to at-risk Veterans potentially facing homelessness. Establishing a senior-level leadership position within the call center will ensure NCCHV continues to proactively engage with senior leadership across HPO and with other stakeholders. This strategic role would also enable subordinate managers to prioritize daily operational management, thereby supporting the ongoing success and sustainability of the call center.

Veterans Justice Outreach Homeless Prevention (VJO)

Authority for action

- 38 U.S.C. §2022: Coordination of outreach services for Veterans at risk of homelessness

Purpose

The mission of the Veterans Justice Programs (VJP) is to identify justice-involved Veterans and contact them through outreach, to facilitate access to VA services at the earliest possible point. These outreach services serve as VA's front door to homeless services. VJP teams focus on outreach to Veterans in jails and prisons, as prior history of incarceration is one of the strongest predictors of future homelessness in men, as well as dramatically increases Veterans' risk of suicide. VJP accomplish this by building and maintaining partnerships between VA and key elements of the criminal justice system.

2025 Planned Accomplishments

- The 2025 goal is to serve 55,000 Justice-Involved Veterans to meet the expanded demand.
- The VJO workforce of approximately 505 VJO staff will support outreach and linkage to VA services for justice-involved Veterans and respond to the growth of Veteran focused interventions in local criminal justice systems, including by providing direct support to the more than 730 VTCs and other Veteran-focused court programs (as of December 2024).

- Ongoing support through VJO Specialists and Peer Specialists, including those awarded in 2024, to develop and/or expand partnerships with local criminal justice agencies to facilitate justice-involved Veterans' access to VA treatments.

2026 Budget Request

The 2026 Budget request is $81.8 million for VJO, $7 million (9.4%) above the 2025 current estimate, to support outreach and linkage to VA services for justice-involved Veterans by over 500 frontline VJO staff. The VJO workforce of Specialists and Peer Specialists respond to the continued growth of Veteran-focused interventions in local criminal justice systems, including by providing direct support to more than the 720 VTCs and other Veteran-focused court programs in which they currently serve Veterans. Staff work to develop and expand partnerships with local criminal justice agencies to facilitate justice-involved Veterans' access to needed VA treatment at the earliest possible point. The 2026 budget request also supports current program office staff that support ongoing operations for VJO.

2026 Planned Accomplishments

- The 2026 goal is to serve 60,000 Justice-Involved Veterans to meet the expanded demand.
- Support VAMCs VJO Specialists and Peer Specialists 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.
- 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 the more than 730 VTCs and other Veteran-focused court programs in which they currently serve Veterans.

Evidence

The demand for VJO services is expected to continue growing through 2026. 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 VTCs and/or Veteran-specific housing units in local jails. Based on VJP's internal gap analysis the number of VTCs and other Veteran-focused courts will total more than 800, and the number of Veteran-specific housing units in prisons and local jails is now over 170 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.

Communities across the country continue to launch new Veteran-specific criminal justice programs, such as VTCs 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 staff to serve justice-involved Veterans in the communities they serve, and VHA anticipates the continued need for additional VJO capacity, which will translate into additional VJO positions in 2026.

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 2024, according to a program evaluation conducted by VA's Center for Innovation to Implementation (Finlay et al. (2024), 94% of Veterans served by VJO Specialists went on to access face-to-face VHA services. Of these Veterans:

- 69% were diagnosed with one or more mental health disorders, and 92% of those with such diagnoses entered VHA mental health treatment.
- 50% were diagnosed with one or more substance use disorders, and 69% of those with such diagnoses entered VHA substance use disorder treatment.

Citations

Finlay, A. K., Blue-Howells, J., Stimmel, M., Yu, M., Stewart, K. & Clark, S. (2024). Veterans Justice Program: Connecting Veterans with Veterans Health Administration Mental Health and Substance Use Disorder Treatment [Fact Sheet 2024]. Menlo Park, CA: Center for Innovation to Implementation.

Legal Services for Veterans (LSV)

Authority for action

- 38 U.S.C. §2022A: Legal services for homeless Veterans and veterans at risk for homelessness (LSV-H) Grant Program
- 38 U.S.C. §5906: Legal Services for Veterans—Legal Assistance for Access to VA Programs (LSV-A) Grant Program

Purpose

Legal Services for Veterans (LSV) is a new program within VA Homeless Programs, 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 separate streams of grant funding, Legal Services for Homeless Veterans and Veterans At-Risk for Homelessness (LSV-H) and Legal Services for Veterans – Legal Assistance for Access to VA Programs (LSV-A), to support the provision of legal services to Veterans by eligible non-VA entities.

The purpose of the LSV-H grant is to address unmet legal needs that present barriers to housing stability, by providing legal services to Veterans who are homeless or at risk of becoming homeless. The allowable legal services covered under LSV-H grant include housing law; family law; income support; criminal defense (in matters related to homelessness); military discharge or dismissal upgrades; protective orders and other legal matters related to domestic or intimate partner violence. Additionally, pursuant to 38 U.S.C. 2022A(e), for any year, no less than 10% of the amount authorized to be appropriated for these grants shall be used to provide legal services to women Veterans.

The purpose of LSV-A grant is to assess the feasibility and advisability of awarding grants to eligible entities; to establish new legal assistance clinics or enhance existing legal assistance clinics or other pro bono efforts in locations other than VA facilities. The LSV-A grant will include legal

assistance with any VA program administered by the Secretary and legal assistance associated with improving the status of a military discharge or characterization of service in the Armed Forces.

2025 Planned Accomplishments

- Publish a Notice of Funding Opportunity (NOFO), proposing to award $42 million for LSV-H grants, over a two-year grant cycle beginning October 1, 2025, through September 30, 2027.
- Support an increase of 30% in Veterans receiving legal services to address barriers to housing.

2026 Budget Request

The 2026 budget request for the LSV program is $58.1 million, $10 million (20.8%) above the 2025 Current Estimate. In addition to sustaining the provision of legal services enabled by LSV-H grants awarded in 2025, these funds will expand grantees' capacity to deliver legal services and ensure that VA's capacity to monitor and administer LSV grants keeps pace with this growth. The 2026 budget will support the initial grant cycle for LSV-A, funding an additional 100 grants, and supporting the expansion of existing LSV-H awards. The 2026 budget request includes $1.7 million for program office administration, oversight, and grants management and payment systems support, which will support ongoing operations for LSV-H as well as the implementation and oversight of LSV-A, which has distinct regulations and eligibility criteria.

2026 Planned Accomplishments

- Increase legal services grants from 85 to 185.
- Implement LSV-A grant program, serving a distinct and historically underserved subset of former services members.
- Improve compliance with expanded oversight services.

Evidence

The new grant programs for legal services for Veterans were mandated through P.L. 116-315, *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020*, Sec. 4202 and P.L. 116-283, *William M. (Mac) Thornberry National Defense Authorization Act for 2021*, Sec. 548.

Homeless Patient Aligned Care Team (HPACT)

Authority for action

- 38 U.S.C. Chapter 17
- 38 U.S.C. § 7301: Functions of the Veterans Health Administration: in general
- 38 C.F.R. 17.38 - Medical benefits package

Purpose

The HPACT program is a multi-disciplinary, population-tailored primary care intervention designed around the unique needs and distinct challenges Veterans experiencing homelessness 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 use needs of homeless Veterans entering the VA system. The program serves as a conduit for treatment engagement and involvement in VA Homeless Programs and clinical services and support through a "no wrong door" policy. The HPACT program provides and coordinates health care that Veterans 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. 7301(b), Title 38 CFR Section 17.38.

2025 Planned Accomplishments

- Deliver timely, accessible, high-quality benefits, care and services to meet the unique needs of Veterans and all eligible beneficiaries through awarding at least five new HPACT sites and 25 additional staff positions at current HPACT sites to increase the capacity of homeless Veterans served and healthcare services provided.
- Increase HPACT MMU healthcare encounters with Veterans by 50% from the 2024 total of 2,710 HPACT MMU encounters (to at least 4,065 HPACT MMU encounters).
- Target participation from HPACT and HPACT MMU teams in at least 85% of the unsheltered surges that take place.

2026 Budget Request

The 2026 Budget request is $21.8 million, an increase of $819,000 (3.9%) for the HPACT program above the 2025 Current Estimate. The budget request reflects a commitment to sustaining the program's operations and ensuring the well-being of both program participants and staff.

The 2026 budget provides funding necessary to support current HPACT staffing, including new positions awarded in 2025. This funding will enable the provision of staff to provide comprehensive care and support to Veterans experiencing homelessness, including physicians, registered nurses, social workers, physical or occupational therapists, and peer support specialists. The 2026 budget provides staffing support for the sustainment of the HPACT MMU program. The MMUs play a vital role in conducting outreach and delivering direct medical, mental health, and social services to Veterans experiencing homelessness in the community setting, including to those living in rural settings. The 2026 budget is necessary to support the sustainment of current HPACT program efforts to bring primary care services to Veterans experiencing homelessness.

2026 Planned Accomplishments

- Ongoing support/sustainment for current HPACT staff that includes the implementation/start-up and expansion of HPACT teams based on 2025 awards.
- Continued deployment of the HPACT MMU program to conduct outreach to vulnerable Veterans, including those living in rural communities including capturing utilization and total encounter numbers with an increase of at least 10% from 2025.
- Target participation from HPACT and HPACT MMU in 100% of the unsheltered surges by providing medical, mental health care, and connections to VA and community services as needed.
- Expand dissemination of Opioid Overdose Education and Naloxone Distribution (OEND) procedures to all HPACT sites by providing operational guidance, training, and technical assistance to HPACT medical staff to increase naloxone availability for high-risk Veterans.

Evidence

In 2012, the HPACT program began with a total of 32 pilot sites. As of May 1, 2025, there are 92 HPACT teams and providers operating at 61 VAMCs, Community Based Outpatient Clinics (CBOCs), and Community Resource and Referral Centers (CRRC) across the country. HPACTs are in every VISN 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 (O'Toole, et al., 2016). Veterans in HPACTs were housed in permanent housing 81 days faster than those not enrolled in a HPACT (Johnson, et al., 2017). 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 (Jones, et al., 2019). In addition, HPACTs show high rates of depression care including early access to care and follow-up indicating the HPACT model allows for more opportunities for depression treatment (Jones, et al., 2023). Finally, the HPACT MMU program has been shown as a successful and innovative way to provide healthcare and engage Veterans in the community setting while increasing connections with VA services (Weber, et al., 2025). The benefits of HPACT and potential expansion is the program's ability to address the multiple medical and social needs of Veterans in one setting. This is accomplished by incorporating five core elements that distinguish HPACT from traditional primary care models:

- 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 integrated 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.

Citations:

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Homeless Veterans Community Employment Services (HVCES)

Authority for action

- 38 U.S.C. Chapter 17
- 38 U.S.C.§2031. General treatment
- 38 U.S. Code §2033. Additional services at certain locations

Purpose

Homeless Veteran Community Employment Services (HVCES) provides employment services to Veterans participating in VA homeless programs to increase access to permanent housing and improve housing stability. Simply put, Veterans must have access to stable income and

opportunities for economic reintegration to maintain housing. HVCES accomplishes this 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 and Vocational Rehabilitation Counselors 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.

2025 Planned Accomplishments

- National employment targets for Veterans housed and receiving case management in HUD-VASH will be met or exceeded.
- VHA will continue to focus at the national and local levels on 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), to improve employment outcomes for Veterans served. Training will be provided to staff to improve employment services to Veterans to address challenges that may be preventing Veterans experiencing homelessness from returning to competitive employment, such as a poor work history; lack of transportation and appropriate clothing; history of justice involvement; and/or co-occurring substance use and mental health issues.

2026 Budget Request

The 2026 budget request for HVCES is $22.4 million, $581,000 (2.7%) above the 2025 Current Estimate, to support the sustainment of 180 FTE employment staff and program office staff providing program oversight. The primary goal of this budget is to support VHA's objective of preventing returns to homelessness and allow targeted sites to increase the reach of their services across local catchment areas, including rural locations and tribal lands served by VAMCs.

2026 Planned Accomplishments

- VHA homeless programs will continue to prioritize collaboration with DOL programs, including VETS, HVRP, and SCSEP.
- HVCES will explore more intensive employment services for Veterans in the HUD-VASH program's graduation phase with the goal to improve employment outcomes and/or ensure income maximization, with emphasis on the importance of income for long-term housing stability and self-sufficiency.

Evidence

Research consistently demonstrates that employment plays a crucial role in improving outcomes for Veterans, particularly in the areas of mental health and housing stability (Elbogen, Molloy and al. 2020). Key findings include:

- Employment significantly reduces the risk of suicide among Veterans. Meaningful employment provides a sense of purpose, social connection, and stability, serving as protective factors against suicidal ideation and behavior.
- Gainful employment is linked to improved mental health outcomes for Veterans. It offers structure, routine, and a sense of accomplishment, positively impacting overall well-being and reducing symptoms of depression, anxiety, and post-traumatic stress disorder (PTSD).
- Employment is a critical factor in achieving and maintaining housing stability. Veterans who secure employment are more likely to secure and sustain stable housing, reducing the risk of homelessness.

The evidence presented, including the below success rates and utilization of various strategies within the HCVES program, demonstrates the benefits of continued investment in the HCVES program. The data shows the significant impact the program has had in helping Veterans exit homelessness, secure competitive employment, and improve their overall well-being.

- During 2024, approximately 12,828 unique Veterans successfully exited homeless programs with competitive employment.
- The employment rates for HUD-VASH and GPD Veterans have exceeded the national target of 50% and 55% respectively, supporting Veterans in finding employment and achieving self-sufficiency.
- In 2024, there were more than 13,000 newly documented, unique instances of employment for Veterans engaged in or who have exited from VA homeless programs or services. Indicating that HVCES staff are consistently helping Veterans find employment opportunities and improve their overall well-being.

Citation

- Elbogen, E. B., Molloy, K., Wagner, H. R., Kimbrel, N. A., Beckham, J. C., Van Male, L., Leinbach, J., & Bradford, D. W. (2020). Psychosocial protective factors and suicidal ideation: Results from a national longitudinal study of Veterans. Journal of affective disorders, 260, 703–709. https://doi.org/10.1016/j.jad.2019.09.062

National Homeless Registry

Authority for action

- 38 U.S.C. §2068: Mental health consultations
- 38 U.S.C. §2041: Housing assistance for homeless Veterans
- P.L. 117-328, Division U, Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022, § 309: System for Sharing and Reporting Data.
- P.L. 117-328, Division V, Strong Veterans Act of 2022, Sec. 404: Mental Health Consultations

Purpose

The National Homeless Registry is a comprehensive repository of Veterans who have been identified as homeless or at risk for homelessness at any time since October 1, 2005, and their associated housing, employment, clinical, administrative, and benefits 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. It is the primary means by which VA evaluates the effectiveness of its continuum of homeless programs and services. 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 VA health care records, 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. This also includes strategic technical assistance with Registry data information toward the mission of ending Veteran homelessness and the manpower resources to progress the implementation of HOMES enhancements.

2025 Planned Accomplishments

- Sustain HOMES for homeless program operations, which is critical to program reporting capabilities, including VAMC level and leadership reporting dashboards to support national initiatives, data sharing with community providers, and national/VISN/VAMC level insights to support program operations.
- Support continued implementation of the data sharing and reporting requirements of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022, Sec. 309, System for Sharing and Reporting Data.
- Support implementation of the requirements of 38 U.S.C. §2068 as amended by 117-328, the STRONG Veterans Act of 2022, § 404(b).
- Ensure knowledge transfer and capacity building for data management, in preparation for VA staff restructuring and anticipated departures of key technical supports in partner offices.

2026 Budget Request

The 2026 budget request is $6.9 million for the National Homeless Registry, an increase of $500,000 (7%) above the 2025 current estimate. This budget supports key initiatives ensuring the effective operation of homeless programs and services. This budget addresses critical needs, such as data mandated legislation implementation, training, data sharing, and system maintenance, to enhance program capabilities and improve outcomes for Veterans experiencing homelessness. The requested budget aims to ensure the successful implementation of key new legislative mandated initiatives, support ongoing training needs, and maintain the functionality of the HOMES system. These investments are critical for program operations, reporting capabilities, and data sharing, ultimately enhancing the effectiveness of homeless programs and services.

2026 Planned Accomplishments

- Successful implementation of section 309 of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022 and strategic efforts, which requires a system for data sharing between HOMES and HUD's Homeless Management Information System (HMIS) by the end of calendar year 2025. This includes completion of data import beta testing in targeted communities and evaluation of expanded categories of data collection to inform strategy for bringing data sharing to national scale.
- Continued support of requirements, including data tracking, monitoring, and reporting of section 404(b) of the STRONG Veterans Act of 2022 (38 U.S.C. §2068) to enhance HOMES programming that allows homeless program staff at VAMCs to capture clinical data offering mental health consultations for Veterans entering homeless programs office programs.
- Evaluation of the homeless programs office data management lifecycle to streamline and centralize National Homeless Registry and HOMES data reporting and visualization tools. This will reduce external dependencies and increase internal capacity. Review utilization rates of all operational dashboards and reports to identify opportunities for consolidation or retirement and prioritize new, emerging business intelligence products to address Veteran homelessness.

Evidence

This initiative has proven to be highly effective and efficient in advancing the VA's mission to end Veterans' homelessness.

- In 2010, funding was successfully secured to establish a consolidated repository of Veteran data, known as the National Homeless Registry. This registry serves as a robust foundation for guiding program development and conducting research to enhance services for Veterans experiencing homelessness.
- The National Homeless Registry plays a pivotal role in supporting various Homeless Program Initiatives aimed at advancing the VA's mission to end Veteran homelessness. These initiatives encompass a wide range of critical areas, including productivity and workload capture compliance, permanent housing placement and outreach goals, centralized technical assistance for VISN and VAMCs, identification of service gaps, performance measurement and program evaluation, data sharing initiatives with federal partners and community organizations, identification and dissemination of innovative practices, tracking and reporting mechanisms for homeless programs, prioritization of clinical staffing levels, and the development, management, and sustainment of the HOMES platform.

The National Homeless Registry significantly enhances program efficiency by providing a centralized platform for data collection, analysis, and reporting. This streamlined approach enables proactive identification of service gaps, supports effective resource allocation, and facilitates the dissemination of innovative practices. Moreover, the registry contributes to robust program

evaluation efforts, ensuring continuous improvement and better outcomes for Veterans experiencing homelessness.

The National Center on Homelessness among Veterans (The Center)

Authority for action

- 38 U.S.C. § 2067: National Call Center on Homelessness Among Veterans
- P.L. 117-328, Division U, Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health care Improvement Act of 2022, § 313: Study on Financial and Credit Counseling.

Purpose

P.L. 114-315, The Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016, Sec. 713, codified the National Center on Homelessness among Veterans (NCHAV). The NCHAV conducts and supports research on Veterans experiencing homelessness or at-risk of homelessness; assesses the effectiveness of relevant VA programs; identifies and disseminates best practices and helps integrates these practices into policies, programs, and services for homeless and at-risk Veterans populations; and serves as a resource center for all research and training activities carried out by VA and by other Federal and non-Federal entities with respect to Veteran homelessness. The NCHAV operates within an integrated organizational model and is comprised of the following cores:

- Research & Methodology Core
- Model Development & Implementation Core
- Education & Dissemination Core

2025 Planned Accomplishments

- Complete a comprehensive evaluation of staff well-being, safety, and reasons for turnover in VHA Homeless Programs to best serve Veterans. Data from 1,273 employees in VHA Homeless Programs have been collected through direct surveys and interviews.
- Conduct a 10-year and 20-year longitudinal analysis of 87,684 Veterans and 249,529 Veterans, respectively, who have participated in VHA Homeless Programs. This analysis will use existing VA administrative data to understand trajectories of Veterans in the program over time to improve programming for long-time recovery of Veterans.
- Develop a stepped model for Motivational Interviewing (MI) for VHA Homeless Program staff to better serve homeless Veterans with behavior change. A two-day training is offered followed by four community-of-practice sessions and two individual coaching sessions. To date, 73 VHA Homeless Program staff have been trained.

2026 Budget Request

The 2026 budget request for is $9.6 million, which sustains the 2025 current estimate funding level supporting NCHAV's annual operations, which are planned to enhance the NCHAV's clinical research program, train clinicians on evidence-based practices to serve Veterans, and to develop

new interventions, technologies, and data methods to improve programming for Veterans at risk for or experiencing homelessness. The budget will support a full range of services based on conducted market research that does not include adjustments for regional labor market conditions. The budget will support mission-critical data and training for clinical operations serving homeless Veterans.

2026 Planned Accomplishments

- Conduct a five-year prospective study of over 5,000 low-income Veterans to understand profiles of Veterans at different levels of risk for homelessness and other adverse outcomes that can inform VA prevention efforts.
- Complete pilots of several new interventions for homeless and at-risk Veterans that help them rebuild social support and family relationships, and address suicide risk in community emergency departments.
- Provide over 15 educational courses to VA clinicians, complete over 20 published research studies that can be disseminated to VA program offices, and six intramural grants for local researchers to study homeless and at-risk Veterans on diverse topics.

Evidence

The NCHAV has a strong track record of helping VA develop many of its current homeless programs, has produced over 100 training and educational courses, and generated over 200 peer-reviewed published research studies. The NCHAV also helps manage a network of other 35 affiliated local researchers at VA medical centers across the country. Thousands of audience members and readers have received these educational and research products, including VA clinicians and leaders. In addition, the NCHAV directs a national fellowship program that develops the new generation of VA providers, researchers, and program administrators on Veteran homelessness. The NCHAV works with its operational partners within VA Homeless Programs and other stakeholders, such as community organizations, other VHA program offices, government agencies, and academic affiliates, to identify key areas of research and program/process evaluations, educational needs, and program integration opportunities. As a result, the NCHAV has developed and/or piloted numerous housing models and interventions for Veterans at risk of homelessness and who have experienced homelessness. These programs are now VHA Homeless Programs' foundational services, including Homeless PACTs, SSVF, Housing First approach, Community Resource and Referral Centers (CRRCs), Low Demand Safe Haven residential and GPD transitional housing programs, and the National Homeless Registry.

Annually, the NCHAV generates numerous peer-reviewed publications, trainings, and on-line resources for thousands of both VA and non-VA providers on issues related to homelessness and provides grants to the NCHAV affiliated researchers to assist in expanding the NCHAV's research capabilities.

Whole Health

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations 1/							
Medical Services (0160):	$66,939	$97,937	$82,990	$89,826	$91,622	$6,836	$1,796
Medical Support and Compliance (0152):	$18,556	$19,502	$23,005	$24,876	$25,374	$1,871	$498
Medical Facilities (0162):	$1,029	$1,850	$1,276	$1,405	$1,433	$129	$28
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$86,524**	**$119,289**	**$107,271**	**$116,107**	**$118,429**	**$8,836**	**$2,322**

[1/]Whole Health budget includes the Patient Centered Care request of $79.8 million which supports P.L. 114-198 §933 (part of *Jason's Law*). None of this amount is included in the Opioid Prevention, Treatment and Program funding table shown earlier in the chapter.

Authority for action

- 38 U.S.C. Chapter 17. Hospital, Nursing Home, Domiciliary, and Medical Care
- P.L. 114-198, Comprehensive Addiction and Recovery Act of 2016
    - Sec. 933, Pilot program on integration of complementary and integrative health and related issues for Veterans and family members of Veterans1
- Consolidated Appropriations Act, 2024, Division A, H. Comm. Print 56-550, Book 1: Creative Arts Therapies

Purpose

Whole Health is an approach to healthcare that empowers and equips people to take charge of their health and well-being and to live their life to the fullest with a focus that goes beyond "what's the matter with you" to "what matters to you". Robust outcome evaluations demonstrate the effectiveness of the Whole Health approach (for example, decreases in opioid use, invasive spine procedures, and stress levels as well as increased engagement in health care, including mental health services, evidence-based disease management and prevention services, and self-care).

2025 Planned Accomplishments

- Continue to increase access to Whole Health/CIH services. As of the end of quarter 2 in 2025, 34% of Veterans receiving care (2,161,413) have participated in Whole Health/CIH.
- Increase CIH encounters by 3.45% over levels.
- Continue the focus of 540 trained Whole Health Integration Champions (WHICs) in Patient Care and Mental health in integrating Whole Health/CIH services, tools, and resources into Veteran interactions, both in-person and virtually.
- Achieve 70% of VAMCs in having 0.75% of Veterans receiving care who also receive Health and Wellness coaching, a core Whole Health/CIH approach.

2026 Budget Request

The Whole Health/CIH funding request for 2026 is $116.1 million, $8.8 million (8.2%) above the 2025 Current Estimate. The 2026 request includes $89.6 million for Whole Health care at the VISN and facility level and $21.5 million to support the national direction and implementation of Whole

Health in VHA. This national support includes Whole Health/CIH education, CIH service support, Whole Health/CIH research and evaluation, Whole Health/CIH strategic partnerships, and Whole Health/CIH system development. In addition, $5.0 million of the 2026 request level will provide creative arts to Veterans. The 2026 request will ensure increased access for Veterans using Whole Health, including CIH and HWC, resulting in a comprehensive experience supporting their overall well-being. The request will support training, evaluation, and national program office oversight related to implementation and policy guidance consistent with the statutory requirements in the Comprehensive Addiction and Recovery Act of 2016.

2026 Planned Accomplishments

The Whole Health program plans to achieve the following accomplishments with its 2026 funding:

- Continue growth in Whole Health/CIH expansion with 2% growth of Veteran population accessing Whole Health/CIH services above 2025 or achieving and sustaining 28% of the Veteran population accessing Whole Health/CIH services within each Network.
- Expand Whole Health integration champions to support clinicians' ability to deliver Whole Health clinical care which prioritizes a Veteran's meaning and purpose in setting shared goals and increases awareness of optimal ways to deliver CIH services both in VHA and through community care network.
- Expand use of the validated three-item well-being signs tool, currently in use in various levels at over 120 VAMCs, to keep Veteran well-being and improved quality of life at the center of care delivery.
- Continue monitoring outcomes connected to unique Veteran use of CIH, including improved patient-reported outcomes, increased tobacco cessation, increased completion of evidence-based psychotherapies, reduction in opioid use and downstream invasive spine procedures for Veterans with chronic pain, and improved clinical quality metrics for preventive screenings and chronic disease management.

Evidence

In February 2020, the first stage of an evaluation of the outcomes of the Whole Health flagship effort was completed by a team from VA Quality Enhancement Research Initiative (QUERI). The Whole Health report (Bokhour, et al., 2020) served as the basis for the congressional progress report mandated in the Comprehensive Addiction and Recovery Act of 2016. Even relatively early during the Whole Health deployment at the initial 18 implementation facilities (flagships), this evaluation indicated positive results, including:

- Opioid use among comprehensive Whole Health/CIH users decreased 38% compared with only an 11% decrease among those with no Whole Health/CIH use (Bokhour et al., 2022). *(Data collected Oct 2017-March 2019)*
- Veterans who used Whole Health/CIH services reported:
    - Improvements in perceptions of the care received as being more patient centered
    - Improvements in engagement in health care and self-care

- Improvements in engagement in life indicating improvements in mission, aspiration and purpose
- Improvements in perceived stress indicating improvements in overall well-being

Ongoing evaluation has shown the below evidence of impact of Whole Health/CIH on Veteran well-being:

- Whole Health/CIH utilization was associated with improvements in eight selected clinical quality measures including blood sugar control in people with diabetes, rates of colon and breast cancer screening, and vaccination rates. Quality continued to increase after initial Whole Health/CIH utilization highlighting ongoing patient engagement (Zhang X, et al. ICIMH March 2025). *(Data from October 2022 to March 2023)*
- Increased completion of evidence-based psychotherapy protocols (30-50%) in Veterans with PTSD utilizing Whole Health/CIH services (Etingen et al., ICIMH March 2025). *(Data analyzed from 2018 through 2022)*
- Statistically significant improvement in overall satisfaction in female Veterans on the Survey of Health Experiences of Patients (SHEP) (Zhang X, et al. ICIMH March 2025). (*Data collected in 2019, 2020, and 2021)*
- Decrease in downstream utilization of invasive spine procedures of 20-40% over 18 months in Veterans with chronic low back pain in Whole Health/CIH users vs. non-users (Zeliadt SB et al.,2025). *(Data analyzed from 2018, 2019, and 2020)*
- The use of meditation, acupuncture, clinical hypnosis, and Whole Health/CIH coaching on downstream use of cessation medications and long-term quit rates was explored among current smokers compared to matched controls (Zeng et al., ICIMH March 2025). *(Data from October 2017 to March 2023 with follow-up through March 2024)*
    - Increased tobacco cessation rates (11-23% higher) among those who used meditation, coaching, and acupuncture.
    - Increased use of tobacco cessation medications (44-49% higher) among those who used meditation, coaching or clinical hypnosis.
- In a study of 3,306 Veterans utilizing complementary/integrative health approaches for chronic pain, 40% experienced clinically significant improvement in their pain over a six-month period (Data collected June 2029-April 2023) (Zeliadt et al., ICIMH March 2025).

A recent National Academies of Sciences, Engineering and Medicine report from February of 2023 entitled "Achieving Whole Health: A New Approach for Veterans and the Nation" (National Academies of Sciences) reviewed the evidence for the Whole Health approach in depth and concluded that "Whole health is a common good that benefits everyone" that should be scaled and disseminated across the entire U.S. healthcare system. They found strong

evidence that this initiative has been effective in improving Veterans' lives but noted that there was still work to be done within the VA to ensure access to Whole Health.

Citations:

- Etingen B, Douglas J, Coggeshall S, Reed DE II, Engel C, Hogan TP, Rosser E, Bokhour BG, Zeliadt SB. Associations Between Use of Whole Health Care and Completion of Trauma-Focused Psychotherapy Among Veterans with Posttraumatic Stress Disorder. Podium Presentation. 2025 International Congress on Integrative Medicine and Health: Seattle, WA; 03/05/2025
- Zeng S, Coggeshall S, Rosser E, Taylor SL, Burgess D, Luo G, Zeliadt S. The Effect of Real-World Diffusion of CIH Therapies and Whole Health Coaching on Tobacco Cessation Outcomes in the Veterans Health Administration. Oral Presentation. 2025 International Congress on Integrative Medicine and Health (ICIMH). Seattle, WA. March 2025.
- Zhang X, Douglas J, Eck C, Luo G, Bokhour BG, Zeliadt SB. Whole Health is Positively Associated with Multiple Measures of Care Quality: A National Evaluation of the Veterans Health Administration (VA). Oral Presentation. 2025 International Congress on Integrative Medicine and Health (ICIMH). Seattle, WA. March 2025

Programs for Select Veteran Populations

This section provides narrative descriptions of selected programs that serve certain Veteran populations. The obligations shown in each table below reflect the cost of total health care services provided to each designated Veteran population. However, some programs overlap and therefore cannot be added together to determine the overall funding amount. For example, the cost of health care services provided to a female Gulf War Veteran would appear in both the Gulf War and Women Veterans Health Care funding lines.

AIDS / HIV Program

Description (*dollars in thousands*)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary & Mandatory Obligations by Category:							
Medical Services	$1,532,743	$1,528,227	$1,645,598	$1,763,088	$1,888,198	$117,490	$125,110
Medical Community Care	$248,968	$234,066	$271,120	$293,437	$316,765	$22,317	$23,328
Medical Support and Compliance	$165,943	$159,762	$178,780	$192,005	$206,026	$13,225	$14,021
Medical Facilities	$123,865	$140,054	$133,664	$143,702	$154,330	$10,038	$10,628
Obligations [Total]	$2,071,519	$2,062,108	$2,229,162	$2,392,232	$2,565,319	$163,070	$173,087

Authority for Action:

- 38 U.S.C. § 1703, Veterans Community Care Program.
- 38 U.S.C. § 7301, Functions of Veterans Health Administration.
- 38 U.S.C. § 7332, Confidentiality of certain medical records.
- 38 U.S.C. § 7333, Nondiscrimination against alcohol and drug abusers and persons infected with the human immunodeficiency virus.
- 38 C.F.R. § 17.38, Medical benefits package.

Population Covered:
The scope of VHA's National HIV Program includes Veterans living with HIV (VLHIV), i.e., Veterans in VHA care with either diagnosed or undiagnosed HIV infection. It also includes Veterans who are not infected but who are at increased risk of exposure to and acquisition of HIV infection through sexual transmission, injection drug use (IDU), or both. Because HIV is part of a syndemic of viral hepatitis, sexually transmitted infections (STIs), mental health and substance use disorders, and other health issues, the scope of VHA's National HIV Program necessarily includes issues related to these other conditions.

Types of Services Provided:

- **Strategic/operational overview:** VA follows the White House goals for HIV treatment and prevention as described by the National HIV/AIDS Strategy (NHAS) and the Ending the HIV Epidemic campaign (EHE), a signal initiative of President Trump's first term. VA is a lead Federal agency for construction, revision, and implementation of both NHAS and EHE, which are designed to achieve the President's goal of ending new HIV infections by 2030 through HIV testing, linkage to and retention in care, treatment in patients with HIV infection, and prevention of new infections in at-risk patients.
- **HIV Treatment:** Implementing the most current version of NHAS in VHA requires addressing high rates of medical and psychiatric co-morbidities, including mental health and substance use disorders, cardiovascular disease, renal dysfunction, and metabolic disorders among VLHIV in VA care. VHA's National HIV Program ensures that these Veterans receive the highest quality comprehensive clinical care by timely linkage to care after their initial diagnosis, retention in care, initiation and monitoring of anti-retroviral therapy and treatment of co-morbidities.
- **HIV Prevention:** VHA's HIV prevention efforts are based on NHAS and EHE, and incorporate recommendations by the U.S. CDC and the U.S. Preventive Services Task Force (USPSTF), as well as Clinical Preventive Guidance Statements issued by VHA's National Health Promotion and Disease Prevention Program. VHA's deployment of HIV **Pr**e-**E**xposure **P**rophylaxis (PrEP) for HIV prevention is based on FDA approval of drugs shown to be safe and effective for this indication. VA continues to actively promote the broader use of PrEP across the VHA system by addressing local and systemic barriers to increased uptake, as well as working to increase access to nonpharmacological measures to prevent new HIV infection, such as making condoms universally available to all Veterans in VHA care.

Workload

		2025		**2026**	**2027**		
Description	2024 Actual	Budget Estimate 1/	Current Estimate	**Revised Request**	**Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Unique Patients							
AIDS/HIV	38,951	33,656	39,438	**39,903**	**40,338**	465	435

1/ The methodology used for unique patients now includes patients who are suspected of HIV exposure and are receiving anti-retroviral drugs, a change from prior Congressional Justifications.

Health Outcomes Military Exposures (HOME)
(formerly Post Deployment Health Services (PDHS))

HOME: Gulf War Program

Description (*dollars in thousands*)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary & Mandatory Obligations by Category:							
Medical Services	$5,307,548	$6,284,272	$6,286,204	$7,428,362	$8,784,634	$1,142,158	$1,356,271
Medical Community Care	$1,337,096	$1,690,770	$1,587,058	$1,877,633	$2,223,249	$290,575	$345,616
Medical Support and Compliance	$832,021	$987,650	$985,912	$1,165,368	$1,378,539	$179,456	$213,171
Medical Facilities	$826,435	$1,143,540	$979,811	$1,158,506	$1,370,857	$178,695	$212,351
Obligations [Total]	$8,303,100	$10,106,231	$9,838,985	$11,629,869	$13,757,280	$1,790,884	$2,127,410

HOME: Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND)/Operation Inherent Resolve (OIR) Program

Description (*dollars in thousands*)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary & Mandatory Obligations by Category:							
Medical Services	$10,689,212	$12,435,943	$12,571,061	$14,678,894	$17,034,114	$2,107,834	$2,355,220
Medical Community Care	$3,252,363	$3,686,379	$3,838,780	$4,496,661	$5,232,657	$657,882	$735,995
Medical Support and Compliance	$1,534,965	$1,757,668	$1,805,031	$2,107,536	$2,445,582	$302,506	$338,045
Medical Facilities	$1,244,036	$1,700,301	$1,461,380	$1,704,717	$1,976,596	$243,337	$271,879
Obligations [Total]	$16,720,576	$19,580,291	$19,676,251	$22,987,809	$26,688,949	$3,311,558	$3,701,139

HOME: Program Office

Description (*dollars in thousands*)	2024 Actual	2025 Budget Estimate 1/	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary & Mandatory Obligations:							
Focus Areas:							
Airborne Hazards and Burn Pits Center of Excellence	$13,580	$15,165	$9,219	$10,000	$10,200	$781	$200
War Related Illness and Injury Study Center	$21,595	$20,705	$26,781	$26,970	$27,509	$189	$539
Medical Exposures and Depleted Uranium Surveillance Center 1/	$3,374	*N/A*	$3,374	$3,374	$3,441	$0	$67
All Other HOME Obligations 1/	$30,234	*N/A*	$36,322	$37,058	$37,800	$736	$742
HOME [Total]	$68,783	$82,838	$75,696	$77,402	$78,950	$1,706	$1,548
Account Category:							
Medical Services	*$51,158*	*$63,734*	*$53,201*	*$54,623*	*$55,715*	*$1,422*	*$1,092*
Medical Support & Compliance	*$17,625*	*$19,104*	*$22,495*	*$22,779*	*$23,235*	*$284*	*$456*
Medical Care Total	*$68,783*	*$82,838*	*$75,696*	*$77,402*	*$78,950*	*$1,706*	*$1,548*

1/ Certain details not displayed in the 2025 Congressional Justification.

Workload

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Unique Patients							
Gulf War	498,867	508,711	517,193	**536,995**	**558,158**	19,802	21,163
OEF/OIF/OND/OIR	1,411,447	1,440,372	1,500,043	**1,589,273**	**1,680,251**	89,230	90,978

Authority for action

The activities of the office are governed by the following public laws, Federal Registry and Presidential, VA/VHA initiatives.

Public Laws

- P.L. 99-576, Veterans' Benefits Improvement and Health Care Authorization Act of 1986
- P.L. 100-321, Radiation-Exposed Veterans Compensation Act of 1988
- P.L. 100-322, Veterans Benefits and Services Act of 1988
- P.L. 102-4, Agent Orange Act of 1991
- P.L. 105-277, Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999
- P.L. 105-368, Veterans Programs Enhancement Act of 1998
- P.L. 107-103, Veterans Education and Benefits Expansion Act of 2001
- P.L. 108-170, Veterans Health Care, Capital Asset and Business Improvement Act of 2003
- P.L. 108-183, Veterans Benefits Act of 2003
- P.L. 109-417, Pandemic and All-Hazards Preparedness Act of 2006
- P.L. 117-168, Promise to Address Comprehensive Toxics (PACT) Act of 2022

Presidential directive

- Homeland Security Presidential Directive 10 (HSPD-10) Biodefense for the 21st Century

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 (AHOBPR): 38 U.S.C. §527, P.L. 112-260 §201; and P.L 102-585

Purpose

Exposures to contaminants and environmental hazards during military service poses a major health concern for Veterans and cohorts of all generations. Health Outcomes Military Exposures (HOME) governs Congressionally mandated programs related to environmental, occupational and garrison exposures that may have affected U.S. Veterans and some family members during military service. These programs cover Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), Gulf War, Vietnam, WWII, Medical Exposures and Depleted Uranium Surveillance Center (MEDU),

and atomic Veteran's policy and activities related to the oversight of military environmental exposure (MEE) exams at the local Veterans health facilities.

The office conducts surveillance and studies Veterans' health and health care outcomes. Findings from these research studies inform clinical care given by health professionals and provide sound science for decisions from policymakers, including Department of Veterans Affairs (VA) and Congress. This research improves health care best practices and policy decisions related Veterans' benefits support. HOME subject matter experts continuously review current scientific literature and provide data to develop policy recommendations for the Secretary, VA (SECVA) grounded in science regarding health outcomes for military-related exposures. HOME responds to questions of environmental health. In addition, HOME responds to other emerging issues such as exposures to anomalous health events, directed energy, prophylactic medications, rare cancers, respiratory illness, fuels, fire-fighting foams (PFAS), directed vaccines and concerns for intergenerational issues. Scientific literature reviews for determination of presumptions as directed by the Military Environmental Exposure Sub-Committee (MEESC), subordinate to the VA Operations Board (VAOB) and the VA Executive Board (VAEB).

HOME coordinates the work of Veterans Exposure Team - Health Outcomes Military Exposures (VET-HOME), VA's national telehealth hub performing congressionally mandated toxic exposure screening, environmental health registry evaluations, and military environmental exposure assessments for Veterans anywhere in the United States or U.S. territories. The National War Related Illness and Injury Study Centers (WRIISCs) are located California , New Jersey and Washington DC, In 2023 HOME established 3 new WRIISC- Women's Operational Military Exposure Network (WOMEN); WRIISC - Complex Exposure Threats Center (CETC); WRIISC – HOME Exposure- Related Care Transformation Center (EXPRT), to address sex-specific needs, response strategies to evaluate complex exposures with unknown pathology and accelerating the implementation of education and research on military exposure concerns.

2025 Planned Accomplishments

- Completion of 7 Congressionally Mandated Reports and numerous Congressional Tracking Reports and Congressional inquiries.
- Creation of new Centers of Excellence - Women's Operational Military Exposure Network (WOMEN) Center of Excellence and the Complex Environmental Threats Center (CETC).
- Full operation of VET-HOME for evaluation of military environmental exposures.
- Development of the Military Environmental Exposures Sub-Council for PACT Act §202 to review conditions for consideration of presumption and development of VA Presumption model.

2026 Budget Request

The HOME funding request for 2026 is $77.4 million, $1.7 million (2.2%) above the 2025 Current Estimate. This funding request reflects increased funding for required statistical analysis for major components that will provide improvements to the ability to establish presumptions of toxic exposure, analysis on treatment of Veteran's medical conditions relate to toxic exposures, study of health trends of post-9/11 Veterans, cancer rates among Veterans, health effects of jet fuels, study

of Fort McClellan and advancements needed for the Individual Longitudinal Exposure Record. These activities are directly linked to P.L. 117-168, *PACT Act of 2022* that requires VA to engage in efforts to improve the health outcomes of Veterans who were exposed to chemical, physical, environmental, and airborne hazards during their military service. This requires maintenance of existing staff and contracting with other entities to provide data and recommendations to SECVA that will cover four main priority areas, including registries, research, reviewing and adjudicating claims for both benefits and health care.

2026 Planned accomplishments

- Fully hire sufficient staff (specifically epidemiologists) both within HOME and all auxiliary programs to meet the Congressional mandates.
- Professionalize the VAMC environmental health coordinator and clinician positions.
- Support the missileers, air force pilots, explosive ordinance, military occupational blast exposure, special operations forces cancer study and other research.

Evidence

- At least six million VHA enrollees will have a documented toxic exposure screening.
- At least 95% of requested AHOBPR exams will be completed.
- As of April 2025, over 112,000 Veterans have enrolled in VA health care from the PACT Act of 2022.
- At least 76,000 healthcare professionals have completed the War-related Illness and Injury Module One training and/or received military environmental exposure education. More than 1,161 VA clinicians earned the American College of Preventive Medicine (ACPM) Level 1 certification.
- Released VHA Directive 1309: Presumptive Decision Process. This directive established a new presumptive decision process (PDP) for reviewing potential presumptive conditions related to toxic exposure during Veterans' military service.

Traumatic Brain Injury (TBI) and Polytrauma System of Care (PSC)

*TBI: OEF/OIF/OND/OIR**

Description (*dollars in thousands*)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary & Mandatory Obligations by Category:							
Medical Services	$247,014	$248,623	$277,260	$312,494	$352,344	$35,234	$39,850
Medical Community Care	$19,557	$21,195	$21,752	$24,354	$27,306	$2,602	$2,952
Medical Support and Compliance	$39,038	$40,028	$43,770	$49,293	$55,542	$5,523	$6,249
Medical Facilities	$41,526	$49,707	$46,553	$52,424	$59,065	$5,871	$6,642
Obligations [Total]	$347,135	$359,553	$389,334	$438,564	$494,258	$49,230	$55,693

TBI: All Veteran Care

Description (*dollars in thousands*)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary & Mandatory Obligations by Category:							
Medical Services	$746,457	$826,881	$816,889	$899,577	$989,073	$82,688	$89,496
Medical Community Care	$134,695	$153,745	$145,900	$158,680	$172,218	$12,781	$13,538
Medical Support and Compliance	$123,247	$137,194	$134,845	$148,444	$163,159	$13,599	$14,715
Medical Facilities	$130,761	$167,706	$143,230	$157,882	$173,768	$14,652	$15,886
Obligations [Total]	$1,135,159	$1,285,527	$1,240,863	$1,364,583	$1,498,219	$123,720	$133,635

*Included in TBI-All Veteran Care.

Authority for Action

- 38 U.S.C. § 1705, Management of health care for Veterans.
- 38 U.S.C. § 1710, Eligibility for hospital, nursing home, and domiciliary care.
- 38 U.S.C. § 7327, Centers for research, education, and clinical activities on complex multi-trauma associated with combat injuries.
- 38 U.S.C.§ 8111, Sharing of Department and Department of Defense health-care resources.
- 38 U.S.C. § 8153, Sharing of health-care resources.

Population Covered

The VHA Polytrauma System of Care (PSC) serves eligible Veterans and Active Duty Service members, including Special Operations Forces, who experience service-related health problems. VA has a long-standing Memorandum of Agreement with DoD for the treatment of Active-Duty Service members with TBI and Polytrauma. Services for Active-Duty Service members receive Defense Health Agency or Tricare authorizations. This includes persons with:

- TBI (whether military-related deployment related or not),
- Blast and non-blast related traumatic injuries including but not limited to amputations, musculoskeletal injuries, and open wounds,
- Other acquired brain injuries including, but not limited to, stroke, brain tumors, infection, poisoning, hypoxia, ischemia, encephalopathy, or substance abuse, as appropriate for specific cases,
- Physical, cognitive, emotional, and behavioral impairments related to the brain injury or

- Impairments that are clinically and functionally significant and lead to activity and participation restrictions.

Types of Services Provided
With its focus on coordinated medical and rehabilitation care from acute inpatient rehabilitation to community reintegration, PSC is uniquely positioned to address the complex constellation of physical, mental, and psychosocial conditions specific to the service-related experience. Through PSC, 144 specialized TBI and polytrauma programs are available throughout VHA. All services are interdisciplinary team based, include life-long follow up care and relate to community resources. Specialized PSC clinical programming for Veterans with TBI and polytrauma includes:

- 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.

Workload

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Unique Patients							
TBI-OEF/OIF/OND/OIR 1/	71,416	71,156	76,060	**81,316**	**86,828**	5,256	5,512
TBI-All Veteran Care	139,624	138,093	146,112	**153,583**	**160,847**	7,471	7,264

1/ Included in TBI-All Veteran Care.

Women Veterans Health Care

Women Veterans Health: All Care

Description (*dollars in thousands*)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary & Mandatory Obligations by Category:							
Medical Services	$8,125,117	$8,529,995	$9,445,700	$11,026,843	$12,877,298	$1,581,143	$1,850,454
Medical Community Care	$2,799,376	$2,797,393	$3,254,630	$3,799,666	$4,438,107	$545,036	$638,441
Medical Support and Compliance	$1,162,546	$1,199,039	$1,351,328	$1,577,355	$1,841,892	$226,028	$264,537
Medical Facilities	$912,041	$1,131,258	$1,060,300	$1,237,828	$1,445,526	$177,528	$207,698
Obligations [Total]	$12,999,081	$13,657,684	$15,111,958	$17,641,692	$20,602,823	$2,529,734	$2,961,131

Women Veterans Health: Women Veterans-Specific Care [1/]

Description (*dollars in thousands*)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary & Mandatory Obligations by Category:							
Medical Services	$561,786	$586,279	$652,341	$753,113	$870,540	$100,772	$117,427
Medical Community Care	$259,399	$282,156	$301,839	$348,750	$403,836	$46,912	$55,085
Medical Support and Compliance	$91,668	$97,080	$106,427	$122,786	$141,920	$16,359	$19,134
Medical Facilities	$73,228	$94,269	$85,021	$98,132	$113,420	$13,112	$15,288
Obligations [Total]	$986,081	$1,059,784	$1,145,627	$1,322,781	$1,529,716	$177,154	$206,935

[1/] Included in Women Veterans Health-All Care.

Description (*dollars in thousands*)	2024 Actual	2025 Budget Estimate 1/	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary & Mandatory Obligations:							
Women's Health Innovation and Staffing Enhancement Initiative	$80,030	$210,318	$154,871	$221,179	$225,603	$66,308	$4,424
Mini-Residency Program 2/	$895	*N/A*	$2,079	$2,400	$2,448	$321	$48
All Other Office of Women's Health Program 3/	$17,205	$34,723	$20,633	$29,047	$29,628	$8,414	$581
Obligations 1/ [Total]	$98,130	$245,041	$177,583	$252,626	$257,679	**$75,043**	**$5,053**
Account Category:							
Medical Services	*$89,128*	*$231,001*	*$165,315*	*$233,923*	*$238,601*	*$68,608*	*$4,678*
Medical Support & Compliance	*$9,002*	*$32,659*	*$12,268*	*$16,581*	*$16,913*	*$4,313*	*$332*
Medical Facilities	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Medical Care Total	*$98,130*	*$245,041*	*$177,583*	*$250,504*	*$255,514*	*$72,921*	*$5,010*

1/ Excludes the cost of the Veterans Childcare Program which is no longer managed by this office
2/ Details not displayed in the 2025 Congressional Justification.
3/ Includes obligations previously displayed as PACT Act and MAMMO Act implementation.

Women Veterans Workload

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Unique Patients							
Women Veterans Health-Gender-Specific Care 1/	426,277	445,101	463,468	**502,803**	**541,942**	39,335	39,139
Women Veterans Health-All Care	714,750	710,824	765,312	**824,103**	**888,871**	58,791	64,768

1/ Included in Women Veterans Total Unique Patients.

Authority for action

- 38 U.S.C. §1710. Eligibility for hospital, nursing home, and domiciliary care.
- 38 U.S.C. §1703 note. Establishment of Women Veteran Training Module for Non-Department of Veterans Affairs Health Care Providers
- 38 U.S.C. §1720D. Counseling and treatment for sexual trauma
- 38 U.S.C. §1786. Care for newborn children of women Veterans receiving maternity care
- 38 U.S.C. §6303 note. Expansion of Capabilities of Women Veterans Call Center
- 38 U.S.C. §7310. Office of Women's Health
- 38 U.S.C. §8110 note. Staffing of Women's Health Care Primary Care Providers at Medical Facilities of the Department of Veterans Affairs

- P.L. 116-315, Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, Title V, Deborah Sampson Act of 2020
    - Sec. 5202. Additional funding for primary care and emergency care clinicians in women Veterans health care mini-residency program
- P.L. 118-42, Consolidated Appropriations Act 2024
    - Sec. 234. Authority for fertility counseling and treatment using assisted reproductive technology, and adoption reimbursement, to a covered Veteran

Purpose

The women Veteran population is the fastest growing demographic within VA and is anticipated to grow from 944,000 enrolled in 2023 to over 1.3 million by 2033 (Source: 2024 Enrollee Health Care Projection Model). The Office of Women's Health (OWH) supports implementation of high-quality, comprehensive women's health care at all sites of care across VA to provide services to meet the unique needs of women Veterans. OWH oversees initiatives associated with the implementation and evaluation of comprehensive care, including the availability of designated Women's Health Primary Care Providers (WH-PCP) at all sites of care, care coordination initiatives, provider support, informatics tools, evidence-based quality improvement initiatives, reproductive health, and clinical education and training. VA has enhanced provision of care to women Veterans by requiring women be assigned to designated WH-PCPs, trained practitioners experienced in women's clinical care. This practice is evidence-based and enhances satisfaction and quality of care for women Veterans. To ensure VA meets the needs for the increasing numbers of women Veterans, VHA provides training to primary care providers (enabling them to become designated WH-PCP) through large-scale, educational initiatives, such as the highly regarded large national mini-residency programs, supporting local facility led mini-residency programs, and training at rural sites. Due to the rapid growth of the women Veteran population, turnover, as well as attrition of providers, VA continues to have an ongoing need to train approximately 900 primary care providers become WH-PCPs annually.

Despite successful training initiatives, there are still significant gaps in women's health staffing across the system. 7% of community-based outpatient clinics (CBOC) do not have even one WH-PCP and nearly 20% of medical centers do not have a gynecologist. OWH leads the Women's Health Innovation and Staffing Enhancements (WHISE) initiative that provides funding to fill critical gaps in women's health staffing or women specific equipment needs. OWH's Reproductive Health Division works to support VHA in delivering high-quality, reproductive health care to women Veterans across the lifespan. Areas of clinical priority include pregnancy and family planning care, fertility and family-building services (i.e., in-vitro fertilization (IVF) and assisted reproductive technology (ART)); medical and surgical management of gynecologic conditions; and midlife reproductive health needs (i.e., menopause, pelvic floor disorders, and sexual function).

2025 Planned Accomplishments

- Establish the first VA surgical academic advanced fellowship program in minimally invasive gynecologic surgery at five VHA sites. This will expand the gynecology workforce with specialty training in minimally invasive gynecologic surgery.

- Launch a Newborn Supply Kit program pilot in partnership with the Department of Health and Human Services (HHS) and external partner Baby2Baby to provide medically necessary essentials to support postpartum Veterans and their newborns.
- Offer three more national Women's Health Mini-Residency trainings to ensure women Veterans receive high quality, patient driven healthcare.
- Complete site visits, assessments, and evidence-based quality improvement initiatives at ten women's health programs through the Women Veteran's Achieving Comprehensive Health Innovation and Enhancement for Women Veterans through Evidence Based Quality Improvement (ACHIEVE) project.
- Continue WHISE program to enhance access and provide necessary services to women Veterans including funding support for hiring primary care providers, gynecologists, maternity care coordinators and other critical front line women's health positions.

2026 Budget Request

The 2026 Budget request for the OWH is $229.7 million, an increase of $60.3 million (35.6%) over the 2025 Current Estimate. This budget request supports the implementation and evaluation of high-quality, comprehensive healthcare for women Veterans at all sites of care across VHA enterprise. As such, the budget supports the primary functions of the OWH across the three teams of Comprehensive Health, Reproductive Health, and Healthcare Education. OWH supports implementation of critical gynecologic services across VHA, including ongoing implementation of expanded eligibility for fertility care benefits to new groups of Veterans, expansion of the VA Advanced Fellowship Program in Minimally Invasive Gynecologic Surgery to grow the VA Gynecology workforce and improve VA's ability to provide direct gynecology care to Veterans, and the development of enhanced menopause care resources and training for clinicians to ensure Veterans have access to cutting-edge menopause care across the enterprise. Recent legislation has highlighted unique areas of attention. Maternity care coordination support is required by the Protecting Moms Who Served Act. In response to the demonstrated increased needs of Veterans in the year postpartum, VA has expanded the maternity care coordination program to follow pregnant Veterans throughout their pregnancy and one year postpartum.

OWH supports national training to women's health providers. The 2026 budget request supports large face to-face mini-residencies that provide hands-on training in clinical skills, local mini-residency programs, as well as the traveling rural mini-residency program to bring training to rural providers. The budget includes realignment and restructuring of the Women's Health traveling Mini Residency Training Program, currently funded by the Office of Rural Health. The enterprise-wide initiative is set to expire at the end of 2026. OWH also oversees the national Women Veteran's Call Center which conducts outgoing outreach calls and incoming calls to provide outreach information about benefits and services specific to women Veterans.

In addition to supporting national program office staff, the 2026 budget supports field-based "just-in-time" subject matter experts through memorandum of understanding agreements. This includes multiple critical initiatives, such as the Women's Health Evaluation Initiative, projects focused on reducing maternal morbidity and mortality among Veterans, clinical experts who support the national mini-residency program, and quality improvement oversight in facility women Veterans' programs.

The Women's Health Innovative and Staffing Enhancement (WHISE) funding request will enable the facilities to request staffing, training, equipment and quality improvement initiatives to address gaps unique to their health care systems.

2026 Planned Accomplishments

- OWH will offer two national Women's Health Mini-Residency Programs in 2026. OWH will continue to engage with VISN and local leadership to identify participants to ensure that women's health clinical training needs are met and training is provided for staff at sites with the greatest need.
- Complete ACHIEVE site visits, assessments, and evidence-based quality improvement initiatives at 8 women's health programs through Evidence Based Quality Improvement (ACHIEVE) project.
- Complete a menopause needs assessment for women Veterans, continue work on a VA-DoD clinical practice guideline for menopause, and establish a VHA National E-Consult service to provide expert guidance on complex menopause management for primary care providers and gynecologists across the enterprise.
- Lead national training on trauma-informed care and establish trauma-informed care champions at the highest levels of leadership and practice to fully integrate trauma-informed care practices across VISNs and facilities.
- Continue the WHISE program to provide funding to close gaps in availability of frontline women's health providers and staff, to ensure access to care.

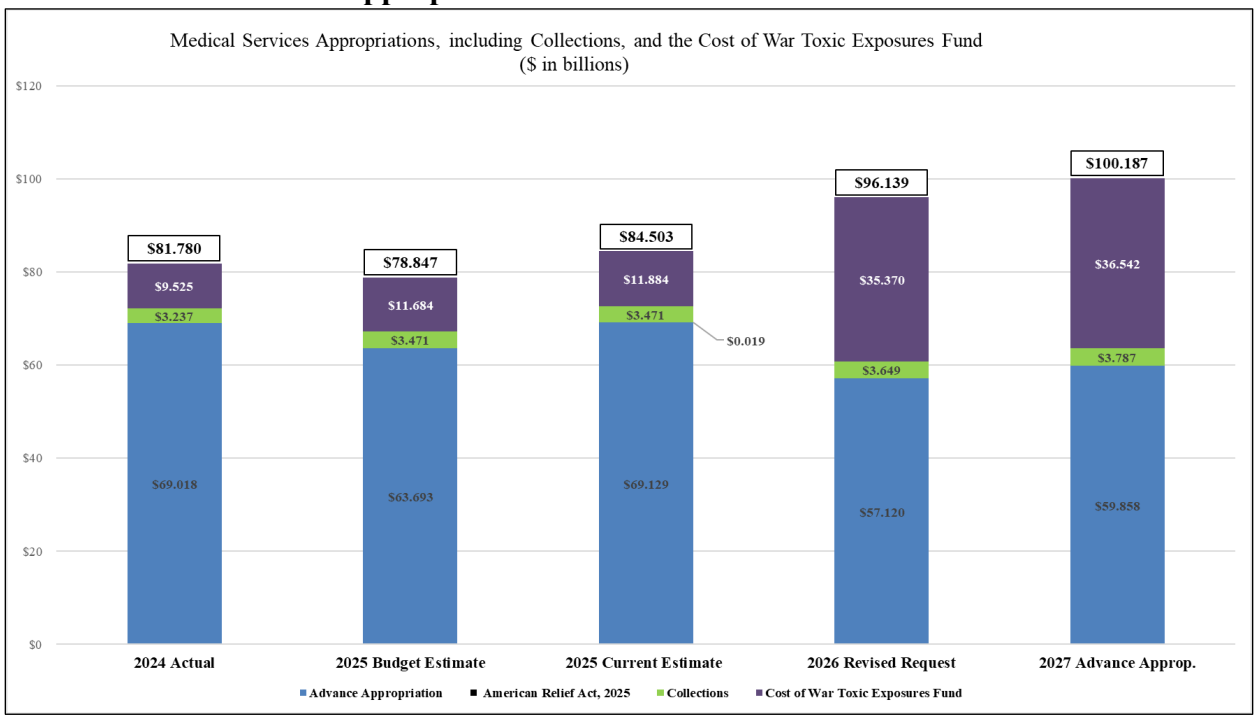
Evidence

Since August of 2022, VHA has enrolled over 100,000 women Veterans with nearly 19,000 exclusively due to the PACT Act. Presumptive conditions identified through PACT Act include reproductive cancers, resulting in an increase in enrolled service-connected women in VA and women specifically seeking care for reproductive cancers.

- Women assigned to WH-PCPs had higher satisfaction on five composite satisfaction scores including access, communication, shared decision making, self-management support, and comprehensiveness (Bastian, 2014).
- Women assigned to WH-PCPs were more likely to receive age-appropriate cervical cancer screening (94.4% versus 91.9%) and breast cancer screening (86.0 vs 83.3 percent). These rates in VA substantially exceed breast and cervical cancer screening rates in other health care data sets such as Medicaid, Medicare and commercial populations (Bean-Mayberry, 2015).
- Clinicians who complete the national and rural health trainings increase access of care to trained and equipped clinicians, sustained increased self-reported comfort managing WH topics (improvements in KAPS), share their knowledge locally with others who care for women Veterans.
- WH-PCPs are twice as likely to remain WH-PCPs in VA, reducing turnover.
- The gynecology workforce has grown with over 88 percent of VA sites having gynecology FTEE. Expanded VHA policies for reproductive care will require additional gynecologists

at all sites of care. Shifting services form the community care to direct care providers will result in cost savings.

Chart: Medical Services Appropriations and Collections[1/]



[1/] 2024 Actual reflects enacted rescissions. 2025 Current Estimate includes transfers of appropriations among Medical Care and other VA accounts. 2026 Revised Request reflects a proposed cancellation. In all years, discretionary appropriations are prior to transfers to the joint VA-DoD health care accounts.

2026 Revised Request

To realign funding among accounts, the Department of Veterans Affairs (VA) proposes to cancel $15.9 billion from the enacted 2026 discretionary advance appropriation of $75.0 billion for the Medical Services (MS) account and requests $35.4 billion in mandatory appropriations from the Cost of War Toxic Exposures Fund (TEF) for MS in 2026; and to transfer $2.0 billion from Medical Services to Medical Facilities. When combined with unobligated balances, reimbursements, and transfers with other accounts, the projected 2026 obligations level in the MS category is $97.0 billion.

Appropriation Language

For necessary expenses for furnishing, as authorized by law, inpatient and outpatient care and treatment to beneficiaries of the Department of Veterans Affairs and veterans described in section 1705(a) of title 38, United States Code, including care and treatment in facilities not under the jurisdiction of the Department, and including medical supplies and equipment, bioengineering

services, food services, and salaries and expenses of healthcare employees hired under title 38, United States Code, assistance and support services for caregivers as authorized by section 1720G of title 38, United States Code, loan repayments authorized by section 604 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111–163; 124 Stat. 1174; 38 U.S.C. 7681 note), monthly assistance allowances authorized by section 322(d) of title 38, United States Code, grants authorized by section 521A of title 38, United States Code, and administrative expenses necessary to carry out sections 322(d) and 521A of title 38, United States Code, and hospital care and medical services authorized by section 1787 of title 38, United States Code; $59,858,000,000, plus reimbursements, which shall become available on October 1, 2026, and shall remain available until September 30, 2027: Provided, That, of the amount made available on October 1, 2026, under this heading, $2,000,000,000 shall remain available until September 30, 2028: Provided further, That of the $75,039,000,000 that became available on October 1, 2025, previously appropriated under this heading in the Full-Year Continuing Appropriations Act, 2025 (division A of Public Law 119–4), $15,889,000,000 is hereby permanently cancelled: Provided further, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs shall establish a priority for the provision of medical treatment for veterans who have service-connected disabilities, lower income, or have special needs: Provided further, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs shall give priority funding for the provision of basic medical benefits to veterans in enrollment priority groups 1 through 6: Provided further, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs may authorize the dispensing of prescription drugs from Veterans Health Administration facilities to enrolled veterans with privately written prescriptions based on requirements established by the Secretary: Provided further, That the implementation of the program described in the previous proviso shall incur no additional cost to the Department of Veterans Affairs: Provided further, That the Secretary of Veterans Affairs shall ensure that sufficient amounts appropriated under this heading for medical supplies and equipment are available for the acquisition of prosthetics designed specifically for female veterans: Provided further, That nothing in section 2044(e) of title 38, United States Code, may be construed as limiting amounts that may be made available under this heading for fiscal years 2026 and 2027 in this or prior Acts.

The following tables display the discretionary, mandatory, and combined sources of funds for MS.

Table: Medical Services Discretionary Funding Crosswalk 2024-2027

(dollars in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Appropriation Medical Services (0160)							
Advance Appropriation	$74,004,000	$71,000,000	$71,000,000	$75,039,000	$59,858,000	$4,039,000	($15,181,000)
Annual Appropriation Adjustment	$0	$0	$0	$0	$0	$0	$0
Advance Appropriation Rescission (P.L. 118-42)	($3,034,205)	$0	$0	$0	$0	$0	$0
Unobligated Balances Rescission (P.L. 118-42, sec. 259)	($1,951,750)	$0	$0	$0	$0	$0	$0
P.L. 118-158, American Relief Act, 2025 (Hurricane Supplemental)	$0	$0	$19,258	$0	$0	($19,258)	$0
Proposed Cancellation	$0	$0	$0	($15,889,000)	$0	($15,889,000)	$15,889,000
Net Appropriation	**$69,018,045**	**$71,000,000**	**$71,019,258**	**$59,150,000**	**$59,858,000**	**($11,869,258)**	**$708,000**
Transfers To:							
North Chicago Demo. Fund (0169) from Medical Services (0160)	($397,454)	($384,926)	($384,926)	($416,125)	($477,700)	($31,199)	($61,575)
DoD-VA Hlth Care Sharing Incentive Fund (0165) from Medical Services (0160).	($15,000)	($15,000)	($15,000)	($15,000)	($15,000)	$0	$0
Medical Facilities (0162)	$0	$0	$0	($2,030,000)	$0	($2,030,000)	$2,030,000
Medical Community Care (0140)	$0	($7,307,318)	($2,090,089)	$0	$0	$2,090,089	$0
Transfers To [Subtotal]	($412,454)	($7,707,244)	($2,490,015)	($2,461,125)	($492,700)	$28,890	$1,968,425
Transfers From:							
Medical and Prosthetic Research (0161)	$0	$0	$8,318	$0	$0	($8,318)	$0
Board of Veterans' Appeals (1122)	$0	$0	$9,870	$0	$0	($9,870)	$0
General Administration (0142)	$0	$0	$26,901	$0	$0	($26,901)	$0
Information Technology Systems (0167)	$0	$0	$174,034	$0	$0	($174,034)	$0
Medical Care Collections Fund (5287)	$3,236,812	$3,470,595	$3,471,000	$3,649,000	$3,787,000	$178,000	$138,000
Transfers From [Subtotal]	$3,236,812	$3,470,595	$3,690,123	$3,649,000	$3,787,000	($41,123)	$138,000
Discretionary Budget Authority Total	$71,842,403	$66,763,351	$72,219,366	$60,337,875	$63,152,300	($11,881,491)	$2,814,425
Reimbursements Medical Services (0160)	$138,025	$119,759	$138,025	$138,025	$138,025	$0	$0
Unobligated Balance (SOY):							
P.L. 118-158, American Relief Act, 2025 (Hurricane Supplemental)	$0	$0	$0	$16,766	$0	$16,766	($16,766)
P.L. 111-32 (H1N1 no-year)	$7	$7	$7	$7	$7	$0	$0
P.L. 110-28 (Emergency Supplemental no-year)	$136	$136	$136	$136	$136	$0	$0
No-Year (all other)	$2,663,890	$4,579,519	$4,826,827	$0	$0	($4,826,827)	$0
2-Year	$1,050,837	$2,000,000	$324,646	$1,185,555	$0	$860,909	($1,185,555)
Unobligated Balance (SOY) [Subtotal]	$3,714,870	$6,579,662	$5,151,616	$1,202,464	$143	($3,949,152)	($1,202,321)
Unobligated Balance (EOY):							
P.L. 118-158, American Relief Act, 2025 (Hurricane Supplemental)	$0	$0	($16,766)	$0	$0	$16,766	$0
P.L. 111-32 (H1N1 no-year)	($7)	($7)	($7)	($7)	($7)	$0	$0
P.L. 110-28 (Emergency Supplemental no-year)	($136)	($136)	($136)	($136)	($136)	$0	$0
No-Year (all other)	($4,826,827)	$0	$0	$0	$0	$0	$0
2-Year	($324,646)	($1,000,000)	($1,185,555)	$0	$0	$1,185,555	$0
Unobligated Balance (EOY) [Subtotal]	($5,151,616)	($1,000,143)	($1,202,464)	($143)	($143)	$1,202,321	$0
Lapse Medical Services (0160)	($128)	$0	$0	$0	$0	$0	$0
Subtotal	$70,543,554	$72,462,629	$76,306,543	$61,678,221	$63,290,325	($14,628,322)	$1,612,104
Prior Year Recoveries	$110,867	$0	$0	$0	$0	$0	$0
Discretionary Obligations (0160) [Subtotal]	**$70,654,421**	**$72,462,629**	**$76,306,543**	**$61,678,221**	**$63,290,325**	**($14,628,322)**	**$1,612,104**

Table: Medical Services Mandatory Funding Crosswalk 2024-2027

(dollars in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
ARP Act, sec. 8007 (0160XP)							
Unobligated Balance (SOY)	$2,850	$2,850	$2,850	$2,850	$2,850	$0	$0
Unobligated Balance (EOY)	($2,850)	($2,850)	($2,850)	($2,850)	($2,850)	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0
Prior Year Recoveries	$5	$0	$0	$0	$0	$0	$0
Obligations, ARP Act, sec. 8007 (0160XP) [Total]	$5	$0	$0	$0	$0	$0	$0
American Rescue Plan Act Obligations [Subtotal]	**$5**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Cost of War Toxic Exposures Fund							
Mandatory Appropriation	$9,525,428	$11,683,896	$11,883,896	$35,370,000	$36,542,000	$23,486,104	$1,172,000
Unobligated Balance (SOY)	$3,815,453	$2,346,075	$1,653,930	$0	$0	($1,653,930)	$0
Realignment of Unobligated Balances	$18,765	$0	($387,599)	$0	$0	$387,599	$0
Unobligated Balance (EOY)	($1,653,930)	$0	$0	$0	$0	$0	$0
Obligations, TEF [Total]	**$11,705,716**	**$14,029,971**	**$13,150,227**	**$35,370,000**	**$36,542,000**	**$22,219,773**	**$1,172,000**
VACAA, sec. 801 (0160XA)							
Unobligated Balance (SOY):	$8,817	$4,980	$2,413	$0	$0	($2,413)	$0
Unobligated Balance (EOY):	($2,413)	$0	$0	$0	$0	$0	$0
Subtotal	$6,404	$4,980	$2,413	$0	$0	($2,413)	$0
Prior Year Recoveries	$4	$0	$0	$0	$0	$0	$0
Obligations (0160XA) [Total]	**$6,408**	**$4,980**	**$2,413**	**$0**	**$0**	**($2,413)**	**$0**
Mandatory Budget Authority [Subtotal]	$9,525,428	$11,683,896	$11,883,896	$35,370,000	$36,542,000	$23,486,104	$1,172,000
Mandatory Obligations [Subtotal]	**$11,712,129**	**$14,034,951**	**$13,152,640**	**$35,370,000**	**$36,542,000**	**$22,217,360**	**$1,172,000**

Table: Medical Services All Funding Sources Crosswalk 2024-2027

(dollars in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Budget Authority [Grand Total]	$81,367,831	$78,447,247	$84,103,262	$95,707,875	$99,694,300	$11,604,613	$3,986,425
Obligations [Grand Total]	**$82,366,550**	**$86,497,580**	**$89,459,183**	**$97,048,221**	**$99,832,325**	**$7,589,038**	**$2,784,104**
FTE							
Medical Services (0160)	222,328	290,658	236,063	120,858	114,840	(115,205)	(6,018)
Cost of War Toxic Exposures Fund (1126MS)	81,717	0	66,400	181,616	187,634	115,216	6,018
VACAA, sec. 801 (0160XA)	21	31	11	0	0	(11)	0
FTE [Total]	304,066	290,689	302,474	302,474	302,474	0	0

Summary of Obligations by Functional Area

To provide better visibility into the spending under MS, additional detail on obligations by the following program activities are reflected in the following charts, beginning with total obligations.

Table: Medical Services Total Obligations by Program

(dollars in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Health Care Services	$58,476,977	$59,862,880	$61,748,240	$65,902,583	$65,443,083	$4,154,343	($459,500)
Beneficiary Travel	$2,029,950	$2,126,009	$2,139,468	$2,248,986	$2,364,111	$109,518	$115,125
Caregivers Support Program	$2,128,907	$2,872,200	$2,644,205	$3,225,345	$3,549,827	$581,140	$324,482
CHAMPVA (excluding Caregivers)	$544,959	$570,897	$682,454	$774,660	$860,594	$92,206	$85,934
Equipment	$1,162,249	$2,229,619	$1,811,122	$2,088,230	$2,191,985	$277,108	$103,755
Homeless Programs and Grants 1/	$2,043,592	$2,086,387	$2,087,088	$2,176,446	$2,469,939	$89,358	$293,493
Pharmaceutical Ingredients	$10,601,145	$11,136,381	$12,416,159	$14,098,128	$15,811,856	$1,681,969	$1,713,728
Prosthetic Supplies and Services	$5,011,980	$5,310,639	$5,653,512	$6,241,476	$6,842,716	$587,964	$601,240
Readjustment Counseling Service	$255,915	$302,568	$276,935	$292,367	$298,214	$15,432	$5,847
Obligations [Subtotal]	**$82,255,674**	**$86,497,580**	**$89,459,183**	**$97,048,221**	**$99,832,325**	**$7,589,038**	**$2,784,104**
VA Prior-Year Recoveries	$110,876	$0	$0	$0	$0	$0	$0
Total Obligations	$82,366,550	$86,497,580	$89,459,183	$97,048,221	$99,832,325	$7,589,038	$2,784,104

1/This line reflects the Homeless program office Medical Services budget and excludes Homeless program efforts funded by General Purpose. For more information, please see the Homeless Program Table in the Medical Care Chapter.

Table: Medical Services Discretionary Obligations by Program

(dollars in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Health Care Services 1/	$50,476,535	$57,057,548	$50,258,502	$34,473,484	$32,972,567	($15,785,018)	($1,500,917)
Beneficiary Travel	$1,280,965	$2,126,009	$1,730,378	$1,066,716	$1,142,666	($663,662)	$75,950
Caregivers Support Program 1/	$2,128,907	$2,872,200	$2,644,205	$3,225,345	$3,549,827	$581,140	$324,482
CHAMPVA (excluding Caregivers)	$544,959	$570,897	$682,454	$774,660	$860,594	$92,206	$85,934
Equipment	$1,162,164	$0	$1,811,122	$2,088,230	$2,191,985	$277,108	$103,755
Homeless Programs and Grants 2/	$2,043,592	$2,086,387	$2,087,088	$2,176,446	$2,469,939	$89,358	$293,493
Pharmaceutical Ingredients	$7,638,537	$2,136,381	$11,162,347	$11,339,497	$12,961,817	$177,150	$1,622,320
Prosthetic Supplies and Services	$5,011,980	$5,310,639	$5,653,512	$6,241,476	$6,842,716	$587,964	$601,240
Readjustment Counseling Service	$255,915	$302,568	$276,935	$292,367	$298,214	$15,432	$5,847
Obligations [Subtotal]	**$70,543,554**	**$72,462,629**	**$76,306,543**	**$61,678,221**	**$63,290,325**	**($14,628,322)**	**$1,612,104**
VA Prior-Year Recoveries	$110,867	$0	$0	$0	$0	$0	$0
Total Obligations	$70,654,421	$72,462,629	$76,306,543	$61,678,221	$63,290,325	($14,628,322)	$1,612,104

1/ Amounts for the Caregivers Support Program and Health Care Services differ from the President's Budget Appendix due to revised program cost estimates from subsequently available data

2/ This line reflects the Homeless program office Medical Services budget and excludes Homeless program efforts funded by General Purpose. For more information, please see the Homeless Program Table in the Medical Care Chapter.

Table: Medical Services Mandatory Obligations by Program
(dollars in thousands)

Description:	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
ARP Act, sec. 8007 (0160XP)							
Health Care Services	$0	$0	$0	$0	$0	$0	$0
ARP Act, sec. 8007 Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Prior Year Recoveries	$5	$0	$0	$0	$0	$0	$0
ARP Act, sec. 8007 Obligations [Total]	**$5**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Cost of War Toxic Exposures Fund (TEF)							
Health Care Services	$7,994,123	$2,800,352	$11,487,325	$31,429,099	$32,470,516	$19,941,774	$1,041,417
Beneficiary Travel	$748,985	$0	$409,090	$1,182,270	$1,221,445	$773,180	$39,175
Equipment	$0	$2,229,619	$0	$0	$0	$0	$0
Pharmaceutical Ingredients	$2,962,608	$9,000,000	$1,253,812	$2,758,631	$2,850,039	$1,504,819	$91,408
TEF Obligations [Subtotal]	**$11,705,716**	**$14,029,971**	**$13,150,227**	**$35,370,000**	**$36,542,000**	**$22,219,773**	**$1,172,000**
VACAA, sec. 801							
Health Care Services	$6,319	$4,980	$2,413	$0	$0	($2,413)	$0
Equipment	$85	$0	$0	$0	$0	$0	$0
VACAA, sec. 801 Obligations [Subtotal]	**$6,404**	**$4,980**	**$2,413**	**$0**	**$0**	**($2,413)**	**$0**
Prior Year Recoveries	$4	$0	$0	$0	$0	$0	$0
VACAA, sec. 801 Obligations [Total]	**$6,408**	**$4,980**	**$2,413**	**$0**	**$0**	**($2,413)**	**$0**
MSC Obligations - Mandatory Funds [Total]	**$11,712,129**	**$14,034,951**	**$13,152,640**	**$35,370,000**	**$36,542,000**	**$22,217,360**	**$1,172,000**

In 2026, total obligations are projected to increase by $7.6 billion above the 2025 current estimate, with four programs accounting for $7.0 billion of the increase and all other adjustments accounting for the remaining increase:

- **Health Care Services (+$4.2 billion).** The estimated costs are expected to increase by almost 7%, reflecting the impact of personnel cost increases outside of the civilian pay raise (assumed to be zero), medical contract costs, and other factors.
- **Pharmaceutical Ingredients (+$1.7 billion).** The estimated cost for this program is expected to increase by about 13% from 2025 based on expected trends.
- **Prosthetic Supplies and Services (+$588 million).** The estimated cost for this program is expected to increase by approximately 10% from 2025 based on expected trends.
- **Caregivers Support Program (+$581 million).** This increase is consistent with growth projected by the program's actuarial model and potential program changes.

Summary of the 2027 Advance Appropriations Request

The 2026 budget request reflects a 2027 discretionary advance appropriation request of $59.9 billion; and an allocation of $36.5 billion out of the total 2027 mandatory advance appropriation request for the TEF. When combined with all other resources, the projected 2027 obligations level in the MS category is $99.8 billion, an increase of $2.8 billion (2.9%) above the 2026 level.

Medical Services Program Funding Requirements

VA is committed to providing the best access to care for Veterans. VA will continue to pursue efforts to improve Veterans' access to timely, high-quality care, ensuring that VA provides Veterans with the health care choices they earned.

The Medical Services category provides support for both VA direct care and community care, and increases in care provided in either setting resulted in increased costs in Medical Services. The Medical Services funded support activities include beneficiary travel, pharmacy costs, and clinical care coordination activities.

The following tables provide additional detail on nine distinct activities of the Medical Services account: Health Care Services, Beneficiary Travel, Caregivers Support Program, CHAMPVA (excluding Caregivers), Equipment, Homeless Programs and Grants, Pharmaceutical Ingredients, Prosthetic Supplies and Services, and Readjustment Counseling Service.

Health Care Services

		2025		2026	2027		
Description (dollars in thousands)	2024 Actual	Budget Estimate	Current Estimate	Revised Request	Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$50,476,535	$57,057,548	$50,258,502	$34,473,484	$32,972,567	($15,785,018)	($1,500,917)
Mandatory Obligations	$8,000,442	$2,805,332	$11,489,738	$31,429,099	$32,470,516	$19,939,361	$1,041,417
Medical Services Obligations |Grand Total|	**$50,476,535**	**$57,057,548**	**$50,258,502**	**$34,473,484**	**$32,972,567**	**($15,785,018)**	**($1,500,917)**

The Medical Services Health Care Services activity reflects primarily personnel and contracting costs to support the following health care activities:

- Ambulatory care (without pharmacy)
- Dental
- Inpatient
- Mental health
- Rehabilitative care
- Long term care

Medical Services FTE represents the largest share of VHA obligations by object class. They include:

- Physicians
- Dentists

- Registered nurses
- Licensed practical nurses, licensed vocational nurses, and nurse assistants
- Non-physician providers, such as podiatrists, physician assistants, psychologists, nurse practitioners, chiropractors, and optometrists
- Health technicians and allied health, such as respiratory therapists, physical therapists, dietitians, social workers, radiology technologists, pharmacists, audiologist and speech pathologists, nuclear medicine technologists, and laboratory aids
- Wage board

Beneficiary Travel [1/]

		2025		2026	2027		
Description (dollars in thousands)	2024 Actual	Budget Estimate	Current Estimate	Revised Request	Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$1,280,965	$2,126,009	$1,730,378	$1,066,716	$1,142,666	($663,662)	$75,950
Mandatory Obligations (including VMCHF and TEF)	$748,985	$0	$409,090	$1,182,270	$1,221,445	$773,180	$39,175
Obligations [Grand Total]	**$2,029,950**	**$2,126,009**	**$2,139,468**	**$2,248,986**	**$2,364,111**	**$109,518**	**$115,125**

[1/] This table displays obligations only in Medical Services for this activity line. A breakout of the $2.0 billion in total 2024 obligations for the Beneficiary Travel cost can be found in the Medical Care Chapter, Obligations by Object table.

		2025		2026	2027		
	2024 Actual	Budget Estimate	Current Estimate	Revised Request	Advance Approp.	+/- 2025-2026	+/- 2026-2027
Beneficiary Travel-Mileage	$316,157	$343,978	$317,268	$318,383	$319,502	$1,115	$1,119
Beneficiary Travel-Special Mode	$1,635,612	$1,678,561	$1,740,982	$1,846,268	$1,957,074	$105,286	$110,806
All Other Beneficiary Travel	$114,449	$103,470	$117,486	$120,603	$123,803	$3,117	$3,200
Beneficiary Travel Total	**$2,066,218**	**$2,126,009**	**$2,175,736**	**$2,285,254**	**$2,400,379**	**$109,518**	**$115,125**

VA administers a Beneficiary Travel (BT) Program to help alleviate the costs of travel to medical appointments for eligible Veterans. Travel benefit eligibility for Veterans is based on either the characteristics of the Veteran, the type of medical appointment, or a combination of the two. Others who are not Veterans, including family members or those accompanying Veterans to appointments, may also be eligible for the benefit, based on qualifying criteria. Travel costs are reimbursed to beneficiaries. Costs covered by the program include a per-mile rate (currently $0.415) for travel in private vehicles, special mode travel (e.g., ambulance, wheelchair van), tolls, parking fees, airfare, meals, and lodging subject to a deductible and/or qualifying event.

Eligibility is based upon receipt of VA disability compensation service connection and/or low income (i.e., VA pension thresholds) or special administrative authority. The current BT regulations only provide authorization for BT within the States, Territories and possessions of the United States, the District of Columbia and the Commonwealth of Puerto Rico.

Caregivers Support Program

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$2,128,907	$2,872,200	$2,644,205	$3,225,345	$3,549,827	$581,140	$324,482
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$2,128,907**	**$2,872,200**	**$2,644,205**	**$3,225,345**	**$3,549,827**	**$581,140**	**$324,482**

The Medical Services category portion of the Caregiver Support Program includes respite care, stipend payments, CHAMPVA payments, and case management costs. It excludes administrative costs. For more information on the Caregivers Support Program please see the Medical Care chapter.

CHAMPVA

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$544,959	$570,897	$682,454	$774,660	$860,594	$92,206	$85,934
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$544,959**	**$570,897**	**$682,454**	**$774,660**	**$860,594**	**$92,206**	**$85,934**

The Medical Services Category portion of the CHAMPVA Program includes the pharmacy costs and the cost to VA medical center for delivering care in VA facilities. Medical Services excludes payment to providers and program administration. For more information on the CHAMPVA Program please see the Medical Care chapter.

Medical Equipment [1/]

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$1,162,164	$0	$1,811,122	$2,088,230	$2,191,985	$277,108	$103,755
Mandatory Obligations	$85	$2,229,619	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$1,162,249**	**$2,229,619**	**$1,811,122**	**$2,088,230**	**$2,191,985**	**$277,108**	**$103,755**

[1/] This table only displays obligations for medical equipment. 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 is a foundational element of Veteran healthcare. Some examples of lifesaving equipment include linear accelerators to provide radiation treatment for cancer; computerized tomography scanners that provide imaging to screen for lung cancer; physiologic monitoring systems that display patient vital signs in real time; anesthesia delivery systems that induce and maintain anesthesia in surgical patients; and laboratory analyzers that determine blood glucose measurements.

VA continues to deploy new medical equipment at all medical centers in response to the most critical and time-sensitive needs. Modernized medical equipment expands Veterans' access to care, provides clinical functionality that meets or exceeds community standards, enhances patient safety and mitigates information security risks.

The Medical Services estimated obligations level is $2.1 billion in 2026. Modernizing VHA's medical equipment, while improving its safety and cybersecurity, requires deliberate systems engineering and extensive collaboration across VA lines of business and VHA clinical programs.

Homeless Programs and Grants

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$2,043,592	$2,086,387	$2,087,088	$2,176,446	$2,469,939	$89,358	$293,493
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$2,043,592**	N/A	**$2,087,088**	**$2,176,446**	**$2,469,939**	**$89,358**	**$293,493**

The Medical Services category portion of the Homeless Program centrally managed funding includes grants, case management, and other direct program costs but excludes direct administrative costs. For more information on the Homeless Program please see the Medical Care chapter.

Pharmaceutical Ingredients

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$7,638,537	$2,136,381	$11,162,347	$11,339,497	$12,961,817	$177,150	$1,622,320
Mandatory Obligations	$2,962,608	$9,000,000	$1,253,812	$2,758,631	$2,850,039	$1,504,819	$91,408
Obligations [Grand Total]	**$10,601,145**	N/A	**$12,416,159**	**$14,098,128**	**$15,811,856**	**$1,681,969**	**$1,713,728**

This category represents the cost of pharmaceutical ingredients. For more information on Pharmacy Care, please see the Medical Care chapter.

Prosthetic Supplies and Services

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$5,011,980	$5,310,639	$5,653,512	$6,241,476	$6,842,716	$587,964	$601,240
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$5,011,980**	N/A	**$5,653,512**	**$6,241,476**	**$6,842,716**	**$587,964**	**$601,240**

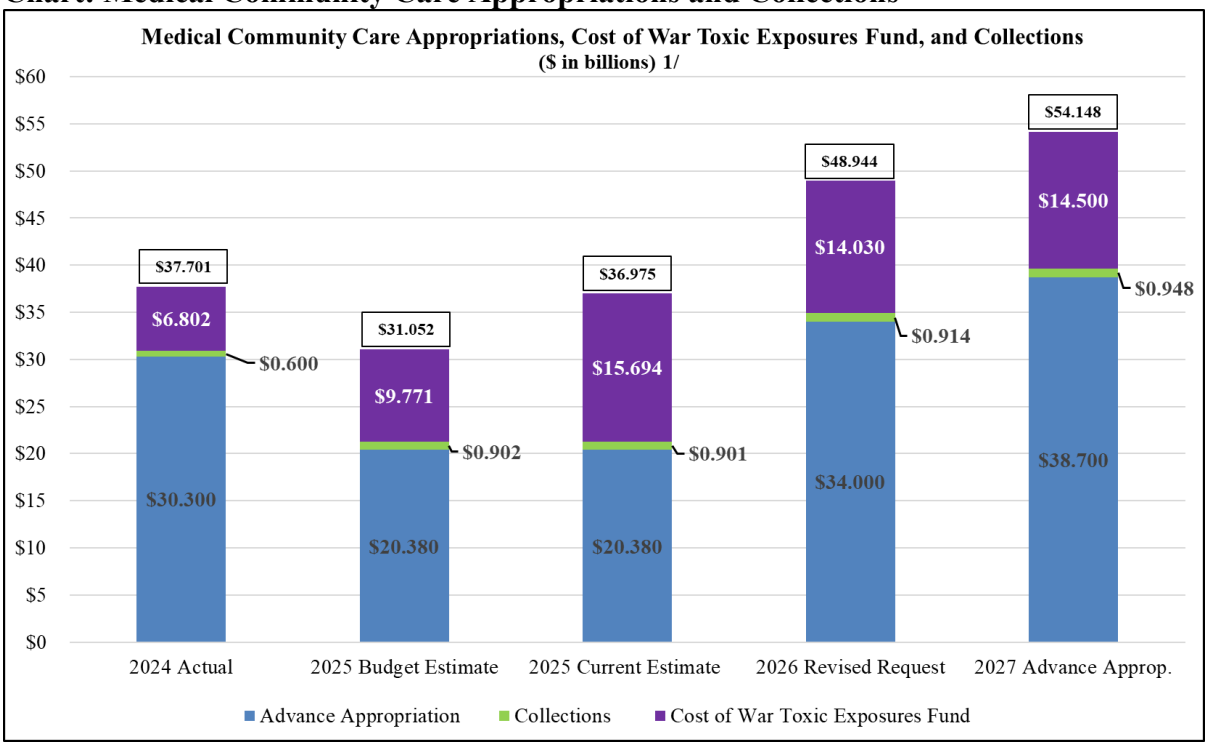
Prosthetic and Sensory Aids Services (PSAS) are foundational at the VA. Services provided include prosthetic and orthotic devices, sensory aids, medical equipment, and support services for Veterans, whether the care is delivered by VA providers or in the community care program. PSAS serves Veterans with needs related to amputation, spinal cord injury/disorders, polytrauma and traumatic brain injury, hearing and vision, podiatric care, cardio-pulmonary disease, speech and swallowing deficits, geriatric impairments, neurologic dysfunction, muscular dysfunction, women's health, orthopedic care, diabetes/metabolic disease, peripheral vascular disease, cerebral vascular diseases, and other medical disorders. For more information, please see the Medical Care chapter.

Readjustment Counseling Services

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$255,915	$302,568	$276,935	$292,367	$298,214	$15,432	$5,847
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$255,915**	**$302,568**	**$276,935**	**$292,367**	**$298,214**	**$15,432**	**$5,847**

The Medical Services category portion of Readjustment Counseling Services includes providers, contracts, and travel. For more information on Readjustment Counseling Services please see the Medical Care chapter.

Chart: Medical Community Care Appropriations and Collections



1/ 2024 Actual reflects an enacted rescission. 2025 Current Estimate includes transfers of appropriations among Medical Care accounts. In all years, discretionary appropriations are prior to transfer to the Joint DoD-VA Medical Facility Demonstration Fund.

2026 Revised Request

The Department of Veterans Affairs (VA) is maintaining the enacted 2026 discretionary advance appropriation of $34.0 billion for the Medical Community Care (MCC) account, while requesting $3 billion of the advance appropriation already enacted be canceled and the same amount of $3 billion be provided with two-year period of availability, to provide additional funding flexibility in VA's ability to provide community care. The budget also requests $14.0 billion in mandatory appropriations from the Cost of War Toxic Exposures Fund (TEF) for MCC in 2026. When combined with medical care collections, unobligated balances, reimbursements, and transfers, the projected 2026 obligations level in the MCC category is $48.8 billion.

Providing Veterans with timely access to high-quality health care is essential whether through a VA facility or community provider. VA will continue to use a combination of care at VA facilities and in the community to meet Veterans' needs. 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.

2027 Advance Appropriations Request

The 2026 budget request reflects a 2027 discretionary advance appropriation request of $38.7 billion; and an allocation of $14.5 billion out of the total 2027 mandatory advance appropriation request for the TEF. When combined with all other resources, the projected 2027 obligations level in the MCC category is $54.0 billion, an increase of $5.2 billion (10.6%) above the 2026 level.

Appropriation Language

For necessary expenses for furnishing health care to individuals pursuant to chapter 17 of title 38, United States Code, at non-Department facilities, $3,000,000,000, to remain available until September 30, 2027; and, in addition, $38,700,000,000, plus reimbursements, which shall become available on October 1, 2026, and shall remain available until September 30, 2028: Provided, That of the $34,000,000,000 that became available on October 1, 2025, previously appropriated under this heading in the Full-Year Continuing Appropriations Act, 2025 (division A of Public Law 119–4), $3,000,000,000 is hereby permanently cancelled.

Tables: Community Care Funding Crosswalks 2024-2027
(dollars in thousands)

The following five tables show funding crosswalks for 2024-2027 for the VA community care program, separately by funding sources as follows:

- MCC, discretionary funding,
- Veterans Choice Fund (VCF), mandatory funding for Medical Care only,
- American Rescue Plan Act, mandatory funding,
- TEF, mandatory funding, and
- Grand total: MCC, VCF, American Rescue Plan (ARP) Act, and TEF.

Table: Medical Community Care (0140) Discretionary Funding Crosswalk 2024-2027

(dollars in thousands)

Medical Community Care (0140) - Discretionary Crosswalk, 2024-2027 (dollars in thousands)							
		2025		2026	2027		
Description	2024 Actual	Budget Estimate	Current Estimate	Revised Request	Advance Approp.	+/- 2025-2026	+/- 2026-2027
APPROPRIATION							
Advance Appropriation Medical Community Care (0140)	$33,000,000	$20,382,000	$20,382,000	$34,000,000	38,700,000	$13,618,000	$4,700,000
Annual Appropriation Adjustment	$0	$0	$0	$3,000,000	-	$3,000,000	($3,000,000)
Advance Appropriation Rescission 1/	($2,657,977)	$0	$0	($3,000,000)	-	($3,000,000)	$3,000,000
Appropriation [sub-total]	$30,342,023	$20,382,000	$20,382,000	$34,000,000	$38,700,000	$13,618,000	$4,700,000
TRANSFERS TO (-)							
North Chicago Demo. Fund (0169) from Medical Community Care (0140)	($51,291)	($93,500)	($93,500)	($103,500)	($110,500)	($10,000)	($7,000)
Transfers to [sub-total]	($51,291)	($93,500)	($93,500)	($103,500)	($110,500)	($10,000)	($7,000)
TRANSFERS FROM (+)							
Medical Services (0160)	$0	$7,307,318	$2,090,089	$0	$0	($2,090,089)	$0
Medical Support & Compliance (0152)	$0	$0	$81,092	$0	$0	($81,092)	$0
Medical Facilities (0162)	$0	$600,000	$1,983	$0	$0	($1,983)	$0
Medical Care Collections Fund (5287)	$599,722	$901,747	$901,000	$914,000	$948,000	$13,000	$34,000
Transfers from [sub-total]	$599,722	$8,809,065	$3,074,164	$914,000	$948,000	($2,160,164)	$34,000
Budget Authority Total	**$30,890,454**	**$29,097,565**	**$23,362,664**	**$34,810,500**	**$39,537,500**	**$11,447,836**	**$4,727,000**
UNOBLIGATED BALANCE (SOY)							
No-Year	$182,096	$0	$264,898	$1,338	$0	($263,560)	($1,338)
2-Year	$1,213,957	$1,512,724	$351,438	$0	$0	($351,438)	$0
Unobligated Balance (SOY) [sub-total]	$1,396,053	$1,512,724	$616,336	$1,338	$0	($614,998)	($1,338)
UNOBLIGATED BALANCE (EOY)							
No-Year Medical Community Care (0140)	($264,898)	$0	($1,338)	$0	$0	$1,338	$0
2-Year	($351,438)	($976,005)	$0	$0		$0	$0
Unobligated Balance (EOY) [sub-total]	($616,336)	($976,005)	($1,338)	$0	$0	$1,338	$0
Lapse	($83)	$0	$0	$0	$0	$0	$0
OBLIGATIONS [sub total]	$31,670,088	$29,634,284	$23,977,662	$34,811,838	$39,537,500	$10,834,176	($74,349,338)
PRIOR YEAR RECOVERIES	$84,137	$0	$0	$0	$0	$0	$0
	$31,754,225	**$29,634,284**	**$23,977,662**	**$34,811,838**	**$39,537,500**	**$10,834,176**	**$4,725,662**
OBLIGATIONS [total]							

1/2024 Actual reflects rescission enacted in P.L. 118-42. 2026 Revised Request reflects proposed cancellation.

Table: Veterans Choice Fund (0172) Medical Care Only Crosswalk 2024-2027

(dollars in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
UNOBLIGATED BALANCE (SOY)							
No-Year	$304,826	$304,826	$304,622	$0	$0	($304,622)	$0
Unobligated Balance (SOY) [sub-total]	$304,826	$304,826	$304,622	$0	$0	($304,622)	$0
UNOBLIGATED BALANCE (EOY)							
No-Year	($304,622)	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [sub-total]	($304,622)	$0	$0	$0	$0	$0	$0
OBLIGATIONS [sub total]	$204	$304,826	$304,622	$0	$0	($304,622)	$0
PRIOR YEAR RECOVERIES	$93	$0	$0	$0	$0	$0	$0
OBLIGATIONS [Total]	**$297**	**$304,826**	**$304,622**	**$0**	**$0**	**($304,622)**	**$0**

[1/] Excludes OI&T Obligations

Table: Medical Community Care, American Rescue Plan Act Crosswalk 2024-2027

(dollars in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
UNOBLIGATED BALANCE (SOY)							
ARP Act § 8007	$176	$176	$176	$176	$176	$0	$0
Unobligated Balance (SOY) [Subtotal]	**$176**	**$176**	**$176**	**$176**	**$176**	**$0**	**$0**
UNOBLIGATED BALANCE (EOY)							
ARP Act § 8007 - no year	($176)	($176)	($176)	($176)	($176)	$0	$0
Unobligated Balance (EOY) [Subtotal]	**($176)**	**($176)**	**($176)**	**($176)**	**($176)**	**$0**	**$0**
OBLIGATIONS	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Table: Medical Community Care, Cost of War Toxic Exposures Fund Crosswalk 2024-2027

(dollars in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
MANDATORY APPROPRIATION							
P.L. 118-5 (2024/2028, TEF)	$6,801,538	$0	$0	$0	$0	$0	$0
P.L. 118-5 (2025/2029, TEF)	$0	$0	$9,894,178	$0	$0	($9,894,178)	$0
P.L. 119-4 (no-year, TEF)	$0	$0	$5,800,000	$0	$0	($5,800,000)	$0
Request (no-year, TEF)	$0	$9,770,646	$0	$14,030,000	$14,500,000	$14,030,000	$470,000
Mandatory Appropriation [Subtotal]	**$6,801,538**	**$9,770,646**	**$15,694,178**	**$14,030,000**	**$14,500,000**	**($1,664,178)**	**$470,000**
UNOBLIGATED BALANCE (SOY)							
P.L. 118-5 (5-year, base year 2024, TEF)	$0	$1,229,354	$2,001,538	$0	$0	($2,001,538)	$0
Unobligated Balance (SOY) [Subtotal]	**$0**	**$1,229,354**	**$2,001,538**	**$0**	**$0**	**($2,001,538)**	**$0**
UNOBLIGATED BALANCE (EOY)							
P.L. 118-5 (5-year, base year 2024, TEF)	($2,001,538)	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	**($2,001,538)**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
OBLIGATIONS	**$4,800,000**	**$11,000,000**	**$17,695,716**	**$14,030,000**	**$14,500,000**	**($3,665,716)**	**$470,000**

Table: Medical Community Care, Veterans Choice Fund (Medical Care Only), American Rescue Plan Act, Cost of War Toxic Exposures Fund Crosswalk 2024-2027

(dollars in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations							
Medical Community Care (0140)	$31,754,225	$29,634,284	$23,977,662	$34,811,838	$39,537,500	$10,834,176	$4,725,662
Discretionary Obligations [Total]	**$31,754,225**	**$29,634,284**	**$23,977,662**	**$34,811,838**	**$39,537,500**	**$10,834,176**	**$4,725,662**
Mandatory Obligations							
Veterans Choice Act (P.L. 113-146)							
Veterans Choice Fund, Medical Care							
Administration (0172XA)	$0	$1,000	$0	$0	$0	$0	$0
Medical Care (0172XB)	$214	$36,056	$300	$0	$0	($300)	$0
Emergency Hepatitis C (0172XC)	$0	$0	$0	$0	$0	$0	$0
Emergency Community Care (0172XE)	($10)	$101	$0	$0	$0	$0	$0
Medical Community Care (0172XG)	$0	$267,669	$304,322	$0	$0	($304,322)	$0
Veterans Choice Fund Prior-Year Recoveries	$93	$0	$0	$0	$0	$0	$0
Veterans Choice Fund [Subtotal]	**$297**	**$304,826**	**$304,622**	**$0**	**$0**	**($304,622)**	**$0**
American Rescue Plan (ARP) Act							
Section 8007 - Medical Community Care	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
PACT Act							
Cost of War Toxic Exposures Fund	$4,800,000	$11,000,000	$17,695,716	$14,030,000	$14,500,000	($3,665,716)	$470,000
PACT [Subtotal]	**$4,800,000**	**$11,000,000**	**$17,695,716**	**$14,030,000**	**$14,500,000**	**($3,665,716)**	**$470,000**
Mandatory Obligations [Total]	**$4,800,297**	**$11,304,826**	**$18,000,338**	**$14,030,000**	**$14,500,000**	**($3,970,338)**	**$470,000**
Obligations [Grand Total]	**$36,554,522**	**$40,939,110**	**$41,978,000**	**$48,841,838**	**$54,037,500**	**$6,863,838**	**$5,195,662**

Tables: Community Care Obligations by Program

(dollars in thousands)

The following four tables show community care obligations by program, separately by funding sources as follows:

- MCC, discretionary funding
- TEF, mandatory funding
- VCF, mandatory funding
- Grand total MCC category: MCC, TEF, and VCF

Medical Community Care Obligations by Program

(dollars in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Health Care Services:							
Ambulatory Care	$10,498,189	$15,144,985	$7,918,667	$11,312,454	$13,085,080	$3,393,787	$1,772,626
Dental Care	$1,240,425	$1,576,100	$1,118,432	$1,386,574	$1,531,126	$268,142	$144,552
Inpatient Care	$8,206,279	$0	$5,035,356	$7,205,018	$8,004,342	$2,169,662	$799,324
Mental Health Care	$1,644,400	$1,973,128	$968,071	$2,909,874	$2,878,951	$1,941,803	($30,923)
Prosthetics	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$0	$6,596	$0	$0	$0	$0	$0
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	$21,589,293	$18,700,809	$15,040,526	$22,813,920	$25,499,499	$7,773,394	$2,685,579
Long-Term Services and Supports Community Care:							
Community Nursing Home	$1,683,382	$1,893,463	$1,101,379	$1,589,346	$1,717,884	$487,967	$128,538
Community Non-Institutional Care	$4,643,168	$4,898,994	$3,285,204	$5,188,609	$6,423,777	$1,903,405	$1,235,168
State Nursing Home	$1,731,909	$1,745,012	$1,945,841	$2,206,275	$2,503,751	$260,434	$297,476
State Home Domiciliary	$48,717	$62,662	$52,784	$57,086	$61,739	$4,302	$4,653
State Home Adult Day Care	$545	$1,986	$2,816	$3,046	$3,294	$230	$248
Community Long-Term Services and Supports [Total]	$8,107,721	$8,602,117	$6,388,024	$9,044,362	$10,710,445	$2,656,338	$1,666,083
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,971,417	$2,327,454	$2,547,024	$2,951,384	$3,325,299	$404,360	$373,915
Caregivers	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune Family	$1,657	$3,904	$2,088	$2,172	$2,257	$84	$85
Other Health Care Programs community care [Total]	$1,973,074	$2,331,358	$2,549,112	$2,953,556	$3,327,556	$404,444	$374,000
Obligations [Subtotal]	**$31,670,088**	**$29,634,284**	**$23,977,662**	**$34,811,838**	**$39,537,500**	**$10,834,176**	**$4,725,662**
VA Prior-Year Recoveries	$84,137	$0	$0	$0	$0	$0	$0
Obligations [Total]	**$31,754,225**	**$29,634,284**	**$23,977,662**	**$34,811,838**	**$39,537,500**	**$10,834,176**	**$4,725,662**

Cost of War Toxic Exposures Fund (TEF) Obligations by Program

(dollars in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Health Care Services:							
Ambulatory Care	$1,671,201	$0	$6,081,809	$4,871,109	$5,034,288	($1,210,700)	$163,179
Dental Care	$122,144	$0	$428,278	$324,847	$335,729	($103,431)	$10,882
Inpatient Care	$1,535,289	$10,943,411	$5,488,068	$4,192,121	$4,332,556	($1,295,947)	$140,435
Mental Health Care	$260,359	$56,589	$935,221	$723,859	$748,108	($211,362)	$24,249
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]	$3,588,993	$11,000,000	$12,933,376	$10,111,936	$10,450,681	($2,821,440)	$338,745
Long-Term Services and Supports Community Care:							
Community Nursing Home	$343,456	$0	$1,335,038	$1,000,962	$1,034,494	($334,076)	$33,532
Community Non-Institutional Care	$867,551	$0	$3,427,302	$2,917,102	$3,014,825	($510,200)	$97,723
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]	$1,211,007	$0	$4,762,340	$3,918,064	$4,049,319	($844,276)	$131,255
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]	**$4,800,000**	**$11,000,000**	**$17,695,716**	**$14,030,000**	**$14,500,000**	**($3,665,716)**	**$470,000**
VA Prior-Year Recoveries	$0	$0	$0	$0	$0	$0	$0
Total Obligations	**$4,800,000**	**$11,000,000**	**$17,695,716**	**$14,030,000**	**$14,500,000**	**($3,665,716)**	**$470,000**

Veterans Choice Fund Obligations by Program

(dollars in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Health Care Services:							
Ambulatory Care	$59	$304,826	$304,622	$0	$0	($304,622)	$0
Dental Care	$0	$0	$0	$0	$0	$0	$0
Inpatient Care	$16	$0	$0	$0	$0	$0	$0
Mental Health Care	$0	$0	$0	$0	$0	$0	$0
Prosthetics	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$0	$0	$0	$0	$0	$0	$0
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	$75	$304,826	$304,622	$0	$0	($304,622)	$0
Long-Term Services and Supports Community Care:							
Community Nursing Home	$0	$0	$0	$0	$0	$0	$0
Community Non-Institutional Care	$129	$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]	$129	$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]	**$204**	**$304,826**	**$304,622**	**$0**	**$0**	**($304,622)**	**$0**
VA Prior-Year Recoveries	$93	$0	$0	$0	$0	$0	$0
Total Obligations	**$297**	**$304,826**	**$304,622**	**$0**	**$0**	**($304,622)**	**$0**

Total MCC Category Obligations by Program

(dollars in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Health Care Services:							
Ambulatory Care	$12,169,449	$15,449,811	$14,305,098	$16,183,563	$18,119,368	$1,878,465	$1,935,805
Dental Care	$1,362,569	$1,576,100	$1,546,710	$1,711,421	$1,866,855	$164,711	$155,434
Inpatient Care	$9,741,584	$10,943,411	$10,523,424	$11,397,139	$12,336,898	$873,715	$939,759
Mental Health Care	$1,904,759	$2,029,717	$1,903,292	$3,633,733	$3,627,059	$1,730,441	($6,674)
Prosthetics	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$0	$6,596	$0	$0	$0	$0	$0
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	$25,178,361	$30,005,635	$28,278,524	$32,925,856	$35,950,180	$4,647,332	$3,024,324
Long-Term Services and Supports Community Care:							
Community Nursing Home	$2,026,838	$1,893,463	$2,436,417	$2,590,308	$2,752,378	$153,891	$162,070
Community Non-Institutional Care	$5,510,848	$4,898,994	$6,712,506	$8,105,711	$9,438,602	$1,393,205	$1,332,891
State Nursing Home	$1,731,909	$1,745,012	$1,945,841	$2,206,275	$2,503,751	$260,434	$297,476
State Home Domiciliary	$48,717	$62,662	$52,784	$57,086	$61,739	$4,302	$4,653
State Home Adult Day Care	$545	$1,986	$2,816	$3,046	$3,294	$230	$248
Community Long-Term Services and Supports [Total]	$9,318,857	$8,602,117	$11,150,364	$12,962,426	$14,759,764	$1,812,062	$1,797,338
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,971,417	$2,327,454	$2,547,024	$2,951,384	$3,325,299	$404,360	$373,915
Caregivers	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune Family	$1,657	$3,904	$2,088	$2,172	$2,257	$84	$85
Other Health Care Programs community care [Total]	$1,973,074	$2,331,358	$2,549,112	$2,953,556	$3,327,556	$404,444	$374,000
Obligations [Subtotal]	**$36,470,292**	**$40,939,110**	**$41,978,000**	**$48,841,838**	**$54,037,500**	**$6,863,838**	**$5,195,662**
VA Prior-Year Recoveries	$84,230	$0	$0	$0	$0	$0	$0
Obligations [Subtotal]	$36,554,522	$40,939,110	$41,978,000	$48,841,838	$54,037,500	$6,863,838	$5,195,662
Obligations [Total]	**$36,554,522**	**$40,939,110**	**$41,978,000**	**$48,841,838**	**$54,037,500**	**$6,863,838**	**$5,195,662**

In 2026, total obligations are projected to increase by $6.9 billion above the 2025 current estimate in the following areas:

- **Health Care Services (+$4.6 billion).** Estimates are projected to increase due to revised actuarial trends based on the most recent data, which accounts for the latest demographic trends, including impacts of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022 (P.L. 117-168) on enrollment and utilization of VA health care, and modes of care delivery. The increase is also associated with the change in access standards for the Mental Health Residential Rehabilitation Program, which is anticipated to result in increased community care costs.
- **Long-Term Services and Support (+$1.8 billion).** Estimates are projected to increase due to the latest demographic trends and modes of care delivery. The enrollment dynamics that have a significant impact on long-term services and support are priority level transitions and the aging of the enrollee population.
- **Other Health Care Programs (+$404.4 million).** VA-provided health service programs not projected by the Enrollee Health Care Projection Model are expected to yield a net increase of $404.4 million, driven largely by Civilian Health and Medical Program (CHAMPVA) program costs.

Medical Community Care Description

Veterans may be eligible to receive care from a community provider when VA cannot provide the care needed. This care is provided on behalf of and paid for by VA. Community care is available to Veterans based on certain conditions and eligibility requirements, and in consideration of a Veteran's specific needs and circumstances. In general, community care must be first authorized by VA before a Veteran can receive care from a community provider.

VA also provides health care to Veterans' family members and dependents through programs like CHAMPVA. Care for Veterans' family members and dependents is provided based on specific eligibility requirements, which vary by program. Additional information regarding these health care programs can be found in the "Medical Community Care Programs" section below.

In addition to funding payments for health care services to non-VA providers, the MCC category funds clinical service delivery requirements for community care. This funding includes care coordination and referrals, eligibility verification, and enrollment. Resources are also used to establish care network requirements such as developing contracts that serve as vehicles for VA to purchase care for Veterans from community providers as well as develop and maintain information technology (IT) functions. MCC also funds short-term prescription medications for a 14-day or fewer supply filled at a non-VA pharmacy.

Some obligations related to VA's provision of community care are funded through the Medical Support and Compliance and IT accounts. These accounts fund administrative expenses such as claims processing performed by the Third-Party Administrator (TPA) and the Veterans Health Administration (VHA) and software required to meet system requirements.

Medical Community Care Programs for Veterans' Family Members and Dependents

Camp Lejeune Family Member Program (CLFMP)

Authority for Action

P.L. 112-154, Honoring America's Veterans and Caring for Camp Lejeune Families Act and 38 U.S.C. §1787

Purpose

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 the years of 1957-87. Family members of such Veterans who resided, or were in utero, at Camp Lejeune for at least 30 days during that period are eligible for reimbursement of hospital care and medical services for 15 specified illnesses and conditions, and VA is the payer of last resort. Hospital care and medical services may only be furnished to family members to the extent and in the amount provided in advance in appropriations acts for such purpose. In addition, VA may only provide reimbursement for such hospital care and medical services provided to a family member after all other claims and remedies against third parties for such care and services have been exhausted.

The Consolidated and Further Continuing Appropriations Act of 2015 (P.L. 113-235), signed on December 16, 2014, expanded the Camp Lejeune exposure period by changing the beginning date from January 1, 1957, to August 1, 1953.

VA began providing care to Camp Lejeune Veterans on August 6, 2012, the day the initial law was enacted, and published regulations supporting implementation of this statutory requirement on September 11, 2013. VA began enrolling and reimbursing family members for medical care related to treatment of the Camp Lejeune conditions on October 24, 2014, 30 days after the family member interim final rule was published in the Federal Register and became effective. Under the rule, qualified family members with at least 30 days of Camp Lejeune residency from 1957-87 may receive reimbursement for treatment received up to two years prior to the date on their eligibility determination. For family members with at least 30 days of Camp Lejeune residency from August 1, 1953, through December 31, 1956, VA may only provide claims reimbursement for covered treatment received on or after December 16, 2014. VA may not reimburse family members for Camp Lejeune-related care prior to March 26, 2013, the date when Congress provided funding to the Camp Lejeune Family Member Program (CLFMP).

2025 Planned Accomplishments

VA will continue to promptly reimburse family members for care related to the 15 qualifying health conditions. Future goals include expanding outreach efforts to continue to educate Veterans, medical providers, and family members about CLFMP. The expectation is that CLFMP will experience small growth based on historical program data and the ongoing media attention the VA has received about toxic exposure benefits.

CHAMPVA and Other Dependent Programs

VA provides health care benefit administration for the beneficiaries of the following programs: CHAMPVA, Foreign Medical Program (FMP), Spina Bifida Health Care Benefits Program, and Children of Women Vietnam Veterans (CWVV). This includes reimbursement for inpatient, outpatient, durable medical, pharmacy, travel, and limited dental. Covered medical claims are reimbursed to the provider or the beneficiary directly.

Authority for Action

- 38 U.S.C. § 1724, Hospital Care, Medical Services and Nursing Home Care Abroad
- 38 U.S.C. § 1781, Medical Care for Survivors and Dependents of Certain Veterans
- 38 U.S.C. § 1802, Spina Bifida Conditions Covered
- 38 U.S.C. § 1803, Health Care
- 38 U.S.C. § 1811, Definitions
- 38 U.S.C. § 1812, Covered Birth Defects
- 38 U.S.C. § 1813, Health Care
- 38 U.S.C. § 1821, Benefits for Children of Certain Korea Service Veterans Born with Spina Bifida

- 38 U.S.C. § 1822, Benefits for Children of Certain Thailand Service Veterans Born with Spina Bifida
- 38 U.S.C. § 5104(c), Options Following Decision by Agency of Original Jurisdiction

Purpose

CHAMPVA
The Veterans Health Care Expansion Act of 1973 (P.L. 93-82) authorized VA to provide a health benefits program that shares the cost of medical supplies and services with eligible beneficiaries. The Veterans' Survivor Benefits Improvements Act of 2001 (P.L. 107-14) extended CHAMPVA benefits, as a secondary payer to Medicare, to CHAMPVA beneficiaries over age 65. To be eligible for CHAMPVA benefits, the beneficiary must be the spouse or child of a Veteran who has a total and permanent service-connected disability, or the widowed spouse or child of a Veteran who: (a) died as a result of a service-connected disability; (b) had a total, permanent disability resulting from a service-connected condition at the time of death; or (c) died on active duty and in all cases the family member is not eligible for medical benefits under the Department of Defense TRICARE Program.

CHAMPVA by law is a secondary payer to other health insurance plans to include Medicare. CHAMPVA assumes primary payer status for Medicaid, Indian Health Service (IHS), and State Victims of Crime Compensation Programs.

The Veterans Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163 § 102) further expanded CHAMPVA to include primary family caregivers of certain seriously injured Veterans. Eligible primary family caregivers are authorized to receive health care benefits through CHAMPVA when the primary family caregiver is not eligible for any other health care coverage (including TRICARE, Medicare, and Medicaid).

FMP
FMP is a health care benefits program for U.S. Veterans with VA-rated service-connected conditions that are residing or traveling abroad, including the Philippines as of October 1, 2017. Under FMP, VA assumes payment responsibility for certain necessary medical services associated with the treatment of Veterans' service-connected conditions, with certain exclusions. The FMP program office does not pay for compensation and pension exams or travel.

Spina Bifida Health Care Program
Under the Department of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997 (P.L. 104-204 § 421), VA administers the Spina Bifida Health Care Benefits Program for birth children of Vietnam Veterans diagnosed with spina bifida (excluding spina bifida occulta). Additionally, the Veterans Benefit Act of 2003 (P.L. 108-183 § 102) authorized birth children with spina bifida of certain Veterans who served in Korea to be eligible for care under this program. Prior to October 10, 2008, the program provided reimbursement only for medical services associated with spina bifida. However, under the Veterans' Mental Health and Other Care Improvements Act of 2008 (P.L. 110-387), the program provides reimbursement for comprehensive medical care. The Blue Water Navy Vietnam Veterans

Act of 2019 (P.L. 116-23 § 1116(b)) authorizes birth children of certain Veterans who served in Thailand to be eligible for care under this program.

CWVV
Under the Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419 § 401), VA administers the CWVV program for children with certain birth defects born to women Vietnam Veterans. The CWVV program provides reimbursement only for covered birth defects.

Indian Health Services (IHS) / Tribal Health Programs (THP) / Urban Indian Organizations (UIO) Reimbursement Agreements Program

Authority for Action

- 25 U.S.C. § 1645 Chapter 18, Indian Health Care
- 38 U.S.C. § 8153, Sharing of health-care resources.

Purpose
The Reimbursement Agreement Program (RAP) reimburses participating Indian Health Service (IHS) facilities, Tribal Health Programs (THPs), and Urban Indian Organizations (UIOs) for care they provide to eligible Native Veterans. The VA will reimburse care provided directly, referred to as direct care, and for IHS/THP facilities, care purchased under their purchased referred care (PRC) or contracted travel program.

VA will reimburse for services the VA has the authority to provide or purchase for the Veteran, following special Veteran eligibility rules. Generally, this includes services in the VA medical benefits package, 38 CFR § 17.38, Medical Benefits Package. Examples of these services are basic and preventive care; outpatient; inpatient; ambulatory surgical services; dental; prescription drugs; etc. These services are provided at IHS/THP/UIO hospitals, clinics, or facilities, while PRC services are provided away from an IHS or THP facility but paid for by the IHS/THP facility.

2025 Planned Accomplishments

- In 2025, VA is projected to disperse $38.9 million.
- Executed revised agreements will expand the program to include PRC and contracted travel. New and future agreements will continue to adopt the expanded scope of services.
- VA expects to expand by 4 to 6 THP /UIO facilities.
- VA expects to reimburse services for over 3,000 unique Veterans.

2026 Budget Request
The budget request for VA reimbursement to IHS/THP/UIO in 2026 is $ 41.7 million, $3.8 million above the 2025 Current Estimate. Funding is requested to fulfill VA's obligation to reimburse IHS/THP/UIO facilities for care they provide to eligible Veterans, as required by 25 U.S.C. § 1645. The increase is to reflect annual inflation and program expansion costs.

2026 Planned Accomplishments

- In 2026, VA is projected to disperse $41.7 million.
- VA expects to expand by 2 to 4 THP /UIO facilities.
- VA expects to increase utilization by participating facilities.
- VA also plans to maintain relationships with IHS and tribal governments, through outreach, education, and training, which supports Native Veterans.

Evidence

In 2024, RAP dispersed $31.6 million covering over 3,600 unique Veterans. This funding supports services from 73 IHS, 122 THP, and 9 UIO facilities currently participating.

Administrative Costs Justification

The Medical Community Care category includes funding for necessary operating costs, such as contracting and administration fees, for VA's Community Care Network (CCN) contracts. VA will continue its practice to utilize Veterans Care Agreements to procure services when a provider is not available under CCN.

Community Care Network

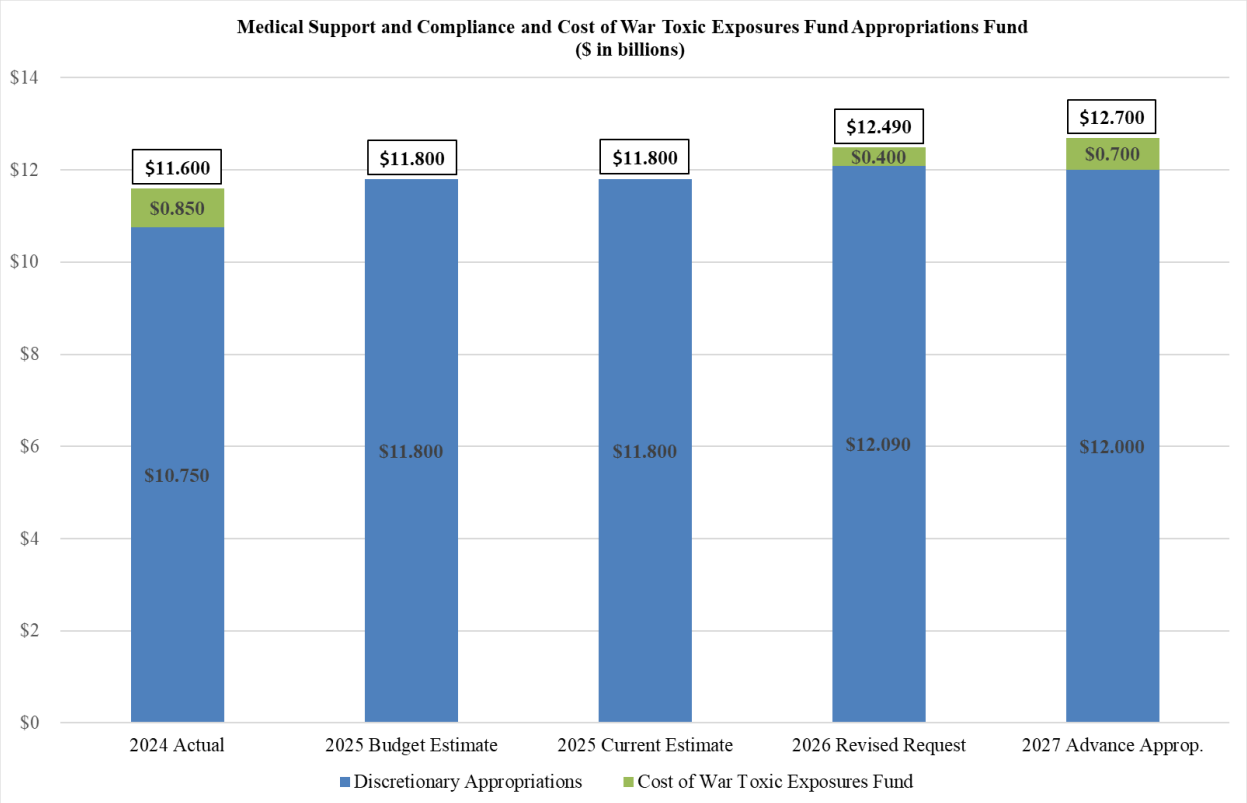
The request for the Medical Community Care account includes the certain costs associated with the CCN contracts. The 2024 obligations of $865.7 million were paid to a TPA and covers 5 regions. Administrative costs associated with the CCN contract include:

- Per member/per month administrative fees which is the negotiated contract rate multiplied by the number of active Veterans receiving care monthly.
- Recurring costs associated with contract modifications such as, but not limited to, urgent care call center (actual per month, or fixed rate per call), reprocessing fees (per claim) and other adjustments, as needed.
- New contract modifications are one-time monetary adjustments added through the issuance of a new task order.
- Incentive/disincentives based on TPA performance.
- Optional tasks not included in the original contract or additional modifications.

CHAMPVA Consolidated Mail Outpatient Pharmacy (CMOP)

In 2024, CHAMPVA expensed $544.8 million for prescriptions provided through the CMOP. This is an increase of 15.8% from 2023. Expected annual cost increases for 2024 were between 8.0% to 13.0% based off historical spending trends, inflation costs, and projected utilization, and the growth from 2023 to 2024 exceeded projections.

Chart: Medical Support and Compliance Appropriations [1/]



[1/] 2024 Actual reflects an enacted rescission. 2025 Current Estimate includes transfers of appropriations among Medical Care accounts. 2026 Revised Request reflects a proposed cancellation. In all years, discretionary appropriations are prior to transfer to the Joint DoD-VA Medical Facility Demonstration Fund.

2026 Revised Request

To realign funding among accounts, the Department of Veterans Affairs (VA) proposes to cancel $610.0 million from the enacted 2026 discretionary advance appropriation of $12.7 billion for the Medical Support and Compliance (MSC) account and requests $400.0 million in mandatory appropriations from the Cost of War Toxic Exposures Fund (TEF) for MSC in 2026. When combined with unobligated start-of-year balances, reimbursements, and transfers to other accounts, the projected 2026 obligations level in the MSC category is $12.5 billion.

The MSC budget funds expenses related to the management, security, and administration of the VA health care system. This includes VA medical center (VAMC) leadership teams and support

functions, such as quality of care oversight, security services, legal services, billing and coding activities, acquisition, human resource management, logistics and supply chain management, and financial management. The MSC budget also funds the Veterans Integrated Service Network (VISN) offices, including network leadership teams, as well as expenses related to the Veterans Health Administration's (VHA) Central Office (VHACO) programs, including national program leadership and staff.

The MSC appropriation finances the supporting structures that underlie VHA's ability to deliver high-quality health care services to Veterans and eligible beneficiaries. Approximately 63% of the 2026 total funding for this appropriation category is designated for VAMC and VISN direct allocations. The remaining 37% of the funding is designated for VHACO programs to support staff and allocate resources to VAMCs for specific tasks. This funding ensures:

- leadership teams are in place to govern,
- appropriate oversight to safeguard quality of care for Veterans is available,
- essential security services are provided,
- needed supplies and medications are ordered,
- mission-critical health care provider vacancies are filled, and
- financial services and oversight are provided, required medical equipment is procured, and patient encounters are appropriately recorded.

2027 Advance Appropriations Request

The 2026 budget request reflects a 2027 discretionary advance appropriation request of $12.0 billion; and an allocation of $700.0 million out of the total 2027 mandatory advance appropriation request for the TEF. When combined with all other resources, the projected 2027 obligations level in the MSC category is $12.7 billion, an increase of $193.8 million (1.5%) above the 2026 level.

Appropriation Language

For necessary expenses in the administration of the medical, hospital, nursing home, domiciliary, construction, supply, and research activities, as authorized by law; administrative expenses in support of capital policy activities; and administrative and legal expenses of the Department for collecting and recovering amounts owed the Department as authorized under chapter 17 of title 38, United States Code, and the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.),$12,000,000,000, plus reimbursements, which shall become available on October 1, 2026, and shall remain available until September 30, 2027: Provided, That, of the amount made available on October 1, 2026, under this heading, $350,000,000 shall remain available until September 30, 2028: Provided further, That of the $12,700,000,000 that became available on October 1, 2025, previously appropriated under this heading in the Full-Year Continuing Appropriations Act, 2025 (division A of Public Law 119–4), $610,000,000 is hereby permanently cancelled.

The following table displays the discretionary, mandatory, and combined sources of funds for MSC.

Table: **MSC Crosswalk, 2024-2027**

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Appropriation Medical Support & Compliance (0152)							
Advance Appropriation	$12,300,000	$11,800,000	$11,800,000	$12,700,000	$12,000,000	$900,000	($700,000)
Advance Appropriation Rescission (P.L. 118-42)	($1,550,000)	$0	$0	$0	$0	$0	$0
Annual Appropriation Adjustment	$0	$0	$0	$0	$0	$0	$0
P.L. 118-158, American Relief Act, 2025 (Hurricane Supplen	$0	$0	$330	$0	$0	($330)	$0
Proposed Cancellation 1/	$0	$0	$0	($610,000)	$0	($610,000)	$610,000
Net Appropriation	**$10,750,000**	**$11,800,000**	**$11,800,330**	**$12,090,000**	**$12,000,000**	**$289,670**	**($90,000)**
Transfers To							
Medical Community Care (0140)	$0	$0	($81,092)	$0	$0	$81,092	$0
JALFHCC (0169)	($30,996)	($42,193)	($42,193)	($47,819)	($64,035)	($5,626)	($16,216)
Transfers To [Subtotal]	($30,996)	($42,193)	($123,285)	($47,819)	($64,035)	$75,466	($16,216)
Discretionary Budget Authority [Total]	$10,719,004	$11,757,807	$11,677,045	$12,042,181	$11,935,965	$365,136	($106,216)
Reimbursements	$62,697	$64,706	$62,697	$62,697	$62,697	$0	$0
Unobligated Balance (SOY)							
P.L. 111-32 (H1N1 no-year)	$111	$111	$111	$111	$111	$0	$0
2-Year	$150,689	$251,010	$348,679	$0	$0	($348,679)	$0
Unobligated Balance (SOY) [Subtotal]	$150,800	$251,121	$348,790	$111	$111	($348,679)	$0
Unobligated Balance (EOY)							
P.L. 111-32 (H1N1 no-year)	($111)	($111)	($111)	($111)	($111)	$0	$0
2-Year	($348,679)	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	($348,790)	($111)	($111)	($111)	($111)	$0	$0
Lapse	($430)	$0	$0	$0	$0	$0	$0
Subtotal	$10,583,281	$12,073,523	$12,088,421	$12,104,878	$11,998,662	$16,457	($106,216)
Prior Year Recoveries	$557	$0	$0	$0	$0	$0	$0
Discretionary Obligations (0152) [Total]	**$10,583,838**	**$12,073,523**	**$12,088,421**	**$12,104,878**	**$11,998,662**	**$16,457**	**($106,216)**
Cost of War Toxic Exposures Fund (1126)							
Appropriation	$850,000	$0	$0	$400,000	$700,000	$400,000	$300,000
Realignment of Balances	$0	$0	$387,599	$0	$0	($387,599)	$0
Unobligated Balance (SOY)	$26,049	$0	$28,399	$0	$0	($28,399)	$0
Unobligated Balance (EOY)	($28,399)	$0	$0	$0	$0	$0	$0
Obligations (1126) [Total]	**$847,650**	**$0**	**$415,998**	**$400,000**	**$700,000**	**($15,998)**	**$300,000**
VACAA, sec. 801 (0152XA)							
Unobligated Balance (SOY)	$3,629	$256	$1,582	$0	$0	($1,582)	$0
Unobligated Balance (EOY)	($1,582)	$0	$0	$0	$0	$0	$0
Subtotal	$2,047	$256	$1,582	$0	$0	($1,582)	$0
Prior Year Recoveries	$5	$0	$0	$0	$0	$0	$0
Obligations (0152XA) [Total]	**$2,052**	**$256**	**$1,582**	**$0**	**$0**	**($1,582)**	**$0**
Mandatory Budget Authority [Total]	$850,000	$0	$0	$400,000	$700,000	$400,000	$300,000
Mandatory Obligations [Total]	**$849,702**	**$256**	**$417,580**	**$400,000**	**$700,000**	**($17,580)**	**$300,000**
Budget Authority [Grand Total]	$11,569,004	$11,757,807	$11,677,045	$12,442,181	$12,635,965	$765,136	$193,784
Obligations [Grand Total]	**$11,433,540**	**$12,073,779**	**$12,506,001**	**$12,504,878**	**$12,698,662**	**($1,123)**	**$193,784**
FTE							
Medical Support & Compliance (0152)	60,815	66,658	64,326	64,440	62,562	114	(1,878)
Cost of War Toxic Exposures Fund (1126)	6,846	0	2,666	2,563	4,441	(103)	1,878
VACAA, Section 801 (0152XA) 1/	13	0	11	0	0	(11)	0
FTE [Total]	**67,674**	**66,658**	**67,003**	**67,003**	**67,003**	**0**	**0**

Summary of Obligations by Program Activity

To provide better visibility into the spending under MSC, additional detail on obligations by the following program activities are reflected in the following charts, beginning with total obligations.

Table: MSC Total Obligations by Program Activity

Description: ($ in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
VISN and Medical Center Based:							
VAMC	$5,838,971	$6,112,014	$6,161,174	$6,161,174	$6,256,653	$0	$95,479
VISN	$1,667,186	$1,455,538	$1,744,033	$1,744,033	$1,771,060	$0	$27,027
VHA Central Office Based:							
Clinical Services	$173,223	$246,586	$232,873	$232,873	$236,482	$0	$3,609
Patient Care Services	$240,055	$321,379	$246,183	$246,183	$249,998	$0	$3,815
Discovery, Education and Affiliate Networks	$94,363	$119,447	$109,123	$109,123	$110,814	$0	$1,691
Operations	$208,460	$256,541	$236,503	$236,503	$240,168	$0	$3,665
Integrated Veterans Care	$482,104	$488,971	$450,560	$450,560	$457,542	$0	$6,982
Quality and Patient Safety	$186,540	$199,229	$183,668	$183,668	$186,514	$0	$2,846
Support Services	$626,590	$729,335	$646,880	$646,880	$656,904	$0	$10,024
Human Capital Management	$427,481	$416,992	$384,422	$384,422	$390,379	$0	$5,957
Digital Health Office 1/	$209,081	$203,750	$198,709	$198,709	$201,788	$0	$3,079
All Other Support and Program Offices	$1,278,924	$1,523,997	$1,911,873	$1,910,750	$1,940,360	($1,123)	$29,610
Central Office Based Obligations [Subtotal]	**$3,926,821**	**$4,506,227**	**$4,600,794**	**$4,599,671**	**$4,670,949**	**($1,123)**	**$71,278**
Prior Year Recoveries	$562	$0	$0			$0	$0
MSC Obligations [Total]	**$11,433,540**	**$12,073,779**	**$12,506,001**	**$12,504,878**	**$12,698,662**	**($1,123)**	**$193,784**

1/ The Digital Health Office was established in 2024.

Table: MSC Discretionary Obligations by Program Activity

Description: ($ in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Annual Appropriations							
VISN and Medical Center Based:							
VAMC	$4,989,274	$6,112,014	$5,743,594	$5,761,174	$5,556,653	$17,580	($204,521)
VISN	$1,667,186	$1,455,538	$1,744,033	$1,744,033	$1,771,060	$0	$27,027
VHA Central Office Based:							
Clinical Services	$173,223	$246,586	$232,873	$232,873	$236,482	$0	$3,609
Patient Care Services	$240,055	$321,379	$246,183	$246,183	$249,998	$0	$3,815
Discovery, Education and Affiliate Networks	$94,363	$119,191	$109,123	$109,123	$110,814	$0	$1,691
Operations	$208,460	$256,541	$236,503	$236,503	$240,168	$0	$3,665
Integrated Veterans Care	$482,104	$488,971	$450,560	$450,560	$457,542	$0	$6,982
Quality and Patient Safety	$186,540	$199,229	$183,668	$183,668	$186,514	$0	$2,846
Support Services	$626,590	$729,335	$646,880	$646,880	$656,904	$0	$10,024
Human Capital Management	$427,481	$416,992	$384,422	$384,422	$390,379	$0	$5,957
Digital Health Office 1/	$209,081	$203,750	$198,709	$198,709	$201,788	$0	$3,079
All Other Support and Program Offices	$1,278,924	$1,523,997	$1,911,873	$1,910,750	$1,940,360	($1,123)	$29,610
Central Office Based Obligations [Subtotal]	**$3,926,821**	**$4,505,971**	**$4,600,794**	**$4,599,671**	**$4,670,949**	**($1,123)**	**$71,278**
Prior Year Recoveries	$557	$0	$0	$0	$0	$0	$0
MSC Obligations - Discretionary Funds [Total]	**$10,583,838**	**$12,073,523**	**$12,088,421**	**$12,104,878**	**$11,998,662**	**$16,457**	**($106,216)**

1/ The Digital Health Office was established in 2024.

Table: MSC Mandatory Obligations by Program Activity

Description: ($ in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Cost of War Toxic Exposures Fund (TEF)							
VAMC	$847,650	$0	$415,998	$400,000	$700,000	($15,998)	$300,000
TEF Obligations [Subtotal]	**$847,650**	**$0**	**$415,998**	**$400,000**	**$700,000**	**($15,998)**	**$300,000**
VACAA, sec. 801							
VAMC	$2,047	$0	$1,582	$0	$0	($1,582)	$0
Discovery, Education and Affiliate Networks	$0	$256	$0	$0	$0	$0	$0
VACAA, sec. 801 Obligations [Subtotal]	**$2,047**	**$256**	**$1,582**	**$0**	**$0**	**($1,582)**	**$0**
Prior Year Recoveries	$5	$0	$0	$0	$0	$0	$0
MSC Obligations - Mandatory Funds [Total]	**$849,702**	**$256**	**$417,580**	**$400,000**	**$700,000**	**($17,580)**	**$300,000**

The following sections provide a description for each of the program activities shown in the previous tables, together with obligations detail. In March 2025, VA began a Department-wide review of its mission, organization, and structure to identify and eliminate waste, reduce burdensome processes and bureaucracy, and ensure taxpayer dollars will be invested wisely to support Veterans. MSC's program activities are prior to any changes that may result from this review.

VAMC Program

Description ($ in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$4,989,274	$6,112,014	$5,743,594	$5,761,174	$5,556,653	$17,580	($204,521)
Cost of War Toxic Exposures Fund	$847,650	$0	$415,998	$400,000	$700,000	($15,998)	$300,000
VACAA, sec. 801	$2,047	$0	$1,582	$0	$0	($1,582)	$0
Mandatory Obligations	$849,697	$0	$417,580	$400,000	$700,000	($17,580)	$300,000
Obligations [Total]	$5,838,971	$6,112,014	$6,161,174	$6,161,174	$6,256,653	$0	$95,479

Funding in this account for VAMC-based activities supports the management, operation, oversight, security, and administration of the VA's health care system. This includes VAMC leadership teams (Director, Chief of Staff, Chief Medical Officer, and Chief Nurse), VAMC support functions (quality of care oversight, security services, legal services, billing and coding activities, acquisition, procurement, and logistics activities), human resource management, logistics and supply chain management, and fiscal management. Of the many functions required to operate VHA facilities, one essential function is revenue generation. This process begins at VAMC and clinic locations with the verification of insurance and coding of inpatient and outpatient encounters.

VISN Program

Description ($ in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$1,667,186	$1,455,538	$1,744,033	$1,744,033	$1,771,060	$0	$27,027
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$1,667,186	$1,455,538	$1,744,033	$1,744,033	$1,771,060	$0	$27,027

These funds provide the necessary resources for the VISN offices that provide regional support, management, and oversight to VAMCs, clinics, and other field activities within their regions. This includes, but is not limited to, network leadership teams (Network Director, Deputy Network Director, Chief Financial Officer, Chief Medical Officer, and Chief Information Officer) and clinical and administrative functional leads, which are centrally located to provide leadership to those programs within each VISN. Each VISN office is responsible for coordinating the delivery of health care to Veterans by leveraging and integrating operations at all VA health care facilities within the VISN.

Clinical Services

Description ($ in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$173,223	$246,586	$232,873	$232,873	$236,482	$0	$3,609
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$173,223	$246,586	$232,873	$232,873	$236,482	$0	$3,609

The Office of the Assistant Under Secretary for Health (AUSH) for Clinical Services (CS) and the Chief Medical Officer provides leadership for the many VHA clinical programs and their necessary coordination with clinical and administrative leadership within the VISNs, integrated clinical community committees, and service-based communities of practice. The Office of the AUSHCS strives to provide Veterans and their families with high-quality, integrated, and standardized CS that serve as the benchmark for health care excellence and value.

Patient Care Services

Description ($ in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$240,055	$321,379	$246,183	$246,183	$249,998	$0	$3,815
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$240,055	$321,379	$246,183	$246,183	$249,998	$0	$3,815

The Office of Patient Care Services (PCS) 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 AUSHPCS also serves as the Chief Nursing Officer (CNO). The CNO is the Senior Advisor to the USH and to key VHA and Department officials on all matters relating to VA nursing and the delivery of PCS. The CNO collaborates inter-professionally to enhance and support evidence-based professional practice,

workforce research and education, and the VA nursing workforce to strengthen leadership and teamwork to provide quality patient-driven care for the Nation's Veterans.

Discovery, Education, and Affiliate Networks

Description ($ in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$94,363	$119,191	$109,123	$109,123	$110,814	$0	$1,691
VACAA, sec. 801	$0	$256	$0	$0	$0	$0	$0
Obligations [Total]	$94,363	$119,447	$109,123	$109,123	$110,814	$0	$1,691

The Office of Discovery, Education, and Affiliate Networks (DEAN) ensures that Veterans have access to the most innovative health care solutions by promoting medical research initiatives, training health care professions, and developing community partnerships. DEAN is responsible for:

- managing education and training programs for health profession students and residents to enhance the quality of care provided to Veteran patients as required by 38 U.S.C. § 7302;
- applying basic, translational, clinical, health services and rehabilitative research to apply scientific knowledge to develop effective care solutions for Veterans; and
- providing innovative project management of the design, evaluation, and diffusion of new processes that facilitate health care innovations in the field to better serve Veterans.

Operations

Description ($ in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$208,460	$256,541	$236,503	$236,503	$240,168	$0	$3,665
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$208,460	$256,541	$236,503	$236,503	$240,168	$0	$3,665

The Office of the AUSH for Operations is responsible for overseeing the delivery of health care services. The Office of the AUSH for Operations provides oversight for 18 VISNs, 172 VAMCs, and over 1,000 outpatient sites of care.

Integrated Veteran Care

Description ($ in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$482,104	$488,971	$450,560	$450,560	$457,542	$0	$6,982
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$482,104	$488,971	$450,560	$450,560	$457,542	$0	$6,982

The Office of Integrated Veteran Care (IVC) was established in 2022 by the VHA USH. IVC creates a more seamless and coordinated experience for any Veteran who accesses the VHA system, within VHA or the community. IVC positions VHA for better coordination and resource alignment, while also offering streamlined and simplified access processes for the field and for Veterans.

Quality and Patient Safety

Description ($ in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$186,540	$199,229	$183,668	$183,668	$186,514	$0	$2,846
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$186,540	$199,229	$183,668	$183,668	$186,514	$0	$2,846

The Office of Quality and Patient Safety provides oversight, expertise, and support to advance the highest standards of care, innovation, responsible stewardship, and ethical practice within the VA health care system.

Support Services

Description ($ in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$626,590	$729,335	$646,880	$646,880	$656,904	$0	$10,024
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$626,590	$729,335	$646,880	$646,880	$656,904	$0	$10,024

The Office of the AUSH for Support provides facilities, engineering, equipment, occupational safety and health, procurement and logistics support services, expertise, and program oversight to enable effective and efficient medical facility operations, clinical services, and patient care services.

Human Capital Management

Description ($ in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$427,481	$416,992	$384,422	$384,422	$390,379	$0	$5,957
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$427,481	$416,992	$384,422	$384,422	$390,379	$0	$5,957

The Office of Human Capital Management (HCM) is committed to achieving individual and organizational high performance for the VHA workforce to serve the Nation's Veterans. HCM supports the human capital needs of VHA employees and health professions trainees. HCM provides guidance, information, and consultation to VHACO components, VHA health care facilities, VISNs, and external entities such as health professional organizations, Congress, and other Federal agencies. HCM oversees VHA's succession and workforce planning, identifies and monitors talent needs and trends within the organization, and links succession planning and business strategies, presenting VHA with the opportunity to reach long-term goals and achieve human capital objectives. To drive change and the long-term development of people and culture to address future challenges as VA continues its modernization transformation, HCM conducts a Department-wide assessment of organizational health annually, providing data analytics and action planning consultation to ensure results are used to improve the workplace. MSC funds support additional HCM functions including administrative, financial, and logistical oversight for all VHA headquarters program offices and staff.

Digital Health Office

Description ($ in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$209,081	$203,750	$198,709	$198,709	$201,788	$0	$3,079
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$209,081	$203,750	$198,709	$198,709	$201,788	$0	$3,079

The Digital Health Office, established in 2024, works to deliver modern, innovative, and human-centered digital health solutions to create outstanding health care experiences for Veterans and their care teams, by:

- continuously improving the patient experience (including Veterans, caregivers, and their survivors), and promoting scalable digital health solutions;
- continuously improving clinician and care team experience through scalable digital health solutions, thereby improving the delivery of safe, quality, and timely care; and
- integrating digital health solutions and ways of working to simplify, standardize, and automate (for example, through process automation to allow care teams to work at the top of their license and self-service tools for patients).

All Other Support and Program Offices

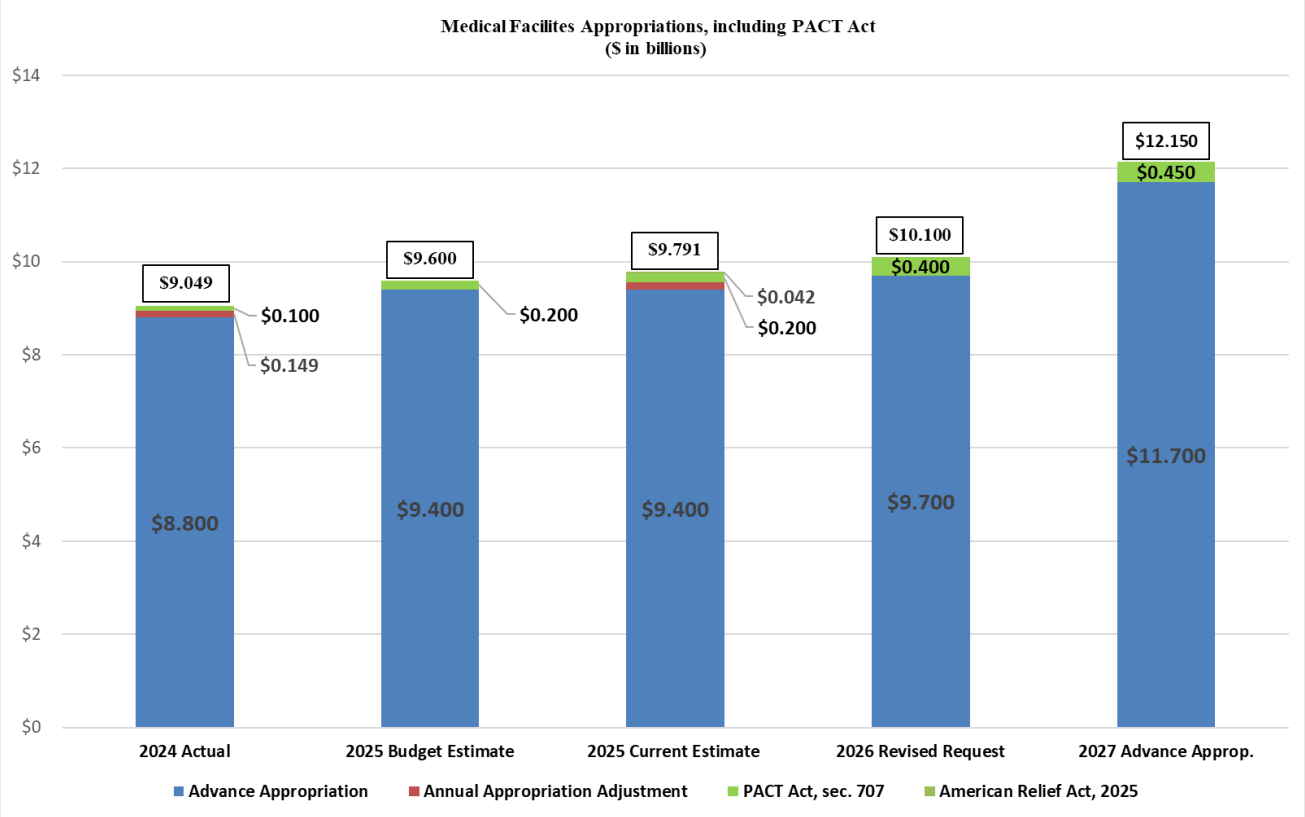
Description ($ in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations	$1,278,924	$1,523,997	$1,911,873	$1,910,750	$1,940,360	($1,123)	$29,610
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$1,278,924	$1,523,997	$1,911,873	$1,910,750	$1,940,360	($1,123)	$29,610

The VHA program offices in this line include:

- Patient Advocacy,
- Readjustment Counseling,
- Women's Health,
- Health Care Transformation,
- Finance,
- Strategy,
- Research Oversight,
- Integrity and Compliance,
- Chaplain Services,
- Governance, Regulations, Appeals, and Policy,
- Chief of Staff,
- Office of the Deputy USH, and
- Office of the USH.

Section G: Medical Facilities Category

Chart: Medical Facilities Appropriations[1]



[1] 2025 Current Estimate includes transfers of appropriations among Medical Care accounts. In all years, discretionary appropriations are prior to transfer to the Joint DoD-VA Medical Facility Demonstration Fund.

2026 Revised Request

The Department of Veterans Affairs (VA) proposes to maintain the enacted 2026 discretionary advance appropriation of $9.7 billion for the Medical Facilities (MF) account and transfer $2.0 billion from Medical Services to Medical Facilities. When combined with other funding, unobligated start-of-year balances, reimbursements, and transfers to other accounts, the projected 2026 obligations level in the MF category is $11.9 billion.

In addition to discretionary funding, Title VII of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act) provides mandatory appropriations in the MF category:

- Section 705 appropriated $922.0 million in fiscal year 2022 for the Department's enhanced-use lease program to be available until expended, a portion of which was allocated to the

Medical Facilities account. In 2026, VA estimates obligating $13.3 million from this funding source.

- Section 707 appropriated $5.5 billion in fiscal years 2023-2031 of which $1.9 billion was appropriated in 2023, $100 million in 2024, $200 million in 2025, and $400 million will be made available in 2026. Section 707 also makes available $450 million in 2027, $600 million in 2028, $610 million in 2029, $620 million in 2030, and $650 million in 2031. These funds are available until expended for major medical facility leases, and the $1.9 billion appropriated in 2023 supports the leases authorized by section 702 of the PACT Act. In 2026, VA estimates obligating $872.4 million from this funding source.

The MF budget provides for the operations and maintenance of the capital infrastructure required to provide health care to the Nation's Veterans. These costs include utilities, engineering, capital planning, leases, laundry services, grounds maintenance, trash removal, housekeeping, fire protection, pest management, facility repair and maintenance, and property disposition and acquisition.

Appropriation Language

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; $11,700,000,000, plus reimbursements, which shall become available on October 1, 2026, and shall remain available until September 30, 2027: Provided, That, of the amount made available on October 1, 2026, under this heading, $500,000,000 shall remain available until September 30, 2028.

The following tables display the discretionary, mandatory, and combined sources of funds for the Medical Facilities category.

Table: Medical Facilities Discretionary Crosswalk, 2024-2027

($ in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Appropriation Medical Facilities (0162)							
Advance Appropriation	$8,800,000	$9,400,000	$9,400,000	$9,700,000	$11,700,000	$300,000	$2,000,000
Annual Appropriation Adjustment	$149,485	$0	$149,485	$0	$0	($149,485)	$0
P.L. 118-158, American Relief Act, 2025 (Hurricane Supplemental)	$0	$0	$41,660	$0	$0	($41,660)	$0
Appropriations Request [Subtotal]	**$8,949,485**	**$9,400,000**	**$9,591,145**	**$9,700,000**	**$11,700,000**	**$108,855**	**$2,000,000**
Transfers To							
Medical Community Care (0140)	$0	($600,000)	($1,983)	$0	$0	$1,983	$0
JALFHCC (0169)	($40,570)	($66,021)	($66,021)	($79,322)	($87,683)	($13,301)	($8,361)
Transfers To [Subtotal]	($40,570)	($666,021)	($68,004)	($79,322)	($87,683)	($11,318)	($8,361)
Transfers From							
Medical Services (0160)	$0	$0	$0	$2,030,000	$0	$2,030,000	($2,030,000)
Transfers From [Subtotal]	$0	$0	$0	$2,030,000	$0	$2,030,000	($2,030,000)
Budget Authority [Total]	$8,908,915	$8,733,979	$9,523,141	$11,650,678	$11,612,317	$2,127,537	($38,361)
Reimbursements	$19,653	$16,571	$19,653	$19,653	$19,653	$0	$0
Unobligated Balance (SOY)							
P.L. 118-158, American Relief Act, 2025 (Hurricane Supplemental)	$0	$0	$0	$28,434	$0		
P.L. 117-328 § 252 (EO 14507 no-year, 1124XN) 1/	$75,000	$0	$75,000	$75,000	$75,000	$0	$0
P.L. 117-103 § 253 (Infrastructure no-year)	$85,871	$0	$65,029	$0	$0	($65,029)	$0
P.L. 115-244 § 248 (NRM no-year)	$58,366	$0	$12,748	$0	$0	($12,748)	$0
P.L. 115-141 § 255 (NRM no-year)	$3,932	$0	$76	$0	$0	($76)	$0
P.L. 111-32 (H1N1 no-year)	$5	$5	$5	$5	$5	$0	$0
P.L. 110-28 (Emergency Supplemental no-year)	$5,800	$5,800	$5,800	$5,800	$5,800	$0	$0
No-Year (all other)	$8,252	$8,252	$8,468	$8,468	$8,468	$0	$0
2-Year	$267,385	$409,235	$472,274	$250,000	$0	($222,274)	($250,000)
Unobligated Balance (SOY) [Subtotal]	$504,611	$423,292	$639,400	$367,707	$89,273	($271,693)	($278,434)
Unobligated Balance (EOY)							
P.L. 118-158, American Relief Act, 2025 (Hurricane Supplemental)	$0	$0	($28,434)	$0	$0	$28,434	$0
P.L. 117-328 § 252 (EO 14507 no-year, 1124XN) 1/	($75,000)	$0	($75,000)	($75,000)	($75,000)	$0	$0
P.L. 117-103 § 253 (Infrastructure no-year)	($65,029)	$0	$0	$0	$0	$0	$0
P.L. 115-244 § 248 (NRM no-year)	($12,748)	$0	$0	$0	$0	$0	$0
P.L. 115-141 § 255 (NRM no-year)	($76)	$0	$0	$0	$0	$0	$0
P.L. 111-32 (H1N1 no-year)	($5)	($5)	($5)	($5)	($5)	$0	$0
P.L. 110-28 (Emergency Supplemental no-year)	($5,800)	($5,800)	($5,800)	($5,800)	($5,800)	$0	$0
No-Year (all other)	($8,468)	($8,252)	($8,468)	($8,468)	($8,468)	$0	$0
2-Year	($472,274)	$0	($250,000)	$0	$0	$250,000	$0
Unobligated Balance (EOY) [Subtotal]	($639,400)	($14,057)	($367,707)	($89,273)	($89,273)	$250,000	$0
Lapse	($168)	$0	$0	$0	$0	$0	$0
Subtotal	$8,793,611	$9,159,785	$9,814,487	$11,948,765	$11,631,970	$2,134,278	($316,795)
Prior Year Recoveries	$18,371	$0	$0	$0	$0	$0	$0
Discretionary Obligations (0162) [Total]	**$8,811,982**	**$9,159,785**	**$9,814,487**	**$11,948,765**	**$11,631,970**	**$2,134,278**	**($316,795)**
Discretionary Budget Authority	$8,908,915	$8,733,979	$9,523,141	$11,650,678	$11,612,317	$2,127,537	($38,361)
Discretionary Obligations [Total]	**$8,811,982**	**$9,159,785**	**$9,814,487**	**$11,948,765**	**$11,631,970**	**$2,134,278**	**($316,795)**

1/ P.L. 117-328 sec. 252 provided that of the unobligated balances available in fiscal year 2023 in the "Recurring Expenses Transformational Fund" (RETF), $75,000,000 be for the deployment, upgrade, or installation of infrastructure or equipment to support goals established in Executive Order 14057. This RETF funding is reflected in the Medical Facilities category as its execution is consistent with Non-Recurring Maintenance in VHA.

Table: Medical Facilities Mandatory Crosswalk, 2024-2027

($ in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
PACT Act, sec. 705 (0162XU)							
Unobligated Balance (SOY)	$229,656	$188,281	$203,680	$133,970	$120,710	($69,710)	($13,260)
Unobligated Balance (EOY)	($203,680)	($147,673)	($133,970)	($120,710)	($108,272)	$13,260	$12,438
Subtotal	$25,976	$40,608	$69,710	$13,260	$12,438	($56,450)	($822)
Prior Year Recoveries	$2,355	$0	$0	$0	$0	$0	$0
Obligations PACT Act, sec. 705 (0162XU) [Total]	**$28,331**	**$40,608**	**$69,710**	**$13,260**	**$12,438**	**($56,450)**	**($822)**
PACT Act, sec. 707 (0162XL)							
Mandatory Appropriations	$100,000	$200,000	$200,000	$400,000	$450,000	$200,000	$50,000
Unobligated Balance (SOY) (base year 2023)	$1,855,998	$1,772,407	$1,790,100	$1,326,553	$774,268	($463,547)	($552,285)
Unobligated Balance (SOY) (base year 2024+)	$0	$0	$94,965	$293,905	$373,810	$198,940	$79,905
Unobligated Balance (EOY) (base year 2023)	($1,790,100)	($982,218)	($1,326,553)	($774,268)	$0	$552,285	$774,268
Unobligated Balance (EOY) (base year 2024+)	($94,965)	($181,631)	($293,905)	($373,810)	($755,746)	($79,905)	($381,936)
Obligations PACT Act, sec. 707 (0162XL) [Total]	**$70,933**	**$808,558**	**$464,607**	**$872,380**	**$842,332**	**$407,773**	**($30,048)**
VACAA, sec. 801 (0162XA)							
Unobligated Balance (SOY)	$10,394	$0	$12,687	$0	$0	($12,687)	$0
Unobligated Balance (EOY)	($12,687)	$0	$0	$0	$0	$0	$0
Subtotal	($2,293)	$0	$12,687	$0	$0	($12,687)	$0
Prior Year Recoveries	$3,002	$0	$0	$0	$0	$0	$0
Obligations (0162XA) [Total]	**$709**	**$0**	**$12,687**	**$0**	**$0**	**($12,687)**	**$0**
Mandatory Budget Authority	$100,000	$200,000	$200,000	$400,000	$450,000	$200,000	$50,000
Mandatory Obligations [Total]	**$99,973**	**$849,166**	**$547,004**	**$885,640**	**$854,770**	**$338,636**	**($30,870)**

Table: Medical Facilities Discretionary & Mandatory Total and FTE, 2024-2027

($ in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary and Mandatory Budget Authority [Grand Total]	$9,008,915	$8,933,979	$9,723,141	$12,050,678	$12,062,317	$2,327,537	$11,639
Discretionary and Mandatory Obligations [Grand Total]	**$8,911,955**	**$10,008,951**	**$10,361,491**	**$12,834,405**	**$12,486,740**	**$2,472,914**	**($347,665)**
FTE							
Medical Facilities (0162)	27,487	25,839	26,523	26,523	26,523	0	0
VACAA, Section 801 (0162XA)	0	0	0	0	0	0	0
FTE [Total]	**27,487**	**25,839**	**26,523**	**26,523**	**26,523**	**0**	**0**

Summary of Obligations by Functional Area

To provide better visibility into the spending under this appropriation, additional detail on obligations by the following categories are reflected in the following tables.

Table: Medical Facilities Discretionary Obligations by Program Activity

($ in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Discretionary Program (0162)							
Engineering & Environmental Management	$1,004,416	$1,105,447	$1,162,022	$1,046,043	$1,063,903	($115,979)	$17,860
Engineering Service	$1,317,947	$1,444,496	$1,532,652	$1,364,765	$1,388,344	($167,887)	$23,579
Ground Maintenance & Fire Protection	$160,052	$175,341	$187,321	$167,219	$170,108	($20,102)	$2,889
Leases	$1,211,445	$1,460,843	$1,103,204	$1,618,346	$3,006,863	$515,142	$1,388,517
Non-Recurring Maintenance	$2,331,275	$2,000,000	$2,565,853	$4,837,500	$3,037,500	$2,271,647	($1,800,000)
Operating Equipment Maintenance & Repair	$575,151	$551,727	$671,850	$598,650	$608,993	($73,200)	$10,343
Other Facilities Operation Support	$71,823	$50,438	$83,723	$74,446	$75,732	($9,277)	$1,286
Plant Operation	$1,017,651	$1,131,489	$1,213,000	$1,083,746	$1,102,470	($129,254)	$18,724
Recurring Maintenance & Repair	$598,519	$682,518	$699,394	$623,280	$634,048	($76,114)	$10,768
Textile Care Processing & Maintenance	$233,672	$300,808	$278,572	$252,764	$257,131	($25,808)	$4,367
Transportation	$271,660	$256,678	$316,896	$282,006	$286,878	($34,890)	$4,872
Obligations Before Prior Year Recoveries (0162)	$8,793,611	$9,159,785	$9,814,487	$11,948,765	$11,631,970	$2,134,278	($316,795)
Prior Year Recoveries	$18,371	$0	$0	$0	$0	$0	$0
Obligations After Prior Year Recoveries [Subtotal]	**$8,811,982**	**$9,159,785**	**$9,814,487**	**$11,948,765**	**$11,631,970**	**$2,134,278**	**($316,795)**
Discretionary Program (1124XN) - Recurring Expenses Transformational Fund							
Non-Recurring Maintenance (Base)	$0	$0	$0	$0	$0	$0	$0
RETF Obligations Before Prior Year Recoveries [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Prior Year Recoveries	$0	$0	$0	$0	$0	$0	$0
Obligations After Prior Year Recoveries [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Obligations [Total] (0162)	**$8,811,982**	**$9,159,785**	**$9,814,487**	**$11,948,765**	**$11,631,970**	**$2,134,278**	**($316,795)**

Table: Medical Facilities Mandatory Obligations by Program Activity

($ in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Mandatory Program (0162) - PACT Act, Sec 705							
Engineering & Environmental Management	$7,969	$12,960	$9,000	$9,360	$9,734	$360	$374
Non-Recurring Maintenance	$18,007	$27,648	$60,710	$3,900	$2,704	($56,810)	($1,196)
Prior Year Recoveries	$2,355	$0	$0	$0	$0	$0	$0
Obligations PACT Act, sec. 705	**$28,331**	**$40,608**	**$69,710**	**$13,260**	**$12,438**	**($56,450)**	**($822)**
Mandatory Program (0162) - PACT Act, Sec 707							
Engineering & Environmental Management	$0	$5,642	$0	$0	$0		
Leases	$37,449	$802,916	$464,607	$872,380	$842,332	$407,773	($30,048)
Non-Recurring Maintenance	$15,661	$0	$0	$0	$0	$0	$0
Plant Operation	$17,823	$0	$0	$0	$0	$0	$0
Obligations PACT Act, sec. 707	**$70,933**	**$808,558**	**$464,607**	**$872,380**	**$842,332**	**$407,773**	**($30,048)**
Mandatory Program (0162) -VACAA Sec. 801							
Engineering & Environmental Management	$304	$0	$12,687	$0	$0	($12,687)	$0
Non-Recurring Maintenance	($2,975)	$0	$0	$0	$0	$0	$0
Operating Equipment Maintenance & Repair	$12	$0	$0	$0	$0	$0	$0
Other Facilities Operation Support	$9	$0	$0	$0	$0	$0	$0
Plant Operation	$18	$0	$0	$0	$0	$0	$0
Recurring Maintenance & Repair	$138	$0	$0	$0	$0	$0	$0
Textile Care Processing & Maintenance	$201	$0	$0	$0	$0	$0	$0
Obligations Before Prior Year Recoveries [Subtotal]	**($2,293)**	**$0**	**$12,687**	**$0**	**$0**	**($12,687)**	**$0**
Prior Year Recoveries	$3,002	$0	$0	$0	$0	$0	$0
Obligations After Prior Year Recoveries [Subtotal]	**$709**	**$0**	**$12,687**	**$0**	**$0**	**($12,687)**	**$0**
Mandatory Obligations [Total] (0162)	**$99,973**	**$849,166**	**$547,004**	**$885,640**	**$854,770**	**$338,636**	**($30,870)**

Summary of Obligations by Functional Area

To provide better visibility into the spending under Medical Facilities, additional detail on obligations by the following program activities are reflected in the following tables, beginning with total obligations.

Table: Medical Facilities Total Obligations by Program Activity

($ in thousands)

Description	2024 Actual 2/	2025 Budget Estimate	2025 Current Estimate	2026 Revised Request	2027 Advance Approp.	+/- 2025-2026	+/- 2026-2027
Program:							
Engineering & Environmental Management	$1,012,689	$1,124,049	$1,183,709	$1,055,403	$1,073,637	($128,306)	$18,234
Engineering Service	$1,317,947	$1,444,496	$1,532,652	$1,364,765	$1,388,344	($167,887)	$23,579
Ground Maintenance & Fire Protection	$160,052	$175,341	$187,321	$167,219	$170,108	($20,102)	$2,889
Leases	$1,248,894	$2,263,759	$1,567,811	$2,490,726	$3,849,195	$922,915	$1,358,469
Non-Recurring Maintenance 1/	$2,361,968	$2,027,648	$2,626,563	$4,841,400	$3,040,204	$2,214,837	($1,801,196)
Operating Equipment Maintenance & Repair	$575,163	$551,727	$671,850	$598,650	$608,993	($73,200)	$10,343
Other Facilities Operation Support	$71,832	$50,438	$83,723	$74,446	$75,732	($9,277)	$1,286
Plant Operation	$1,035,492	$1,131,489	$1,213,000	$1,083,746	$1,102,470	($129,254)	$18,724
Recurring Maintenance & Repair	$598,657	$682,518	$699,394	$623,280	$634,048	($76,114)	$10,768
Textile Care Processing & Maintenance	$233,873	$300,808	$278,572	$252,764	$257,131	($25,808)	$4,367
Transportation	$271,660	$256,678	$316,896	$282,006	$286,878	($34,890)	$4,872
Obligations Before Prior Year Recoveries (0162)	$8,888,227	$10,008,951	$10,361,491	$12,834,405	$12,486,740	$2,472,914	($347,665)
Prior Year Recoveries	$23,728	$0	$0	$0	$0	$0	$0
Obligations Total After Prior Year Recoveries (0162)	**$8,911,955**	**$10,008,951**	**$10,361,491**	**$12,834,405**	**$12,486,740**	$2,472,914	($347,665)

1/ The 2024 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/ 2024 actual total is in alignment with the total in the 2026 Budget Appendix; however, the individual program amounts are different due to data availability timing.

In 2026, total obligations are projected to increase by $2.5 billion above the 2025 current estimate in the following areas:

- **Non-Recurring Maintenance (NRM) (+$2.2 billion).** NRM anticipated obligations are $4.8 billion, to allow for increased investment in critical VHA infrastructure. are projected to increase, largely influenced by the major leases authorized by section 702 of the PACT Act.
- **Leases (+$922 million).** Leases are projected to increase, influenced by the major leases authorized by section 702 of the PACT Act, in support of efforts to increase Veterans' access to care.
- **All Other Changes (-$665 million).** Obligations in all other programs are projected to decrease.

Summary of the 2027 Advance Appropriation Request

The Medical Facilities discretionary advance appropriations request is $11.7 billion, an increase of $2 billion from the 2026 discretionary enacted advance appropriation. The 2027 request ensures continuity of Veterans' health care services. In 2027, total obligations are projected to decrease by $347.7 million from the 2026 revised request level in the following areas. Funding needs in 2027 will be reassessed as part of the 2027 President's Budget.

Medical Facilities Program Funding Requirements

The Medical Facilities appropriation supports the operation and maintenance of 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. A detailed explanation of the types and numbers of VHA health care facilities can be found in the *Medical Facilities by Type* chapter.

The staff and associated funding supported by this appropriation are responsible for: keeping the VA hospitals and clinics climate controlled; maintaining a clean and germ- and pest-free environment; sanitizing and washing hospital linens, surgical scrubs and clinical coats; cleaning and sterilizing the medical equipment; keeping the hospital signage clear and current; maintaining the trucks, buses, and cars in good operating condition; ensuring the parking lots and walk ways are sanded and free of snow and ice; cutting the grass; keeping the boiler plants and air conditioning units operating effectively; and undertaking certain repairs and alterations to the buildings to keep them in good condition.

Construction of new or replacement facilities are paid for under the Major Construction or Minor Construction appropriations. See *Volume 4* for additional detail.

When combined all funding sources, the projected 2026 obligations level in the MF category is $12.8 billion. The sections that follow detail the operations of each of the account's 11 program activities. All dollar amounts are represented in thousands.

Engineering and Environmental Management Services

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations [Subtotal]	**$1,004,416**	**$1,105,447**	**$1,162,022**	**$1,046,043**	**$1,063,903**	**($115,979)**	**$17,860**
PACT Act, sec. 705	$7,969	$12,960	$9,000	$9,360	$9,734	$360	$374
PACT Act, sec. 707	$0	$5,642	$0	$0	$0	$0	$0
VACAA, sec. 801	$304	$0	$12,687	$0	$0	($12,687)	$0
Mandatory Obligations [Subtotal]	**$8,273**	**$18,602**	**$21,687**	**$9,360**	**$9,734**	**($12,327)**	**$374**
Obligations [Total]	**$1,012,689**	**$1,124,049**	**$1,183,709**	**$1,055,403**	**$1,073,637**	**($128,306)**	**$18,234**

Engineering and Environmental Management Services are associated with personal services and other costs associated with the oversight and management of engineering activities; fire and safety engineering activities; project engineers, resident engineers, drafters, technicians, construction inspectors, and clerical employees and all supplies and materials needed for preparation of specifications and drawings and contractual service cost for recurring projects; fleet, green, and energy managers for related studies and activities.

Engineering Service

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations [Subtotal]	**$1,317,947**	**$1,444,496**	**$1,532,652**	**$1,364,765**	**$1,388,344**	**($167,887)**	**$23,579**
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$1,317,947**	**$1,444,496**	**$1,532,652**	**$1,364,765**	**$1,388,344**	**($167,887)**	**$23,579**

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)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations [Subtotal]	**$160,052**	**$175,341**	**$187,321**	**$167,219**	**$170,108**	**($20,102)**	**$2,889**
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$160,052**	**$175,341**	**$187,321**	**$167,219**	**$170,108**	**($20,102)**	**$2,889**

Grounds Maintenance and Fire Protection costs are associated with the maintenance of roads, walks, parking areas and lawn management, as well as personal services and other costs associated with fire truck operation, supplies, and materials.

Leases

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations [Subtotal]	**$1,211,445**	**$1,460,843**	**$1,103,204**	**$1,618,346**	**$3,006,863**	**$515,142**	**$1,388,517**
PACT Act, sec. 707, sec. 702	$32,414	$802,916	$463,547	$552,285	$18,522	$88,738	($533,763)
PACT Act, sec. 707, non sec. 702	$5,035	$0	$1,060	$320,095	$823,810	$319,035	$503,715
Mandatory Obligations [Subtotal]	**$37,449**	**$802,916**	**$464,607**	**$872,380**	**$842,332**	**$407,773**	**($30,048)**
Obligations [Total]	**$1,248,894**	**$2,263,759**	**$1,567,811**	**$2,490,726**	**$3,849,195**	**$922,915**	**$1,358,469**

Leases can have many functions, including clinical space for CBOCs, administrative workspace for Veterans' support, research, and warehouses for storage of supplies and equipment, which is 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 2026 request seeks Congressional Committee approval for three major leases. See *Volume 4* for additional detail.

VA uses both in-house Lease Contracting Officers and the General Services Administration (GSA) to procure medical facility space and administrative space. When VA procures the lease, it is through a delegation granted on a lease-by-lease basis by GSA. These leases are critical to meeting Veterans' needs by providing services close to Veteran populations and maintaining the flexibility to relocate or resize to address changing demographic trends.

Non-Recurring Maintenance (NRM)

		2025		**2026**	**2027**		
	2024	Budget	Current	**Revised**	**Advance**	+/-	+/-
Description (dollars in thousands)	Actual	Estimate	Estimate	**Request**	**Approp.**	2025-2026	2026-2027
Discretionary Obligations - All Other	$2,258,615	$2,000,000	$2,488,000	$4,837,500	$3,037,500	$2,349,500	($1,800,000)
P.L. 117-328 § 252 (EO 14507 no-year, 1124) 1/	$0	$0	$0	$0	$0	$0	$0
P.L. 117-103 § 253 (Infrastructure no-year)	$23,227	$0	$65,029	$0	$0	($65,029)	$0
P.L. 115-244 § 248 (NRM no-year)	$45,577	$0	$12,748	$0	$0	($12,748)	$0
P.L. 115-141 § 255 (NRM no-year)	$3,856	$0	$76	$0	$0	($76)	$0
Discretionary Obligations [Subtotal]	**$2,331,275**	**$2,000,000**	**$2,565,853**	**$4,837,500**	**$3,037,500**	**$2,271,647**	**($1,800,000)**
PACT Act, sec. 705	$18,007	$27,648	$60,710	$3,900	$2,704	($56,810)	($1,196)
PACT Act, sec. 707	$15,661	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	($2,975)	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$30,693**	**$27,648**	**$60,710**	**$3,900**	**$2,704**	**($56,810)**	**($1,196)**
Obligations [Total]	**$2,361,968**	**$2,027,648**	**$2,626,563**	**$4,841,400**	**$3,040,204**	**$2,214,837**	**($1,801,196)**
Non-Add (Included Above):							
Discretionary Obligations - Base NRM	$1,843,979	$1,500,000	$2,065,853	$3,837,500	$2,537,500	$1,771,647	($1,300,000)
Mandatory Obligations - Base NRM	$30,693	$27,648	$60,710	$3,900	$2,704	($56,810)	($1,196)
Discretionary Obligations - EHRM NRM	$487,296	$500,000	$500,000	$1,000,000	$500,000	$500,000	($500,000)
Mandatory Obligations - EHRM NRM	$0	$0	$0	$0	$0	$0	$0
Base NRM/EHRM NRM Obligations [Subtotal]	**$2,361,968**	**$2,027,648**	**$2,626,563**	**$4,841,400**	**$3,040,204**	**$2,214,837**	**($1,801,196)**

Note: The 2024 NRM actual in the above table includes additional object classes than what is displayed in the Budget Overview chapter's Obligations by Object table, such as Personnel Compensation and benefits, Other Contractual Services, Supplies & Materials and Equipment.

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

NRM program funds additions, alterations, and modifications to land, buildings, other structures, nonstructural improvements of land, and fixed equipment (that is, equipment permanently attached to or part of the building or structure). NRM funds 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 process. This inclusion ensures a research focus for mitigation within a ten-year window of identified research infrastructure deficiencies.

NRM projects are broken into three categories, as discussed and defined below.

Sustainment projects:
NRM sustainment projects involve the provision of resources that will convert functional space to a different program function within existing buildings or spaces, without adding any new space. Each sustainment project must be equal to, or less than, the amount outlined in title 38, United States Code, section 8104 (currently $30 million, as adjusted in the *National Defense Authorization Act for Fiscal Year 2024, P.L. 108-136*). The total project cost includes all amounts and expenditures associated with design, impact, contingency, and construction costs.

Infrastructure Modernization projects:
NRM infrastructure modernization projects involve the provision of resources to repair, modernize, replace, renovate, and provide for new building systems, and do not convert functional space to a different program function. Such projects have no project cost limitation; however, any work to be done beyond the underlying building system must be ancillary to the overall total project cost (that is, 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 2026 revised request and 2027 advance appropriation request support continued implementation of Electronic Health Record Modernization program with $1 billion in 2026 and $500 million in 2027 for NRM projects that will support infrastructure modifications at VA facilities that are necessary prerequisites to the completion of the Initial Operating Capacity phase and broader nationwide rollout.

The types of building systems permitted for NRM infrastructure projects consist of the following: building thermal and moisture protection; doors and windows; interior finishes only directly related with building system work; conveyance and transport systems; fire suppression; plumbing; heating, ventilation, and air conditioning; electrical systems; communication systems; safety and security systems; utility systems, boiler plants, chiller plants, water filtration and treatment plants, cogeneration plants, central energy plants, elevator towers, connecting corridors, and stairwells.

Clinical Specific Initiative Projects:
Clinical Specific Initiative (CSI) projects are emergent projects that cannot be planned due to dynamic health care environments. Associated funding for these projects is distributed to the VISNs at the beginning of each year to obligate towards existing clinical building space that addresses workload gaps or supports access. For CSI projects, only high-cost/high-tech medical equipment site prep/installation projects may involve the construction of new program functional building space.

Operating Equipment Maintenance and Repair

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations [Subtotal]	**$575,151**	**$551,727**	**$671,850**	**$598,650**	**$608,993**	**-$73,200**	**$10,343**
VACAA, sec. 801	$12	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	$12	$0	$0	$0	$0	$0	$0
Obligations [Total]	**$575,163**	**$551,727**	**$671,850**	**$598,650**	**$608,993**	**-$73,200**	**$10,343**

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.

Other Facilities Operation Support

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations [Subtotal]	**$71,823**	**$50,438**	**$83,723**	**$74,446**	**$75,732**	**-$9,277**	**$1,286**
VACAA, sec. 801	$9	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$9**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$71,832**	**$50,438**	**$83,723**	**$74,446**	**$75,732**	**($9,277)**	**$1,286**

This function includes other facilities operation costs associated with inpatient and outpatient providers and miscellaneous benefits and services.

Plant Operations

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations [Subtotal]	**$1,017,651**	**$1,131,489**	**$1,213,000**	**$1,083,746**	**$1,102,470**	**($129,254)**	**$18,724**
PACT Act, sec. 707	$17,823	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$18	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$17,841**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$1,035,492**	**$1,131,489**	**$1,213,000**	**$1,083,746**	**$1,102,470**	**($129,254)**	**$18,724**

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, and renewable energy; and all plant operations.

Recurring Maintenance and Repair

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations [Subtotal]	**$598,519**	**$682,518**	**$699,394**	**$623,280**	**$634,048**	**($76,114)**	**$10,768**
VACAA, sec. 801	$138	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$138**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$598,657**	**$682,518**	**$699,394**	**$623,280**	**$634,048**	**($76,114)**	**$10,768**

Recurring Maintenance and Repair services encompass all projects where the minor improvement is below $25,000. Examples include maintenance service contracts, routine repair of facilities, upkeep of land, painting interior and exterior walls, repair of water leaks in pipes and roofs, and replacement of light bulbs, carpet, ceiling, and floor tiles.

Textile Care Processing and Management

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations [Subtotal]	**$233,672**	**$300,808**	**$278,572**	**$252,764**	**$257,131**	**($25,808)**	**$4,367**
VACAA, sec. 801	$201	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$201**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$233,873**	**$300,808**	**$278,572**	**$252,764**	**$257,131**	**-$25,808**	**$4,367**

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)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Discretionary Obligations [Subtotal]	**$271,660**	**$256,678**	**$316,896**	**$282,006**	**$286,878**	**($34,890)**	**$4,872**
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$271,660**	**$256,678**	**$316,896**	**$282,006**	**$286,878**	**($34,890)**	**$4,872**

Transportation Services include the costs to operate facilities' motor vehicles, including the purchase and operation of VA vans and buses, facility maintenance vehicles, and the clinical motor vehicle pool operations.

Actuarial Model Projections

Models Used to Inform the Budget Request
The Department of Veterans Affairs (VA) uses three actuarial models to support formulation of most 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, and children of women Vietnam Veterans), and some components for the PCAFC program (caregiver travel, VA oversight, administrative salaries, and contracts).

VA Enrollee Health Care Projection Model
The VA EHCPM supports approximately 86% 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, workload, and costs for the enrolled Veteran population in more than 150 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, sex, priority level, and geographic location.
- **Workload.** 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").
- **Cost.** Total health care costs are developed by multiplying the expected VA workload 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 2024 EHCPM (Base Year 2023) was used to build the 2026 and 2027 Medical Care budget request. The 2024 EHCPM was updated using workload through 2023 to reflect information on the enrollee population and their utilization of VHA health care. In addition, the 2024 EHCPM includes a calibration to available 2024 workload and cost data. See additional details in the "Impact of the 2024 EHCPM Update" section.

The cost basis used to build the EHCPM projections includes the Medical Services, Medical Community Care, Medical Support and Compliance, and Medical Facilities appropriations, but excludes non-recurring maintenance. The projections include all care provided in VA facilities (direct care) or paid for by VA (community care).

Key Drivers of Growth in Projected Resource Requirements

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

Historically, growth in cost requirements to provide care to enrolled Veterans is 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 cost growth; however, their impact varies significantly by the type of health care service. An assumption that VA's level of management of health care delivery will improve over time reduces the cost of providing care to enrollees.

The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act became Public Law No 117-168 in August of 2022, expanding benefits for Veterans exposed to certain toxins in the course of their military service, with a focus on Gulf War era Veterans as well as new groups of Vietnam Veterans who were exposed to Agent Orange. The 2024 EHCPM projects enrollment and workload for Title I, which changes enrollment eligibility timelines, and Titles III and IV, which expand eligibility based on conditions presumed to be associated with hazardous exposures. PACT Act affects VHA enrollment by expanding eligibility for selected Veterans and by either introducing or increasing service-connected ratings for some Veterans, which increase the enrollment priority level for which the Veteran is eligible.

Since the implementation of the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act in June 2019, significant community care growth has been observed for many services, and enrollees with enhanced community care access due to these provisions had been responsible for a larger percentage of that growth.

Community care growth from 2022-23, no longer appears to be related to drive-time eligibility status to the same degree that was observed from 2019-22, suggesting that the impact of drive-time provisions on total community care growth was tapering. This suggests that the implementation of this MISSION Act provision had reached a stable level and continuing community care growth is being driven by different factors, such as VA productivity/capacity or VA provider referral patterns. Therefore, no additional MISSION Act drive-time adjustments were included in the 2024 EHCPM.

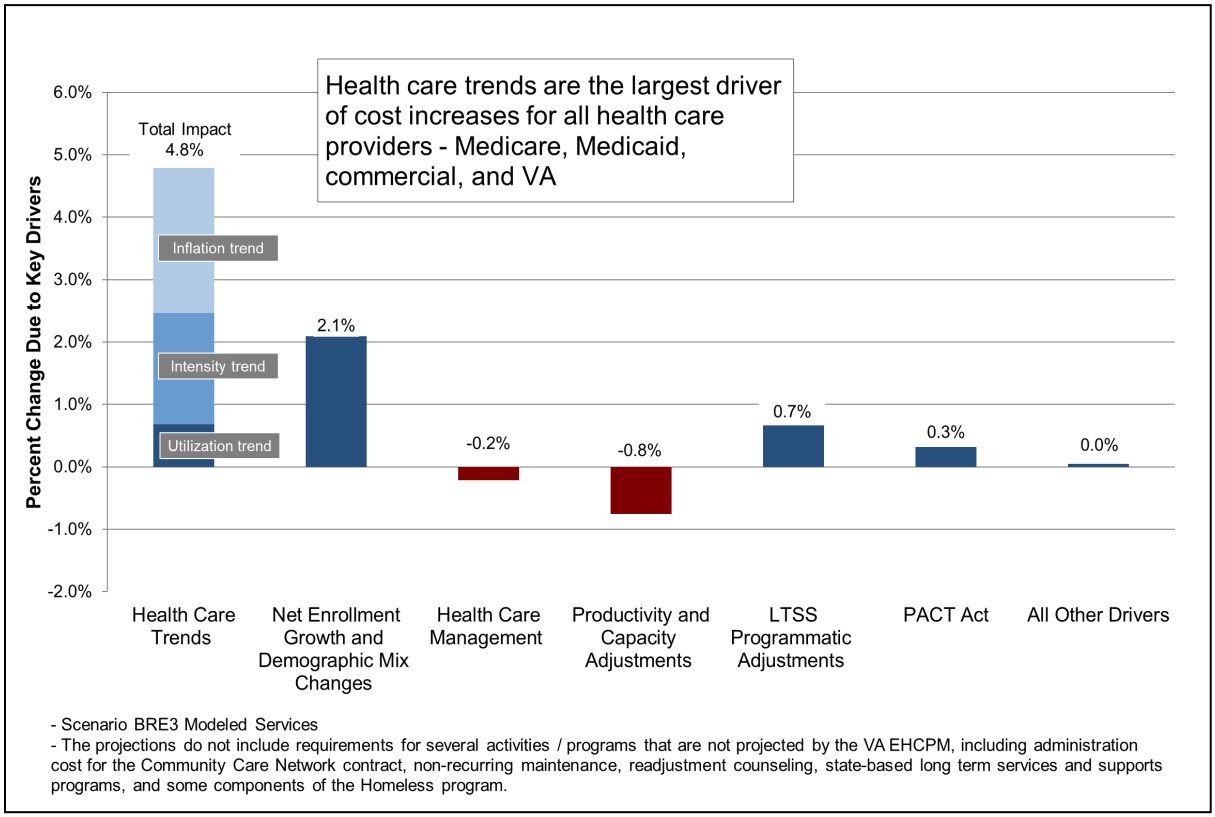
In 2023, the COVID-19 pandemic had largely settled into the endemic stage with relatively little continued impact on changes in health care utilization patterns. For VHA, enrollee health care workload had broadly returned to pre-pandemic expected levels or settled at a "new normal" that reflects a longer-term shift in health care workload. For some specific service areas, particularly mental health care, long term services and supports (LTSS), and inpatient rehabilitation care, the effects of COVID-19 deferred care remain and it is expected that there will be continued recovery of health care workload in 2024 and beyond. However, these impacts are no longer considered to be key drivers of costs.

VHA staffing levels continued to increase throughout the COVID-19 pandemic and recovery period, while direct care workload largely remained below 2019 levels through 2022. This led to a significant increase in direct care unit costs over the course of the pandemic. Although the annual growth in unit costs has returned much closer to historical levels, the higher costs persisted in 2023. In response to these changes, VHA is assuming that staffing levels will remain flat from 2025-27, which is expected to reduce VHA capacity to provide for the growing demand for VA direct care services. VHA has observed an improvement in productivity rates of the direct care system, suggesting that more workload may be provided by the fixed staffing level. Productivity improvements consistent with recent historical experience are assumed to continue through 2027. These changes are assumed to be independent of total enrollee reliance on VA, so that projected changes in VHA capacity are modeled with complementary changes in community care utilization. Only inpatient and ambulatory services available in both VA direct and community care settings are impacted by these staffing-level and productivity changes.

Historical growth for many LTSS programs has been accelerating in the past few fiscal years and has significantly exceeded growth that would be expected based on demographic changes and other factors that would typically be captured in the EHCPM, particularly for Home and Community Based Services. The 2024 EHCPM includes increased projected workload of certain services beyond demographic trends to continue through the budget years.

Figure A quantifies the key drivers of the projected increase in cost requirements for 2025 for all modeled services. Health care trends, net enrollment growth and demographic mix changes, and health care management and their impact on the resources required to provide health care to enrolled Veterans are discussed in detail in the following sections. PACT Act, LTSS programmatic adjustments, and all other drivers are discussed throughout the chapter.

Figure A. Key Drivers of Projected Cost Change, 2025-26



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 cost requirements independent of any enrollment growth or demographic mix changes. The health care trends incorporated into the EHCPM are informed by federal policy and anticipated trends in Medicare, together with VA-specific trends for pharmacy and prosthetics, and private sector trends for community care.

Inflation is comprised of personnel and non-personnel components. Inflation on VA's personnel costs is determined by federal wage policy, including wage increases and freezes. VA's projected inflation for pharmacy and prosthetics products reflects VA's well-managed purchasing programs for these products. VA's expected inflation on supplies, utilities, and other necessities, is based on projected Consumer Price Index - Urban (CPI-U) and Producer Price Index inflation trends for these items.

Utilization and intensity 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, when newer high-cost specialty drugs become available, which increases VA's prescription drug costs.

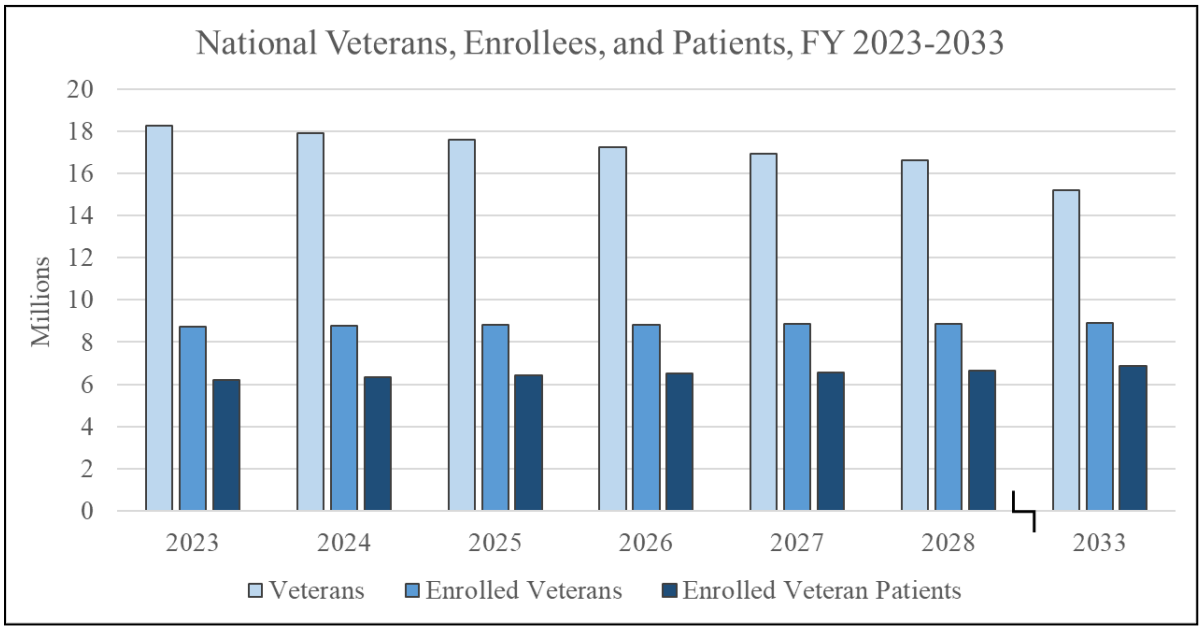
VA's utilization and intensity trends for Medicare-covered medical services are informed by anticipated Medicare utilization and intensity trends, as projected by the Center for Medicare & Medicaid Services' Office of the Actuary. They have been adjusted downward for efficiencies in the VA health care 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 (for example, changing demographics) and some cannot (such as, future economic downturns, pandemics, and future military conflicts).

- Growth of the Post-9/11 Era Combat Veteran and female enrolled populations.
- Enrollee age, sex, mortality, income, travel distance to VA facilities, and geographic migration patterns.
- Increases in prevalence of service-connected conditions and changes in enrollee income levels. These are associated with transitions between enrollment priorities.
- Health care utilization patterns of Post-9/11 Era Combat Veteran, female, disabled, new enrollees, and other enrollee cohorts with unique utilization patterns for particular services.
- Economic conditions, including changes in local unemployment rates and home values (as a proxy for asset values) over time.
- Policies, presidential executive orders, regulations, and new legislation, such as the elimination of net worth from the VA Means Test, automatic income verification through tax records, expanding eligibility with the PACT Act, and MISSION Act.

Using current assumptions, the 2024 EHCPM has projected Veteran enrollment in VHA to increase slightly from 2023 to 2028 and then slightly decline after 2032. The overall Veteran population is expected to decrease over time (Figure B).

Figure B. National Veterans, Enrollees, and Patients, 2023-2033



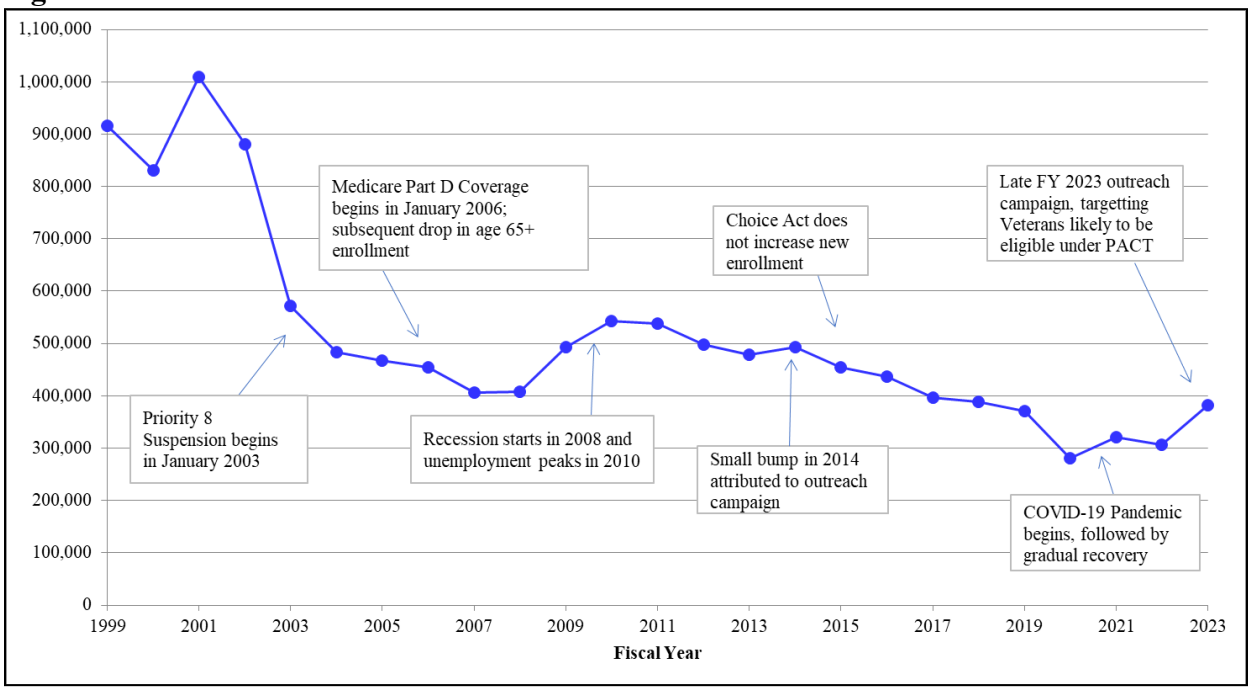
High enrollment rates for Post-9/11 Era Combat Veterans and Gulf War Veterans and expanded eligibility under the PACT Act are causing projected enrollment patterns to differ from the continuous decrease in the overall Veteran population. Enrollment is projected to increase in the short-term while new enrollment is expected to outpace mortality. After 2032, 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 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 because 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 period.

As can be seen in Figure C, the new enrollment declined between 2015 and 2017. Thus, even in the Veterans Choice Act environment, greater than expected new enrollment was not the driver of the growth in enrollee use of VA health care. This growth was the result of current enrollees increasing their reliance on VA versus their other health care options (for example, Medicare, Medicaid, and commercial insurance). See the section on Enrollee Reliance in this chapter for details.

The rate of new enrollment decreased significantly during the initial response to COVID-19 in 2020 and remained suppressed to varying degrees through 2021. By the end of 2022, rates of new enrollment among Veterans under age 65 had recovered to and surpassed pre-COVID levels, indicating a return to normal and potentially a fulfillment of previously pent-up demand. For Veterans age 65+, however, the rates continue to be suppressed while gradually approaching pre-COVID levels. Annual new enrollment rates are projected to increase further since 2023 due to the PACT Act.

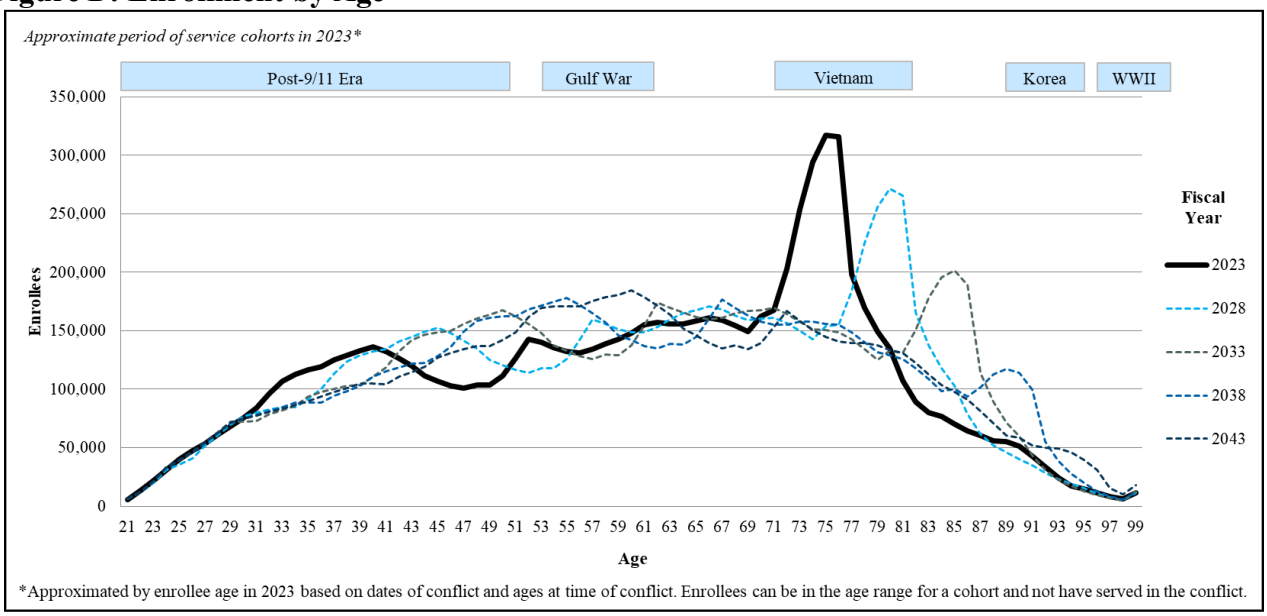
Figure C. New Enrollment Over Time



Net enrollment growth (new enrollment minus deaths) is not a significant driver of increases in annual cost requirements for most VA health care services. Enrollees who are dying are generally sicker and need more 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 (such as, priority transitions) and changes in the broader environment (for example, 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 2023 and projected enrollment by age and highlights the relative size of the Vietnam Era enrollee cohort compared to other period-of-service cohorts.

Figure D. Enrollment by Age

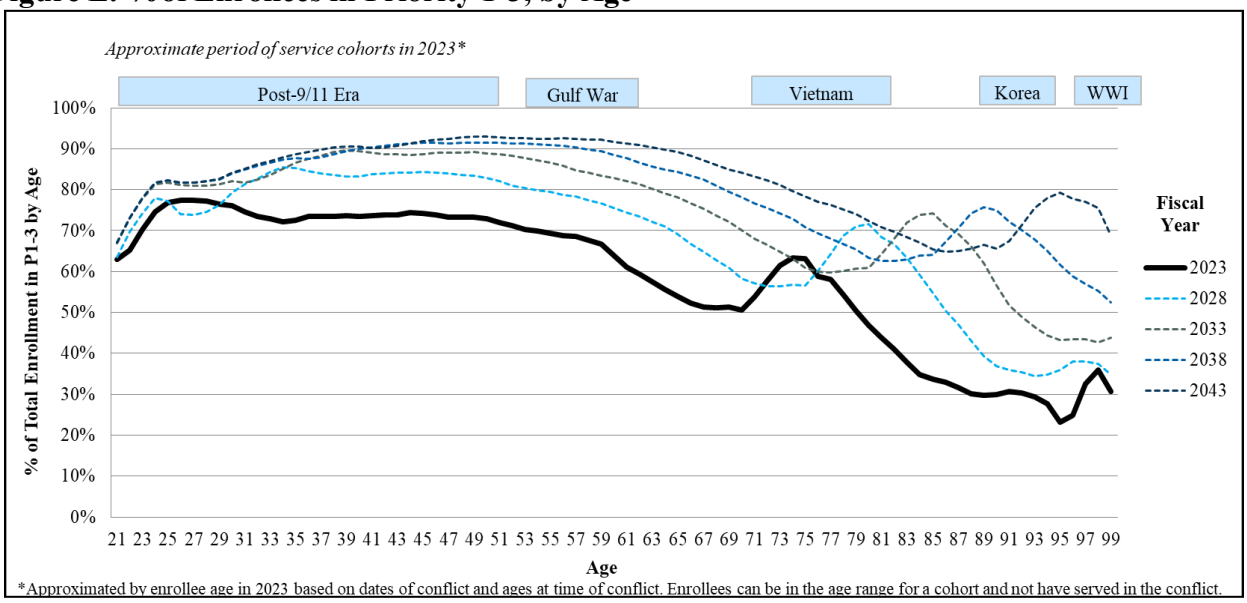


Aging has less of an impact on costs than might be expected because reliance on VA for health care decreases beginning at age 65 as enrollees become eligible for Medicare coverage (see section on Enrollee Reliance below). Although the large Vietnam Era enrollee cohort that has mostly become Medicare 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 (for example, 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 30% 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 because of adjudication for service-connected disabilities by the Veterans Benefits Administration (VBA). The number of enrollees being adjudicated for service-connected disabilities has escalated in recent years. This is largely a result of the scope and definitions of service-connected conditions broadening over time and the improved capture of service- connected conditions at the time of military separation. These enrollees are expected to increase their reliance on VA health care, resulting in an increase in VA medical care costs.

Figure E shows the significant projected growth in service-connected status for Post-9/11 Era Combat Veteran, Gulf War, and Vietnam enrollee populations over the next 20 years. As a result of the increasing numbers of enrollees moving into Priorities 1-3, projected enrollment is declining in Priorities 5, 7, and 8.

Figure E. % of Enrollees in Priority 1-3, by Age



As a result of the previously mentioned trend of enrollees being adjudicated to higher service- connected priorities, as of 2023, 10% of enrollees had transitioned into Priority 1a (70% or higher service-connected disability) over the previous three years, compared with 5% as of 2013. The Priority 1a population is projected to continue to grow by 21% between 2023-26 and by 54% between 2023-33.

Aging and the changes in the Priority 1a population are significant drivers of projected cost increases for LTSS. VA is mandated by law to provide continuing care nursing home services to Priority 1a enrollees. Additionally, World War II and Korean War era enrollees are in the age bands (greater than age 85) that are the highest users of LTSS and are driving the recent and near- term annual growth in LTSS cost requirements, and Vietnam Era Veterans will be an increasing driver of LTSS costs, with most having aged beyond age 75 by 2027.

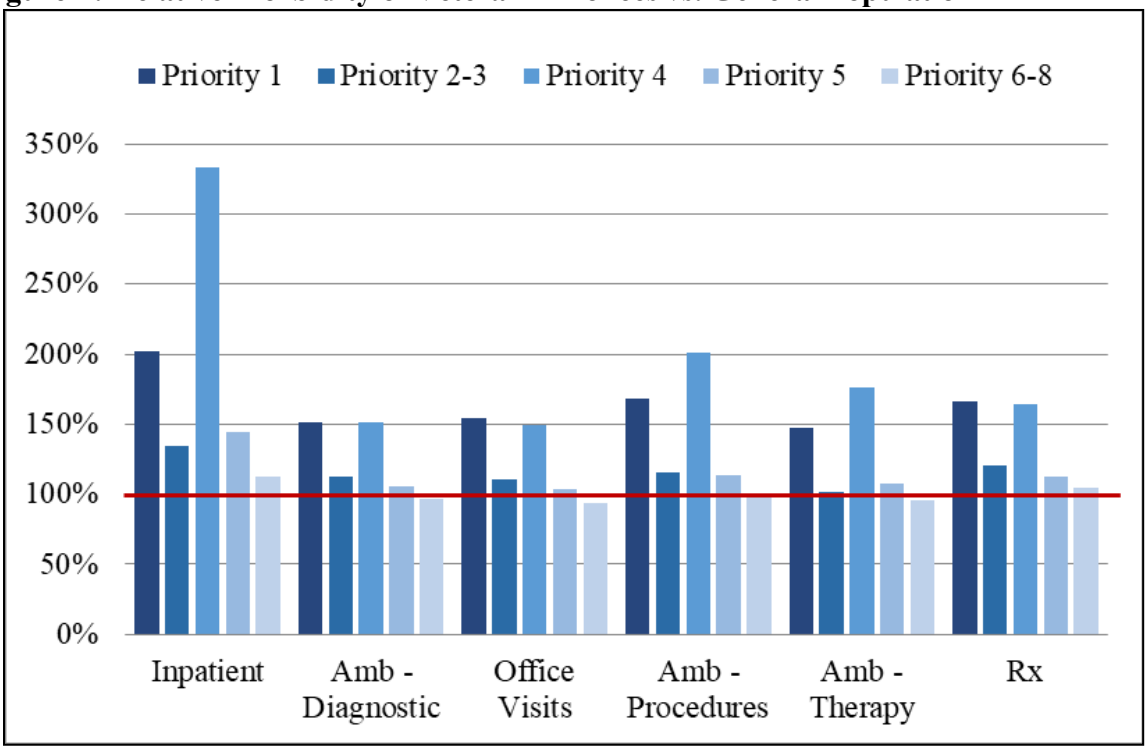
Enrollee Morbidity

The VA enrollee population consists largely of older males, which is typically the segment of the population with the highest health care costs. Even after accounting for the age and sex mix of the enrollee population, the VA enrollee population is significantly more morbid (sicker) than the general population in the U.S., and this higher morbidity further increases VA's cost of providing care.

Using a diagnosis-based methodology, the average morbidity of the VA enrollee population is estimated to be approximately 28% higher than that of the general U.S. population. This analysis is corroborated by the 2023 VA Survey of Veteran Enrollees' Health and Use of Health Care which shows that 37% of enrollees rated their physical health as "fair" or "poor" compared to other people their age. Only 15.1% of the U.S. adult population responded similarly in Centers for Disease Control's National Center for Health Statistics' 2023 National Health Interview Survey.

Morbidity varies significantly by priority level and health care service. For example, the morbidity of Priority 4 (catastrophically disabled) enrollees results in inpatient care costs that are over three times that of the general U.S. population, even after accounting for the age and sex differences in the populations. Figure F shows the relative morbidity of enrollees by priority compared to the general population for several large categories of health care services. In the figure, 100% reflects the cost of health care based on the morbidity of the general U.S. population.

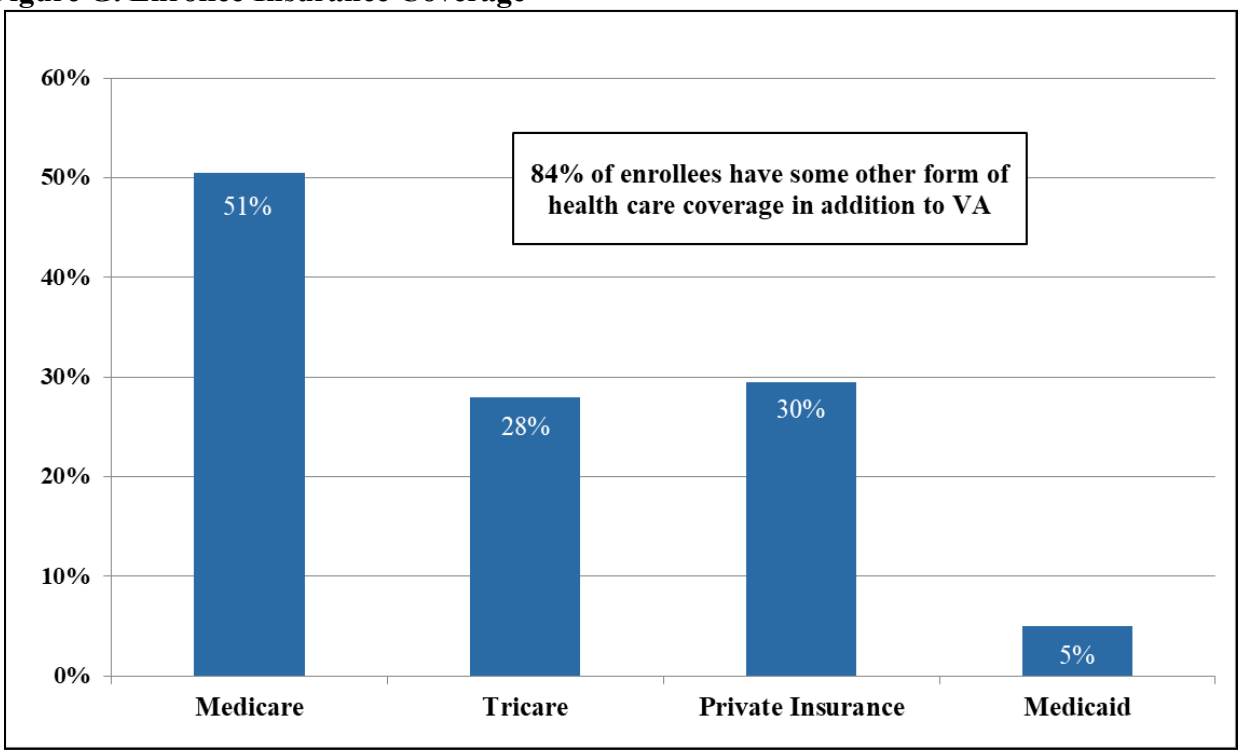
Figure F. Relative Morbidity of Veteran Enrollees vs. General Population



Enrollee Reliance on VA Health Care

Reliance refers to the portion of an enrollee's total health care needs that VA will provide either at VA facilities or purchase in the community. A unique aspect of the enrolled Veteran population is that enrollees have many options for health care coverage in addition to VA: Medicare, Medicaid, TRICARE, Indian Health Service, and private insurance. According to the VHA Survey of Enrollees, in 2023 approximately 84% of enrollees had one or more other sources of public or private health care coverage in addition to VA (Figure G). Enrollees with multiple sources of other health insurance are included in multiple categories in Figure G below.

Figure G. Enrollee Insurance Coverage



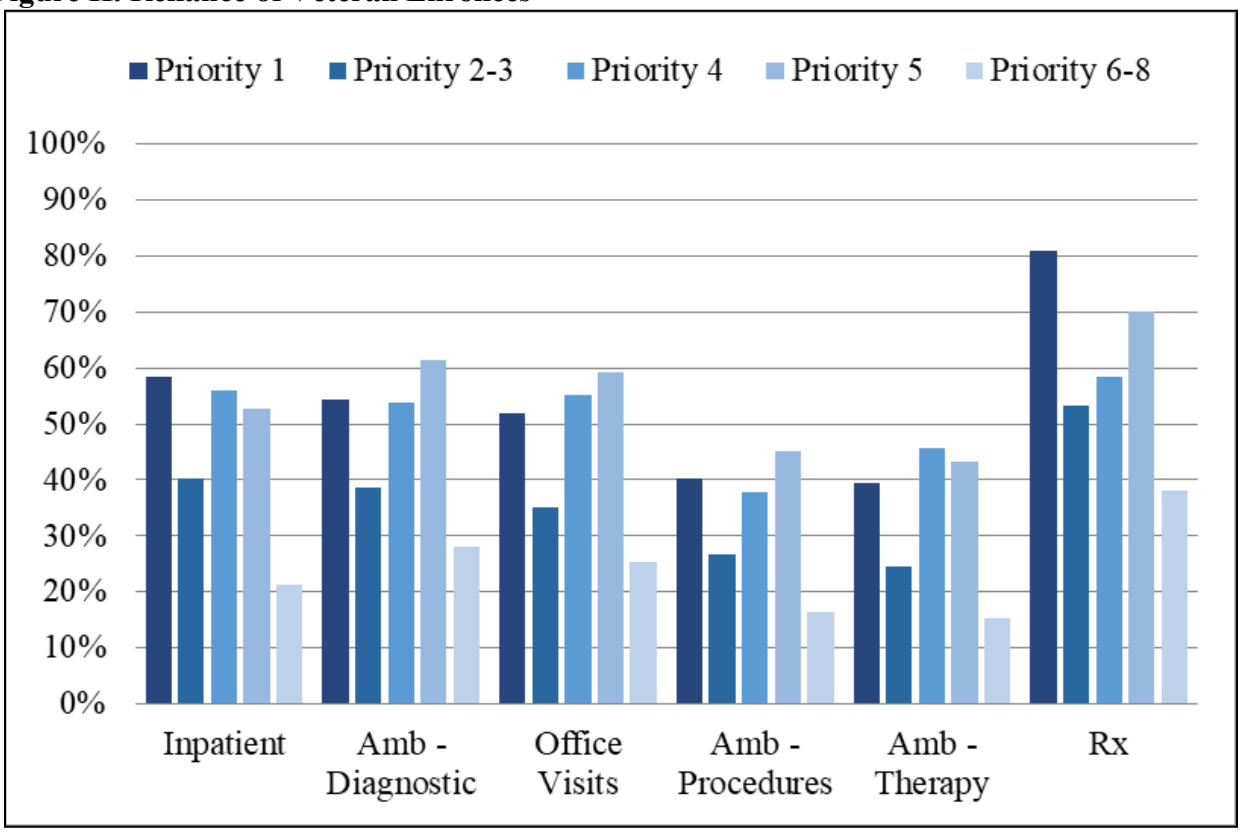
As a result, most enrollees do not use VA as their sole source of health care. On average, enrollees rely on VA for only 45% of their health care needs (excluding LTSS). This represented $114 billion in 2023. If the Veterans enrolled in 2023 had chosen to receive all their health care in VA (100% reliance), this would have required an additional $141 billion for a total of $256 billion in 2023.

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; or cost sharing associated with services (e.g., dialysis) in the private sector compared to VA. The Veterans Choice Act and MISSION Act significantly expanded enrollee access to care in the community paid for by VA, thus increasing enrollees' overall reliance on VA health

care. Additionally, enrollees have exhibited a "generational shift" in their reliance on VA, slowly increasing reliance on VA over time for both VA direct care and community care. For example, enrollees aged 65-69 in 2023 had on average, higher reliance than enrollees aged 65-69 in 2018. Similar community care growth is attributed to the generational shift as well. VA expects this impact to continue as younger (and more reliant) enrollees age, and older (and less reliant) enrollees leave VA.

Figure H shows reliance by priority for several large categories of health care services. For example, Priority 4 enrollees get approximately 56% 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 24% of the enrollee population in 2023 and are expected to grow to 30% in 2033.

- Enrollees who used VA prior to the Eligibility Reform Act of 1996 (enrollees Pre) differ from those who enrolled after (enrollees Post). Enrollees Pre are both sicker and more reliant on VA for health care and therefore, have higher utilization rates. These higher utilization rates are observed even after accounting for the higher average age of the enrollees Pre. Enrollees Pre represented only 12% of enrollees in 2023 but accounted for 24% of modeled costs. Since there are no new enrollees Pre, this group is declining overtime due to mortality. Enrollees Pre are projected to decline to 7% of the population by 2033, but still account for 14% of costs.
- Enrollees who served immediately after Vietnam (post-Vietnam Era) have the highest health care utilization relative to other enrollees when they were at the same age. These enrollees exhibit higher than expected needs for many mental health and substance abuse services. This cohort represents about 17% of the enrollee population in 2023.
- 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 28% of the enrollee population in 2023.
- World War II Era enrollees are high utilizers of LTSS, since those services are typically provided to older enrollees. This cohort represents less than half a percent of overall enrollment in 2023.
- Women are one of the fastest growing enrollee cohorts. Women comprised 11% of the enrollee population in 2023 and are expected to grow to 15% by 2033. 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 chiropractic services, but less likely to use acute inpatient services.

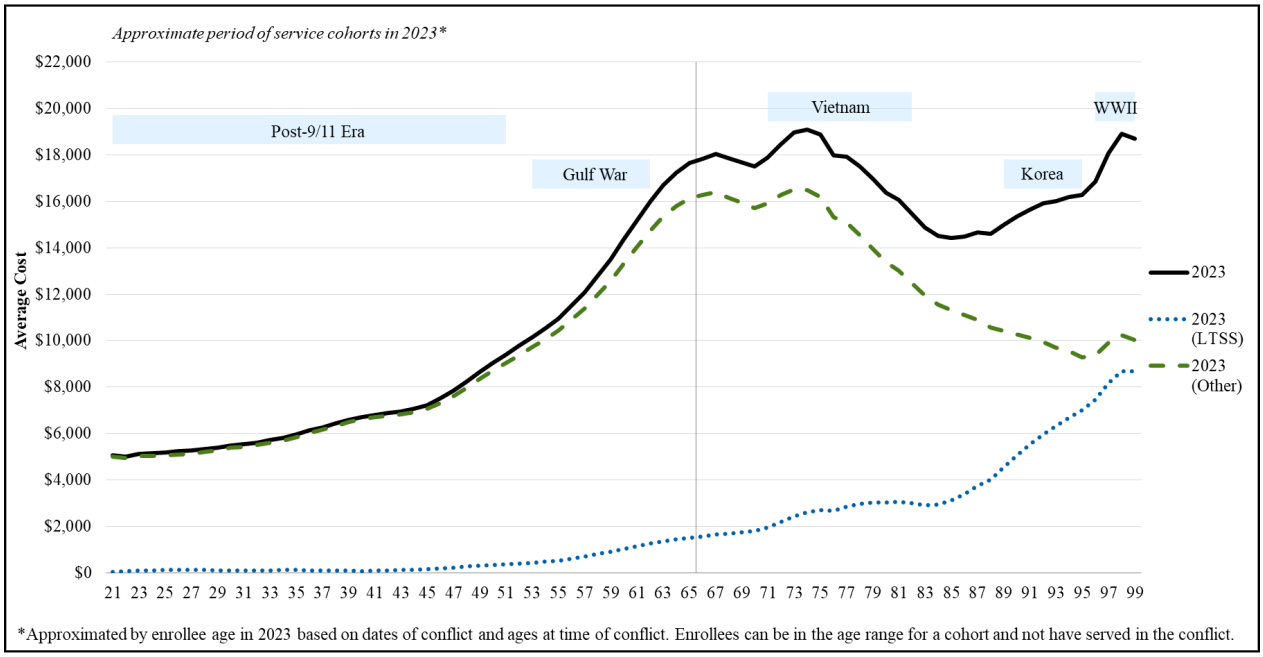
Cost Requirements by Enrollee Age

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 while others decrease requirements. Figure I shows the net impact of all the factors on costs.

In Figure I, actual 2023 costs by age highlight the impact of key factors influencing costs per enrollee. For the under age 65 enrollee population, the figure shows the impact of the increase in need for health care services as enrollees age. It also highlights how the impact of aging is mitigated by a decline in reliance on VA health care beginning at age 65 when enrollees typically become eligible for Medicare. Enrollees who have become Medicare eligible more recently have shown a slightly lower decline in reliance than older enrollees.

Costs per enrollee increase again beginning at age 70, attributed to the higher proportion of Priority 1 enrollees among the Vietnam era period of service. The impact of providing LTSS to enrollees (services that are generally not covered by Medicare) on costs by age is also illustrated.

Figure I. Average Costs per Enrollee by Age



Health Care Management and Dynamics of the VA Health Care System

The VA health care system is continually evolving due to VA's efforts to enhance its practice of health care, provide Veterans access to the services they need, and improve its level of health care management.

The EHCPM includes assumptions for initiatives to increase capacity for mental health, homeless services, and LTSS. These initiatives are discussed in the service-specific sections. The EHCPM also includes assumptions that VA's level of management in providing health care will improve over time and reduce the cost of providing care to enrollees. Most of these efficiencies result from improvements in VA's level of management in inpatient care. 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 because 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 national system redesign programs, including Virtual Improvement Program and Strong Practice Forums.

- Admission appropriateness and continued stay reviews through the National Utilization Management Initiative.

Assumptions for improvement in VA's level of health care management may increase or decrease ambulatory workload 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 workload for inpatient acute bed days and admissions.

Cost Requirements by Service Category
The following sections discuss the key drivers of increases in cost requirements for categories of health care services.

Ambulatory Primary and Specialty Care
Ambulatory care projections are developed for the full range of services provided under a typical private sector health plan (such as, office visits, radiology, pathology, surgeries) as well as specialized services offered by VA (for example, 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.

Costs required to provide ambulatory care services to enrolled Veterans are expected to grow in 2026-27. The projected increase in ambulatory care costs is largely due to the impact of health care trends. VA's cost of providing ambulatory services is expected to increase due to inflation and changes in health care practice that increase the cost per service (intensity trends). Further, utilization of ambulatory care is expected to grow due to changes in health care practice independent of any changes in enrollee demographics. For example, use 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 cost requirements for ambulatory care. The growth in the Priority 1-3 population has a positive impact. Aging is driving an increase in annual cost requirements. However, the impact of aging can vary by service. For example, use of hearing aid services increases significantly with age, while use of maternity services decreases significantly with age.

Modeled Ambulatory Primary and Specialty Care

Diagnostics

- Cardiovascular
- Colonoscopy
- Dermatology Services and Diagnostic Exams
- Hearing and Speech Exams
- Miscellaneous Medical Services and Diagnostics
- Non-Invasive Vascular Studies
- Ophthalmology Services and Diagnostic Exams
- Pathology
- Pulmonology Services, Diagnostic Exams, and Ventilator Management
- Radiology – CT
- Radiology – General
- Radiology – MRI
- Radiology – Mammography Diagnostic
- Radiology – Mammography Screening
- Radiology – Nuclear Medicine
- Radiology – PET and PET/CT
- Radiology – Radiation Oncology
- Radiology – Ultrasound
- Vision Exams

Evaluation and Management Services

Office Visits, including Physical Exams, Urgent Care Visits, and Telephone Care Visits

- Compensation & Pension Exams (only those provided in VA facilities)
- Outpatient Medication Therapy Management
- Case Management – Rehabilitation
- Telephone Evaluation and Management

Professional Services and Procedures

- Ambulance
- Ambulatory Surgery - Ambulatory Surgery Center Setting
- Ambulatory Surgery - Office Setting
- Ambulatory Surgery - Outpatient Setting
- Anesthesia
- Emergency Room Visits
- Eye Glasses Services
- Hearing Aid Services
- Prosthetics and Orthotics Services
- Maternity
- Nutritional Counseling
- Observation Care

The PACT Act is driving increases in annual costs for all ambulatory services.

Changes in enrollee reliance are increasing VA's cost requirements for providing dialysis services. Enrollee reliance on VA for dialysis and related services increased from 34% in 2014 to an estimated 49% in 2023 and is expected to continue to increase through 2031. This increase in reliance is due in part to lower cost sharing in VA compared to Medicare.

Modeled Ambulatory Primary and Specialty Care (cont'd)

Therapies

- Allergy Testing and Immunotherapy
- Chiropractic
- Dialysis and Related Services
- Nephrology – End Stage Renal Disease Services
- Immunizations
- Office Administered Drugs
- Physical Therapy, Occupational Therapy, and Speech and Language Pathology

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 medication and supplies.

Modeled Pharmacy

Outpatient Prescriptions

- Prescription Drugs
- Over-the-Counter Medication
- Prescription Related Supplies

Costs required to provide pharmacy services to enrolled Veterans are expected to increase significantly in 2026-27, driven primarily by health care trends, especially intensity and inflation, and the impact of priority transitions and aging. VA's well-managed pharmacy benefit management program and contracting practices do moderate these impacts, but price increases and new high-cost medications are still contributing substantially to VA's cost of providing prescription drugs. The prescription drug pipeline is monitored regularly, and potential impacts of emerging treatments are assessed in collaboration with the VA Pharmacy Benefits Management Services. This information is considered when setting the trend assumptions for prescription drugs. The use of glucagon-like peptide-1 (GLP-1) drugs for the treatment of diabetes, obesity, and other conditions is expected to contribute significantly to increased costs in 2026-27.

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 workload for inpatient encounters, ambulatory workload 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.

Costs required to provide inpatient acute services to enrolled Veterans are expected to grow in both 2026 and 2027. The projected increase in costs 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 costs are increasing, workload growth is more moderate, being dampened by several factors:

Aging and priority transitions are increasing inpatient medical and surgical workload projections but are largely offset by a negative impact of net enrollment growth (new enrollment minus deaths). Net enrollment growth is reducing this workload because the enrollees who are dying are generally sicker than new enrollees.

Improvements in VA's level of management in inpatient care reduces workload by improving management processes (such as, early discharge planning), reducing hospitalizations for ambulatory care sensitive conditions and readmissions through care coordination, disease management, expansion of home telehealth services, and the continuing

Modeled Inpatient Acute Care

Inpatient Acute

- Medical
- Surgical
- Maternity Deliveries
- Maternity Non-Deliveries

Inpatient Encounters

- Acupuncture
- Anesthesia
- Cardiovascular
- Case Management - Rehabilitation Therapists
- Colonoscopy
- Dermatology Services and Diagnostic Exams
- Dialysis and Related Services
- Emergency and Observation – Facility Component
- Emergency and Observation – Professional Component
- Eye Glasses Services
- Hearing Aid Services
- Hearing and Speech Exams
- Inpatient Evaluation and Management Services - Non- Mental Health
- Maternity
- Medication Therapy Management
- Miscellaneous Medical Services and Diagnostics
- Nephrology – End Stage Renal Disease Services
- Non-Invasive Vascular Studies
- Nutritional Counseling
- Office Administered Drugs
- Ophthalmology Services and Diagnostic Exams
- Pathology
- Prosthetic and Orthotic Services
- PT/OT/SLP
- Pulmonology Svcs, Diag Exams, Ventilator Mgmt
- Radiology – CT
- Radiology – General
- Radiology – MRI
- Radiology – Mammography (All)
- Radiology – Nuclear Medicine
- Radiology – PET and PET/CT
- Radiology – Radiation Oncology
- Radiology – Ultrasound
- Recreational Therapy
- Surgical Procedures
- Vision Exams

transition of care from an inpatient to outpatient environment.

- VA's cost of providing inpatient maternity care is increasing due to high-cost trend for maternity services in the private sector (most maternity care is purchased).

Mental Health Care

Mental health projections are developed for a continuum of mental health services, including general outpatient mental health, evidence-based psychotherapies, intensive outpatient programs, residential rehabilitation treatment, and inpatient mental health care (the cost of mental health inpatient encounters includes diagnostics, therapies, professional services, and procedures provided in the inpatient environment). These services treat a variety of common mental health conditions as well as conditions requiring more specialized and/or intensive interventions including the most severe and persisting mental health conditions.

Costs required to provide mental health services to enrolled Veterans are expected to grow in 2026-27. The projected increase in costs is due to the impact of health care trends, primarily inflation on the cost per service, and VA's initiatives to expand access to mental health care through increased substance use disorder staffing.

Utilization of mental health services is expected to grow (independent of any change due to enrollment dynamics) due to VA's initiatives to increase capacity. For example, Intensive Community Mental Health Recovery Services is projected to grow 73% through 2026 due to increases in the delivery of telehealth services.

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 Co
  (10% from 2022-25) and their high proportion of service-connected status (almost 83% of these enrollees are projected to be in service-connected Priorities 1-3 by 2025) are driving increases in workload for this population. From 2022 to 2025, the utilization of Mental Health services by this population is expected to increase by 47% for inpatient services and increase by 35% for ambulatory. This growth varies by service.

Modeled Mental Health Care

Mental Health Inpatient

- Inpatient Acute Mental Health
- Inpatient Acute Mental Health and Substance Use Disorder Extended Stays
- Inpatient Acute Substance Use Disorder
- Inpatient Mental Health Residential Rehabilitation
- Inpatient Compensated Work Therapy/Transitional Residence (CWT/TR)
- Inpatient Sustained Treatment and Rehabilitation (STAR)

Mental Health Inpatient Encounters

- Mental Health
- Mental Health Inpatient E&M Services
- Psychotherapy
- Substance Use Disorder
- Psychosocial Rehabilitation and Recovery Centers
- Intensive Community Mental Health Recovery Services
- Work Therapy
- Mental Health Residential Rehabilitation Treatment Program Inpatient Encounters
- Homeless

Mental Health Outpatient

- Outpatient Mental Health
- Psychotherapy
- Outpatient Substance Use Disorder
- Mental Health Office Visits
- Psychosocial Rehabilitation and Recovery Centers
- Intensive Community Mental Health Recovery Services
- Work Therapy
- Mental Health Residential Rehabilitation Treatment Program Outpatient and Residential Stay
- Homeless

- In addition, post-Vietnam Era enrollees use a significant amount of inpatient mental health and substance abuse services.

However, the aging of the non-Post-9/11 Era Combat Veteran enrollee population is mitigating the projected growth in utilization of mental health services because use of mental health services declines at older ages. For example, utilization of many mental health services peaks around 60 then drops off dramatically by age 65.

Rehabilitative Care

Projections are developed for two special rehabilitative care inpatient services provided by VA: Blind Rehabilitation, and Spinal Cord Injury/ Disorders (SCI/D) services. These services promote the health, independence, quality of life, and productivity of individuals.

Modeled Inpatient Rehabilitative Care

- Blind Rehabilitation Services
- Spinal Cord Injury and Disorders

VA operates 13 Blind Rehabilitation Centers, which provide 4-6 weeks of inpatient adjustment- to-blindness training to help blinded Veterans achieve a realistic level of independence. VA operates 25 Spinal Cord Injury Centers. These provide expertise in treating new and longstanding spinal cord injuries and disorders and provide rehabilitation, medical care, prosthetics, and training in skills needed to live and work with SCI/D and maintain quality of life.

Costs required to provide Rehabilitative Care to enrolled Veterans are expected to grow in both 2026 and 2027. The projected increase in costs is largely due to the impact of inflation on the cost per bed day for rehabilitative care.

Priority transitions are also driving increases in cost requirements for these services. Aging is driving growth in workload 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 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, for example, basic medical supplies cost very little while sophisticated implant and artificial limbs are much more expensive.

The requirements to provide prosthetic services to enrolled Veterans are expected to grow in both 2026 and 2027. The projected increase in costs is primarily due to health care trends, aging of the enrollee population, and the transition of enrollees into higher priority groups.

Modeled Prosthetics

- Glasses/Contacts
- Hearing Aids
- Surgical Implants
- Cardiothoracic Surgical Implants
- Medical Equipment & Supplies (e.g. diabetic socks, blood pressure monitors, dressing aids)
- Home Telehealth Devices
- Oxygen
- Respiratory Equipment
- Wheeled Mobility Devices
- Orthotics
- Artificial Limbs
- Blind Aids (e.g. magnifiers, talking products, training computer software)
- VA Specialized Products and Services (e.g., environmental modifications (ramps), services for service dogs)

The cost of prosthetic devices generally grows each year due to inflation and changes in health care practice. Extensive development and use of national committed-use contracts, as well as regional and local contracts, are expected to mitigate the expected inflation trends for prosthetics to some extent. These contracts provide quality assurance through active participation of clinicians and subject-matter experts in developing requirements of the devices and the ability to obtain the best value for VA. As discussed in the Impact of 2024 EHCPM Update section, inflation increased significantly in the wake of the pandemic and is a leading driver of the increased costs across all modeled prosthetic categories in 2023. The cost of prosthetic devices such as hearing aids, oxygen, 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 workload 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.

Further, VHA care has rapidly expanded to deliver health care in new and novel ways. Expansion of programs delivering this care are prescribing devices with new technologic capabilities for prevention and monitoring. Examples include a shift to more Bluetooth-enabled devices that upload to a Connected Care Portal and are then downloaded to the Veteran's Electronic Health Record (for example, blood pressure monitors, continuous glucose monitors, International Normalized Ratio (INR) home use monitors), application for monitoring gait, application for speech therapy progress, watches that monitor tremors in Parkinson's patients, power wheelchair enhancements to monitor wheelchair operation, pressure sensing devices to remotely monitor pressure to prevent skin breakdown and ulcers, and remotely monitored total joints.

The increasing number of enrollees being adjudicated for service-connected disabilities is also driving increases in prosthetics workload. As enrollees transition from non-service-connected priorities into Priorities 1-3, they are expected to reflect the significantly higher utilization rates of enrollees in Priorities 1-3, particularly for blind aids, artificial limbs, wheeled mobility devices, and VA specialized products and services.

Overall aging has a large impact on prosthetic services but does vary by service. For example, the use of hearing aids (which are often not covered by private insurance or Medicare) increases significantly with age, while utilization of surgical implants shows minor increases as enrollees elect to use Medicare for surgical procedures. Aging is driving material increases in utilization of hearing aids, blind aids, and wheeled mobility devices. The continued growth of the Post-9/11 Era Combat Veteran enrollee population, their aging, and their increase in service-connected conditions (and the resulting transition into service-connected Priorities 1-3) is driving significant changes in workload for prosthetics services for this population. Since almost this entire population is not yet eligible for Medicare (with the associated decline in reliance on VA), aging is also driving increases in this population's use of prosthetics, particularly for glasses/contacts, oxygen, and VA specialized products and services.

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 purchased care. State Veterans Homes provide facility-based care and HCBS but are not projected by the EHCPM.

Costs required to provide LTSS to enrolled Veterans are expected to increase in 2026-27. The projected growth for costs is primarily the impact of inflation and two enrollment dynamics that have a very significant impact on LTSS in both facility and HCBS settings: priority transitions and the aging of the enrollee population. This growth is tempered by the impact of net new enrollment (new enrollees minus deaths). This net effect tends to reduce LTSS workload because death rates are higher for older enrollees with relatively high utilization of LTSS, while new enrollment is primarily younger enrollees who tend to not yet need these services.

Modeled Long-Term Services and Supports

Facility Based Services

- VA Community Living Centers, long-stay (>90 days)
- VA Community Living Centers, short-stay
- Community Nursing Homes, long-stay
- Community Nursing Homes, short-stay

Home and Community Based Services

- VA Adult Day Health Care
- Community Adult Day Health Care
- Home Based Primary Care
- Home Respite Care
- Purchased Skilled Home Care
- Home Hospice Care
- Homemaker/ Home Health Aide Programs
- Spinal Cord Injury & Disorders Home Care
- Community Residential Care
- Home Telehealth
- Home-Based Bowel and Bladder Care
- Veteran Directed Home Health Care

Enrollees transitioning into service-connected priorities are driving significant growth in workload for facility-based LTSS as well as HCBS. In particular, the growth in Priority 1a enrollees (70% service-connected or more) is driving significant growth for long-stay facility- based LTSS. VA is legislatively mandated by the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) to provide continuing facility-based care for enrolled Veterans who have a 70% or greater service-connected disability, as well as those who need such care for a service- connected disability, or who have a rating of total disability based on individual un-employability. Additionally, the PACT Act is now contributing to the already significant growth through increases to priority transition rates, especially into Priorities 1-3 and higher enrollment rates as of 2023.

The aging of the enrollee population is also having a significant impact on costs and workload. Unlike other modeled services, reliance on certain LTSS does not decline after Medicare eligibility, due to limited Medicare coverage for long-stay facility-based

services and HCBS. Currently World War II and Korea era enrollees are in the age bands that are the highest users of LTSS. Vietnam era Veterans will be an increasing driver of LTSS, with most having aged beyond 75 by 2027. CLC short-stay, which is used primarily for post-acute care and hospice care, is less impacted by aging than the other facility-based care categories.

Projected workload 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 for three categories of dental care services are 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

Costs required to provide dental services to enrolled Veterans are expected to grow in 2026-27. The projected increase is driven by inflation and the transition of enrollees into higher priority groups.

Impact of 2024 EHCPM Update

EHCPM projections supporting the VA budget are developed based on data that are three years removed from the beginning of the budget year (or 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 2024 EHCPM (Budget Year 2023) was used to build the 2026 and 2027 VHA Medical Care budget requests. The 2024 EHCPM fully returns to the typical modeling process used prior to the COVID-19 pandemic and is updated using workload through 2023 to reflect emerging information on the enrollee population and their utilization of VHA health care. These analyses are tied to the most recent fiscal years of data and establish assumptions that are based on this recent information, which then persist throughout the full EHCPM projection period or are adjusted to reflect expected changes.

The 2024 EHCPM includes a calibration to available 2024 workload and cost data for both VA direct care and VA community care. This workload detail was paired with high level service category cost detail for community care and VA direct care workload. Both the workload and cost calibrations were applied by service without consideration for changes in workload or cost by other demographic variables (e.g., submarket, enrollment priority, sex). The underlying variation is retained from 2023 calibration and reflects non-calibration workload adjustments by these other variables.

The EHCPM does not separately model VHA staffing needs that correspond to workload and cost projections. However, it is assumed that projected changes in workload represent a proxy for changes in the underlying VHA staffing levels. VHA policies around expected staffing changes are modeled as adjustments to the EHCPM workload, and it is assumed that these capacity changes in the VA direct care system are independent of total enrollee reliance on VA. It is assumed that increases/decreases in VHA capacity are offset by complementary decreases/increases in community care services. Using this approach, the 2024 EHCPM projects VA direct care and community care workload and cost consistent with an assumption that VHA staffing levels and direct care workload will remain relatively flat in 2025-27.

Additional modeling considerations were given to VHA system productivity changes. Since the onset of the COVID-19 pandemic, workload levels within the VA direct care system have not kept pace with the growth in staffing, resulting in reductions in productivity levels within the VHA system and increases in costs per service. However, in recent years VHA amplified efforts to improve system productivity, which resulted in increased productivity levels. The 2024 EHCPM reflects assumptions that VHA system productivity will continue to increase in 2025-27 with an approximately 3% increase from 2024 levels. This productivity results in additional VA direct care workload growth in provider-based services (excludes pharmacy and prosthetics services), which partially offsets the impact of FTEs remaining flat over this period.

Inflation increased significantly in the wake of the pandemic. For the 2024 EHCPM, the non- personnel inflation trend derives from the 2023 Medicare Trustee's Report. Normally, a 20-year historical average trend would be used to project inflation from 2023-27; however, 2023-24 projections are based on a more recent CMS Market Basket forecast to recognize the near-term inflation experience. Similarly, pharmacy cost trends consider expected increases in the Consumer Price Index for All Urban Consumers, which directly impacts the acquisition cost of many brand-name and specialty drugs.

The PACT Act affects VHA enrollment by expanding eligibility for selected Veterans and by either introducing or increasing service-connected ratings for some Veterans, which increase the enrollment priority level for which the Veteran is eligible. With the 2024 EHCPM, a significant portion of the PACT Act was implemented in the 2023 base period, including additional new enrollment and shifts in priority levels. The projected impact of the PACT Act is shown as incremental changes after 2023 arising from future enrollment and priority mix changes. Over the short-term, this incremental impact decreased relative to the post 2023 incremental impact in the 2023 EHCPM due to there being significantly

more post-9/11 combat era Veterans enrolled in 2023 than previously projected. This impact is incorporated into the baseline.

Growth for many LTSS programs has been accelerating in the past few fiscal years and has significantly exceeded growth that would be expected based on demographic changes and other factors that would typically be captured in the EHCPM, particularly for Home and Community Based Services. This growth was driven by efforts to transition higher cost nursing home care to the lower cost HCBS setting and expand HCBS access to more Veterans, including expansions in new programs like Veteran Directed Care. The 2024 EHCPM includes increased projected workload of certain services beyond demographic trends to continue through the budget years.

Historically, the most significant factors changing the EHCPM's projections were external and could not be anticipated in advance, such as the impacts of the COVID-19 pandemic, the MISSION Act, the civilian wage freeze policy, American Reinvestment and Recovery Act (ARRA) funding, and the PACT Act. Please see the section entitled "Uncertainty Associated with Actuarial Projections in the VA Enrollee Health Care Projection Model" later in this chapter for more information on the impact of the PACT Act on the VA health care system as well as on sources of risk inherent in modeling.

Table: 2026 Revised Estimate and 2027 Advance Appropriation EHCPM Model & Non-Model Obligations

All Funding Sources
($ in thousands)

Description	2026 Revised Estimate			2027 Advance Appropriation		
	EHCPM	Non-EHCPM	Total	EHCPM	Non-EHCPM	Total
Health Care Services	$128,864,545	$12,192,179	$141,056,724	$136,765,146	$9,100,362	$145,865,508
Long-Term Care	$19,143,462	$2,716,330	$21,859,792	$20,885,957	$3,003,190	$23,889,147
Non-Add Included in Above Rows:						
Non-Recurring Maintenance (excluding PACT Act § 705)	*$0*	*$4,837,500*	*$4,837,500*	*$0*	*$3,037,500*	*$3,037,500*
State Home Programs	*$0*	*$2,266,407*	*$2,266,407*	*$0*	*$2,568,784*	*$2,568,784*
Other Health Care Programs:						
Camp Lejeune Families (P.L. 112-154)	$0	$7,597	$2,172	$0	$2,257	$2,257
Caregivers (Including CHAMPVA)	$0	$2,422,410	$3,264,938	$0	$3,590,212	$3,590,212
CHAMPVA & Other Dependent Prgs	$0	$2,335,332	$3,726,092	$0	$4,185,941	$4,185,941
Homeless Program Grants	$0	$1,067,265	$935,890	$0	$1,131,841	$1,131,841
PACT Act § 705 Enhanced-Use Leases	$0	$40,608	$13,260	$0	$12,438	$12,438
Readjustment Counseling	$0	$370,361	$370,474	$0	$377,883	$377,883
Obligations [Grand Total]	$148,008,007	$21,152,082	$171,229,342	$157,651,103	$21,404,124	$179,055,227

CHAMPVA Model

The 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 ("sponsor") who is rated permanently and totally disabled due to a service-connected disability, or was 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

2023, CHAMPVA covered 679,109 beneficiaries. The number of beneficiaries is expected to rise to approximately 936,003 in 2026 and 979,990 in 2027.

The 2024 CHAMPVA Model was developed using the data from 2013-23 for enrollment and 2013-21 for detailed claims costs, publicly available research, and input from a development team. 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 costs for providing care to beneficiaries.

For each fiscal year, sponsors are projected at an individual level, with modeled individual beneficiaries linked to each sponsor. Three categories of beneficiaries are projected: spouses, minor children, and helpless children. Beneficiaries eligible for CHAMPVA as a primary caregiver enrolled in the PCAFC (for example, those who are not also an eligible spouse or child of a sponsor) are not modeled in the CHAMPVA projection model. Starting with the 2020 Model, such caregivers were projected as part of the PCAFC Model. The Veteran population basis underlying the enrollment assumptions and projections is primarily based on VetPop2020.

The claims cost model is driven by enrollment counts produced from the enrollment model, assumed annual claim cost trends, age/sex cost relativity factors, and the actual (historical) CHAMPVA paid claims data. The projected beneficiaries from the enrollment model are then linked to the claims cost model to generate costs. It does include assumptions for the impact of the CHAMPVA Modernization of Regulations (RIN 2900-AP02 and the PACT Act of 2022 on expenditures. The PACT Act is expected to make more Veterans eligible to be sponsors for the CHAMPVA program due to increases in heath conditions presumed to be related to military service. This Act is estimated to increase CHAMPVA Veteran sponsor counts both for living and deceased Veterans.

Significant enrollment growth for the CHAMPVA program was observed in 2023. Enrollment growth assumptions were increased over long-term growth rates for years 2024 through 2028 to account for this recent growth under the assumption that it would continue for several years and then revert to a long-term average by 2028.

PCAFC Model

From the program's inception in May 2011, through September 30, 2020, the PCAFC provided comprehensive assistance to caregivers of certain Veterans and Service Members who were seriously injured during service on or after September 11, 2001. For enrolled Veterans, their primary caregivers are eligible for a monthly stipend payment, health care expense reimbursement through the CHAMPVA program (if they have no other health insurance), education and training, mental health care services, respite care services, travel, lodging and per diem expenses to attend required caregiver training, and travel to and from the Veteran's medical appointments.

On October 1, 2020, because of the MISSION Act of 2018, the program eligibility requirements were expanded to include eligible Veterans who were seriously injured prior

to May 7, 1975. As of October 1, 2022, PCAFC is open to eligible Veterans who sustained or aggravated a serious injury (or illness) in the line of duty during any service era. Additional information regarding the PCAFC program can be found in the Caregiver Support Program section of the 2026 budget submission.

The PCAFC Model was developed in 2015 and is updated each year. 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 costs are the majority of total PCAFC costs. The CHAMPVA benefit cost projections in the PCAFC is limited to primary caregivers who qualify for CHAMPVA purely through their involvement in the PCAFC. CHAMPVA beneficiaries who qualify for CHAMPVA by being eligible spouses or children of a Veteran are projected as part of the CHAMPVA Model. The PCAFC Model does not include other PCAFC program expenses such as training, travel, lodging, and per diem.

Projections are developed using a combination of historical program experience, projected enrollment pattern assumptions, stipend payment and cost trends, projected health care cost trends, projected payment tier/level enrollment distribution, projected PACT Act impacts, and assumptions regarding policy decisions.

PCAFC costs are largely driven by projected enrollment into the PCAFC program. From 2011-16, there was a steady increase in the number of caregivers enrolled in the PCAFC program. From 2017-21, the program saw a reduced number of total Veteran sponsors and caregivers. However, due to program expansion to include Vietnam and Prior service era Veterans and Post-Vietnam service era Veterans, the number of caregivers grew and is expected to continue to grow.

Lastly, the PACT Act is expected to increase PCAFC enrollment due to Veteran eligibility based on increased heath conditions presumed to be related to military service. This Act is estimated to increase PCAFC Veteran sponsor counts.

Uncertainty Associated with Actuarial Projections in the VA EHCPM

VA develops the VA EHCPM, an actuarial projection of enrollment, workload, and costs, 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 2026 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 costs 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 costs is inherently challenging. Most 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 costs over time, to gain a deeper understanding and to communicate it to users. The EHCPM provides this cohesive and critical framework for evaluating and communicating results and the key drivers of those results. There is significant inherent uncertainty and there is risk of emerging experience differing from projections. Understanding the key drivers enables greater insight into the sources of risk and how they contribute to uncertainty.

The EHCPM produces projections of enrollment, workload, and costs based on numerous model assumptions about how the future will be the same or different from experience. There is uncertainty about how actual emerging experience will compare with these assumptions. A framework for assessing actuarial projection uncertainty involves identifying, analyzing, and responding to underlying risks, consistent with Principal 7 of the Government Accountability Office's "Standards for internal control in the federal government."

The EHCPM is a projection model, which is based on a set of assumptions that affect the projection output over time. Because the assumptions are specified for each scenario, the projection output is a single estimate, usually referred to as the best estimate. This type of model is referred to as a deterministic model. By contrast, a stochastic model uses assumptions that are sampled randomly from preset distributions, resulting in projection outputs that land in a random distribution. The decision to make the EHCPM a deterministic model, wherein each scenario results in a single best estimate, is driven by practical purposes, including having the ability to explain the contribution of each assumption to the budget projection. In this approach, the projection output does not state the expected variability around the best estimate. Instead, variability is communicated to stakeholders using alternate "what if" scenarios, sensitivity testing where practical, and through a qualitative discussion of the risks that contribute to uncertainty.

Many of the sources of risk that create uncertainty in the projections cannot be statistically measured in the first place. For example, there is uncertainty about future combat operations

and deployment levels, which can have a material impact on long term enrollment levels and morbidity. Yet, VA cannot ascribe a probability to these future events. This is another reason why the EHCPM is not a stochastic model that produces a statistical range of projection results. Instead, variation is presented using scenarios that vary based on changing selected assumptions. This approach allows stakeholders to understand how the projection changes when underlying assumptions are changed and to understand the magnitude of their impact.

Within the EHCPM, a sudden event can occur that can have a large impact on enrollment, workload, or costs. 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, workload, and cost change over time. For example, an economic downturn is an event that can lead to higher enrollment and greater enrollee reliance. Consequently, the potential for an economic recession can manifest in greater uncertainty about future enrollment and utilization levels. The underlying sources of risk which affect the EHCPM's assumptions and projection outputs are outlined below.

Identified Sources of Risk, Affected EHCPM Assumptions and Projection Outputs

Sources of Risk	Assumptions	Projection Output
• Acts of nature	• Cost per service	• Costs
• Combat and deployments	• Community care reimbursement schedule	• Enrollment
• Demand allocation between VA facilities and community care*	• Enrollee mortality	• Utilization
	• Enrollment rates	
• Economic Conditions	• Geographic migration	
• Enrollee and Veterans preferences*	• Health care management	
• Enrollment policy	• Inflation	
• Health care practice*	• Intensity trends	
• Health status	• Morbidity	
• Inflation*	• Priority transitions	
• Legislative, regulatory and judicial policy*	• Reliance	
• Management policies and initiatives*	• Utilization differences across demographic groups	
• Non-VA health care coverage	• Utilization trends	

*Indicates a source of risk with the highest impact for the Budget Scenario.

Role of Reliance in Risk and Uncertainty in the Model

VA estimates that 84% of enrollees have public or private health care coverage other than VA. Enrollees with multiple sources of coverage can choose to use their VA or non-VA coverage for each health care service. Reliance is defined as the portion of enrollees' total health care needs expected from the VA health care system, including both VA direct care and community care paid by VA, versus other health care options. For example, if an enrollee received 10 office visits in a year, 4 from VA and 6 through Medicare, that enrollee would be considered 40% (= 4 / 10) reliant on VA for office visits.

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 2023, average reliance was estimated to be approximately 45% 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 costs. A 1% unexpected

increase in reliance levels (that is, additive increase, or 100 points) is estimated to cause the EHCPM's budget projection to increase by around 2.2%, or $2.6 billion.

Characterizing the Degree of Uncertainty

There are different ways to categorize sources of risk in terms of the type of uncertainty each brings into the model.

- Likelihood – Some events are very rare, and others occur more frequently. For example, a major overhaul to health care law is relatively rare, whereas unexpected changes in the inflation rate are nearly guaranteed, regular occurrences (though the magnitude and direction of the unexpected change are not known in advance).
- Magnitude – Notwithstanding the likelihood of an event occurring, the magnitude of the event is very important. For example, a pandemic is a rare, but high impact event.
- Single vs. Recurring Impact – Some events will create a one-time upward or downward shift in an assumption or the model projections (e.g., opening a new facility). Other sources of risk will lead to recurring changes in cost, therefore bending the cost 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 previous conditions and, thereby; have less impact over a strategic planning timeline.

A particular source of risk can influence the uncertainty about several model assumptions and to varying degrees. Similarly, each model assumption is uncertain due to the underlying influence of several sources of risk. Generally, utilization trends and reliance levels create a greater uncertainty in the model projections than other key drivers such as enrollment rates, which only have a marginal impact on total enrollment in any given period. The list below is sorted in approximate order of impact over the budget horizon.

Affected EHCPM Assumptions by Level of Uncertainty

Assumptions	Contributes most to which projection output
Reliance	Utilization
Utilization trends	Utilization
Inflation	Costs
Intensity trends	Costs
Morbidity	Utilization
Utilization differences across demographic groups	Utilization
Health care management	Utilization
Priority transitions	Enrollment
Enrollment rates	Enrollment
Cost per service	Costs
Community care reimbursement schedule	Costs
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, workload, and cost 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, workload, and costs that occurred during the model's base year. For example, the base year of the 2024 EHCPM was 2023. 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 effort 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. These data are a valuable information in understanding a more complete picture of medical conditions, overall utilization, and reliance on VA health care for many enrollees ages 65 and over. A corresponding data set for Veterans under age 65 is not available, since health care data is fragmented across numerous private sector and government programs. As a result, modeling for Veterans under 65 years of age is primarily based on the VA health care and supplemented by VA's annual Survey of Enrollees, which provides self-reported responses on enrollee reliance. Through this process, VA arrives at an effective means of assessing overall utilization and reliance for enrollees under age 65.

Other outside data sources include date of death files from the Social Security Administration (SSA) and the VA/Department of Defense Identity Repository (VADIR) data. Since many Veteran enrollees may die outside of VA facilities and there is no direct requirement for their families or physicians to report this to VA, it is important to supplement dates of death that are reported within VA with information from outside sources, including SSA. This allows for a more up to date and accurate count of current enrollees. The VADIR data includes military discharge dates along with information about active-duty theaters of deployment, and this data is used to identify post-9/11 combat Veterans, other deployment cohorts, and to track time since separation.

Reducing the Impact of Reporting Lag

Most data sources have some degree of reporting lag. Enrollee deaths are not all immediately reported to VA and thus, there is a lag in complete reporting of enrollee deaths. For community care, there is a gap between the provision of the service and the date of payment. 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 adjusting for reporting lag is that more recent, relevant data can be used to develop model assumptions. By contrast, waiting an extended period 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 about two years old when it is becomes available; therefore, a review on trends is performed to better estimate key assumptions such as morbidity and

reliance during the base year. For the development of the 2024 EHCPM, the data match was only available through 2021.

Other Steps to Reduce Uncertainty

Some events or processes give rise to uncertainty that cannot be reduced through deeper analysis alone; for example, it is not possible to predict natural disasters or new military conflicts. Other risks that create uncertainty are more accurately measured by accessing better sources of data and gathering data that is more representative of the base year experience. Sometimes, sources of uncertainty, such as a new law, can be anticipated before their impacts show up in actual experience data, prompting model assumptions to be initially established and refined over time.

As an example, the model historically assumed that reliance for a given enrollee demographic profile was stable over time. As additional longitudinal data emerged, VA identified changes in enrollee reliance due to a generational shift (that is, 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. 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. 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, which includes monitoring separate drivers of enrollment change monthly. As a result, material deviations from the projected enrollment trajectory can be isolated to the specific assumption that is causing the deviation to occur.

- Comprehensive annual analysis of prior year workload and costs – Establishes a new starting point for the workload and cost projections and creates a new data set for evaluating projection assumptions and differences in workload patterns across demographic categories. Key model assumptions are tested against the new data and changes are made where appropriate. Workload and cost 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.
- Ad hoc interim utilization review – Identifies material deviations at the service category level on a periodic basis. These deviations are investigated, and stakeholders are alerted to the new observations. Oftentimes, the interim results are not sufficiently conclusive to warrant an immediate change in the projections but are incorporated into later model scenarios, as appropriate.
- Consultation with work groups of subject matter experts on major model components (e.g., mental health, women's health, pharmacy, health care economics) – Evaluates differences between historical experience and prior projections and updates methodology. 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) to better understand uncertainty in the projections.

There are several important examples for assessing uncertainty, which inform the approach that is taken with the EHCPM. These include government and private industry examples for risk analysis:

- Comptroller General of the United States published standards for internal control for the Federal Government
- National Association of Insurance Commissioners Risk Based Capital Plan and Own Risk and Solvency Assessment Summary Report
- State Medicaid Agencies
- Actuarial Standards Board of the American Academy of Actuaries Actuarial Standards of Practice

Approaches to Address Evolving Events and Policies

Many risks are difficult to predict and occur suddenly, such as combat deployments, pandemics, and economic recessions. In addition, new policy directions can be considered by leadership, influenced by judicial decisions, or led by Congress.

Depending on the timing of the event, the projections supporting the VA health care budget may not include estimates of the impact of the event or policy direction. However, as the event or policy unfolds, estimates are developed that provide high-level impacts to inform budgeting for these costs. These high-level estimates allow for flexibility when the policy is in flux or when detailed information is not available to support integration into the EHCPM. These estimates are revised as new information and/or analyses are available.

The EHCPM scenario documentation identifies policies that are included in the scenario, provided as a high-level estimate, or not modeled.

Assessment of EHCPM Projection Uncertainty from the Perspective of Underlying Sources of Risk

Sources of risk are discussed below, including their impact on key model assumptions and potentially different impacts by projection time horizon. Sources of risk that impact 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, workload trends, cost per service, and community care reimbursement schedule:

- An act of nature is an unpredictable episode that can dramatically increase mortality and morbidity among vulnerable segments of the enrollee population until the disaster is contained.
- Uncertainty comes in part from the inability to predict the start of and severity of the act of nature. It also comes from unpredictable differences in how society responds.

Time horizon

Short-term and long-term:

- The impact of acts of nature is modeled primarily within a three to four-year period, with anticipating a return to normal over longer time horizons. In the case of COVID-19, there were short-term changes, such as the deferral or suppression of some health care, which reverted to normal over time. On the other hand, there were permanent changes, such as the accelerated and widespread adoption of telemedicine.
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Budget Scenario

In 2023, the COVID-19 pandemic settled into the endemic stage with relatively little continued impact on changes in health care utilization. For VHA, enrollee health care utilization broadly returned to pre-pandemic expected levels or settled at a new normal level that reflects a longer-term shift in health care utilization. The effects of COVID deferred care remain for some specific service areas, particularly mental health care, LTSS, and inpatient rehabilitation care, and it is expected that there will be continued recovery of health care utilization in the coming years. At the same time, increased inflation followed in the wake of the pandemic, leading to higher unit cost levels at VHA.

The pandemic also affected enrollee health status and mortality and health care practice patterns. See the Health Status and Health Care Practice sections for discussion.

Allocation between VA Direct Care and Community Care

The EHCPM projects total enrollee demand for VA health care. Then, the total projected demand is allocated to VA direct care and community care based on eligibility criteria for community care, referral authorities, operational guidelines, and VA direct care staffing and capacity.

Assumptions most affected

Reliance, cost per service:

- The projected resource requirements for VA direct care and community care represent a division of the total enrollee demand projected by the EHCPM. Therefore, both care locations need to be funded at the projected cost levels to meet the total projected enrollee demand for VA health care. For example, if VA direct care is not funded at the projected level, VA would need to purchase this care in the community, which would increase the projected resource requirements for community care.

  The EHCPM implicitly assumes that clinical productivity levels among VA providers remain fixed throughout the projection period based on historical data and

that changes in staffing and capacity are consistent with workload changes over time. However, a change in clinical productivity would affect the distribution of workload between the direct care and community care and the corresponding cost levels.

- In addition, the EHCPM projects significant growth for ambulatory care services in both VA facilities and in community care. If VA is not able to change staffing and capacity in VA facilities to meet changes in resource needs, then this projected increase in services will need to be met in the community, which would increase the projected resource requirements for community care. Under the MISSION Act, if VA cannot provide care in VA facilities in a timely manner, enrollees are eligible to receive care in the community.

  Likewise, if VA's community care network cannot expand to meet the projected growth in demand, VA may not be able to meet all of enrollees' projected demand. This limitation would suppress enrollees' preferred reliance on VA health care.

  Mismatches in resource availability or the inability to increase capacity in VA facilities or the community care network to meet the projected service growth could disrupt timely access to care for enrollees.

  Also, because these two locations of care require different funding streams and operational support, there is risk associated with the allocation of care between locations and not just the total amount of care provided by VA. In particular, over-funding VA direct care without a commensurate increase in the workload provided will not be offset by a decrease in community care obligations resulting in elevated VA direct care unit costs.

Time horizon

Short-term:

- The allocation of the total projected health care demand between VA direct care and community care allows VA to budget and plan to meet enrollees total demand for VA health care. The short-term uncertainty is that emerging experience will be different than the projected allocation of care between these settings, causing operational disruption.

Budget Scenario

The Budget Scenario assumes the projected future growth in services follows the historical split between VA direct care and community care except for (a) short-term changes in VA direct care staffing and capacity and (b) short-term changes in VHA productivity levels. If these staffing, capacity and productivity levels do not align with direct care workload, then there is an elevated risk that more or less care will shift to the community than what was projected.

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 is 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 Era Combat Veterans have different health care needs and enrollment rates than Veterans of the earlier Gulf War era. Similarly, Vietnam era Veterans (representing about 28% of current enrollees) have different health care needs than WWII Veterans (currently representing less than 1% of enrollees), even after adjusting for the passage of time and aging. For example, exposure to Agent Orange during the Vietnam War 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. Generational differences show up in various model assumptions, including enrollment rates, and reliance.
- Women Veterans currently represent about 11% of enrollees, which is projected to reach 15% by 2033. Women Veterans historically enrolled at a lower rate than their male counterparts. However, women combat Veterans enrolled at, or in some cases above, the level of their male counterparts. 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.

Economic Conditions

Economic conditions influence individual behavior primarily due to changes in employment 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 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 a 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 February 2025 economic projections to assume that the unemployment rate is 3.6% in 2023, then increases to 4.0% in 2024-25. This primary economic forecast is supplemented by the Bureau of Labor Statistics forecasted Civilian Non-institutional Population. The budget scenario models stable economic conditions.

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. Therefore, individual preferences will influence the result.

Assumptions most affected

Enrollment rates, reliance:

- Enrollment with VA is free 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 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 their care through VA. Indeed, enrollee reliance trended 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 costs.

Average Reliance for All Enrollees Across All Services (Excluding LTSS)

	2018	2019	2020	2021
Estimated Aggregate Reliance*	37.9%	39.2%	38.8%	40.8%

* Reliance is shown through the most recent Medicare Fee-for-Service data available at the time of EHCPM update

Average costs per enrollee tend to increase with age, but the impact of reduced reliance on VA among older Veterans tends to outweigh this trend. Reliance 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 has changed over time with increases in Medicare Part B premium and the expansion of Medicare Advantage plans, including Medicare Advantage plans catering specifically to Veterans. 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, or differently than what has been observed in historical data, then it can have a very large impact on the required budget.

VA 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. Changes in the availability and cost of other health insurance, such as changes in the availability of Medicare Advantage plans catering to Veterans, Medicaid eligibility, and enhanced premium tax credits for Exchange plans, can also cause potentially significant changes in VA preferences in a relatively short period of time. Longer-term trends in preferences may be identified directionally but are difficult to predict. Due to the significant slack in demand for new enrollment and reliance, even small changes in how these preferences trend over time can compound substantially over a long-term horizon.

Budget Scenario

The pandemic caused a reduction in enrollment rates beginning in 2020, and they have gradually returned to typical levels in recent years. This process was slower for older Veterans and quicker for younger Veterans (with some evidence of pent-up demand leading to higher, short-term enrollment rates). The pandemic is not expected to impact longer-term enrollment rates.

The PACT Act brought one of the most significant expansions of enrollment eligibility in years, leading to significant new enrollment and shifts in priority levels among existing enrollees. The impact is expected to grow into the future.

Enrollment policy

VA has discretion over many aspects of enrollment eligibility. For example, VA can decide to expand enrollment to previously suspended income levels.

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; therefore, the initial assumptions are likely to be revised substantially in subsequent model updates.
- The PACT Act began to be implemented in August 2022. This change caused shifts in priority levels due to presumed service connection of numerous new medical conditions and granting Priority 6 eligibility to new cohorts of Veterans. Most changes involved enrollees getting a priority upgrade, which may have induced some additional reliance on VA for care as well as encourage enrollment for the first time if not already enrolled.

Time horizon

Short-term and long-term:

- There is uncertainty in the short-term due to Veteran responses to policy changes, and this can compound more substantially over the long-term horizon.

Health 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, the discovery of more effective Hepatitis C treatments in the mid-2010s, and the more recent approvals of glucagon-like peptide-1 (GLP-1) drugs for the treatment of obesity.

Although the productivity of health care and administrative staff within a health care system tends to be stable over short-term time frames, these rates are subject to change and do represent a material source of uncertainty. For example, the COVID-19 pandemic produced

a combination of reduced VHA workload levels and increasing staffing levels resulted in a significant drop in the productivity level of the VA health care system.

Assumptions most affected

Utilization trends, intensity trends, morbidity, mortality, cost per service:

- 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 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.
- Changes in system productivity can lead to changes in workload levels as well as the average cost per service. As productivity levels increase/decrease, this implies that the same staff level can provide more/fewer healthcare services. Also, there are often marginal costs associated with individual services (e.g., cost of supplies needed for an office surgery); therefore, the additional services provided at that same staffing level are not obtained without additional cost. Therefore, uncertainty around health care system productivity contributes to uncertainty around workload rates and unit cost.

Time horizon

Short-term and long-term:

- Due to the gradual nature of most innovations, whether it be changing practice patterns or the gradual adoption of new medical technologies, the uncertainty about their effects compounds more significantly over the long-term.
- However, short-term breakthroughs, especially the introduction of new and expensive pharmaceuticals, contribute to uncertainty over the shorter-term budget horizon. For example, the introduction of genotype-specific Hepatitis C drugs (e.g., Harvoni, Viekira, Daklinza) beginning in 2014, which had an initial price approaching $100,000 per patient, came to market quickly and within the time frame of the three-year budget projection.

- Similarly, the general stability from year to year in system productivity rates suggest that uncertainly compounds over time and leads to more significant long-term uncertainty.

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, the increase in video telehealth care could be sustained, or the significant disruption in regular care patterns could affect future treatment protocols. These possibilities, among others, cause a higher than usual level of uncertainty in emerging health care patterns. The Budget Scenario assumes some long-term changes in health care practice. For LTSS, many VA adult day health care centers (ADHC) closed during the initial lockdowns in 2020 and 2021, and many of them went on to permanently close. Based on these developments, the Budget Scenario reflects lower long-term utilization because of the reduced supply of ADHCs. VA continues to evaluate emerging experience and available information to assess whether long-term changes in health care practice for other services are developing and measurable, and the assumptions will be revised as appropriate.
- Separate trend adjustments were applied in the Budget Scenario to account for additional GLP-1 utilization and cost not already captured in the EHCPM projections. The anticipated demand for these medications exceeds the broader utilization, intensity, and cost trends assumed more broadly for prescription drugs.
- Recent improvement in productivity levels within the VHA system, as well as ongoing efforts to improve provider-level productivity, suggest that continued increases in VHA productivity can reasonably be expected. The Budget Scenario assumes productivity increases in 2025-27 at levels consistent with recent experience, such that overall productivity will increase by approximately 3% over this period.

Health Status

Acute illnesses among enrollees may require substantial care by VA, and ongoing treatment for chronic medical conditions account for a significant part of VA direct care and community care workload. However, due to the approximately nine million Veterans currently enrolled, of which approximately six million are patients during the year, the uncertainty about the workload required for individuals is spread and diversified across a very large population.

If there are systematic changes in the prevalence and severity of medical conditions across a large portion of the enrollee population, then this diversification may become less effective at reducing potential volatility in the overall demand for health care services.

Assumptions most affected

Morbidity, utilization trends, utilization differences across demographic groups:

- Systematic changes across large groups of enrollees will impact morbidity levels for specific service categories at the market and national level. For example, increases in opioid addiction raise uncertainty about how to model long term substance abuse disorder morbidity. These types of systematic changes in disease prevalence tend to be gradual and may be detected through ongoing monitoring of workload and through consultation with VHA program offices.

Time horizon

Short-term and long-term:

- Due to the diversification of risks across a large enrollee population, short-term uncertainty arises more from systematic and sudden changes across a broad portion of the population, such as a pandemic. Uncertainty is greater over the long-term, as emerging trends in disease prevalence compound over a longer period.

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, several 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. The deferral of treatments and the deferral of preventive care services, which could lead to missed or delayed identification of health care conditions.
- While most patients contracting the virus appear to have recovered fully, there is uncertainty about the potential for emerging complications.

The Budget Scenario does not include any adjustments to reflect these factors. VA continues to consult with subject matter experts, reviewing literature, and analyzing emerging data.

Inflation

The cost of goods and services tends to increase over time, and the rate of inflation is difficult to forecast over both short and long periods. 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 costs.
- Staff salaries and benefit levels, including required retirement contributions, are a significant part of VA's costs that are determined by circumstances outside the Department. Assumptions are set regarding the trajectory of wage schedules and benefit levels for staff, though the actual amounts are uncertain.
- Community care claim costs are directly linked to the amounts paid to community providers for each service according to negotiated fee schedules. Those schedules are in turn often tied to Medicare fee-for-service payment rates, which are impacted by inflation.

Time horizon

Short-term and long-term:

- Divergence of actual inflation trends over the EHCPM's assumptions will have a small impact over the short-term, but they may compound substantially over time.
- While the fee schedules for community care may be set over a short period of time, over the long-term it is more difficult to anticipate the reimbursement levels that will be negotiated in the future. Similarly, uncertainty around inflation in both variable and fixed expenses will compound over time for services at VA facilities.
- Salaries are a significant component of VA facilities cost per service and change based on federal wage policy, which is generally set just prior to the impacted calendar year. In the short-term, differences between the actual wage increase/freeze and the assumptions in the EHCPM are addressed in the budget submission.

Budget Scenario

The CPI based forecast for VA's operational expenses was updated from using a twenty-year average inflation forecast (appropriate for the stable inflation environment preceding this year) to reflect a rise in inflation based on the recent CPI outcomes. This adjustment was applied to the near-term fiscal year forecasts before reverting to a stable inflation rate for the long term.

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 costs. 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 costs. 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. 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 eligibility 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, MISSION Act of 2018, and Elizabeth Dole Act of 2025) – Among other reforms, these acts expanded access to community care. This event introduced more uncertainty about how community care utilization and costs would trend over time. While the Choice Act did not significantly increase enrollment, it did create more demand on the system for the eligible groups of enrollees. Community care growth has continued since the implementation of the MISSION Act, though the full impact of the MISSION Act is still uncertain. The Elizabeth Dole Act may affect community care in several ways, including reforming the protocols for making referrals based on best medical interest.
- The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act – This act became Public Law No 117-168 in August of 2022, expanding benefits for Veterans exposed to certain toxins in the course of their military service, with a focus on Gulf War era Veterans as well new groups of Vietnam Veterans who were exposed to Agent Orange. Since its passage, the PACT Act has increased the number of enrollees, patients, and overall costs to VA. PACT Act has also had a significant impact on the priority mix among current enrollees. There is significant uncertainty about the full impact of PACT Act as emerging experience develops. These drivers of enrollment, utilization, and costs will be impacted by several factors, including but not limited to VBA caseload levels, the timing of adjudication and program implementation, the kind of outreach from VHA to Veterans, and the response among Veterans to the PACT Act. Over

time, by evaluating emerging experience, the uncertainty and variability will diminish.

Time horizon

Short-term and long-term:

- Unlike other sources of risk, historical experience is not always an effective guide to projecting the course of future legislative or regulatory changes. The short-term uncertainty is that emerging experience will be different than projected. Uncertainty is greater over the long term, as the divergence between the two compounds over a longer period.

Budget Scenario

- The budget scenario includes estimated impacts for several MISSION Act provisions, including the enhanced drive time access, best medical interest provisions, and wait time benefit. Analyses of community care growth from 2022-23suggests that the implementation of the MISSION Act drive time provision had reached a stable level and continuing community care growth is being driven by different factors, such as the MISSION Act's other provisions, VA's productivity and capacity, or VA provider referral patterns. Based on currently available data, VA cannot determine definitively what the driver of the continued community care growth is and; therefore, how long, and to what degree, it will continue to drive accelerated community care growth and changed in enrollee behavior. This dynamic adds to the overall model uncertainty.
- As the PACT Act continues to influence enrollment eligibility, it will contribute to additional uncertainty around the rate of new enrollment and priority changes. The speed at which new conditions are recognized as being presumptive for service-connection, along with the pace of claim submissions to and adjudication by VBA, will influence the rate and magnitude of enrollment changes over time.

Management Policies and Initiatives

VA leadership exercises some discretion in how health care benefits are provided through program policies and initiatives, as well as whether care is provided in the VA direct care system or through community care. 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, care location, cost per service, priority transitions, reliance, utilization trends.

- Changes in management policies and initiatives range from broad, sweeping transformations of the health care system through leadership priorities to detailed decisions by program offices that promote patient centered care. Examples of policies and initiatives that have impacted the EHCPM include:
    - ***Programmatic adjustments for LTSS*** – VA is required to meet the LTSS needs of Veterans by providing facility-based care for enrollees with service-connected disabilities of 70% or greater as well as for those in need of such care due to service- connected conditions. Resources permitting, VA also must provide such care for enrollees who do not meet these criteria. VA is also required to provide home and community-based services to all enrollees as needed. Each year, the Office of Geriatrics and Extended Care provides policy assumptions to shift projected utilization to align with their initiative of keeping enrollees out of long-term facility-based care for as long as is feasible.
    - ***Mental health and homeless staff hiring initiatives*** – VA places a high priority on ensuring that all enrolled Veterans have access to needed mental health services. VA also offers a wide array of special programs and initiatives specifically designed to help homeless Veterans live as self-sufficiently and independently as possible. Staffing for these programs, and subsequently projected utilization, can be dependent on temporary specific purpose funds targeted for hiring mental health providers. Each year, the Office of Mental Health and Suicide Prevention and the Homeless Program Office provide guidance on the presence of internal and external drivers impacting staffing so that appropriate adjustments can be made to projected utilization.
    - ***Inpatient System Redesign*** – VA seeks to continuously improve its level of inpatient care management through initiatives such as the Flow Improvement Inpatient Initiative, full implementation of utilization management review programs, and improvements in disease management and care coordination through the Patient Aligned Care Team initiative. The EHCPM incorporates assumptions about VA's current efficiency level and the impact of system redesign on its future level. These assumptions are incorporated into the EHCPM to project utilization. Any expected savings from increased efficiency are reported as clinical efficiencies in the budget impact analysis.
    - ***Federal Health Electronic Health Record (EHR) Modernization*** – VA aims to transition VA facilities from the legacy system, VistA, to the commercial Federal EHR system which will better align with other federal agencies and enables better coordination of care for Veterans. In recent years, several VA medical centers transitioned to the Federal EHR system as early steps of a nationwide transition. Some of these facilities reported

short-term decreases in productivity, resulting in reduced workload for Veterans, as staff acclimate to the new system. While productivity for many services rebounded to pre-transition levels at most facilities, some care continued to be provided at reduced levels for extended periods after the transition, resulting in deviations from what was projected in the EHCPM and what has emerged for these facilities. Both the long-term productivity impact of the Federal EHR implementation and the timeline for the nationwide rollout are not fully determined and could continue to impact the EHCPM projections.

- ***VHA Staffing Levels and System Capacity*** – Beyond specific programmatic requirements about staffing, VA generally expects that there is adequate staffing and capacity in the direct care system to meet the current needs of enrollees. As a default, the EHCPM assumes a linear relationship between VA direct care workload growth and staffing growth. The ratio of total direct care workload to staffing is referred to as system productivity. The implicit assumption is that increases in staffing levels implied by workload growth do not impact system productivity. As workload increases, staffing levels will also increase while the average productivity remains the same.

Time horizon

Short Term

- Both the long-term productivity impact of the Federal EHR implementation and the timeline for the nationwide rollout are uncertain. It is possible that the productivity impacts of early adopters represent challenges that will be mitigated for later adopters, resulting in minimal productivity change. It is also possible that complexities within the new system, relative to the VistA system, will result in long term productivity impacts. Further, management decisions on the speed with which all facilities transition to the Federal EHR produced uncertainty around the timeline for a full transition.
- Changes in VHA capacity have an immediate impact on the expected workload levels for VA direct care. This will occur with staffing reductions, since independent of productivity increases, smaller staff levels within VHA facilities will imply lower workload levels. The opposite is true with staffing increases, though there may be some loss of productivity with large increases in staffing, as newer staff generally require a ramp-up period to achieve productivity levels of staff with longer tenure.

Long-term:

- The expectation is that changes in the organization will occur gradually. In the long-term, there is uncertainty about their efficacy.

Budget Scenario

- VHA staffing levels continued to increase throughout the COVID-19 pandemic. The higher staffing levels, combined with reduced direct care workload led to a significant increase in VA direct care unit costs over the course of the pandemic. Although the annual growth in unit costs has returned much closer to historical levels, the higher costs have persisted into 2024. In response to these changes, VA is assuming that VHA staffing levels will remain flat from 2025-27, which reduces VHA capacity to provide for the growing demand for VA direct care services. These changes in VHA capacity are assumed to be independent of total enrollee reliance on VA, so that projected changes in VHA capacity are modeled with complementary changes in community care utilization. Only inpatient and ambulatory services available in both VA direct and community care settings are impacted by these staffing-level and productivity changes.

Non-VA Health Care Coverage

Veterans have access to other forms of health care, including through Medicare, Medicaid, employer-sponsored coverage, TRICARE, and individual health insurance. As the availability and affordability of external health care coverage changes, it can materially impact the choices available to a Veteran. For example, the ACA significantly expanded coverage options for individuals beginning in 2014 by regulating and subsidizing individual coverage and funding expanded eligibility for Medicaid coverage in many states. Even for those with coverage, gradual increases in cost sharing over time may cause enrollees to shift more care to VA, thereby increasing reliance.

Medicare coverage is available to most seniors ages 65 and over and many disabled individuals under 65. Medicaid coverage is also available to lower income Veterans. Federal statute and regulation determine eligibility and benefits for Medicare coverage throughout the country whereas both the Federal government and each state's own Medicaid program determines eligibility and benefits of each state's Medicaid coverage. The ACA affects the availability of health care through individual and employer-sponsored coverage. It is difficult to predict long- term changes to these programs.

Assumptions most affected

Reliance, enrollment rates, community care reimbursement schedule:

- The availability, affordability, and scope of health insurance options outside of VA will affect both the likelihood that individual Veterans enroll with VA and once enrolled, may impact the portion of care and scope of services for which they rely on VA.
- Other sources of health insurance will affect a Veteran's behavior in different ways as they age or as their life situation changes. The loss of health coverage from the Department of Defense upon separating from the military is a key motivator for new Veterans to enroll with VA. If a Veteran has not yet enrolled with VA, they may reconsider it at key points in their life, such as after the loss of a job, when nearing

retirement, or after losing health coverage from a spouse. Even when already enrolled, their reliance may change over time as they move from employer-sponsored coverage to Medicare, for example.

- Program changes may increase the benefit richness or generosity of Medicare and Medicaid. These changes can cause some enrollees to have less reliance for VA 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 were expanded, then these options could be more attractive for some Veterans when they are deciding whether to get their care at VA.
- Projections of changes in reliance are hampered by incomplete data on enrollees' non-VA care, specifically, the lack of a comprehensive source to capture claims for enrollees under age 65.
- Community providers often derive a significant part of their income from serving Medicare and Medicaid beneficiaries. Therefore, 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.
- 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.
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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. 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.

Bridging Rental Assistance for Veteran Empowerment (BRAVE)

BRAVE Appropriation Language

Contingent upon enactment of authorizing legislation to create a rental assistance voucher programs for homeless veterans at the Department of Veterans Affairs, for necessary expenses to carry out the Bridging Rental Assistance for Veteran Empowerment (BRAVE) program, $1,100,000,000, to remain available until September 30, 2029, of which up to $100,000,000, shall be available to the Secretary of Veterans Affairs, in consultation with the Director of the Office of Management and Budget, to carry out pilot programs, including any necessary administrative expenses, that aim to end homelessness among veterans.

2026 Budget Request and Program Description

As part of the Administration's effort to end Veteran homelessness, the Bridging Rental Assistance for Veteran Empowerment (BRAVE) program will enable VA to oversee and administer rental assistance to provide the full spectrum of needed supports for Veterans experiencing or at-risk of homelessness, including activities to transition from the current Housing and Urban Development (HUD) – Veterans Affairs (VA) Supportive Housing program. The FY 2026 President's Budget requests $1.1 billion in discretionary funding and also seeks legislative authority needed to implement the program. Without full BRAVE funding, some Veterans will be at risk of not receiving the full range of services they need.

There are approximately 91,000 Veterans under lease through the joint initiative between HUD and VA for Veterans experiencing or at-risk of homelessness. Currently, HUD's Housing Choice Voucher rental assistance is linked with VA-sponsored case management and supportive services. However, there remain unused vouchers where there is a mismatch with demand or limits on available affordable housing.

The proposed program would include providing rental assistance to homeless Veterans. VA would implement robust policies for oversight of property inspections and leasing requirements for landlords, and site-specific rental assistance for homeless Veterans. By managing the full spectrum of services, VA will be better positioned to meet the needs of Veterans. VA is committed to ensuring that no Veteran who is currently receiving HUD-VASH will lose their housing during the transition to VA's BRAVE program.

In addition, the BRAVE proposal would include new pilot authorities for VA to initiate innovative activities to improve the prevention, support, treatment, long-term care or return to independence for Veterans and their families. Up to $100 million of the $1.1 billion request could be used to carry out pilot programs.

Specific elements include:

- Greater and easier portability of vouchers to allow Veterans the flexibility to live in regions of the country where housing stock may be more plentiful, with better re-employment options, or where they would be closer to their support network, etc.
- Greater flexibility in the ability to award Project-Based Vouchers within specific communities to prioritize the needs of Veterans. This is especially critical in those communities where there is limited housing stock and a significant difference between rental assistance amounts and the local rental rates. These site-specific projects could support development of VA-approved communal living arrangements that facilitate Veterans independent living.
- Authority for VA to seamlessly transfer the current and pending assisted households and Project-Based Voucher sites to VA with no change in current requirements in order to ensure no disruption in this service.
- Discretion for VA to determine the optimal structure and arrangement for managing vouchers and the property inspection/landlord leasing processes depending on state, local, Veteran service organization grantees and VA capacities within specific communities.
- Innovation authority to allow the VA to initiate pilot efforts to enhance the services available and living arrangement options to different cohorts of homeless Veterans and their families and improve their outcomes. This is designed to also provide additional flexibilities in expanding housing options and support services available to Veterans.

These authorities are necessary for VA to be able to successfully implement President Trump's Executive Order to establish a National Center for Warrior Independence on the West Los Angeles VA Campus (https://www.whitehouse.gov/presidential-actions/2025/05/keeping-promises-to-Veterans-and-establishing-a-national-center-for-warrior-independence/).

Medical Facilities by Type

As of September 30, 2024, the Veterans Health Administration (VHA) operates a portfolio of approximately 5,717 owned buildings with a total of 153.7 million square feet of space on 15,540 acres of land. The portfolio also includes 1,689 leases with a total of 24.4 million square feet of space.

VHA monitors and classifies sites of care based on the delivered health care services, the associated workload, and the current classification methodology. The table below provides the number of medical care installations by the type of facility. A description of each category of facility, along with the changes in facility counts, is provided after the table. These changes may be due to new site activations, temporary or permanent site deactivations, as well as facility re-classifications based on workload. Tables containing the names and locations of each installation within each facility category are located at the end of the chapter.

Medical Care
Number of Installations

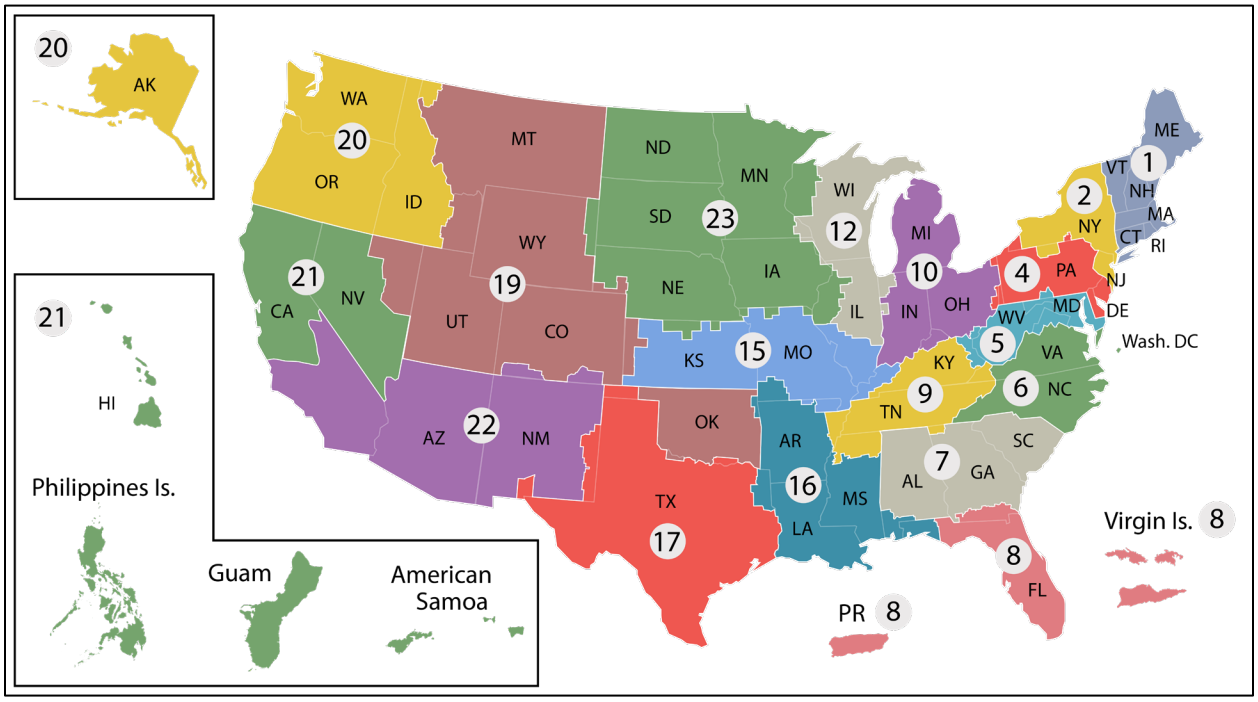
		2025		2026		2027		
Description	2024 Actual 1/	Budget Estimate	Current Estimate	Advance Approp.	Revised Request	Advance Approp.	+/- 2025-2026	+/- 2026-2027
Veterans Integrated Service Networks (VISN)	**18**	**18**	**18**	**18**	**18**	**18**	0	0
VA Medical Centers (VAMC), Total	**170**	**173**	**170**	**173**	**170**	**170**	0	0
Included in VA Medical Centers, Total:								
VA Hospitals	142	144	142	144	142	142	0	0
Community Living Centers (CLC)	135	136	136	137	137	137	1	0
Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)	123	129	126	128	129	131	3	2
VAMC-Based Outpatient Care Sites	170	173	170	173	170	170	0	0
Health Care Centers (HCC)	**12**	**12**	**12**	**12**	**12**	**12**	0	0
Community-Based Outpatient Clinics (CBOC)	**750**	**741**	**755**	**741**	**755**	**755**	0	0
Multi-Specialty CBOC	326	312	327	312	327	327	0	0
Primary Care CBOC	424	429	428	429	428	428	0	0
Other Outpatient Services (OOS) Sites, Total	**433**	**423**	**433**	**423**	**433**	**433**	0	0
Included in OOS Sites, Total:								
Dialysis Centers	71	70	71	70	71	71	0	0
Community Resource and Referral Centers (CRRC)	33	33	33	33	33	33	0	0
Vet Centers	**302**	**303**	**302**	**303**	**303**	**303**	1	0
Mobile Vet Centers	**85**	**86**	**85**	**86**	**85**	**85**	0	0
Vet Center Outstations	**22**	**21**	**24**	**21**	**27**	**27**	3	0

1/ Reflects historical data as of September 30, 2024. Data source: VHA site tracking system (VAST).

Annual Changes in Medical Care Installations

Veterans Integrated Service Networks (VISN)

VHA is geographically separated into five districts and 18 Veterans Integrated Service Networks (VISNs). VISNs are regional systems of care working together to better meet local health care needs and provide greater access to care.



VA Districts by VISN

District	District Name	VISN
1	North Atlantic	1, 2, 4, 5, 6
2	Southeast	7, 8, 9
3	Midwest	10, 12, 15, 23
4	Continental	16, 17, 19
5	Pacific	20, 21, 22

VA Medical Centers (VAMCs)

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. To meet the criteria of a VA Hospital, a facility must report over 500 inpatient acute bed days of care annually.

Based on the workload data in 2024, 170 sites were VAMCs, of which 142 VAMC sites met the criteria of a VA Hospital, while the remaining 28 sites provided a mix of other bed-care services, such as Community Living Centers (CLCs) and/or residential rehabilitation care, thus meeting the VAMC criteria.

Please refer to the section titled "FY 2024 VA Medical Centers and Hospitals" for the complete list of VA Medical Centers and Hospitals in 2024.

CLC
CLCs provide institutional extended care services and may be part of a VA Hospital (e.g., a wing), or a free-standing structure.

In 2024, 135 sites were CLCs. Please refer to the section titled "FY 2024 Community Living Centers (CLC)" for the complete list of CLC sites.

CLC changes in 2025
In 2025, 1 site is projected to be activated, resulting in a net increase from 135 to 136 (+1 CLC):
- +1 CLC: VISN 5 Hershel "Woody" Williams VA Medical Center, Huntington WV (581)

CLC changes in 2026
In 2026, 1 site is projected to be activated, resulting in a net increase from 136 to 137 (+1 CLC):
- +1 CLC: VISN 10 VA Northern Indiana Health Care System, Fort Wayne, IN (610A4)

Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)
MH RRTPs provide rehabilitative care in a residential setting. Like a CLC, it may be part of a VA Hospital or a free-standing structure.

Based on the workload data, 120 sites were MH RRTPs in 2024. Please refer to the section titled "FY 2024 Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)" for the complete list of MH RRTPs sites.

MH RRTP changes in 2025
In 2025, MH RRTPs are projected to increase from 123 to 126 (+3 MH RRTP)
- +1 Domiciliary Substance Use Disorder Program (DOM SUD), Amarillo, TX
- +1 Domiciliary Post-Traumatic Stress Disorder Program (DOM PTSD), Denver, CO
- +1 DOM SUD, Togus, ME

MH RRTP changes in 2026
In 2026, MH RRTPs are projected to increase from 126 to 129 (+3 MH RRTP)
- +1 DOM SUD, Oklahoma City, OK

- +1 DOM SUD, Poplar Bluff, MO
- +1 MH RRTP, Long Beach, CA

MH RRTP changes in 2027
In 2027, MH RRTPs are projected to increase from 129 to 131 (+ 2 MH RRTP)
- +1 MH RRTP, New Orleans, LA
- +1 MH RRTP, Loma Linda, CA

VAMC-Based Outpatient Care Sites
A VAMC-Based Outpatient Care site is a VAMC that provides outpatient care. By definition, all VA Hospitals provide outpatient care, but some free-standing CLCs and/or MH RRTPs also provide outpatient care and are therefore included in this classification.

Outpatient medical facilities are classified based on workload (encounters) by the following services: Primary Care, Mental Health, Specialty Care, and Ambulatory Surgery. Please refer to the "Outpatient Classification Criteria" table below for complete detail.

Outpatient Classification Criteria

Outpatient Medical Facilities	Primary Care Encounters 1/	Mental Health Encounters 1/	Specialty Care Encounters 1/	Ambulatory Surgery Services 2/
Health Care Center (HCC)	Greater than 500	Greater than 500	Greater than 500 in any 2 or more Specialties	Yes
Multi-Specialty CBOC	Greater than 500	Greater than 500	Greater than 500 in any 2 or more Specialties	None
Primary Care CBOC	Greater than 500	Greater than 500	Greater than 500 in any 1 Specialty	None
Primary Care CBOC	Greater than 500	Greater than 500	500 or less in 1 or more Specialties	None
Other Outpatient Service Site (OOS)	Greater than 500	Less than 500	Greater than 0	None
Other Outpatient Service Site (OOS)	Less than or equal to 500	Greater than 500	None	None
Other Outpatient Service Site (OOS)	Less than or equal to 500	Greater than 500	Greater than 0	None
Other Outpatient Service Site (OOS)	Less than or equal to 500	Less than or equal to 500	Greater than 0	None
Other Outpatient Service Site (OOS)	None	Less than or equal to 500	None	None

1/ Source: VSSC Outpatient Encounters data
2/ Source: Surgery and Clinical Inventory data (Ambulatory Surgery Center, Ambulatory Surgery Services and/or Moderate Sedation)

There are four outpatient classifications: (1) Health Care Center (HCC); (2) Multi-Specialty Community Based Outpatient Clinic (MS CBOC); (3) Primary Care Community Based Outpatient Clinic (PC CBOC); and (4) Other Outpatient Services site (OOS).

Health Care Centers (HCC)
HCCs are VA-owned, VA-leased, or contract clinics operated 5 days per week that provide primary care, mental health care, on-site specialty services, and perform ambulatory surgery and/or invasive procedures which may require moderate sedation or general anesthesia.

Based on the workload data, there were 12 HCC sites in 2024. For the complete list of HCCs, please refer to the section titled "FY 2024 Health Care Centers (HCC)".

Multi-Specialty Community Based Outpatient Clinics (MS CBOC)
MS CBOCs (formerly known as CBOCs) are VA-owned, VA-leased, mobile, or contract clinics that offer both primary and mental health care and two or more specialty services physically on site. Access to additional specialty services may be offered by referral or telehealth. These clinics may offer support services, such as pharmacy, laboratory, and x-ray. The clinic may be operational from 1 to 7 days per week. These clinics are permitted to provide invasive procedures with local anesthesia or minimal sedation, but not with moderate sedation or general anesthesia. 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).

Based on the workload data in 2024, 326 sites were MS CBOCs. Please refer to the section titled "FY 2024 Multi-Specialty Community Based Clinics (MS CBOC)" for the complete list of MS CBOC sites.

MS CBOC site changes in 2025
In 2025, MS CBOCs are projected to increase from 326 to 327 (+1 MS CBOC):

- +1 MS CBOC: VISN 5 Prince William County MS CBOC, Prince William County, VA

Primary Care Clinics (PC CBOC)
PC CBOCs are VA-owned, VA-leased, mobile, or contract clinics that offer both medical (physically on site) and mental health care (either physically on site or by telehealth) and may offer support services such as pharmacy, laboratory, and x-ray. The clinics may be operational one to seven days per week. Access to specialty care is not provided on site but may be available through referral or telehealth. PC CBOCs often provide home-based primary care (HBPC) and home telehealth to the populations they serve to meet the primary care and mental health needs of Veterans who have difficulty accessing clinic-based care. These clinics have access to a higher level of care within a VHA network of care. Primary care in VA includes both medical and mental health care services, as they are inseparable in providing personalized, proactive, patient-centered health care. The establishment of a new PC CBOC can only be approved by the Secretary of Veterans Affairs, with Congressional notification consistent with 38 U.S.C. 8119(b) (2), (3), (4).

Based on the workload data, 424 sites were PC CBOCs in 2024. Please refer to the section titled "FY 2024 Primary Community Based Outpatient Clinics (PC CBOC)" for the complete list of PC CBOC sites.

PC CBOC changes in 2025
In 2025, PC CBOCs are projected to increase from 424 to 428 (+4 PC CBOC):

- +1 PC CBOC: VISN 4 Adams County PC CBOC, Adams County, PA
- +1 PC CBOC: VISN 7 Georgetown PC CBOC, Georgetown, SC
- +1 PC CBOC: VISN 23 Cambridge PC CBOC, Cambridge, MN
- +1 PC CBOC: VISN 23 Litchfield PC CBOC, Litchfield, MN

Other Outpatient Services (OOS) Sites
OOS sites are sites in which Veterans receive services that do not generate VHA encounter workload, or do not meet minimum workload criteria to be classified as a CBOC or HCC. Many of the services provided at these sites are contacts made by VA or VHA personnel to provide information, social services, homelessness outreach services, activities to increase Veteran awareness of benefits and services, and support services, such as those provided in Vet Centers. Other services could be more clinical in nature, which can be provided to remote areas through a Telehealth clinic or other arrangement. If any other services are provided in this venue (external to a VA clinic or facility), they must be associated with, attached to, and coordinated by a health care delivery site located in a clinic or facility.

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.

Based on the workload data, there were 71 Dialysis Centers in 2024. Please refer to the section titled, “FY 2024 Outpatient Dialysis Centers” for the complete list of Dialysis Centers.

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.

Based on the workload data, there were 33 CRRC sites in 2024. For the complete list of CRRCs, please refer to the section titled, “FY 2024 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 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 RCS, within the Department of Veterans Affairs.

RCS has completed the transition of Clarksville, TN, and the U.S. Virgin Islands Outstation sites to full Vet Centers in Solano County, CA, and St. Cloud, MN.
Based on the workload data, one Mobile Vet Center was activated in 2024 (+1 MVC):

- +1 MVC: VISN 8 Palm Beach Mobile Vet Center, Palm Beach, FL (0326MVC)

In 2024, there were 302 Vet Centers, 85 Mobile Vet Centers, and 22 Vet Center Outstation sites of care. For the complete list, please refer to the section titled "FY 2024 Vet Centers, Mobile Vet Centers and Vet Center Outstations".

In 2025, Vet Center Outstations will be opened in permanent locations in Cumberland County, NJ, and Sierra Vista, AZ, offering increased services to Veterans, service members and their families in these communities (+2 VC Outstation):

- +1 VC Outstation: VISN 2 Vineland Vet Center Outstation, Vineland, NJ (2301)
- +1 VC Outstation: VISN 22 Sierra Vista Vet Center Outstation, Sierra Vista, AZ (1121)

In 2026, RCS will increase access to care by opening a Vet Center in Fredericksburg, VA (+1 VC) and Vet Center Outstations in Hackettstown, NJ; Leesburg, VA; and Saipan, CNMI (+3 VC Outstation):

- +1 VC: VISN 6, Fredericksburg Vet Center, Fredericksburg, VA
- +1 VC Outstation: VISN 5 Leesburg Vet Center Outstation, VA
- +1 VC Outstation: VISN 2 Hackettstown Vet Center Outstation, NJ
- +1 VC Outstation: VISN 21 Saipan Vet Center Outstation, Mariana Islands

FY 2024 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	VA Hospital in FY 2024 (Yes / No)
1	402	Togus VA Medical Center	VA Medical Center (VAMC)	Yes
1	405	White River Junction VA Medical Center	VA Medical Center (VAMC)	Yes
1	518	Edith Nourse Rogers Memorial Veterans' Hospital	VA Medical Center (VAMC)	Yes
1	523	Jamaica Plain VA Medical Center	VA Medical Center (VAMC)	No
1	523A4	West Roxbury VA Medical Center	VA Medical Center (VAMC)	Yes
1	523A5	Brockton VA Medical Center	VA Medical Center (VAMC)	Yes
1	608	Manchester VA Medical Center	VA Medical Center (VAMC)	No
1	631	Edward P. Boland Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
1	650	Providence VA Medical Center	VA Medical Center (VAMC)	Yes
1	689	West Haven VA Medical Center	VA Medical Center (VAMC)	Yes
2	526	James J. Peters Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
2	528	Buffalo VA Medical Center	VA Medical Center (VAMC)	Yes
2	528A4	Batavia VA Medical Center	VA Medical Center (VAMC)	No
2	528A5	Canandaigua VA Medical Center	VA Medical Center (VAMC)	No
2	528A6	Bath VA Medical Center	VA Medical Center (VAMC)	Yes
2	528A7	Syracuse VA Medical Center	VA Medical Center (VAMC)	Yes
2	528A8	Samuel S. Stratton Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
2	561	East Orange VA Medical Center	VA Medical Center (VAMC)	Yes
2	561A4	Lyons VA Medical Center	VA Medical Center (VAMC)	No
2	620	Franklin Delano Roosevelt Hospital	VA Medical Center (VAMC)	Yes
2	620A4	Castle Point VA Medical Center	VA Medical Center (VAMC)	Yes
2	630	Manhattan VA Medical Center	VA Medical Center (VAMC)	Yes
2	630A4	Brooklyn VA Medical Center	VA Medical Center (VAMC)	Yes
2	630A5	St. Albans VA Medical Center	VA Medical Center (VAMC)	No
2	632	Northport VA Medical Center	VA Medical Center (VAMC)	Yes
4	460	Wilmington VA Medical Center	VA Medical Center (VAMC)	Yes
4	503	James E. Van Zandt Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
4	529A4	Butler VA Medical Center	VA Medical Center (VAMC)	No
4	542	Coatesville VA Medical Center	VA Medical Center (VAMC)	Yes
4	562	Erie VA Medical Center	VA Medical Center (VAMC)	No
4	595	Lebanon VA Medical Center	VA Medical Center (VAMC)	Yes
4	642	Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
4	646	Pittsburgh VA Medical Center-University Drive	VA Medical Center (VAMC)	Yes
4	646A4	H. John Heinz III Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	No
4	693	Wilkes-Barre VA Medical Center	VA Medical Center (VAMC)	Yes
5	512	Baltimore VA Medical Center	VA Medical Center (VAMC)	Yes
5	512A5	Perry Point VA Medical Center	VA Medical Center (VAMC)	No
5	512GD	Loch Raven VA Medical Center	VA Medical Center (VAMC)	No
5	517	Beckley VA Medical Center	VA Medical Center (VAMC)	Yes
5	540	Louis A. Johnson Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
5	581	Huntington / Hershel "Woody" Williams VA Medical Center	VA Medical Center (VAMC)	Yes
5	613	Martinsburg VA Medical Center	VA Medical Center (VAMC)	Yes
5	688	Washington VA Medical Center	VA Medical Center (VAMC)	Yes

FY 2024 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	VA Hospital in FY 2024 (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)	No

FY 2024 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	VA Hospital in FY 2024 (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	442	Cheyenne VA Medical Center	VA Medical Center (VAMC)	Yes
19	554	Rocky Mountain Regional VA Medical Center	VA Medical Center (VAMC)	Yes
19	575	Grand Junction VA Medical Center	VA Medical Center (VAMC)	Yes
19	623	Jack C. Montgomery Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
19	635	Oklahoma City VA Medical Center	VA Medical Center (VAMC)	Yes
19	660	George E. Wahlen Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
19	666	Sheridan VA Medical Center	VA Medical Center (VAMC)	Yes
20	463	Anchorage VA Medical Center	VA Medical Center (VAMC)	No
20	463A4	Joint Base Elmendorf-Richardson VA Medical Center	VA Medical Center (VAMC)	No

FY 2024 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	VA Hospital in FY 2024 (Yes / No)
20	531	Boise VA Medical Center	VA Medical Center (VAMC)	Yes
20	648	Portland VA Medical Center	VA Medical Center (VAMC)	Yes
20	648A4	Portland VA Medical Center-Vancouver	VA Medical Center (VAMC)	No
20	653	Roseburg VA Medical Center	VA Medical Center (VAMC)	Yes
20	663	Seattle VA Medical Center	VA Medical Center (VAMC)	Yes
20	663A4	American Lake VA Medical Center	VA Medical Center (VAMC)	Yes
20	668	Mann-Grandstaff Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
20	687	Jonathan M. Wainwright Memorial VA Medical Center	VA Medical Center (VAMC)	Yes
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)	No
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)	No
23	618	Minneapolis VA Medical Center	VA Medical Center (VAMC)	Yes
23	636	Omaha VA Medical Center	VA Medical Center (VAMC)	Yes
23	636A4	Grand Island VA Medical Center	VA Medical Center (VAMC)	No
23	636A6	Des Moines VA Medical Center	VA Medical Center (VAMC)	Yes
23	636A8	Iowa City VA Medical Center	VA Medical Center (VAMC)	Yes
23	656	St. Cloud VA Medical Center	VA Medical Center (VAMC)	Yes

FY 2024 Community Living Centers

CLC Program Count	VISN	Station Number	Official Name
1	1	402	Maine VA
2	1	518	Edith Nourse Rogers VA
3	1	523A5	Boston VA-Brockton
4	1	608	Manchester VA
5	1	631	Central Western Massachusetts VA-Leeds
6	1	689	Connecticut VA-West Haven
7	2	528	Western New York VA-Buffalo
8	2	528A4	Western New York VA-Batavia
9	2	528A5	Canandaigua VA
10	2	528A6	Bath VA
11	2	528A7	Syracuse VA
12	2	528A8	Samuel S. Stratton VA
13	2	526	James J. Peters VA
14	2	561A4	New Jersey VA-Lyons
15	2	620	Franklin Delano Roosevelt VA - Montrose
16	2	620A4	Hudson Valley VA-Castle Point
17	2	630A5	New York Harbor VA-St. Albans
18	2	632	Northport VA
19	4	460	Wilmington VA
20	4	503	James E. Van Zandt VA
21	4	529	Butler VA
22	4	542	Coatesville VA
23	4	562	Erie VA
24	4	595	Lebanon VA
25	4	642	Philadelphia VA
26	4	646A4	Pittsburgh VA-H.J. Heinz VA
27	4	693	Wilkes-Barre VA
28	5	540	Louis A. Johnson VA
29	5	512	Maryland VA-Baltimore
30	5	512A5	Maryland VA-Perry Point
31	5	613	Martinsburg VA
32	5	688	Washington VA
33	5	517	Beckley VA
34	6	558	Durham VA
35	6	565	Fayetteville VA
36	6	590	Hampton VA
37	6	637	Charles George VA
38	6	652	Hunter Holmes McGuire VA
39	6	658	Salem VA
40	6	659	W.G. (Bill) Hefner VA

FY 2024 Community Living Centers

CLC Program Count	VISN	Station Number	Official Name
41	7	508	Atlanta VA
42	7	508GK	Trinka Davis Veterans Village Clinic
43	7	509A0	Augusta VA-Uptown
44	7	534	Ralph H. Johnson VA
45	7	544	William Jennings Bryan Dorn VA
46	7	557	Carl Vinson VA
47	7	619A4	Central Alabama VA-Tuskegee
48	7	679	Tuscaloosa VA
49	8	516	C.W. Bill Young VA
50	8	546	Miami VA
51	8	548	West Palm Beach VA
52	8	573	Malcom Randall VA
53	8	573A4	North Florida-South Georgia VA-Lake City
54	8	672	Caribbean VA-San Juan
55	8	673	James A. Haley VA
56	8	675	Orlando VA
57	9	596	Lexington VA-Leestown
58	9	621	James H. Quillen VA
59	9	626A4	Alvin C. York VA
60	10	538	Chillicothe VA
61	10	539	Cincinnati VA
62	10	541	Louis Stokes VA
63	10	552	Dayton VA
64	10	506	Ann Arbor VA
65	10	515	Battle Creek VA
66	10	553	John D. Dingell VA
67	10	610	Northern Indiana VA-Marion
68	10	655	Aleda E. Lutz VA
69	12	550	Illiana VA-Danville
70	12	537	Jesse Brown VA
71	12	556	Captain James A. Lovell VA
72	12	578	Edward Hines Jr. VA
73	12	585	Oscar G. Johnson VA
74	12	607	William S. Middleton VA
75	12	676	Tomah VA
76	12	695	Clement J. Zablocki VA
77	15	589A4	Harry S. Truman VA
78	15	589A5	Eastern Kansas VA-Colmery-O'Neil
79	15	589A6	Eastern Kansas VA-Dwight D. Eisenhower
80	15	589A7	Robert J. Dole VA
81	15	657A0	St. Louis VA-Jefferson Barracks
82	15	657A4	John J. Pershing VA
83	15	657A5	Marion VA

FY 2024 Community Living Centers

CLC Program Count	VISN	Station Number	Official Name
84	16	502	Alexandria VA
85	16	520	Gulf Coast VA-Biloxi
86	16	580	Michael E. DeBakey VA
87	16	586	G. V. (Sonny) Montgomery VA
88	16	598A0	Central Arkansas VA-Eugene J. Tobin
89	16	629	New Orleans VA
90	17	549	North Texas VA-Dallas
91	17	549A4	North Texas VA-Sam Rayburn
92	17	671	South Texas VA-Audie L. Murphy
93	17	671A4	South Texas VA-Kerrville
94	17	674	Central Texas VA-Olin E. Teague
95	17	674A4	Central Texas VA-Waco
96	17	504	Thomas E. Creek VA
97	17	519	West Texas VA-George H. O'Brien, Jr.
98	19	635	Oklahoma City VA
99	19	436GJ	Miles City VA Clinic
100	19	442	Cheyenne VA
101	19	554A4	Eastern Colorado VA-Pueblo
102	19	575	Grand Junction VA
103	19	666	Sheridan VA
104	20	531	Boise VA
105	20	648A4	Portland VA-Vancouver
106	20	653	Roseburg VA
107	20	663	Puget Sound VA-Seattle
108	20	663A4	Puget Sound VA-American Lake
109	20	668	Mann-Grandstaff VA
110	21	459	Pacific Islands VA-Spark M. Matsunaga
111	21	570	Central California VA-Fresno
112	21	612	Northern California VA-East Bay (Martinez)
113	21	640	Palo Alto VA
114	21	640A0	Palo Alto VA-Menlo Park
115	21	640A4	Palo Alto VA-Livermore
116	21	654	Sierra Nevada VA-Ioannis A. Lougaris
117	21	662	San Francisco VA
118	22	501	New Mexico VA-Raymond G. Murphy
119	22	644	Carl T. Hayden VA
120	22	649	Northern Arizona VA-Prescott
121	22	678	Southern Arizona VA-Tucson
122	22	600	Long Beach VA
123	22	605	Loma Linda VA
124	22	664	San Diego VA
125	22	691	Greater Los Angeles VA-West Los Angeles
126	22	691A4	Sepulveda VA Clinic

FY 2024 Community Living Centers

CLC Program Count	VISN	Station Number	Official Name
127	23	437	Fargo VA
128	23	438	Sioux Falls VA
129	23	568	Black Hills VA-Fort Meade
130	23	568A4	Black Hills VA-Hot Springs
131	23	618	Minneapolis VA
132	23	636A4	Grand Island VA Clinic
133	23	636A6	Central Iowa VA-Des Moines
134	23	6369AA	Papillion VA Community Living Center
135	23	656	St. Cloud VA

FY 2024 Mental Health Residential Rehabilitation Treatment Programs

MH RRTP Program Count	VISN	Station Number	Official Name	Classification	Type of Service
1	1	405	White River Junction VA	VA Medical Center (VAMC)	Domiciliary Program
2	1	518	Edith Nourse Rogers VA- Bedford	VA Medical Center (VAMC)	Dom & CWT/TR Program
3	1	523	Boston VA-Jamaica Plain	VA Medical Center (VAMC)	Dom & CWT/TR Program
4	1	523A5	Boston VA-Brockton	VA Medical Center (VAMC)	Dom & CWT/TR Program
5	1	631	Central Western Massachusetts VA-Leeds (Northampton)	VA Medical Center (VAMC)	Dom & CWT/TR Program
6	1	689BW	Connecticut - VA West Haven - Maple Street	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary Only
7	1	689BX	Connecticut VA West Haven - Norton Street	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary Only
8	2	528	Western New York VA-Buffalo	VA Medical Center (VAMC)	Domiciliary Program
9	2	528A4	Western New York VA-Batavia	VA Medical Center (VAMC)	Domiciliary Program
10	2	528A5	Canandaigua VA	VA Medical Center (VAMC)	Domiciliary Program
11	2	528A6	Bath VA	VA Medical Center (VAMC)	Domiciliary Program
12	2	528A8	Samuel S. Stratton VA- Albany	VA Medical Center (VAMC)	Domiciliary Program
13	2	561A4	New Jersey VA-Lyons	VA Medical Center (VAMC)	Domiciliary 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 &
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	VA Medical Center (VAMC)	Domiciliary Program
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	Bruce W. Carter VAMC (Miami)	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	573QG	Jacksonville North VA Clinic	VA Medical Center (VAMC)	Domiciliary Program
46	8	672QH	Hato Rey VA Clinic (San Juan)	VA Medical Center (VAMC)	Domiciliary Program
47	8	673QM	Temple Terrace VA Clinic (Tampa)	VA Medical Center (VAMC)	Domiciliary Program
48	8	675GG	Orlando VA (Lake Baldwin)	VA Medical Center (VAMC)	Domiciliary Program
49	8	675	Orlando VA (Lake Nona)	VA Medical Center (VAMC)	Domiciliary Program
50	9	596	Franklin R. Sousley Campus (Lexington VA-Leestown)	VA Medical Center (VAMC)	Domiciliary Program
51	9	603	Robley Rex VA (Louisville)	VA Medical Center (VAMC)	Domiciliary Program
52	9	614	Memphis VA	VA Medical Center (VAMC)	Domiciliary Program
53	9	621	James H. Quillen VA (Mountain Home)	VA Medical Center (VAMC)	Domiciliary Program
54	9	626A4	Alvin C. York VA (Murfreesboro)	VA Medical Center (VAMC)	Domiciliary Program

FY 2024 Mental Health Residential Rehabilitation Treatment Programs

MH RRTP Program Count	VISN	Station Number	Official Name	Classification	Type of Service
55	10	538	Chillicothe VA	VA Medical Center (VAMC)	Domiciliary Program
56	10	539A4	Cincinnati VA-Fort Thomas	VA Medical Center (VAMC)	Domiciliary Program
57	10	541BU	Cleveland VA Domiciliary	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	Stand Alone Domiciliary Only
58	10	541	Louis Stokes Cleveland VA	VA Medical Center (VAMC)	CWT-TR Program
59	10	552	Dayton VA	VA Medical Center (VAMC)	Domiciliary Program
60	10	515	Battle Creek VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
61	10	553A4	Detroit VAMC Valor Center	VA Medical Center (VAMC)	Domiciliary Program
62	10	583BU	Indianapolis VA Domiciliary	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	Stand Alone Domiciliary Only
63	10	610	Northern Indiana VA (Marion)	VA Medical Center (VAMC)	Domiciliary Program
64	12	537	Jesse Brown VA (Chicago)	VA Medical Center (VAMC)	Domiciliary Program
65	12	550	Illiana VA-Danville	VA Medical Center (VAMC)	Dom & CWT/TR Program
66	12	556	Captain James A. Lovell VA (North Chicago)	VA Medical Center (VAMC)	Dom & CWT/TR Program
67	12	578	Edward Hines Jr. VA	VA Medical Center (VAMC)	Domiciliary Program
68	12	607	William S. Middleton VA (Madison)	VA Medical Center (VAMC)	CWT-TR Program
69	12	676	Tomah VA	VA Medical Center (VAMC)	Domiciliary Program
70	12	676PA	La Crosse VA CWT-TR	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	CWT/TR Program
71	12	695	Clement J. Zablocki VA (Milwaukee)	VA Medical Center (VAMC)	Dom & CWT/TR Program
72	15	589	Kansas City VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
73	15	589A4	Harry S. Truman VA (Columbia MO)	VA Medical Center (VAMC)	Dom & CWT/TR Program
74	15	589A5	Eastern Kansas VA - Topeka Division	VA Medical Center (VAMC)	Dom & CWT/TR Program
75	15	589A6	Eastern Kansas VA - Dwight D. Eisenhower (Leavenworth Division) (parent is 589A5)	VA Medical Center (VAMC)	Domiciliary Program
76	15	657A0	St. Louis VA-Jefferson Barracks	VA Medical Center (VAMC)	Domiciliary Program
77	15	657A5	Marion IL VA	VA Medical Center (VAMC)	Domiciliary Program
78	15	589A7	Wichita VA	VA Medical Center (VAMC)	Domiciliary Program
79	16	502	Alexandria VAMC	VA Medical Center (VAMC)	Domiciliary Program
80	16	520	Gulf Coast VA-Biloxi	VA Medical Center (VAMC)	Domiciliary Program
81	16	564	Veterans HCS of the Ozarks - Fayetteville	VA Medical Center (VAMC)	Domiciliary Program
82	16	586BU	Jackson VA Domiciliary	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	Stand Alone Domiciliary Only
83	16	598A0	Central Arkansas VA-Eugene J. Tobin (N.Little Rock)	VA Medical Center (VAMC)	Dom & CWT/TR Program
84	16	580BV	Houston VA Domiciliary	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	Stand Alone Domiciliary Only
85	17	549	North Texas VA-Dallas	VA Medical Center (VAMC)	Dom & CWT/TR Program
86	17	549A4	North Texas VA-Sam Rayburn (Bonham)	VA Medical Center (VAMC)	Dom & CWT/TR Program
87	17	671BU	South Texas VA-Audie L. Murphy (San Antonio) Domiciliary	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	Stand Alone Domiciliary Only
88	17	674	Central Texas VA-Olin E. Teague (Temple)	VA Medical Center (VAMC)	Dom & CWT/TR Program
89	17	674A4	Central Texas VA-Waco	VA Medical Center (VAMC)	Domiciliary Program
90	17	519	West Texas VA-George H. O'Brien, Jr. (Big Spring)	VA Medical Center (VAMC)	Domiciliary Program
91	19	436	Montana VA-Fort Harrison	VA Medical Center (VAMC)	Domiciliary Program
92	19	442	Cheyenne	VA Medical Center (VAMC)	Domiciliary Program
93	19	554BU	Valor Point VA Domiciliary	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	Stand Alone Domiciliary Only
94	19	660	George E. Wahlen VA (Salt Lake)	VA Medical Center (VAMC)	Domiciliary Program
95	19	635PA	Friendship House VA Compensated Work	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	CWT/TR Program
96	19	666	Sheridan VA	VA Medical Center (VAMC)	Domiciliary Program
97	19	575	VA Western Colorado Healthcare System (Grand Junction)	VA Medical Center (VAMC)	Domiciliary Program

FY 2024 Mental Health Residential Rehabilitation Treatment Programs

MH RRTP Program Count	VISN	Station Number	Official Name	Classification	Type of Service
98	20	463	Alaska VA-Anchorage	VA Medical Center (VAMC)	Dom & CWT/TR Program
99	20	531	Boise VA	VA Medical Center (VAMC)	Domiciliary Program
100	20	648A4	Portland VA-Vancouver	VA Medical Center (VAMC)	Domiciliary Program
101	20	663A4	Puget Sound VA-American Lake	VA Medical Center (VAMC)	Dom & CWT/TR Program
102	20	687	Jonathan M. Wainwright VA (Walla Walla)	VA Medical Center (VAMC)	Domiciliary Program
103	20	692	Southern Oregon VA-White City	VA Medical Center (VAMC)	Domiciliary Program
104	21	459	Pacific Islands VA-Spark M. Matsunaga	VA Medical Center (VAMC)	Domiciliary Program
105	21	593	Southern Nevada (Las Vegas)	VA Medical Center (VAMC)	Domiciliary Program
106	21	640A0	Palo Alto VA-Menlo Park	VA Medical Center (VAMC)	Dom & CWT/TR Program
107	21	640BV	Palo Alto VA	VA Medical Center (VAMC)	Domiciliary Program
108	21	662	San Francisco VA	VA Medical Center (VAMC)	CWT/TR Program
109	22	664	San Diego VA	VA Medical Center (VAMC)	Domiciliary Program
110	22	664BV	San Diego VA Domiciliary	Residential Care Site (MH RRTP/DRRTP) (Stand-Alone)	Stand Alone Domiciliary Only
111	22	501	New Mexico VA-Raymond G. Murphy (Albuquerque)	VA Medical Center (VAMC)	Dom & CWT/TR Program
112	22	644	Carl T. Hayden VA (Phoenix)	VA Medical Center (VAMC)	Domiciliary Program
113	22	649	Northern Arizona VA-Prescott	VA Medical Center (VAMC)	Domiciliary Program
114	22	678	Southern Arizona VA-Tucson	VA Medical Center (VAMC)	Domiciliary Program
115	22	691	Greater Los Angeles VA-West Los Angeles	VA Medical Center (VAMC)	Domiciliary Program
116	23	568A4	Black Hills VA-Hot Springs	VA Medical Center (VAMC)	Dom & CWT/TR Program
117	23	568PC	Black Hills VA - Pine Ridge VA CWT-TR	Residential Care Site (CWT/TR) (Stand-Alone)	CWT/TR Program
118	23	568 PB	Black Hills VA - Sturgis VA CWT-TR	Residential Care Site (CWT/TR) (Stand-Alone)	CWT/TR Program
119	23	568PD	Black Hills VA - Rapid City CWT-TR	Residential Care Site (CWT/TR) (Stand-Alone)	CWT/TR Program
120	23	636	Nebraska-Western Iowa VA-Omaha	VA Medical Center (VAMC)	Domiciliary Program
121	23	636A4	Grand Island VA Clinic	VA Medical Center (VAMC)	Dom & CWT/TR Program
122	23	636A6	Central Iowa VA-Des Moines	VA Medical Center (VAMC)	Domiciliary Program
123	23	656	St. Cloud VA	VA Medical Center (VAMC)	Domiciliary Program

FY 2024 Health Care Centers

HCC Count	VISN	Station Number	Station Name & Location
1	1	608BY	Concord VA Clinic, Concord, NH
2	6	565GL	Cumberland County VA Clinic, Fayetteville, NC
3	6	659BY	Kernersville VA Clinic, Kernersville, NC
4	6	659BZ	South Charlotte VA Clinic, Charlotte, NC
5	8	516BZ	Lee County VA Clinic, Cape Coral, FL
6	10	757	Chalmers P. Wylie Veterans Outpatient Clinic, Columbus, OH
7	12	695GD	Milo C. Huempfner VA Outpatient Clinic, Green Bay, WI
8	15	657GJ	Evansville VA Clinic, Evansville, IN
9	17	740	Harlingen VA Clinic, Harlingen, TX
10	17	756	El Paso VA Clinic, El Paso, TX
11	19	436GH	Billings VA Clinic, Billings, MT
12	20	653BY	Eugene VA Clinic, Eugene, OR

FY 2024 Multi-Specialty Community Based Outpatient Clinics

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
1	1	402GE	Lewiston VA Clinic	Lewiston, Maine
2	1	402HB	Bangor VA Clinic	Bangor
3	1	402HC	Portland VA Clinic	Portland, Maine
4	1	405HA	Burlington Lakeside VA Clinic	Burlington Lakeside
5	1	523BY	Lowell VA Clinic	Lowell
6	1	608GC	Somersworth VA Clinic	Somersworth
7	1	631BY	Springfield VA Clinic	Springfield, Massachusetts
8	1	631GE	Worcester VA Clinic	Worcester
9	1	650GB	Hyannis VA Clinic	Hyannis
10	1	689A4	Newington VA Clinic	Newington
11	1	689QA	Errera VA Clinic	Errera
12	2	528GM	Donald J. Mitchell Department of Veterans Affairs Outpatient Clinic	Rome, New York
13	2	528GN	Binghamton VA Clinic	Binghamton
14	2	528GR	Olean VA Clinic	Olean
15	2	528QC	Rochester Calkins VA Clinic	Rochester Calkins
16	2	561BZ	James J. Howard Veterans' Outpatient Clinic	Brick
17	2	620GA	New City VA Clinic	New City
18	2	630GB	Staten Island Community VA Clinic	Staten Island
19	2	632GA	East Meadow VA Clinic	East Meadow
20	2	632HB	Riverhead VA Clinic	Riverhead
21	2	632HD	Patchogue VA Clinic	Patchogue
22	4	460GC	Kent County VA Clinic	Kent County
23	4	460GD	Cape May County VA Clinic	Cape May County
24	4	460HG	Cumberland County VA Clinic	Cumberland County, New Jersey
25	4	503GA	Johnstown VA Clinic	Johnstown
26	4	503GB	DuBois VA Clinic	DuBois
27	4	503GC	State College VA Clinic	State College
28	4	503GD	Huntingdon County VA Clinic	Huntingdon County
29	4	503GE	Indiana County VA Clinic	Indiana County
30	4	529	Abie Abraham VA Clinic	Butler
31	4	562GA	Crawford County VA Clinic	Crawford County
32	4	562GD	Venango County VA Clinic	Venango County
33	4	595GA	Cumberland County VA Clinic	Cumberland County, Pennsylvania
34	4	595GC	Lancaster County VA Clinic	Lancaster County
35	4	595GE	York VA Clinic	York
36	4	642GA	Burlington County VA Clinic	Burlington County
37	4	642GC	Victor J. Saracini Department of Veterans Affairs Outpatient Clinic	Horsham
38	4	642GD	Gloucester County VA Clinic	Gloucester County
39	4	646GA	Belmont County VA Clinic	Belmont County
40	4	646GB	Westmoreland County VA Clinic	Westmoreland County
41	4	646GC	Beaver County VA Clinic	Beaver County
42	4	646GD	Washington County VA Clinic	Washington County
43	4	646GE	Fayette County VA Clinic	Fayette County
44	4	693B4	Allentown VA Clinic	Allentown

FY 2024 Multi-Specialty Community Based Outpatient Clinics

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
45	5	512GA	Cambridge VA Clinic	Cambridge, Maryland
46	5	512GC	Glen Burnie VA Clinic	Glen Burnie
47	5	512GG	Fort Meade VA Clinic	Fort Meade, Maryland
48	5	540GD	Monongalia County VA Clinic	Monongalia County
49	5	581GB	Charleston VA Clinic	Charleston, West Virginia
50	5	613GA	Cumberland VA Clinic	Cumberland
51	5	613GC	Winchester VA Clinic	Winchester
52	5	613GG	Fort Detrick VA Clinic	Fort Detrick
53	5	688GA	Fort Belvoir VA Clinic	Fort Belvoir
54	5	688GD	Charlotte Hall VA Clinic	Charlotte Hall
55	6	558GA	Greenville VA Clinic	Greenville, North Carolina
56	6	558GG	Raleigh III VA Clinic	Raleigh III
57	6	558GH	Clayton-East Raleigh VA Clinic	Clayton East Raleigh
58	6	565GA	Jacksonville VA Clinic	Jacksonville, North Carolina
59	6	565GC	Wilmington VA Clinic	Wilmington, North Carolina
60	6	565GE	Robeson County VA Clinic	Robeson County
61	6	565GF	Goldsboro VA Clinic	Goldsboro
62	6	590GD	Chesapeake VA Clinic	Chesapeake
63	6	590QD	Langley VA Clinic	Langley
64	6	637GA	Franklin VA Clinic	Franklin, North Carolina
65	6	637GC	Hickory VA Clinic	Hickory
66	6	652GC	Henrico County VA Clinic	Henrico County
67	6	652GE	Charlottesville VA Clinic	Charlottesville
68	6	652GI	Massaponax VA Clinic	Massaponax
69	6	658GC	Lynchburg VA Clinic	Lynchburg
70	6	659GA	North Charlotte VA Clinic	North Charlotte
71	7	508GE	Oakwood VA Clinic	Oakwood
72	7	508GH	Lawrenceville VA Clinic	Lawrenceville
73	7	508GJ	Blairsville VA Clinic	Blairsville
74	7	508GQ	Cobb County VA Clinic	Cobb County
75	7	508GS	Pike County VA Clinic	Pike County
76	7	508QF	Atlanta VA Clinic	Atlanta North Arcadia Avenue
77	7	508QJ	Tucker VA Clinic	DeKalb County
78	7	509GB	Aiken VA Clinic	Aiken
79	7	521GA	Huntsville VA Clinic	Huntsville
80	7	521GE	Oxford VA Clinic	Oxford
81	7	521GJ	Birmingham VA Clinic	Birmingham 7th Avenue South
82	7	534BY	Savannah VA Clinic	Savannah, Georgia
83	7	534GB	Myrtle Beach VA Clinic	Myrtle Beach
84	7	534GC	Beaufort VA Clinic	Beaufort
85	7	534GD	Goose Creek VA Clinic	Goose Creek
86	7	534GE	John Gibson, Dan James, William Sapp, and Frankie Smiley VA Clinic	Hinesville
87	7	534GF	North Charleston VA Clinic	North Charleston
88	7	534GG	Brunswick VA Clinic	Brunswick

FY 2024 Multi-Specialty Community Based Outpatient Clinics

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
89	7	544BZ	Lance Corporal Dana Cornell Darnell VA Clinic	Greenville, South Carolina
90	7	544GB	Florence VA Clinic	Florence, South Carolina
91	7	544GD	Anderson VA Clinic	Anderson
92	7	557GA	Macon VA Clinic	Macon
93	7	557GB	Albany VA Clinic	Albany, Georgia
94	7	557GE	Brunswick VA Clinic	Brunswick
95	7	619GA	Robert S. Poydasheff VA Clinic	Columbus, Georgia
96	7	619GD	Wiregrass VA Clinic	Wiregrass
97	7	619GF	Central Alabama Montgomery VA Clinic	Central Alabama Montgomery
98	7	619QB	Fort Moore VA Clinic	Fort Moore
99	8	516GA	Sarasota VA Clinic	Sarasota
100	8	516GC	North Pinellas VA Clinic	North Pinellas
101	8	516GD	Bradenton VA Clinic	Bradenton
102	8	516GE	Port Charlotte VA Clinic	Port Charlotte
103	8	516GF	Naples VA Clinic	Naples
104	8	516GH	Sebring VA Clinic	Sebring
105	8	546BZ	William "Bill" Kling Department of Veterans Affairs Outpatient Clinic	Sunrise
106	8	546GC	Homestead VA Clinic	Homestead
107	8	548GB	Delray Beach VA Clinic	Delray Beach
108	8	573BY	Jacksonville 1 VA Clinic	Jacksonville 1
109	8	573GD	Ocala VA Clinic	Ocala
110	8	573GE	Leo C. Chase Jr. VA Clinic	Saint Augustine
111	8	573GF	Sergeant Ernest I. "Boots" Thomas VA Clinic	Tallahassee
112	8	573GI	The Villages VA Clinic	The Villages
113	8	672B0	Eurípides Rubio Department of Veterans Affairs Outpatient Clinic	Ponce
114	8	672BZ	Mayaguez VA Clinic	Mayaguez
115	8	673BZ	New Port Richey VA Clinic	New Port Richey
116	8	673GB	Lakeland VA Clinic	Lakeland
117	8	673GC	Brooksville VA Clinic	Brooksville
118	8	673GF	Zephyrhills VA Clinic	Zephyrhills
119	8	673GG	South Hillsborough VA Clinic	South Hillsborough
120	8	673QJ	Hidden River VA Clinic	Hidden River
121	8	675GA	Viera VA Clinic	Viera
122	8	675GB	Daytona Beach VA Clinic	Daytona Beach
123	8	675GE	Tavares VA Clinic	Tavares
124	9	596GA	Somerset VA Clinic	Somerset
125	9	596GD	Berea VA Clinic	Berea
126	9	603GA	Fort Knox VA Clinic	Fort Knox
127	9	603GB	New Albany VA Clinic	New Albany
128	9	603GC	Greenwood VA Clinic	Greenwood
129	9	603GD	Stonybrook VA Clinic	Stonybrook
130	9	614GA	Tupelo VA Clinic	Tupelo
131	9	614GB	Jonesboro VA Clinic	Jonesboro
132	9	614GF	Nonconnah Boulevard VA Clinic	Nonconnah Boulevard

FY 2024 Multi-Specialty Community Based Outpatient Clinics

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
133	9	614GG	Jackson VA Clinic	Jackson, Tennessee
134	9	621BY	William C. Tallent Department of Veterans Affairs Outpatient Clinic	Knoxville, Tennessee
135	9	621GI	Dannie A. Carr Veterans Outpatient Clinic	Sevierville
136	9	626GE	Clarksville VA Clinic	Clarksville
137	9	626GF	Chattanooga VA Clinic	Chattanooga
138	9	626GO	International Plaza VA Clinic	International Plaza
139	9	626QB	Charlotte Avenue VA Clinic	Charlotte Avenue
140	10	506GA	Toledo VA Clinic	Toledo
141	10	506GD	Major General Oliver W. Dillard VA Clinic	Canton, Michigan
142	10	515BY	Wyoming VA Clinic	Wyoming
143	10	539GB	Clermont County VA Clinic	Clermont County
144	10	539GC	Dearborn VA Clinic	Dearborn
145	10	539GD	Florence VA Clinic	Florence, Kentucky
146	10	539GE	Hamilton VA Clinic	Hamilton, Ohio
147	10	539GF	Georgetown VA Clinic	Georgetown
148	10	541BY	Canton VA Clinic	Canton, Ohio
149	10	541BZ	Carl Nunziato VA Clinic	Youngstown
150	10	541GB	Lorain VA Clinic	Lorain
151	10	541GD	David F. Winder VA Community Based Outpatient Clinic	Mansfield
152	10	541GF	Lake County VA Clinic	Lake County
153	10	541GG	Akron VA Clinic	Akron
154	10	541GL	Parma VA Clinic	Parma
155	10	552GA	Middletown VA Clinic	Middletown, Ohio
156	10	552GB	Lima VA Clinic	Lima
157	10	552GC	Richmond VA Clinic	Richmond, Indiana
158	10	552GD	Springfield VA Clinic	Springfield, Ohio
159	10	583GA	Terre Haute VA Clinic	Terre Haute
160	10	583GB	Bloomington VA Clinic	Bloomington, Indiana
161	10	583GC	Martinsville VA Clinic	Martinsville
162	10	583GD	Brownsburg VA Clinic	Brownsburg
163	10	583GE	Lafayette VA Clinic	Lafayette, Indiana
164	10	583GF	Wakeman VA Clinic	Wakeman
165	10	583GG	Shelbyville VA Clinic	Shelbyville
166	10	610BY	Jackie Walorski VA Clinic	Mishawaka
167	10	655GA	Navy Corpsman Steve Andrews VA Health Care Clinic	Gaylord
168	10	655GB	Colonel Demas T. Craw VA Clinic	Traverse City
169	10	757GB	Grove City VA Clinic	Grove City
170	10	757GD	Daniel L. Kinnard VA Clinic	Newark
171	12	537BY	Adam Benjamin Jr., Veterans' Administration Outpatient Clinic	Crown Point
172	12	550BY	Bob Michel Department of Veterans Affairs Outpatient Clinic	Peoria
173	12	550GA	Decatur VA Clinic	Decatur, Illinois
174	12	550GD	Springfield VA Clinic	Springfield, Illinois
175	12	550GG	Bloomington VA Clinic	Bloomington, Illinois
176	12	578GA	Joliet VA Clinic	Joliet

FY 2024 Multi-Specialty Community Based Outpatient Clinics

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
177	12	578GC	Kankakee County VA Clinic	Kankakee County
178	12	578GD	Aurora VA Clinic	Aurora, Illinois
179	12	578GE	Hoffman Estates VA Clinic	Hoffman Estates
180	12	578GF	LaSalle VA Clinic	LaSalle
181	12	607GG	Madison West VA Clinic	Madison West
182	12	607GH	Madison East VA Clinic	Madison East
183	12	607HA	Rockford VA Clinic	Rockford
184	12	676GA	Wausau VA Clinic	Wausau
185	12	676GC	La Crosse VA Clinic	La Crosse
186	12	676GD	Wisconsin Rapids VA Clinic	Wisconsin Rapids
187	12	695BY	John H. Bradley Department of Veterans Affairs Outpatient Clinic	Appleton
188	15	589G1	Warrensburg VA Clinic	Warrensburg
189	15	589G8	Jefferson City VA Clinic	Jefferson City
190	15	589GF	Waynesville VA Clinic	Waynesville
191	15	589GH	Camdenton VA Clinic	Camdenton
192	15	589JA	Sedalia VA Clinic	Sedalia
193	15	589JD	Marshfield VA Clinic	Marshfield
194	15	589JF	Honor VA Clinic	Honor
195	15	589JG	Lenexa VA Clinic	Lenexa
196	15	657GH	Cape Girardeau VA Clinic	Cape Girardeau
197	16	502GB	Lafayette VA Clinic	Lafayette, Louisiana
198	16	502GE	Douglas Fournet Department of Veterans Affairs Clinic	Lake Charles
199	16	520BZ	Pensacola VA Clinic	Pensacola
200	16	520GA	Mobile VA Clinic	Mobile
201	16	520GC	Eglin Air Force Base VA Clinic	Eglin Air Force Base
202	16	564BY	Gene Taylor Veterans' Outpatient Clinic	Springfield, Missouri
203	16	564GB	Fort Smith VA Clinic	Fort Smith
204	16	564GC	Branson VA Clinic	Branson
205	16	580BY	Beaumont VA Clinic	Beaumont
206	16	580BZ	Charles Wilson Department of Veterans Affairs Outpatient Clinic	Lufkin
207	16	580GD	Conroe VA Clinic	Conroe
208	16	580GE	Katy VA Clinic	Katy
209	16	580GG	Richmond VA Clinic	Richmond, Texas
210	16	580GH	Tomball VA Clinic	Tomball
211	16	580GJ	Texas City VA Clinic	Texas City
212	16	598GC	Hot Springs VA Clinic	Hot Springs, Arkansas
213	16	598GG	Conway VA Clinic	Conway, Arkansas
214	16	629BY	Baton Rouge VA Clinic	Baton Rouge
215	16	629GA	Houma VA Clinic	Houma
216	16	629GB	Hammond VA Clinic	Hammond
217	16	629GC	Slidell VA Clinic	Slidell
218	16	667GA	Texarkana VA Clinic	Texarkana
219	16	667GB	Monroe VA Clinic	Monroe
220	16	667GC	Longview VA Clinic	Longview

FY 2024 Multi-Specialty Community Based Outpatient Clinics

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
221	17	504BY	Lubbock VA Clinic	Lubbock
222	17	519GA	Wilson and Young Medal of Honor VA Clinic	Permian Basin
223	17	519HC	Abilene VA Clinic	Abilene
224	17	519HF	Colonel Charles and JoAnne Powell VA Clinic	San Angelo
225	17	549BY	Fort Worth VA Clinic	Fort Worth
226	17	549GN	Tyler Centennial VA Clinic	Tyler Centennial
227	17	671GO	North Central Federal VA Clinic	North Central Federal
228	17	671GP	Balcones Heights VA Clinic	Balcones Heights
229	17	671GR	North Bexar VA Clinic	North Bexar
230	17	671GS	North West San Antonio VA Clinic	North West San Antonio
231	17	674BY	Austin VA Clinic	Austin
232	17	740GA	Harlingen VA Clinic-Treasure Hills	Harlingen Treasure Hills
233	17	740GB	McAllen VA Clinic	McAllen
234	17	740GD	Laredo VA Clinic	Laredo
235	17	740GH	South Enterprize VA Clinic	South Enterprize
236	17	756GA	Las Cruces VA Clinic	Las Cruces
237	17	756GB	El Paso Eastside VA Clinic	El Paso Eastside
238	19	436GB	Great Falls VA Clinic	Great Falls
239	19	436GC	David J. Thatcher VA Clinic	Missoula
240	19	436GD	Travis W. Atkins Department of Veterans Affairs Clinic	Bozeman
241	19	442GD	Loveland VA Clinic	Loveland
242	19	442GE	Northern Colorado VA Clinic	Northern Colorado
243	19	554GC	Golden VA Clinic	Golden
244	19	554GD	PFC James Dunn VA Clinic	Pueblo, Colorado
245	19	554GE	PFC Floyd K. Lindstrom Department of Veterans Affairs Clinic	Colorado Springs
246	19	623BY	Ernest Childers Department of Veterans Affairs Outpatient Clinic	Tulsa
247	19	635GA	Lawton VA Clinic	Lawton
248	19	635GB	Wichita Falls VA Clinic	Wichita Falls
249	19	635GJ	Yukon VA Clinic	Yukon
250	19	635GL	North Oklahoma City VA Clinic	North Oklahoma City
251	19	635QB	South Oklahoma City VA Clinic	South Oklahoma City
252	19	660GA	Pocatello VA Clinic	Pocatello
253	19	660GB	Ogden VA Clinic	Ogden
254	20	531GG	Caldwell VA Clinic	Caldwell
255	20	648GA	Robert D. Maxwell Department of Veterans Affairs Clinic	Bend
256	20	648GB	Salem VA Clinic	Salem, Oregon
257	20	648GF	Hillsboro VA Clinic	Hillsboro
258	20	648GG	West Linn VA Clinic	West Linn
259	20	663GB	Silverdale VA Clinic	Silverdale
260	20	663GC	Mount Vernon VA Clinic	Mount Vernon, Washington
261	20	668GA	Elwood “Bud” Link Department of Veterans Affairs Outpatient Clinic	Wenatchee
262	20	668GB	Coeur d 'Alene VA Clinic	Coeur d 'Alene
263	20	668GD	Spokane Valley VA Clinic	Spokane Valley
264	20	692	White City VA Medical Center	White City

FY 2024 Multi-Specialty Community Based Outpatient Clinics

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
265	21	570GA	Merced VA Clinic	Merced
266	21	593GE	Southeast Las Vegas VA Clinic	Southeast Las Vegas
267	21	593GF	Southwest Las Vegas VA Clinic	Southwest Las Vegas
268	21	612B4	Redding VA Clinic	Redding
269	21	612GD	Fairfield VA Clinic	Fairfield
270	21	612GE	Mare Island VA Clinic	Mare Island
271	21	612GG	Chico VA Clinic	Chico
272	21	612GH	McClellan VA Clinic	McClellan Park
273	21	612GK	Sierra Foothills VA Clinic	Sierra Foothills
274	21	612QE	Richard A. Pittman VA Clinic	Stockton
275	21	640BY	San Jose VA Clinic	San Jose
276	21	640HC	Major General William H. Gourley VA-DoD Outpatient Clinic	Monterey
277	21	662GA	South Santa Rosa VA Clinic	South Santa Rosa
278	21	662GC	Eureka VA Clinic	Eureka
279	21	662GD	Ukiah VA Clinic	Ukiah
280	21	662GE	San Bruno VA Clinic	San Bruno
281	21	662GG	Clearlake VA Clinic	Clearlake
282	21	662GH	Oakland VA Clinic	Oakland
283	22	501GK	Santa Fe VA Clinic	Santa Fe
284	22	501GM	Northwest Metro VA Clinic	Northwest Metro New Mexico
285	22	600GA	Placentia VA Clinic	Placentia
286	22	600GB	Santa Ana VA Clinic	Santa Ana
287	22	605BZ	Loma Linda VA Clinic	Loma Linda Redlands
288	22	644BY	Staff Sergeant Alexander W. Conrad Veterans Affairs Health Care Clinic	Southeast Gilbert
289	22	644GA	Northwest VA Clinic	Northwest Surprise
290	22	644GC	Southwest VA Clinic	Southwest Phoenix
291	22	644GI	Phoenix 32nd Street VA Clinic	Phoenix 32nd Street
292	22	664BY	Kearny Mesa VA Clinic	Kearny Mesa
293	22	664GB	Oceanside VA Clinic	Oceanside
294	22	664GC	Chula Vista VA Clinic	Chula Vista
295	22	678GA	Sierra Vista VA Clinic	Sierra Vista
296	22	678GB	Yuma VA Clinic	Yuma
297	22	678GC	Casa Grande VA Clinic	Casa Grande
298	22	678GG	Southeast Tucson VA Clinic	Southeast Tucson
299	22	691GD	Bakersfield VA Clinic	Bakersfield
300	22	691GE	Los Angeles VA Clinic	Los Angeles
301	22	691GG	Antelope Valley VA Clinic	Antelope Valley
302	22	691GL	Santa Maria VA Clinic	Santa Maria
303	22	691GQ	Captain Rosemary Bryant Mariner Outpatient Clinic	Ventura

FY 2024 Multi-Specialty Community Based Outpatient Clinics

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
304	23	438GD	Aberdeen VA Clinic	Aberdeen
305	23	568GA	Rapid City VA Clinic	Rapid City
306	23	618BY	Twin Ports VA Clinic	Twin Ports
307	23	618GD	Maplewood VA Clinic	Maplewood
308	23	618GG	Rochester VA Clinic	Rochester, Minnesota
309	23	618GI	Northwest Metro VA Clinic	Northwest Metro Minnesota
310	23	636A5	Lincoln VA Clinic	Lincoln, Nebraska
311	23	636GA	Norfolk VA Clinic	Norfolk
312	23	636GC	Mason City VA Clinic	Mason City
313	23	636GD	Marshalltown VA Clinic	Marshalltown
314	23	636GF	Quad Cities VA Clinic	Quad Cities
315	23	636GG	Quincy VA Clinic	Quincy, Illinois
316	23	636GH	Waterloo VA Clinic	Waterloo
317	23	636GJ	Dubuque VA Clinic	Dubuque
318	23	636GK	Fort Dodge VA Clinic	Fort Dodge
319	23	636GN	Cedar Rapids VA Clinic	Cedar Rapids
320	23	636GP	Shenandoah VA Clinic	Shenandoah
321	23	636GR	Knoxville VA Clinic	Knoxville, Iowa
322	23	636GS	Ottumwa VA Clinic	Ottumwa
323	23	636GT	Sterling VA Clinic	Sterling
324	23	636GU	Decorah VA Clinic	Decorah
325	23	636GZ	South Des Moines VA Clinic	South Des Moines
326	23	656GA	Brainerd VA Clinic	Brainerd

FY 2024 Primary Community Based Outpatient Clinics

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
1	1	402GA	Presque Isle VA Clinic	Presque Isle
2	1	405GA	Bennington VA Clinic	Bennington
3	1	405GC	Brattleboro VA Clinic	Brattleboro
4	1	405HC	Littleton VA Clinic	Littleton
5	1	405HE	Keene VA Clinic	Keene
6	1	405HF	Rutland VA Clinic	Rutland
7	1	405QB	Newport VA Clinic	Newport, Vermont
8	1	518GA	Lynn VA Clinic	Lynn
9	1	518GB	Haverhill VA Clinic	Haverhill
10	1	518GE	Gloucester VA Clinic	Gloucester
11	1	523BZ	Causeway VA Clinic	Causeway
12	1	523GA	Framingham VA Clinic	Framingham
13	1	523GD	Plymouth VA Clinic	Plymouth
14	1	608GA	Portsmouth VA Clinic	Portsmouth, New Hampshire
15	1	608HA	Tilton VA Clinic	Tilton
16	1	631GC	Pittsfield VA Clinic	Pittsfield
17	1	631GD	Greenfield VA Clinic	Greenfield
18	1	631GF	Fitchburg VA Clinic	Fitchburg
19	1	650GA	New Bedford VA Clinic	New Bedford
20	1	650GD	Middletown VA Clinic	Middletown, Rhode Island
21	1	689GA	Waterbury VA Clinic	Waterbury
22	1	689GB	Stamford VA Clinic	Stamford
23	1	689GC	Willimantic VA Clinic	Willimantic
24	1	689GD	Winsted VA Clinic	Winsted
25	1	689GE	Danbury VA Clinic	Danbury
26	1	689HC	John J. McGuirk Department of Veterans Affairs Outpatient Clinic	New London
27	2	526GA	White Plains VA Clinic	White Plains
28	2	526GB	Yonkers VA Clinic	Yonkers
29	2	528G4	Elmira VA Clinic	Elmira
30	2	528G5	Auburn VA Clinic	Auburn
31	2	528G9	Tompkins County VA Clinic	Tompkins County
32	2	528GB	Jamestown VA Clinic	Jamestown, New York
33	2	528GC	Dunkirk VA Clinic	Dunkirk
34	2	528GD	Niagara Falls VA Clinic	Niagara Falls
35	2	528GK	Lockport VA Clinic	Lockport
36	2	528GL	Potsdam VA Clinic	Potsdam
37	2	528GO	Watertown VA Clinic	Watertown, New York
38	2	528GP	Oswego VA Clinic	Oswego

FY 2024 Primary Community Based Outpatient Clinics

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
39	2	528GQ	West Seneca VA Clinic	West Seneca
40	2	528GT	Glens Falls VA Clinic	Glens Falls
41	2	528GV	Plattsburgh VA Clinic	Plattsburgh
42	2	528GZ	Kingston VA Clinic	Kingston
43	2	561GA	Hamilton VA Clinic	Hamilton, New Jersey
44	2	561GD	Hackensack VA Clinic	Hackensack
45	2	561GE	Jersey City VA Clinic	Jersey City
46	2	561GF	Piscataway VA Clinic	Piscataway
47	2	561GH	Morristown VA Clinic	Morristown, New Jersey
48	2	561GI	Tinton Falls VA Clinic	Tinton Falls
49	2	561GJ	Paterson VA Clinic	Paterson
50	2	620GB	Carmel VA Clinic	Carmel
51	2	620GD	Goshen VA Clinic	Goshen
52	2	620GE	Port Jervis VA Clinic	Port Jervis
53	2	620GG	Poughkeepsie VA Clinic	Poughkeepsie
54	2	632HA	Valley Stream VA Clinic	Valley Stream
55	2	632HC	Bay Shore VA Clinic	Bay Shore
56	4	460GA	Sussex County VA Clinic	Sussex County
57	4	460HE	Atlantic County VA Clinic	Atlantic County
58	4	529GA	Michael A. Marzano Department of Veterans Affairs Outpatient Clinic	Hermitage
59	4	529GB	Lawrence County VA Clinic	Lawrence County
60	4	529GC	Armstrong County VA Clinic	Armstrong County
61	4	529GF	Cranberry Township VA Clinic	Cranberry Township
62	4	542GA	Delaware County VA Clinic	Delaware County
63	4	542GE	West Norriton VA Clinic	West Norriton
64	4	562GB	Ashtabula County VA Clinic	Ashtabula County
65	4	595GD	Berks County VA Clinic	Berks County
66	4	595GF	Schuylkill County VA Clinic	Schuylkill County
67	4	642GF	Camden VA Clinic	Camden
68	4	642GH	West Philadelphia VA Clinic	West Philadelphia
69	4	693GA	Sayre VA Clinic	Sayre
70	4	693GB	Williamsport VA Clinic	Williamsport
71	5	512GE	Pocomoke City VA Clinic	Pocomoke City
72	5	512GF	Eastern Baltimore County VA Clinic	Eastern Baltimore County
73	5	517GB	Greenbrier County VA Clinic	Greenbrier County
74	5	517QA	Princeton VA Clinic	Princeton
75	5	540GB	Wood County VA Clinic	Wood County
76	5	581GA	Prestonsburg VA Clinic	Prestonsburg

FY 2024 Primary Community Based Outpatient Clinics

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
77	5	613GB	Hagerstown VA Clinic	Hagerstown
78	5	613GE	Petersburg VA Clinic	Petersburg
79	5	613GF	Harrisonburg VA Clinic	Harrisonburg
80	5	688GB	Southeast Washington VA Clinic	Southeast Washington
81	5	688GE	Southern Prince George's County VA Clinic	Southern Prince George's County
82	5	688GF	Montgomery County VA Clinic	Montgomery County
83	5	688GG	Lexington Park VA Clinic	Lexington Park
84	6	558GB	Raleigh VA Clinic	Raleigh, North Carolina
85	6	558GC	Morehead City VA Clinic	Morehead City
86	6	558GD	Durham County VA Clinic	Durham County
87	6	558GJ	Cherry Point VA Clinic	Cherry Point
88	6	565GD	Hamlet VA Clinic	Hamlet
89	6	565GG	Lee County VA Clinic	Lee County, North Carolina
90	6	565GH	Brunswick County VA Clinic	Brunswick County
91	6	590GB	Virginia Beach VA Clinic	Virginia Beach
92	6	590GC	Albemarle VA Clinic	Albemarle
93	6	590GE	Portsmouth VA Clinic	Portsmouth, Virginia
94	6	637GB	Master Sergeant Jerry K. Crump VA Clinic	Rutherford County Forest City
95	6	652GB	Fredericksburg 2 VA Clinic	Fredericksburg 2
96	6	652GF	Emporia VA Clinic	Emporia
97	6	658GA	Tazewell VA Clinic	Tazewell
98	6	658GB	Danville VA Clinic	Danville, Virginia
99	6	658GD	Staunton VA Clinic	Staunton
100	6	658GE	Wytheville VA Clinic	Wytheville
101	7	508GF	West Cobb County VA Clinic	West Cobb County
102	7	508GG	Stockbridge VA Clinic	Stockbridge
103	7	508GI	Newnan VA Clinic	Newnan
104	7	508GL	Rome VA Clinic	Rome, Georgia
105	7	508GM	Pickens County VA Clinic	Pickens County
106	7	508GN	Covington VA Clinic	Covington, Georgia
107	7	508QE	Gwinnett County VA Clinic	Gwinnett County
108	7	509GA	Athens VA Clinic	Athens, Georgia
109	7	509QA	Ray Hendrix Department Of Veterans Affairs Clinic	Statesboro
110	7	521GC	Florence VA Clinic	Florence, Alabama
111	7	521GD	Rainbow City VA Clinic	Rainbow City
112	7	521GF	Jasper VA Clinic	Jasper
113	7	521GG	Bessemer VA Clinic	Bessemer
114	7	521GH	Childersburg VA Clinic	Childersburg

FY 2024 Primary Community Based Outpatient Clinics

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
115	7	521GI	Guntersville VA Clinic	Guntersville
116	7	544GC	Rock Hill VA Clinic	Rock Hill
117	7	544GE	Orangeburg VA Clinic	Orangeburg
118	7	544GF	Sumter VA Clinic	Sumter
119	7	544GG	Spartanburg VA Clinic	Spartanburg
120	7	557GC	Milledgeville VA Clinic	Milledgeville
121	7	557GF	Tifton VA Clinic	Tifton
122	7	557HA	Perry VA Clinic	Perry, Georgia
123	7	619GE	Monroe County VA Clinic	Monroe County, Alabama
124	7	619GG	Columbus Downtown VA Clinic	Columbus Downtown
125	7	619QA	Dothan 2 VA Clinic	Dothan 2
126	7	679GA	Selma VA Clinic	Selma
127	8	516GB	St. Petersburg VA Clinic	St. Petersburg
128	8	546GB	Key West VA Clinic	Key West
129	8	546GD	Pembroke Pines VA Clinic	Pembroke Pines
130	8	546GF	Hollywood VA Clinic	Hollywood
131	8	546GH	Deerfield Beach VA Clinic	Deerfield Beach
132	8	548GA	Fort Pierce VA Clinic	Fort Pierce
133	8	548GC	Stuart VA Clinic	Stuart
134	8	548GD	Boca Raton VA Clinic	Boca Raton
135	8	548GE	Vero Beach VA Clinic	Vero Beach
136	8	573GA	Valdosta VA Clinic	Valdosta
137	8	573GJ	St. Marys VA Clinic	St. Marys
138	8	573GK	Marianna VA Clinic	Marianna
139	8	573GL	Palatka VA Clinic	Palatka
140	8	573GM	Waycross VA Clinic	Waycross
141	8	573GO	A.K. Baker VA Clinic	Middleburg
142	8	573QG	Jacksonville North VA Clinic	Jacksonville North
143	8	573QJ	Jacksonville 2 VA Clinic	Jacksonville 2
144	8	573QL	Gainesville VA Clinic	Gainesville-34th Street
145	8	672GC	Arecibo VA Clinic	Arecibo
146	8	672GD	Ceiba VA Clinic	Ceiba
147	8	672GE	Guayama VA Clinic	Guayama
148	8	673GH	Lecanto VA Clinic	Lecanto
149	8	675GC	Kissimmee VA Clinic	Kissimmee
150	8	675GD	Deltona VA Clinic	Deltona
151	8	675GF	Clermont VA Clinic	Clermont
152	9	596GB	Morehead VA Clinic	Morehead

FY 2024 Primary Community Based Outpatient Clinics

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
153	9	596GC	Hazard VA Clinic	Hazard
154	9	603GE	Newburg VA Clinic	Newburg
155	9	603GF	Grayson County VA Clinic	Grayson County
156	9	603GG	Scott County VA Clinic	Scott County
157	9	603GH	Carrollton VA Clinic	Carrollton, Kentucky
158	9	614GC	Holly Springs VA Clinic	Holly Springs
159	9	614GD	Savannah VA Clinic	Savannah, Tennessee
160	9	614GE	Covington VA Clinic	Covington, Tennessee
161	9	614GI	Dyersburg VA Clinic	Dyersburg
162	9	614GN	Helena VA Clinic	Helena, Arkansas
163	9	621GC	Norton VA Clinic	Norton
164	9	621GJ	Bristol VA Clinic	Bristol
165	9	621GK	Campbell County VA Clinic	Campbell County
166	9	626GA	Dover VA Clinic	Dover
167	9	626GC	Bowling Green VA Clinic	Bowling Green
168	9	626GH	Cookeville VA Clinic	Cookeville
169	9	626GJ	Hopkinsville VA Clinic	Hopkinsville
170	9	626GK	McMinnville VA Clinic	McMinnville
171	9	626GL	Roane County VA Clinic	Roane County
172	9	626GM	Columbia VA Clinic	Columbia
173	9	626GN	Athens VA Clinic	Athens, Tennessee
174	9	626GP	Gallatin VA Clinic	Gallatin
175	9	626GQ	Fort Campbell VA Clinic	Fort Campbell
176	10	506GB	Flint VA Clinic	Flint
177	10	506GC	Jackson VA Clinic	Jackson, Michigan
178	10	506GG	Findlay VA Clinic	Findlay
179	10	515GA	Muskegon VA Clinic	Muskegon
180	10	515GB	Lansing VA Clinic	Lansing
181	10	515GC	Benton Harbor VA Clinic	Benton Harbor
182	10	538GA	Athens VA Clinic	Athens, Ohio
183	10	538GB	Portsmouth VA Clinic	Portsmouth, Ohio
184	10	538GC	Marietta VA Clinic	Marietta
185	10	538GD	Lancaster VA Clinic	Lancaster
186	10	538GE	Cambridge VA Clinic	Cambridge, Ohio
187	10	539GA	Bellevue VA Clinic	Bellevue, Kentucky
188	10	541GC	Sandusky VA Clinic	Sandusky
189	10	541GH	East Liverpool VA Clinic	East Liverpool
190	10	541GI	Warren VA Clinic	Warren

FY 2024 Primary Community Based Outpatient Clinics

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
191	10	541GJ	New Philadelphia VA Clinic	New Philadelphia
192	10	541GK	Ravenna VA Clinic	Ravenna
193	10	541QB	Cleveland VA Clinic-Euclid	Cleveland Euclid Avenue
194	10	553GA	Yale VA Clinic	Yale
195	10	553GB	Pontiac VA Clinic	Pontiac
196	10	553GD	Downriver VA Clinic	Downriver
197	10	610GB	Muncie VA Clinic	Muncie
198	10	610GD	Hoosier VA Clinic	Hoosier
199	10	655GC	Oscoda VA Clinic	Oscoda
200	10	655GD	Lieutenant Colonel Clement C. Van Wagoner Department of Veterans Affairs Clinic	Alpena
201	10	655GE	Clare VA Clinic	Clare
202	10	655GF	Bad Axe VA Clinic	Bad Axe
203	10	655GG	Cadillac VA Clinic	Cadillac
204	10	655GH	Pfc. Justin T. Paton Department of Veterans Affairs Clinic	Indian River
205	10	655GI	Grayling VA Clinic	Grayling
206	10	757GA	Zanesville VA Clinic	Zanesville
207	10	757GC	Marion VA Clinic	Marion, Ohio
208	12	537GA	Chicago Heights VA Clinic	Chicago Heights
209	12	537GD	Lakeside VA Clinic	Chicago Lakeside
210	12	537HA	Auburn Gresham VA Clinic	Chicago Auburn Gresham
211	12	550GF	Mattoon VA Clinic	Mattoon
212	12	556GA	Evanston VA Clinic	Evanston, Illinois
213	12	556GC	McHenry VA Clinic	McHenry
214	12	556GD	Kenosha VA Clinic	Kenosha
215	12	578GG	Oak Lawn VA Clinic	Oak Lawn
216	12	585GA	Hancock VA Clinic	Hancock
217	12	585GB	Rhinelander VA Clinic	Rhinelander
218	12	585GC	Menominee VA Clinic	Menominee
219	12	585GD	Ironwood VA Clinic	Ironwood
220	12	585GF	Manistique VA Clinic	Manistique
221	12	585GG	Gladstone VA Clinic	Gladstone
222	12	585HA	Marquette VA Clinic	Marquette
223	12	585HB	Sault Saint Marie VA Clinic	Sault Saint Marie
224	12	695GA	Union Grove VA Clinic	Union Grove
225	12	695GC	Cleveland VA Clinic	Cleveland, Wisconsin
226	12	695GE	Oconomowoc VA Clinic	Oconomowoc
227	15	589G4	Hays VA Clinic	Hays
228	15	589G5	Parsons VA Clinic	Parsons

FY 2024 Primary Community Based Outpatient Clinics

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
229	15	589G7	Hutchinson VA Clinic	Hutchinson
230	15	589GB	Belton VA Clinic	Belton
231	15	589GC	Paola VA Clinic	Paola
232	15	589GE	Kirksville VA Clinic	Kirksville
233	15	589GI	St. Joseph VA Clinic	St. Joseph
234	15	589GJ	Captain Elwin Shopteese VA Clinic	Kansas City, Kansas
235	15	589GR	Lieutenant General Richard J. Seitz Community-Based Outpatient Clinic	Junction City
236	15	589GU	Lawrence VA Clinic	Lawrence
237	15	589GW	Salina VA Clinic	Salina
238	15	589GX	Mexico VA Clinic	Mexico
239	15	589GY	St. James VA Clinic	St. James, Missouri
240	15	589JB	Excelsior Springs VA Clinic	Excelsior Springs
241	15	589JE	Platte City VA Clinic	Platte City
242	15	589JH	Junction City VA Clinic	Junction City
243	15	589QH	Buttonwood Drive VA Clinic	Buttonwood Drive
244	15	657GA	St. Clair County VA Clinic	St. Clair County
245	15	657GB	St. Louis County VA Clinic	St. Louis County
246	15	657GD	St. Charles County VA Clinic	St. Charles County
247	15	657GF	West Plains VA Clinic	West Plains
248	15	657GG	Paragould VA Clinic	Paragould
249	15	657GI	Robert Silvey Department of Veterans Affairs Outpatient Clinic	Farmington, Missouri
250	15	657GK	Mount Vernon VA Clinic	Mount Vernon, Illinois
251	15	657GL	Paducah VA Clinic	Paducah
252	15	657GM	Effingham VA Clinic	Effingham
253	15	657GP	Owensboro VA Clinic	Owensboro
254	15	657GQ	Vincennes VA Clinic	Vincennes
255	15	657GR	Mayfield VA Clinic	Mayfield
256	15	657GS	Franklin County VA Clinic	Franklin County
257	15	657GT	Carbondale VA Clinic	Carbondale
258	15	657GU	Harrisburg VA Clinic	Harrisburg
259	15	657GV	Sikeston VA Clinic	Sikeston
260	15	657GW	Pocahontas VA Clinic	Pocahontas
261	15	657GX	Washington Avenue VA Clinic	Washington Avenue
262	15	657GY	Manchester Avenue VA Clinic	Manchester Avenue
263	15	657QD	Heartland Street VA Clinic	Heartland Street
264	16	502GA	Jennings VA Clinic	Jennings
265	16	502GF	Fort Johnson VA Clinic	Fort Johnson
266	16	502GG	Natchitoches VA Clinic	Natchitoches

FY 2024 Primary Community Based Outpatient Clinics

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
267	16	520GB	Panama City Beach VA Clinic	Panama City Beach, Florida
268	16	520QA	Panama City Beach West VA Clinic	Panama City Beach West
269	16	564GA	Harrison VA Clinic	Harrison
270	16	564GD	Ozark VA Clinic	Ozark
271	16	564GE	Jay VA Clinic	Jay
272	16	564GF	Joplin VA Clinic	Joplin
273	16	580GC	Galveston County VA Clinic	Galveston County
274	16	580GF	Lake Jackson VA Clinic	Lake Jackson
275	16	586GA	Kosciusko VA Clinic	Kosciusko
276	16	586GB	Meridian VA Clinic	Meridian
277	16	586GC	Greenville VA Clinic	Greenville, Mississippi
278	16	586GD	Hattiesburg VA Clinic	Hattiesburg
279	16	586GE	Natchez VA Clinic	Natchez
280	16	586GF	Columbus VA Clinic	Columbus, Mississippi
281	16	586GG	McComb VA Clinic	McComb
282	16	598GA	Mountain Home VA Clinic	Mountain Home, Arkansas
283	16	598GB	El Dorado VA Clinic	El Dorado
284	16	598GD	Mena VA Clinic	Mena
285	16	598GE	Pine Bluff VA Clinic	Pine Bluff
286	16	598GF	Searcy VA Clinic	Searcy
287	16	598GH	Russellville VA Clinic	Russellville
288	16	629GD	St. John VA Clinic	St. John
289	16	629GE	Franklin VA Clinic	Franklin, Louisiana
290	16	629GF	Bogalusa VA Clinic	Bogalusa
291	17	504BZ	Clovis VA Clinic	Clovis
292	17	549A5	Garland VA Medical Center	Garland
293	17	549GD	Denton VA Clinic	Denton
294	17	549GE	Decatur VA Clinic	Decatur, Texas
295	17	549GF	Granbury VA Clinic	Granbury
296	17	549GH	Greenville VA Clinic	Greenville, Texas
297	17	549GJ	Sherman VA Clinic	Sherman
298	17	549GL	Plano VA Clinic	Plano
299	17	549GM	Grand Prairie VA Clinic	Grand Prairie
300	17	671GB	Victoria VA Clinic	Victoria
301	17	671GF	South Bexar County VA Clinic	South Bexar County
302	17	671GK	San Antonio VA Clinic	San Antonio Fredericksburg Road
303	17	671GQ	Shavano Park VA Clinic	Shavano Park
304	17	671GV	North East Bexar VA Clinic	North East Bexar

FY 2024 Primary Community Based Outpatient Clinics

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
305	17	671GW	Southwest VA Clinic	Southwest San Antonio
306	17	674GA	Palestine VA Clinic	Palestine
307	17	674GB	Brownwood VA Clinic	Brownwood
308	17	674GC	Bryan VA Clinic	Bryan
309	17	674GD	Cedar Park VA Clinic	Cedar Park
310	17	674GF	Temple VA Clinic	Temple South General Bruce Drive
311	17	674GG	Copperas Cove VA Clinic	Copperas Cove
312	17	674GH	Killeen VA Clinic	Killeen
313	17	674HB	LaGrange VA Clinic	LaGrange
314	17	740GC	Corpus Christi VA Clinic	Corpus Christi
315	17	740GK	Brownsville VA Clinic	Brownsville
316	17	740QB	Corpus Christi West Point VA Clinic	Corpus Christi West Point
317	17	756GC	El Paso Westside VA Clinic	El Paso Westside
318	17	756GD	El Paso Northeast VA Clinic	El Paso Northeast
319	19	436GF	Kalispell VA Clinic	Kalispell
320	19	436GO	Butte VA Clinic	Butte
321	19	554GB	Aurora VA Clinic	Aurora, Colorado
322	19	554GG	La Junta VA Clinic	La Junta
323	19	554GK	Union Boulevard VA Clinic	Union Boulevard
324	19	554GM	Space Center VA Clinic	Space Center
325	19	623GA	McAlester VA Clinic	McAlester
326	19	623GB	Vinita VA Clinic	Vinita
327	19	623GC	McCurtain County VA Clinic	McCurtain County
328	19	635GD	Ada VA Clinic	Ada
329	19	635GE	Stillwater VA Clinic	Stillwater
330	19	635GF	Altus VA Clinic	Altus
331	19	635GG	Enid VA Clinic	Enid
332	19	635GI	Norman VA Clinic	Norman
333	19	635HB	Ardmore VA Clinic	Ardmore
334	19	660GE	Orem VA Clinic	Orem
335	19	660GG	St. George VA Clinic	St. George
336	19	660GJ	South Jordan VA Clinic	South Jordan
337	19	660QA	Idaho Falls VA Clinic	Idaho Falls
338	19	666GB	Casper VA Clinic	Casper
339	20	463GA	Fairbanks VA Clinic	Fairbanks
340	20	463GB	Soldotna VA Clinic	Soldotna
341	20	463GC	Mat-Su VA Clinic	Mat-Su
342	20	531GE	Twin Falls VA Clinic	Twin Falls

FY 2024 Primary Community Based Outpatient Clinics

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
343	20	531GI	Mountain Home VA Clinic	Mountain Home, Idaho
344	20	648GE	Fairview VA Clinic	Fairview
345	20	648GI	Portland VA Clinic	Portland 1st Avenue
346	20	653GA	North Bend VA Clinic	North Bend
347	20	653GB	Brookings VA Clinic	Brookings
348	20	663GH	Edmonds VA Clinic	Edmonds
349	20	663GI	Olympia VA Clinic	Olympia
350	20	663GK	Everett VA Clinic	Everett
351	20	687GA	Richland VA Clinic	Richland
352	20	687GB	Lewiston VA Clinic	Lewiston, Idaho
353	20	692GA	Klamath Falls VA Clinic	Klamath Falls
354	20	692GB	Grants Pass VA Clinic	Grants Pass
355	21	459GA	Maui VA Clinic	Maui
356	21	459GB	Hilo VA Clinic	Hilo
357	21	459GC	Kailua-Kona VA Clinic	Kailua-Kona
358	21	459GD	Lihue VA Clinic	Lihue
359	21	459GE	Guam VA Clinic	Guam
360	21	459GF	Faleomavaega Eni Fa'aua'a Hunkin VA Clinic	American Samoa
361	21	459GG	Daniel Kahikina Akaka VA Clinic	Kapolei Oahu
362	21	459QC	Windward VA Clinic	Windward
363	21	570GB	Visalia VA Clinic	Visalia
364	21	593GC	Pahrump VA Clinic	Pahrump
365	21	593GD	Northwest Las Vegas VA Clinic	Northwest Las Vegas
366	21	593GG	Northeast Las Vegas VA Clinic	Northeast Las Vegas
367	21	612GI	Yuba City VA Clinic	Yuba City
368	21	612GJ	Yreka VA Clinic	Yreka
369	21	612GM	Modesto VA Clinic	Modesto
370	21	640GA	Capitola VA Clinic	Capitola
371	21	640GC	Fremont VA Clinic	Fremont
372	21	654GE	Reno East VA Clinic	Reno East
373	21	654GF	North Reno VA Clinic	North Reno
374	21	654QB	Capitol Hill VA Clinic	Capitol Hill
375	21	662GF	San Francisco VA Clinic	San Francisco Downtown
376	22	501GA	Artesia VA Clinic	Artesia
377	22	501GB	Farmington VA Clinic	Farmington, New Mexico
378	22	600GD	Santa Fe Springs VA Clinic	Santa Fe Springs
379	22	600GE	Laguna Hills VA Clinic	Laguna Hills
380	22	600GF	Gardena VA Clinic	Gardena

FY 2024 Primary Community Based Outpatient Clinics

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
381	22	605GA	Victorville VA Clinic	Victorville
382	22	605GB	Murrieta VA Clinic	Murrieta
383	22	605GC	Sy Kaplan VA Clinic	Palm Desert
384	22	605GD	Corona VA Clinic	Corona
385	22	605GE	Rancho Cucamonga VA Clinic	Rancho Cucamonga
386	22	605GF	North Loma Linda VA Clinic	North Loma Linda
387	22	605GG	Hemet VA Clinic	Hemet
388	22	644GB	Show Low VA Clinic	Show Low
389	22	644GG	Northeast Phoenix VA Clinic	Northeast Phoenix
390	22	649GA	Kingman VA Clinic	Kingman
391	22	649GB	Flagstaff VA Clinic	Flagstaff
392	22	649GC	Lake Havasu City VA Clinic	Lake Havasu City
393	22	649GE	Cottonwood VA Clinic	Cottonwood
394	22	664GD	Escondido VA Clinic	Escondido
395	22	664GF	Sorrento Valley VA Clinic	Sorrento Valley
396	22	678GE	Green Valley VA Clinic	Green Valley
397	22	678GF	Northwest Tucson VA Clinic	Northwest Tucson
398	22	691GB	Santa Barbara VA Clinic	Santa Barbara
399	22	691GF	East Los Angeles VA Clinic	East Los Angeles
400	22	691GK	San Luis Obispo VA Clinic	San Luis Obispo
401	22	691GP	San Gabriel Valley VA Clinic	San Gabriel Valley

FY 2024 Primary Community Based Outpatient Clinics

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
402	23	437GB	Bismarck VA Clinic	Bismarck
403	23	437GC	Fergus Falls VA Clinic	Fergus Falls
404	23	437GD	Minot VA Clinic	Minot
405	23	437GE	Bemidji VA Clinic	Bemidji
406	23	437GI	Grand Forks VA Clinic	Grand Forks
407	23	437GK	Jamestown VA Clinic	Jamestown, North Dakota
408	23	437QA	North Fargo VA Clinic	North Fargo
409	23	438GA	Spirit Lake VA Clinic	Spirit Lake
410	23	438GC	Sioux City VA Clinic	Sioux City
411	23	438GF	Watertown VA Clinic	Watertown, South Dakota
412	23	568HH	Scottsbluff VA Clinic	Scottsbluff
413	23	618GB	Hibbing VA Clinic	Hibbing
414	23	618GE	Chippewa Valley VA Clinic	Chippewa Valley
415	23	618GJ	Shakopee VA Clinic	Shakopee
416	23	618GK	Albert Lea VA Clinic	Albert Lea
417	23	618GM	Rice Lake VA Clinic	Rice Lake
418	23	618GN	Lyle C. Pearson Community Based Outpatient Clinic	Mankato
419	23	636GI	Lane A. Evans VA Community Based Outpatient Clinic	Galesburg
420	23	636GM	Carroll VA Clinic	Carroll
421	23	636GW	Coralville VA Clinic	Coralville
422	23	636GY	Burlington VA Clinic	Burlington
423	23	656GB	Montevideo VA Clinic	Montevideo
424	23	656GC	Max J. Beilke Department of Veterans Affairs Outpatient Clinic	Alexandria, Minnesota

FY 2024 Other Outpatient Services Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
1	1	402GB	Calais VA Clinic	Calais
2	1	402GC	Rumford VA Clinic	Rumford
3	1	402GF	Lincoln VA Clinic	Lincoln, Maine
4	1	402QA	Fort Kent VA Clinic	Fort Kent
5	1	402QB	Houlton VA Clinic	Houlton
6	1	523GC	Quincy VA Clinic	Quincy, Massachusetts
7	1	523QB	Bedford VA Clinic	Bedford, Massachusetts
8	1	608GD	Conway VA Clinic	Conway, New Hampshire
9	1	631QA	Plantation Street VA Clinic	Plantation Street
10	1	650QA	Eagle Square VA Clinic	Eagle Square
11	1	650QB	Eagle Street VA Clinic	Eagle Street
12	1	689BW	Maple Street VA Domiciliary	Maple Street Domiciliary
13	1	689BX	Norton Street VA Domiciliary	Norton Street Domiciliary
14	1	689GF	Orange VA Clinic	Orange
15	1	689QB	West Haven VA Mobile Clinic	West Haven Mobile
16	2	526GD	Thomas P. Noonan Jr. Department of Veterans Affairs Outpatient Clinic	Sunnyside
17	2	526QA	Bronx VA Mobile Clinic	Bronx Mobile
18	2	528G2	Westport VA Clinic	Westport
19	2	528G3	Oneonta VA Clinic	Oneonta
20	2	528G6	Fonda VA Clinic	Fonda
21	2	528G7	Catskill VA Clinic	Catskill
22	2	528G8	Wellsville VA Clinic	Wellsville
23	2	528GE	Rochester Clinton Crossings VA Clinic	Rochester Clinton Crossings
24	2	528GW	Schenectady VA Clinic	Schenectady
25	2	528GY	Clifton Park VA Clinic	Clifton Park
26	2	528QA	Buffalo VA Clinic	Buffalo Main Street
27	2	528QB	Packard VA Clinic	Packard
28	2	528QF	Wellsboro VA Clinic	Wellsboro
29	2	528QG	Erie West VA Clinic	Erie West
30	2	528QH	South Salina VA Clinic	South Salina
31	2	528QI	Erie East VA Clinic	Erie East
32	2	528QK	Saranac Lake VA Clinic	Saranac Lake
33	2	528QN	Watertown 2 VA Clinic	Watertown 2
34	2	561GK	Sussex VA Clinic	Sussex
35	2	620GF	Monticello VA Clinic	Monticello
36	2	620GH	Eastern Dutchess VA Clinic	Eastern Dutchess
37	2	630GA	Harlem VA Clinic	Harlem

FY 2024 Other Outpatient Services Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
38	2	630QA	New York Harbor 1 VA Mobile Clinic	New York Harbor 1 Mobile
39	2	630QB	New York Harbor 2 VA Mobile Clinic	New York Harbor 2 Mobile
40	2	632QA	Northport 1 VA Mobile Clinic	Northport 1 Mobile
41	2	632QB	Northport 2 VA Mobile Clinic	Northport 2 Mobile
42	4	460HK	Wilmington VA Mobile Clinic	Wilmington Mobile
43	4	529GD	Clarion County VA Clinic	Clarion County
44	4	562GC	McKean County VA Clinic	McKean County
45	4	562GE	Warren County VA Clinic	Warren County
46	4	642QA	Chestnut Street VA Clinic	Chestnut Street
47	4	642QB	Fourth Street VA Clinic	Fourth Street
48	4	646GF	Monroeville VA Clinic	Monroeville
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	4	693QB	Cedar Crest Boulevard VA Clinic	Cedar Crest Boulevard
54	5	512QA	Baltimore VA Clinic	Baltimore West Fayette Street
55	5	517HK	Beckley VA Mobile Clinic	Beckley Mobile
56	5	540GA	Tucker County VA Clinic	Tucker County
57	5	540GC	Braxton County VA Clinic	Braxton County
58	5	581GG	Gallipolis VA Clinic	Gallipolis
59	5	581GH	Lenore VA Clinic	Lenore
60	5	581QA	Huntington Ninth Street VA Clinic	Huntington Ninth Street
61	5	581QB	Huntington VA Mobile Clinic	Huntington Mobile
62	5	613GD	Franklin VA Clinic	Franklin, West Virginia
63	5	688QA	Franklin Street VA Clinic	Franklin Street
64	6	558GE	Hillandale Road VA Clinic	Hillandale Road
65	6	558GF	Wake County VA Clinic	Wake County
66	6	558GI	Croasdaile VA Clinic	Croasdaile
67	6	558QA	Brier Creek VA Clinic	Brier Creek
68	6	565GJ	Jacksonville 2 VA Clinic	Jacksonville 2 North Carolina
69	6	565GM	Jacksonville 3 VA Clinic	Jacksonville 3
70	6	565GN	Jacksonville 4 VA Clinic	Jacksonville 4
71	6	565GO	Johnson Air Force Base VA Clinic	Johnson Air Force Base
72	6	565QA	Robeson Street VA Clinic	Robeson Street
73	6	565QB	Fayetteville VA Mobile Clinic	Fayetteville Mobile
74	6	565QD	Raeford Road VA Clinic	Raeford Road

FY 2024 Other Outpatient Services Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
75	6	565QE	Womack VA Clinic	Womack
76	6	590QC	Hampton 1 VA Mobile Clinic	Hampton 1 Mobile
77	6	652GA	Fredericksburg VA Clinic	Fredericksburg
78	6	652GG	Richmond 1 VA Mobile Clinic	Richmond 1 Mobile
79	6	652GH	Richmond 2 VA Mobile Clinic	Richmond 2 Mobile
80	6	658QA	Salem VA Mobile Clinic	Salem Mobile
81	7	508GO	Northeast Cobb County VA Clinic	Northeast Cobb County
82	7	508GP	South Cobb County VA Clinic	South Cobb County
83	7	508QC	Henderson Mill VA Clinic	Henderson Mill
84	7	508QH	South Fulton County VA Clinic	South Fulton County
85	7	508QI	North DeKalb County VA Clinic	North DeKalb County
86	7	508QK	Atlanta VA Mobile Clinic	Atlanta Mobile
87	7	521QB	Birmingham East VA Clinic	Birmingham East
88	7	521QC	Birmingham VA Mobile Clinic	Birmingham Mobile
89	7	534QB	Trident VA Clinic	Trident
90	7	534QC	Charleston VA Clinic	North Charleston City Hall Lane
91	7	534QD	Charleston VA Mobile Clinic	Charleston Mobile
92	7	534QE	Goose Creek Crowfield VA Clinic	Goose Creek Crowfield
93	7	544HK	Columbia VA Mobile Clinic	Columbia Mobile
94	7	557GG	Robins VA Clinic	Robins
95	7	619QC	Montgomery VA Mobile Clinic	Montgomery Mobile
96	8	516QA	Bay Pines VA Mobile Clinic	Bay Pines Mobile
97	8	546GA	Miami Flagler VA Clinic	Miami Flagler
98	8	546GE	Key Largo VA Clinic	Key Largo
99	8	548GF	Okeechobee VA Clinic	Okeechobee
100	8	548QA	Port Saint Lucie VA Clinic	Port Saint Lucie
101	8	573GN	Perry VA Clinic	Perry, Florida
102	8	573QB	Gainesville Ninety-Eighth Street VA Clinic	Gainesville Ninety-Eighth Street
103	8	573QC	Gainesville Sixty-Fourth Street 1 VA Clinic	Gainesville Sixty-Fourth Street 1
104	8	573QD	Gainesville Sixty-Fourth Street 2 VA Clinic	Gainesville Sixty-Fourth Street 2
105	8	573QE	Gainesville Sixty-Fourth Street 3 VA Clinic	Gainesville Sixty-Fourth Street 3
106	8	573QF	Gainesville 1 VA Clinic	Gainesville 1
107	8	573QH	Ocala West VA Clinic	Ocala West
108	8	573QK	Lake City VA Clinic	Lake City-Commerce Drive
109	8	672GA	Saint Croix VA Clinic	Saint Croix
110	8	672GB	Saint Thomas VA Clinic	Saint Thomas
111	8	672QA	Comerio VA Clinic	Comerio

FY 2024 Other Outpatient Services Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
112	8	672QB	Utuado VA Clinic	Utuado
113	8	672QC	Vieques VA Clinic	Vieques
114	8	672QD	San Juan 1 VA Mobile Clinic	San Juan 1 Mobile
115	8	672QE	San Juan 2 VA Mobile Clinic	San Juan 2 Mobile
116	8	672QF	Saint Thomas VA Mobile Clinic	Saint Thomas Mobile
117	8	672QG	Saint Croix VA Mobile Clinic	Saint Croix Mobile
118	8	673QA	Forty-Sixth Street North VA Clinic	Forty-Sixth Street North
119	8	673QB	Forty-Sixth Street South VA Clinic	Forty-Sixth Street South
120	8	673QH	Bruce B. Downs Boulevard VA Clinic	Bruce B. Downs Boulevard
121	8	673QK	Tampa 1 VA Mobile Clinic	Tampa 1 Mobile
122	8	673QL	Tampa 2 VA Mobile Clinic	Tampa 2 Mobile
123	8	673QM	Temple Terrace VA Clinic	Temple Terrace
124	8	673QN	Sabal Park VA Clinic	Sabal Park
125	8	673QO	Tampa Forty-Second Street VA Clinic	Tampa Forty-Second Street
126	8	675QB	Port Orange VA Clinic	Port Orange
127	8	675QC	Westside Pavilion VA Clinic	Westside Pavilion
128	8	675QE	Orlando 1 VA Mobile Clinic	Orlando 1 Mobile
129	8	675QG	Palm Bay VA Clinic	Palm Bay
130	8	675QH	Orlando 2 VA Mobile Clinic	Orlando 2 Mobile
131	8	675QI	Orlando 3 VA Mobile Clinic	Orlando 3 Mobile
132	9	596QB	Lexington VA Mobile Clinic	Lexington Mobile
133	9	614QA	Phelan Avenue VA Clinic	Phelan Avenue
134	9	621GA	Rogersville VA Clinic	Rogersville
135	9	621GG	Morristown VA Clinic	Morristown, Tennessee
136	9	621GO	Mountain City VA Clinic	Mountain City
137	9	621GP	Morristown East VA Clinic	Morristown East
138	9	621QA	Jonesville VA Clinic	Jonesville
139	9	621QC	Vansant VA Clinic	Vansant
140	9	621QD	Knox County VA Clinic	Knox County
141	9	621QE	Downtown West VA Clinic	Downtown West
142	9	621QF	Johnson City VA Clinic	Johnson City
143	9	621QG	Knox West VA Clinic	Knox West
144	9	621QH	Kingston Pike VA Clinic	Kingston Pike
145	9	621QI	Mountain Home 1 VA Mobile Clinic	Mountain Home 1 Mobile
146	9	626GG	Tullahoma VA Clinic	Tullahoma
147	9	626QA	Albion Street VA Clinic	Albion Street
148	9	626QC	Pointe Centre VA Clinic	Pointe Centre

FY 2024 Other Outpatient Services Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
149	9	626QD	Glenis Drive VA Clinic	Glenis Drive
150	9	626QE	Glenis Drive 2 VA Clinic	Glenis Drive 2
151	9	626QF	Dalton Drive VA Clinic	Dalton Drive
152	9	626QG	Taylor VA Clinic	Taylor
153	10	506GE	Howell VA Clinic	Howell
154	10	506GF	Adrian VA Clinic	Adrian
155	10	506QA	Packard Road VA Clinic	Ann Arbor Packard Road
156	10	506QB	Green Road VA Clinic	Green Road
157	10	515QB	Century Avenue VA Clinic	Century Avenue
158	10	538GF	Wilmington VA Clinic	Wilmington, Ohio
159	10	538QA	Chillicothe VA Mobile Clinic	Chillicothe Mobile
160	10	539QB	Highland Avenue VA Clinic	Highland Avenue
161	10	539QC	Vine Street VA Clinic	Vine Street
162	10	539QD	Norwood VA Clinic	Norwood
163	10	539QE	Cincinnati 1 VA Mobile Clinic	Cincinnati 1 Mobile
164	10	541GM	Cleveland VA Clinic-Superior	Cleveland Superior Avenue
165	10	541QA	Summit County VA Clinic	Summit County
166	10	541QC	Cleveland 1 VA Mobile Clinic	Cleveland 1 Mobile
167	10	541QE	Cleveland East Boulevard 3 VA Mobile Clinic	Cleveland East Boulevard 3 Mobile
168	10	541QF	Cuyahoga County 4 VA Mobile Clinic	Cuyahoga County 4 Mobile
169	10	541QH	Cleveland 3 VA Mobile Clinic	Cleveland 3 Mobile
170	10	541QI	Akron West VA Clinic	Akron West
171	10	552GF	Wright-Patterson VA Clinic	Wright-Patterson
172	10	553QA	Piquette Street VA Clinic	Piquette Street
173	10	583QA	Monroe County VA Clinic	Monroe County, Indiana
174	10	583QB	Indianapolis VA Clinic	Indianapolis Meridian Street
175	10	583QD	Indianapolis YMCA VA Clinic	Indianapolis YMCA
176	10	583QE	Cold Spring Road VA Clinic	Cold Spring Road
177	10	610GE	Defiance VA Clinic	Defiance
178	10	610GF	Huntington VA Clinic	Huntington
179	10	610QA	Fort Wayne VA Clinic	Fort Wayne East State Boulevard
180	10	655QA	Saginaw VA Clinic	Saginaw Barnard Road
181	10	655QC	Saginaw North VA Clinic	Saginaw North
182	10	757QA	Columbus 1 VA Mobile Clinic	Columbus 1 Mobile
183	10	757QB	North James Road 2 VA Mobile Clinic	North James Road 2 Mobile
184	10	757QC	Columbus VA Clinic	Columbus Airport Drive
185	12	537QA	Chicago VA Clinic	Chicago South California Avenue

FY 2024 Other Outpatient Services Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
186	12	537QB	Chicago VA Mobile Clinic	Chicago Mobile
187	12	607GC	Janesville VA Clinic	Janesville
188	12	607GD	Baraboo VA Clinic	Baraboo
189	12	607GE	Beaver Dam VA Clinic	Beaver Dam
190	12	607GF	Freeport VA Clinic	Freeport
191	12	676GE	Clark County VA Clinic	Clark County
192	12	695QA	Milwaukee VA Clinic	Milwaukee MLK Drive
193	15	589G2	Dodge City VA Clinic	Dodge City
194	15	589GD	Nevada VA Clinic	Nevada
195	15	589GV	Iola VA Clinic	Iola
196	15	589GZ	Cameron VA Clinic	Cameron
197	15	589HK	Kansas City VA Mobile Clinic	Kansas City Mobile
198	15	589JC	Shawnee VA Clinic	Shawnee, Kansas
199	15	589QA	Overland Park VA Clinic	Overland Park
200	15	589QB	Sedgwick County VA Clinic	Sedgwick County
201	15	589QD	Wichita VA Mobile Clinic	Wichita Mobile
202	15	589QE	Wichita 1 VA Mobile Clinic	Wichita 1 Mobile
203	15	589QF	Wichita 2 VA Mobile Clinic	Wichita 2 Mobile
204	15	589QG	Wichita 3 VA Mobile Clinic	Wichita 3 Mobile
205	15	657GO	Madisonville VA Clinic	Madisonville
206	15	657QA	Olive Street VA Clinic	Olive Street
207	15	657QB	Jefferson Avenue VA Clinic	Jefferson Avenue
208	15	657QE	Scott Air Force Base VA Clinic	Scott Air Force Base
209	15	657QF	Jefferson Barracks VA Mobile Clinic	Jefferson Barracks Mobile
210	16	502QB	Lafayette Campus B VA Clinic	Lafayette Campus B
211	16	502QC	Alexandria VA Mobile Clinic	Alexandria Mobile
212	16	502QD	Alexandria 2 VA Mobile Clinic	Alexandria 2 Mobile
213	16	520QB	Gulf Coast West VA Mobile Medical Unit-Clinic	Gulf Coast West MMU
214	16	520QC	Naval Hospital Pensacola VA Clinic	Naval Hospital Pensacola
215	16	564QA	Township VA Clinic	Township
216	16	564QB	Sunbridge VA Clinic	Sunbridge
217	16	564QC	North College Avenue VA Mobile Clinic	North College Avenue Mobile
218	16	580GK	Kingwood VA Clinic	Kingwood
219	16	580GL	Sugar Land VA Clinic	Sugar Land
220	16	580QC	Houston 2 VA Mobile Clinic	Houston 2 Mobile
221	16	580QD	Houston 3 VA Mobile Clinic	Houston 3 Mobile
222	16	580QE	Houston Webster VA Clinic	Houston Webster

FY 2024 Other Outpatient Services Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
223	16	580QF	Houston 4 VA Mobile Clinic	Houston 4 Mobile
224	16	586QA	Jackson VA Mobile Clinic	Jackson Mobile
225	16	586QB	Dogwood View Parkway VA Clinic	Dogwood View Parkway
226	16	586QD	Jackson 2 VA Mobile Clinic	Jackson 2 Mobile
227	16	598QA	Little Rock VA Clinic	Little Rock Main Street
228	16	598QB	Little Rock VA Mobile Clinic	Little Rock Mobile
229	16	598QC	Little Rock 2 VA Mobile Clinic	Little Rock 2 Mobile
230	16	598QD	Little Rock 3 VA Mobile Clinic	Little Rock 3 Mobile
231	16	629QA	Baton Rouge South VA Clinic	Baton Rouge South
232	16	629QB	New Orleans South VA Mobile Clinic	New Orleans South Mobile
233	16	629QC	New Orleans VA Mobile Clinic	New Orleans Mobile
234	16	667QA	Knight Street VA Clinic	Knight Street
235	16	667QB	Shreveport 1 VA Mobile Clinic	Shreveport 1 Mobile
236	16	667QC	Shreveport 2 VA Mobile Clinic	Shreveport 2 Mobile
237	17	504GA	Childress VA Clinic	Childress
238	17	504HB	Dalhart VA Clinic	Dalhart
239	17	504QA	Amarillo VA Mobile Clinic	Amarillo Mobile
240	17	519GB	Hobbs VA Clinic	Hobbs
241	17	519GD	Fort Stockton VA Clinic	Fort Stockton
242	17	519QA	Big Spring VA Mobile Clinic	Big Spring Mobile
243	17	519QB	Big Spring 2 VA Mobile Clinic	Big Spring 2 Mobile
244	17	519QC	Big Spring 3 VA Mobile Clinic	Big Spring 3 Mobile
245	17	549GK	Polk Street VA Clinic	Polk Street
246	17	549HK	North Texas VA Mobile Clinic	North Texas Mobile
247	17	549QA	Dallas VA Clinic	Dallas South Lancaster Road
248	17	549QB	Fort Worth New York VA Clinic	Fort Worth New York
249	17	549QC	Tyler Broadway VA Clinic	Tyler Broadway
250	17	671GL	New Braunfels VA Clinic	New Braunfels
251	17	671GT	Walzem VA Clinic	Walzem
252	17	671GU	San Antonio Pecan Valley VA Clinic	San Antonio Pecan Valley
253	17	671QB	Data Point VA Clinic	Data Point
254	17	671QC	Christus Santa Rosa VA Clinic	Christus Santa Rosa San Antonio
255	17	671QD	San Antonio Randolph VA Clinic	San Antonio Randolph
256	17	674QA	Temple VA Mobile Clinic	Temple Mobile
257	17	674QB	Austin VA Mobile Clinic	Austin Mobile
258	17	740QA	McAllen VA Mobile Clinic	McAllen Mobile
259	17	740QC	Corpus Christi VA Mobile Clinic	Corpus Christi Mobile

FY 2024 Other Outpatient Services Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
260	17	756QA	El Paso South Central VA Clinic	El Paso South Central
261	17	756QB	El Paso Central VA Clinic	El Paso Central
262	19	436GI	Glasgow VA Clinic	Glasgow
263	19	436GK	Glendive VA Clinic	Glendive
264	19	436GL	Cut Bank VA Clinic	Cut Bank
265	19	436GM	Lewistown VA Clinic	Lewistown
266	19	436GN	Dr. Joseph Medicine Crow VA Clinic	Billings Spring Creek Lane
267	19	436HC	Merril Lundman Department of Veterans Affairs Outpatient Clinic	Havre
268	19	436QA	Hamilton VA Clinic	Hamilton, Montana
269	19	436QB	Plentywood VA Clinic	Plentywood
270	19	436QC	Helena VA Clinic	Helena, Montana
271	19	436QD	Browning VA Clinic	Browning
272	19	436QE	Miles City VA Clinic	MIles City
273	19	436QF	Montana VA Mobile Clinic	Montana Mobile
274	19	442GB	Sidney VA Clinic	Sidney
275	19	442GC	Fort Collins VA Clinic	Fort Collins
276	19	442HK	Wheatland VA Mobile Clinic	Wheatland Mobile
277	19	442QA	Rawlins VA Clinic	Rawlins
278	19	442QB	Torrington VA Mobile Clinic	Torrington Mobile
279	19	442QD	Laramie VA Mobile Clinic	Laramie Mobile
280	19	442QG	Sterling VA Clinic	Sterling, Colorado
281	19	554GF	Alamosa VA Clinic	Alamosa
282	19	554GH	Lamar VA Clinic	Lamar
283	19	554GI	Burlington VA Clinic	Burlington, Colorado
284	19	554QA	York Street VA Clinic	York Street
285	19	554QB	Jewell VA Clinic	Jewell
286	19	554QC	Salida VA Clinic	Salida
287	19	554QD	Evans VA Clinic	Evans
288	19	554QE	Academy VA Clinic	Academy
289	19	554QF	Garden of the Gods VA Clinic	Garden of the Gods
290	19	575GA	Montrose VA Clinic	Montrose, Colorado
291	19	575GB	Major William Edward Adams Department of Veterans Affairs Clinic	Craig
292	19	575QA	Glenwood Springs VA Clinic	Glenwood Springs
293	19	575QB	Moab VA Clinic	Moab
294	19	575QC	Grand Junction VA Mobile Clinic	Grand Junction Mobile
295	19	575QD	Grand Junction 28 Road VA Clinic	Grand Junction 28 Road
296	19	575QE	Western Colorado VA Mobile Clinic	Western Colorado Mobile

FY 2024 Other Outpatient Services Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
297	19	623GD	Claremore VA Clinic	Claremore
298	19	623QA	Muskogee East VA Clinic	Muskogee East
299	19	623QB	Tulsa Eleventh Street VA Clinic	Tulsa Eleventh Street
300	19	623QC	Yale Avenue VA Clinic	Yale Avenue
301	19	623QD	Bartlesville VA Clinic	Bartlesville
302	19	635GC	Blackwell VA Clinic	Blackwell
303	19	635GH	Clinton VA Clinic	Clinton
304	19	635GK	Shawnee VA Clinic	Shawnee, Oklahoma
305	19	635QA	North May VA Clinic	North May
306	19	635QC	Fourteenth Street VA Clinic	Fourteenth Street
307	19	635QD	Lawton North VA Clinic	Lawton North
308	19	635QE	Tinker VA Clinic	Tinker
309	19	635QF	Oklahoma City VA Mobile Clinic	Oklahoma City Mobile
310	19	660GD	Roosevelt VA Clinic	Roosevelt
311	19	660GK	Elko VA Clinic	Elko
312	19	660QB	Price VA Clinic	Price
313	19	660QD	Cache Valley VA Clinic	Cache Valley
314	19	660QE	Salt Lake City VA Mobile Clinic	Salt Lake City Mobile
315	19	666GC	Riverton VA Clinic	Riverton
316	19	666GD	Cody VA Clinic	Cody
317	19	666GE	Gillette VA Clinic	Gillette
318	19	666GF	Rock Springs VA Clinic	Rock Springs
319	19	666QA	Afton VA Clinic	Afton
320	19	666QB	Evanston VA Clinic	Evanston, Wyoming
321	19	666QC	Worland VA Clinic	Worland
322	20	463GD	Homer VA Clinic	Homer
323	20	463GE	Juneau VA Clinic	Juneau
324	20	531GH	Eastern Oregon VA Clinic	Eastern Oregon
325	20	531GJ	Salmon VA Clinic	Salmon
326	20	648GD	North Coast VA Clinic	North Coast
327	20	648GH	Newport VA Clinic	Newport, Oregon
328	20	648GJ	Loren R. Kaufman VA Clinic	The Dalles
329	20	648GK	Lincoln City VA Clinic	Lincoln City
330	20	653QA	Downtown Eugene VA Clinic	Downtown Eugene
331	20	663GE	North Olympic Peninsula VA Clinic	North Olympic Peninsula
332	20	663GJ	Puyallup VA Clinic	Puyallup
333	20	663HK	Puget Sound VA Mobile Clinic	Puget Sound Mobile

FY 2024 Other Outpatient Services Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
334	20	663QA	Renton VA Clinic	Renton
335	20	663QB	South Lucile Street VA Clinic	South Lucile Street
336	20	663QC	Seattle VA Mobile Clinic	Seattle Mobile
337	20	663QD	American Lake VA Mobile Clinic	American Lake Mobile
338	20	668GC	East Front Avenue VA Clinic	East Front Avenue
339	20	668HK	Spokane VA Mobile Clinic	Spokane Mobile
340	20	668QB	Libby VA Clinic	Libby
341	20	668QD	Bonner County VA Clinic	Bonner County Kootenai
342	20	668QE	Spokane VA Clinic	Spokane 2nd Avenue
343	20	687GC	La Grande VA Clinic	La Grande
344	20	687HA	Yakima Valley VA Clinic	Yakima
345	20	687QB	Morrow County VA Clinic	Morrow County
346	20	687QC	Wallowa County VA Clinic	Wallowa County
347	21	358	Manila VA Clinic	Manila
348	21	459GH	Saipan VA Clinic	Saipan
349	21	459QA	Lanai VA Clinic	Lanai
350	21	459QB	Molokai VA Clinic	Molokai
351	21	570GC	Oakhurst VA Clinic	Oakhurst
352	21	593GH	Master Chief Petty Officer Jesse Dean VA Clinic	Laughlin
353	21	593QC	West Cheyenne VA Clinic	West Cheyenne
354	21	593QD	Southern Nevada VA Mobile Clinic	Southern Nevada Mobile
355	21	612GL	Sonora VA Clinic	Sonora
356	21	612QC	Cypress Avenue VA Clinic	Cypress Avenue
357	21	640QB	Palo Alto 2 VA Mobile Clinic	Palo Alto 2 Mobile
358	21	654GB	Carson Valley VA Clinic	Carson Valley
359	21	654GC	Lahontan Valley VA Clinic	Lahontan Valley
360	21	654GD	Diamond View VA Clinic	Diamond View
361	21	654QA	Kietzke VA Clinic	Kietzke
362	21	654QC	Winnemucca VA Clinic	Winnemucca
363	21	654QD	Virginia Street VA Clinic	Virginia Street
364	21	654QE	Reno VA Mobile Clinic	Reno Mobile
365	21	662QA	Twenty-First Street VA Clinic	Twenty-First Street
366	21	662QB	North Santa Rosa VA Clinic	North Santa Rosa
367	21	662QC	San Francisco VA Mobile Clinic	San Francisco Mobile
368	22	501G2	Las Vegas VA Clinic	Las Vegas
369	22	501GC	Silver City VA Clinic	Silver City
370	22	501GD	Hiroshi "Hershey" Miyamura VA Clinic	Gallup

FY 2024 Other Outpatient Services Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
371	22	501GE	Espanola VA Clinic	Espanola
372	22	501GH	Truth or Consequences VA Clinic	Truth or Consequences
373	22	501GI	Alamogordo VA Clinic	Alamogordo
374	22	501GJ	Durango VA Clinic	Durango
375	22	501GN	Taos VA Clinic	Taos
376	22	501HB	Raton VA Clinic	Raton
377	22	600GC	Cabrillo VA Clinic	Cabrillo
378	22	600QA	West Santa Ana VA Clinic	West Santa Ana
379	22	605QA	Blythe VA Clinic	Blythe
380	22	644GD	Payson VA Clinic	Payson
381	22	644GE	Thunderbird VA Clinic	Thunderbird
382	22	644GF	Globe VA Clinic	Globe
383	22	644GH	Phoenix Midtown VA Clinic	Phoenix Midtown
384	22	644GJ	Mesa VA Clinic	Mesa
385	22	644QA	Phoenix VA Clinic	Phoenix East Thomas Road
386	22	644QB	Phoenix VA Mobile Clinic	Phoenix Mobile
387	22	649GD	Anthem VA Clinic	Anthem
388	22	649QA	Chinle VA Clinic	Chinle
389	22	649QB	Holbrook VA Clinic	Holbrook
390	22	649QD	Page VA Clinic	Page
391	22	649QF	Tuba City VA Clinic	Tuba City
392	22	649QG	Polacca VA Clinic	Polacca
393	22	649QH	Kayenta VA Clinic	Kayenta
394	22	664GA	Imperial Valley VA Clinic	Imperial Valley
395	22	664QA	Rio VA Clinic	Rio
396	22	664QB	San Diego VA Mobile Clinic	San Diego Mobile
397	22	678GD	Safford VA Clinic	Safford
398	22	678QA	Cochise County VA Clinic	Cochise County
399	22	678QB	Pinal County VA Clinic	Pinal County
400	22	678QC	Tucson VA Mobile Clinic	Tucson Mobile
401	22	691QA	Greater Los Angeles VA Mobile Clinic	Greater Los Angeles Mobile

FY 2024 Other Outpatient Services Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
402	23	437GA	Grafton VA Clinic	Grafton
403	23	437GF	Williston VA Clinic	Williston
404	23	437GJ	Dickinson VA Clinic	Dickinson
405	23	437GL	Devils Lake VA Clinic	Devils Lake
406	23	438GE	Wagner VA Clinic	Wagner
407	23	568GB	Pierre VA Clinic	Pierre
408	23	568HA	Newcastle VA Clinic	Newcastle
409	23	568HB	Gordon VA Clinic	Gordon
410	23	568HF	Pine Ridge VA Clinic	Pine Ridge
411	23	568HK	Cheyenne River VA Clinic	Cheyenne River
412	23	568HP	Winner VA Clinic	Winner
413	23	568QA	Fort Yates VA Clinic	Fort Yates
414	23	618GA	St. James VA Clinic	St. James, Minnesota
415	23	618GH	Hayward VA Clinic	Hayward
416	23	618GL	Minneapolis VA Clinic	Minneapolis Harmon Place
417	23	618QA	Fort Snelling VA Clinic	Fort Snelling
418	23	618QB	Ely VA Clinic	Ely
419	23	618QC	Richfield VA Clinic	Richfield
420	23	618QD	Minneapolis VA Mobile Clinic	Minneapolis Mobile
421	23	6369BA	Papillion VA Community Living Center	Papillion CLC
422	23	636GB	North Platte VA Clinic	North Platte
423	23	636GL	Sarpy County VA Clinic	Sarpy County
424	23	636GQ	Holdrege VA Clinic	Holdrege
425	23	636QA	Omaha VA Clinic	Omaha Dorcas Street
426	23	636QB	Des Moines VA Clinic	Des Moines Center Street
427	23	636QC	Linn County VA Clinic	Linn County
428	23	636QG	Iowa City VA Mobile Clinic	Iowa City Mobile
429	23	636QH	Des Moines VA Mobile Clinic	Des Moines Mobile
430	23	636QI	Davenport VA Clinic	Davenport
431	23	636QJ	Iowa City VA Clinic	Iowa City South Clinton Street
432	23	636QK	Omaha VA Mobile Clinic	Omaha Mobile
433	23	636QL	Iowa City 2 VA Mobile Clinic	Iowa City 2 Mobile

FY 2024 Outpatient Dialysis Centers

Dialysis Center Count	Station Number	Station Name	City	State
1	523	VA Boston HCS	Boston	MA
2	650	Providence VA Med Center	Providence	RI
3	689	VA Connecticut HCS	West Haven	CT
4	526	James J. Peters VA Med Center	Bronx	NY
5	528	Albany Stratton VA Med Center	Albany	NY
6	528	VA Western NY HCS	Buffalo	NY
7	561	VA New Jersey HCS	East Orange	NJ
8	630	VA NY Harbor HCS - Brooklyn	Brooklyn	NY
9	630	VA NY Harbor HCS - Manhattan	New York	NY
10	632	Northport VA Med Center	Northport	NY
11	460	Wilmington VA Med Center	Wilmington	DE
12	642	Philadelphia Free Standing Dialysis Center	Philadelphia	PA
13	646	VA Pittsburgh HCS	Pittsburgh	PA
14	693	Wilkes-Barre VA Med Center	Wilkes-Barre	PA
15	688	Washington DC VA Med Center	Washington	DC
16	558	Durham VA Med Center	Durham	NC
17	558	Raleigh Dialysis Center	Raleigh	NC
18	565	Fayetteville VA Med Center	Fayetteville	NC
19	659	Charlotte Dialysis Center	Charlotte	NC
20	659	Kernersville Dialysis Center	Kernersville	NC
21	590	Hampton VA Med Center	Hampton	VA
22	652	Hunter Holmes McGuire VA Med Center	Richmond	VA
23	658	Salem VA Med Center	Salem	VA
24	508	Atlanta VA Med Center	Decatur	GA
25	521	Birmingham VA Med Center	Birmingham	AL
26	534	Ralph H. Johnson VA Med Center	Charleston	SC
27	544	Wm. Jennings Bryan Dorn VA Med Center	Columbia	SC
28	546	Miami VA HCS	Miami	FL
29	548	West Palm Beach VA Med Center	West Palm Beach	FL
30	573	North Florida/South Georgia HCS-Gainesville	Gainesville	FL
31	672	VA Caribbean HCS	San Juan	PR
32	673	James A. Haley Veterans' Hospital	Tampa	FL
33	675	Orlando	Orlando	FL
34	596	Lexington VA Med Center	Lexington	KY
35	614	Memphis VA Med Center	Memphis	TN

FY 2024 Outpatient Dialysis Centers

Dialysis Center Count	Station Number	Station Name	City	State
36	626	Tennessee Valley HCS	Nashville	TN
37	506	VA Ann Arbor HCS	Ann Arbor	MI
38	539	Cincinnati VA Med Center	Cincinnati	OH
39	541	Cleveland- Freestanding Dialysis Center	Cleveland	Oh
40	541	Louis Stokes Cleveland VA Med	Cleveland	OH
41	552	Dayton VA Med Center	Dayton	OH
42	553	John D. Dingell VA Med Center	Detroit	MI
43	583	Richard L. Roudebush VAMC	Indianapolis	IN
44	537	Jesse Brown VA Med Center	Chicago	IL
45	578	Edward Hines, Jr. VA Hospital	Hines	IL
46	695	Milo C Huempfner	Green Bay	WI
47	695	Milwaukee VA Med Center	Milwaukee	WI
48	589	Kansas City VA Med Center	Kansas City	MO
49	657	St. Louis VA Med Center	St. Louis	MO
50	598	Central Arkansas Veterans HCS	Little Rock	AR
51	549	VA North Texas HCS	Dallas	TX
52	671	South Texas Veterans HCS (STVHCS)	San Antonio	TX
53	501	New Mexico VA HCS	Albuquerque	NM
54	678	Southern Arizona VA HCS	Tucson	AZ
55	554	VA Eastern Colorado HCS	Denver	CO
56	648	Portland VA Med Center	Portland	OR
57	663	VA Puget Sound HCS	Seattle	WA
58	459	VA Pacific Islands HCS	Honolulu	HI
59	593	Southern Nevada HCS	North Las Vegas	NV
60	612	David Grant USAF Med Center (JV VA/DoD)	Travis AFB	CA
61	640	VA Palo Alto HCS	Palo Alto	CA
62	662	San Francisco VA Med Center	San Francisco	CA
63	600	VA Long Beach HCS	Long Beach	CA
64	605	VA Loma Linda HCS	Loma Linda	CA
65	664	VA San Diego HCS	San Diego	CA
66	691	VA Great Los Angeles HCS	Los Angeles	CA
67	568	VA Black Hills HCS	Hot Springs	SD
68	618	Minneapolis VA HCS	Minneapolis	MN
69	636	Iowa City VA HCS	Iowa City	IA
70	636	VA Nebraska-Western Iowa HCS	Omaha	NE
71	660	Salt Lake City VA HCS	Salt Lake City	UT

FY 2024 Community Resource and Referral Centers

CRRC Program Count	Station Name	Site Location
1	VA Connecticut Health Care System	West Haven, CT
2	VA New York Harbor Health Care System	Harlem, NY
3	Philadelphia VA Medical Center	Philadelphia, PA
4	VA Maryland Health Care System	Baltimore, MD
5	Washington DC VA Medical Center	Washington, DC
6	Huntington VA Medical Center	Huntington, WV
7	Ralph H. Johnson VA Medical Center	Charleston, SC
8	Atlanta VA Medical Center	Atlanta, GA
9	N. Florida/S. Georgia Veterans Health System	Jacksonville, FL
10	Louis Stokes Cleveland VA Medical Center-Akron CBOC	Akron, OH
11	Louis Stokes Cleveland VA Medical Center	Cleveland, OH
12	John D. Dingell VA Medical Center	Detroit, MI
13	Jesse Brown VA Medical Center	Chicago, IL
14	Clement J. Zablocki VA Medical Center	Milwaukee, WI
15	Michael E. DeBakey VA Medical Center	Houston, TX
16	Southeast Louisiana Veterans Health Care System	New Orleans, LA
17	VA North Texas Health Care System	Dallas, TX
18	VA North Texas Health Care System	Fort Worth, TX
19	VA Eastern Colorado Health Care System	Denver, CO
20	Portland VA Medical Center	Portland, OR
21	VA Puget Sound Health Care System	Seattle, WA
22	VA Southern Nevada Health Care System	Las Vegas, NV
23	San Francisco VA Medical Center	San Francisco, CA
24	VA Long Beach Healthcare System	Long Beach, CA
25	Phoenix VA Medical Center	Phoenix, AZ
26	Greater Los Angeles Health Care System	Los Angeles, CA
27	Iowa City VA Health Care System	Cedar Rapids, IA
28	VA Central Iowa Health Care System (636A8)	Davenport, IA
29	VA Central Iowa Health Care System (636A6)	Des Moines, IA
30	Minneapolis VA Health Care System	Minneapolis, MN
31	VA Nebraska-Western Iowa Health Care System	Omaha Nebraska-Western Iowa, NE
32	Fargo VA Health Care System	Fargo, ND
33	Overton Brooks VA Medical Center	Shreveport, LA

FY 2024 Vet Centers, Mobile Vet Centers and Vet Center Outstations

(Vet Centers with Mobile or Outstation classifications are shaded)

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	460	Vineland Vet Center Outstation	Vineland	NJ	2301	N	Y
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

FY 2024 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)
2	561	Secaucus Mobile Vet Center	Secaucus	NJ	0857MVC	Y	N
2	528A6	Rochester Mobile Vet Center	Rochester	NY	0873MVC	Y	N
4	562	Erie Mobile Vet Center	Erie	PA	0809MVC	Y	N
4	642	Center City Philadelphia Vet Center	Philadelphia	PA	0210V	N	N
4	646	Pittsburgh Vet Center	Pittsburgh	PA	0211V	N	N
4	693	Williamsport Vet Center	Williamsport	PA	0212V	N	N
4	460	Wilmington Vet Center	Wilmington	DE	0215V	N	N
4	595	Harrisburg Vet Center	Harrisburg	PA	0218V	N	N
4	642	Northeast Philadelphia Vet Center	Philadelphia	PA	0219V	N	N
4	646	White Oak Vet Center	White Oak	PA	0220V	N	N
4	693	Scranton Mobile Vet Center	Scranton	PA	0811MVC	Y	N
4	562	Erie Vet Center	Erie	PA	0222V	N	N
4	503	DuBois Vet Center	DuBois	PA	0227V	N	N
4	693	Scranton Vet Center	Scranton	PA	0229V	N	N
4	460	South Jersey Vet Center	Egg Harbor Township	NJ	0230V	N	N
4	646	Wheeling Vet Center	Wheeling	WV	0233V	N	N
4	642	Bucks County Vet Center	Bristol	PA	0238V	N	N
4	642	Norristown Vet Center	Norristown	PA	0239V	N	N
4	595	Lancaster Vet Center	Lancaster	PA	0242V	N	N
4	460	Sussex County Vet Center	Georgetown	DE	0243V	N	N
4	460	Sussex County Mobile Vet Center	Georgetown	DE	0874MVC	Y	N
4	503	DuBois Mobile Vet Center	DuBois	PA	0876MVC	Y	N
5	512	Baltimore Vet Center	Baltimore	MD	0201V	N	N
5	581	Huntington Mobile Vet Center	Huntington	WV	0807MVC	Y	N
5	581	Huntington Vet Center	Huntington	WV	0208V	N	N
5	512	Elkton Vet Center	Elkton	MD	0209V	N	N
5	688	Silver Spring Vet Center	Silver Spring	MD	0213V	N	N
5	688	Washington, D.C. Vet Center	Washington	DC	0214V	N	N
5	540	Morgantown Vet Center	Morgantown	WV	0216V	N	N
5	540	Parkersburg Outstation	Parkersburg	WV	2081OS	N	Y
5	512	Salisbury Outstation	Salisbury	MD	2091OS	N	Y
5	512	Aberdeen Outstation	Aberdeen	MD	2092OS	N	Y
5	517	Beckley Mobile Vet Center	Beckley	WV	0812MVC	Y	N
5	581	Charleston Vet Center	Charleston	WV	0223V	N	N
5	613	Martinsburg Vet Center	Martinsburg	WV	0224V	N	N
5	688	Alexandria Vet Center	Alexandria	VA	0228V	N	N
5	TBD	Leesburg Outstation	Leesburg	VA	TBD	N	Y
5	517	Beckley Vet Center	Beckley	WV	0231V	N	N
5	517	Princeton Vet Center	Princeton	WV	0232V	N	N
5	512	Annapolis Vet Center	Annapolis	MD	0235V	N	N
5	512	Dundalk Vet Center	Dundalk	MD	0236V	N	N
5	688	Prince George's County Vet Center	Clinton	MD	0237V	N	N
5	512	Baltimore Mobile Vet Center	Baltimore	MD	0858MVC	Y	N
6	652	Richmond Mobile Vet Center	Richmond	VA	0808MVC	Y	N
6	590	Chesapeake Vet Center	Chesapeake	VA	0207V	N	N
6	652	Richmond Vet Center	Richmond	VA	0217V	N	N
6	658	Roanoke Vet Center	Roanoke	VA	0226V	N	N
6	558	Greenville Mobile Vet Center	Greenville	NC	0814MVC	Y	N
6	590	Virginia Beach Vet Center	Virginia Beach	VA	0240V	N	N
6	565	Fayetteville Vet Center	Fayetteville	NC	0315V	N	N

FY 2024 Vet Centers, Mobile Vet Centers and Vet Center Outstations

VISN	Station Number	Station Name	City	State	VC / MVC / Outstation Number	MVC (Yes / No)	VC Outstation (Yes / No)
6	659	Charlotte Vet Center	Charlotte	NC	0317V	N	N
6	558	Greenville Vet Center	Greenville	NC	0319V	N	N
6	659	Greensboro Vet Center	Greensboro	NC	0327V	N	N
6	558	Raleigh Vet Center	Raleigh	NC	0328V	N	N
6	558	Spindale Outstation	Spindale	NC	3271OS	N	Y
6	565	Jacksonville Vet Center	Jacksonville	NC	0343V	N	N
6	659	Greensboro Mobile Vet Center	Greensboro	NC	0862MVC	Y	N
7	544	Columbia Mobile Vet Center	Columbia	SC	0817MVC	Y	N
7	534	Charleston Vet Center	North Charleston	SC	0303V	N	N
7	508	Atlanta Vet Center	College Park	GA	0304V	N	N
7	557	Macon Mobile Vet Center	Macon	GA	0818MVC	Y	N
7	544	Greenville Vet Center	Greenville	SC	0316V	N	N
7	534	Savannah Vet Center	Savannah	GA	0323V	N	N
7	544	Columbia Vet Center	Columbia	SC	0324V	N	N
7	508	Lawrenceville Vet Center	Lawrenceville	GA	0329V	N	N
7	557	Macon Vet Center	Macon	GA	0333V	N	N
7	619	Montgomery Vet Center	Montgomery	AL	0334V	N	N
7	508	Marietta Vet Center	Marietta	GA	0342V	N	N
7	557	Augusta Vet Center	Augusta	GA	0346V	N	N
7	534	Myrtle Beach Vet Center	Myrtle Beach	SC	0347V	N	N
7	509	Columbus Vet Center	Columbus	GA	0349V	N	N
7	508	Atlanta Mobile Vet Center	College Park	GA	0860MVC	Y	N
7	521	Birmingham Mobile Vet Center	Hoover	AL	0866MVC	Y	N
7	521	Huntsville Vet Center	Huntsville	AL	0738V	N	N
7	521	Birmingham Vet Center	Hoover	AL	0739V	N	N
8	672	Arecibo Vet Center	Arecibo	PR	0802MVC	Y	N
8	573	Jacksonville Mobile Vet Center	Jacksonville	FL	0813MVC	Y	N
8	672	St. Croix Outstation	Kingshill	VI	3121OS	N	Y
8	516	Clearwater Mobile Vet Center	Clearwater	FL	0816MVC	Y	N
8	516	St. Petersburg Vet Center	St. Petersburg	FL	0301V	N	N
8	573	Jacksonville Vet Center	Jacksonville	FL	0305V	N	N
8	672	San Juan Vet Center	Guaynabo	PR	0307V	N	N
8	672	Arecibo Vet Center	Arecibo	PR	0309V	N	N
8	546	Miami Vet Center	Miami	FL	0310V	N	N
8	546	Fort Lauderdale Vet Center	Lauderdale Lakes	FL	0311V	N	N
8	672	Hatillo Vet Center	Hatillo	PR	0309V	Y	N
8	672	Ponce Vet Center	Ponce	PR	0312V	N	N
8	675	Orlando Vet Center	Orlando	FL	0314V	N	N
8	673	Tampa Vet Center	Tampa	FL	0318V	N	N
8	516	Sarasota Vet Center	Sarasota	FL	0320V	N	N
8	573	Tallahassee Vet Center	Tallahassee	FL	0325V	N	N
8	548	Palm Beach Vet Center	Greenacres	FL	0326MVC	Y	N
8	516	Fort Myers Vet Center	Fort Myers	FL	0330V	N	N
8	573	Gainesville Vet Center	Gainesville	FL	0331V	N	N
8	675	Melbourne Vet Center	Melbourne	FL	0332V	N	N
8	672	U.S. Virgin Islands Vet Center	St Thomas	VI	0308V	N	N
8	546	Pompano Beach Vet Center	Pompano Beach	FL	0336V	N	N
8	548	Jupiter Vet Center	Jupiter	FL	0337V	N	N
8	673	Pasco County Vet Center	New Port Richey	FL	0338V	N	N
8	516	Clearwater Vet Center	Clearwater	FL	0339V	N	N

FY 2024 Vet Centers, Mobile Vet Centers and Vet Center Outstations

VISN	Station Number	Station Name	City	State	VC / MVC / Outstation Number	MVC (Yes / No)	VC Outstation (Yes / No)
8	673	Lakeland Vet Center	Lakeland	FL	0340V	N	N
8	675	Daytona Beach Vet Center	Daytona Beach	FL	0341V	N	N
8	573	Ocala Vet Center	Ocala	FL	0344V	N	N
8	675	Clermont Vet Center	Clermont	FL	0345V	N	N
8	516	Naples Vet Center	Naples	FL	0348V	N	N
8	672	Ponce Mobile Vet Center	Ponce	PR	0861MVC	Y	N
9	596	Lexington Mobile Vet Center	Lexington	KY	0806MVC	Y	N
9	603	Louisville Vet Center	Louisville	KY	0202V	N	N
9	596	Lexington Vet Center	Lexington	KY	0203V	N	N
9	621	Knoxville Mobile Vet Center	Knoxville	TN	0844MVC	Y	N
9	614	Memphis Mobile Vet Center	Memphis	TN	0848MVC	Y	N
9	675	Clermont Mobile Vet Center	Clermont	FL	0864MVC	Y	N
9	621	Johnson City Vet Center	Johnson City	TN	0701V	N	N
9	614	Memphis Vet Center	Memphis	TN	0719V	N	N
9	621	Knoxville Vet Center	Knoxville	TN	0720V	N	N
9	626	Chattanooga Vet Center	Chattanooga	TN	0722V	N	N
9	626	Nashville Vet Center	Nashville	TN	0724V	N	N
9	626	Clarksville Vet Center	Clarksville	TN	0350V	N	N
10	539	Cincinnati Vet Center	Norwood	OH	0204V	N	N
10	541	Cleveland Vet Center	Maple Heights	OH	0205V	N	N
10	541	Parma Vet Center	Parma	OH	0206V	N	N
10	552	Dayton Mobile Vet Center	Kettering	OH	0810MVC	Y	N
10	757	Columbus Vet Center	Columbus	OH	0221V	N	N
10	552	Dayton Vet Center	Kettering	OH	0225V	N	N
10	506	Toledo Vet Center	Toledo	OH	0234V	N	N
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

FY 2024 Vet Centers, Mobile Vet Centers and Vet Center Outstations

VISN	Station Number	Station Name	City	State	VC / MVC / Outstation Number	MVC (Yes / No)	VC Outstation (Yes / No)
12	550	Springfield Vet Center	Springfield	IL	0421V	N	N
12	585	Escanaba Vet Center	Escanaba	MI	0434V	N	N
12	578	Orland Park Vet Center	Orland Park	IL	0435V	N	N
12	578	Aurora Vet Center	Aurora	IL	0436V	N	N
12	695	Green Bay Vet Center	Green Bay	WI	0441V	N	N
12	676	La Crosse Vet Center	La Crosse	WI	0442V	N	N
12	556	Rockford Vet Center	Rockford	IL	0447V	N	N
12	556	Evanston Mobile Vet Center	Evanston	IL	0853MVC	Y	N
12	695	Green Bay Mobile Vet Center	Green Bay	WI	0856MVC	Y	N
15	589A7	Wichita Mobile Vet Center	Wichita	KS	0824MVC	Y	N
15	589	Kansas City Vet Center	Kansas City	MO	0408V	N	N
15	657	St. Louis Vet Center	Creve Coeur	MO	0414V	N	N
15	657A5	Evansville Vet Center	Evansville	IN	0418V	N	N
15	657	Metro East Vet Center	Swansea	IL	0422V	N	N
15	589A7	Wichita Vet Center	Wichita	KS	0426V	N	N
15	589	Manhattan Vet Center	Manhattan	KS	0432V	N	N
15	589A4	Columbia Vet Center	Columbia	MO	0443V	N	N
15	589	Kansas City Mobile Vet Center	Kansas City	MO	0851MVC	Y	N
15	657A5	Evansville Mobile Vet Center	Evansville	IN	0872MVC	Y	N
15	589A4	Columbia Mobile Vet Center	Columbia	MO	0875MVC	Y	N
16	520	Pensacola Mobile Vet Center	Pensacola	FL	0815MVC	Y	N
16	629	New Orleans Mobile Vet Center	New Orleans	LA	0847MVC	Y	N
16	598	Little Rock Mobile Vet Center	Little Rock	AR	0850MVC	Y	N
16	586	Jackson Mobile Vet Center	Jackson	MS	0863MVC	Y	N
16	667	Shreveport Vet Center	Shreveport	LA	0704V	N	N
16	586	Jackson Vet Center	Jackson	MS	0709V	N	N
16	580	Houston Southwest Vet Center	Houston	TX	0710V	N	N
16	580	Houston West Vet Center	Houston	TX	0711V	N	N
16	598	Little Rock Vet Center	North Little Rock	AR	0713V	N	N
16	629	New Orleans Vet Center	New Orleans	LA	0717V	N	N
16	667	Shreveport Mobile Vet Center	Shreveport	LA	0877MVC	Y	N
16	629	Baton Rouge Vet Center	Baton Rouge	LA	0725V	N	N
16	564	Fayetteville Vet Center	Fayetteville	AR	0727V	N	N
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

FY 2024 Vet Centers, Mobile Vet Centers and Vet Center Outstations

VISN	Station Number	Station Name	City	State	VC / MVC / Outstation Number	MVC (Yes / No)	VC Outstation (Yes / No)
17	756	El Paso Vet Center	El Paso	TX	0707V	N	N
17	549	Fort Worth Vet Center	Westworth Village	TX	0708V	N	N
17	671	Laredo Vet Center	Laredo	TX	0712V	N	N
17	504	Lubbock Vet Center	Lubbock	TX	0714V	N	N
17	671	McAllen Vet Center	McAllen	TX	0715V	N	N
17	519	Midland Vet Center	Midland	TX	0716V	N	N
17	671	San Antonio Northeast Vet Center	San Antonio	TX	0721V	N	N
17	674	Killeen Heights Vet Center	Harker Heights	TX	0726V	N	N
17	671	San Antonio Northwest Vet Center	San Antonio	TX	0729V	N	N
17	671	McAllen Mobile Vet Center	McAllen	TX	0879MVC	Y	N
17	549	Mesquite Vet Center	Mesquite	TX	0730V	N	N
17	549	Arlington Vet Center	Pantego	TX	0732V	N	N
17	519	Abilene Vet Center	Abilene	TX	0733V	N	N
19	436	Billings Mobile Vet Center	Billings	MT	0829MVC	Y	N
19	660	Salt Lake City Mobile Vet Center	Murray	UT	0831MVC	Y	N
19	442	Casper Mobile Vet Center	Casper	WY	0834MVC	Y	N
19	554	Pueblo Mobile Vet Center	Pueblo	CO	0836MVC	Y	N
19	436	Missoula Mobile Vet Center	Missoula	MT	0837MVC	Y	N
19	442	Cheyenne Vet Center	Cheyenne	WY	0501V	N	N
19	554	Denver Vet Center	Denver	CO	0504V	N	N
19	436	Billings Vet Center	Billings	MT	0509V	N	N
19	660	Salt Lake City Vet Center	Murray	UT	0514V	N	N
19	442	Casper Vet Center	Casper	WY	0519V	N	N
19	554	Colorado Springs Vet Center	Colorado Springs	CO	0525V	N	N
19	575	Grand Junction Vet Center	Grand Junction	CO	0526V	N	N
19	554	Boulder Vet Center	Boulder	CO	0527V	N	N
19	436	Missoula Vet Center	Missoula	MT	0528V	N	N
19	660	Pocatello Vet Center	Pocatello	ID	0531V	N	N
19	660	Provo Vet Center	Orem	UT	0532V	N	N
19	436	Great Falls Vet Center	Great Falls	MT	0538V	N	N
19	436	Kalispell Vet Center	Kalispell	MT	0539V	N	N
19	660	Saint George Vet Center	Saint George	UT	0540V	N	N
19	554	Pueblo Vet Center	Pueblo	CO	0542V	N	N
19	442	Fort Collins Vet Center	Fort Collins	CO	0543V	N	N
19	660	Major Brent Taylor Vet Center Outstation	North Ogden	UT	5141OS	N	Y
19	635	Lawton Mobile Vet Center	Lawton	OK	0865MVC	Y	N
19	660	Saint George Mobile Vet Center	Saint George	UT	0868MVC	Y	N
19	436	Helena Outstation	Helena	MT	5381OS	N	Y
19	635	Oklahoma City Vet Center	Oklahoma City	OK	0718V	N	N
19	623	Tulsa Vet Center	Tulsa	OK	0723V	N	N
19	635	Lawton Vet Center	Lawton	OK	0728V	N	N
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

FY 2024 Vet Centers, Mobile Vet Centers and Vet Center Outstations

VISN	Station Number	Station Name	City	State	VC / MVC / Outstation Number	MVC (Yes / No)	VC Outstation (Yes / No)
20	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	612	Solano County Outstation	Fairfield	CA	6021OS	N	Y
21	TBD	Mariana Islands Outstation	Saipan	MP	TBD	N	Y
21	459	American Samoa Vet Center	Pago Pago	AS	0616V	N	N
21	662	San Francisco Vet Center	San Francisco	CA	0620V	N	N
21	459	Western Oahu Vet Center	Kapolei	HI	0621V	N	N
21	570	Fresno Vet Center	Fresno	CA	0628V	N	N
21	459	Kauai Vet Center	Lihue	HI	0633V	N	N
21	459	Maui Vet Center	Kahului	HI	0634V	N	N
21	459	Hilo Vet Center	Hilo	HI	0635V	N	N
21	459	Kailua-Kona Vet Center	Kailua-Kona	HI	0636V	N	N
21	612A4	Sacramento Vet Center	Sacramento	CA	0638V	N	N
21	640	Santa Cruz County Vet Center	Capitola	CA	0639V	N	N
21	662	Eureka Vet Center	Eureka	CA	0644V	N	N
21	654	Reno Mobile Vet Center	Reno	NV	0867MVC	Y	N
21	662	Northbay Vet Center	Rohnert Park	CA	0646V	N	N
21	640	Peninsula Vet Center	Menlo Park	CA	0647V	N	N
21	459	Guam Vet Center	Maite	GU	0648V	N	N
21	612A4	Chico Vet Center	Chico	CA	0649V	N	N
21	640	Delta Vet Center	Manteca	CA	0650V	N	N
21	459	Western Oahu Mobile Vet Center	Kapolei	HI	0870MVC	Y	N
21	612A4	Sacramento Mobile Vet Center	Sacramento	CA	0880MVC	Y	N
21	593	Henderson Mobile Vet Center	Henderson	NV	0886MVC	Y	N
22	501	Hopi Mobile Vet Center	Hotevilla	AZ	0832MVC	Y	N
22	649	Prescott Mobile Vet Center	Prescott	AZ	0833MVC	Y	N
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

FY 2024 Vet Centers, Mobile Vet Centers and Vet Center Outstations

VISN	Station Number	Station Name	City	State	VC / MVC / Outstation Number	MVC (Yes / No)	VC Outstation (Yes / No)
22	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	678	Sierra Vista Outstation	Sierra Vista	AZ	1121	N	Y
22	605	Temecula Vet Center	Temecula	CA	0608V	N	N
22	605	Corona Vet Center	Corona	CA	0611V	N	N
22	605	High Desert Vet Center	Victorville	CA	0613V	N	N
22	664	Chula Vista Vet Center	Bonita	CA	0614V	N	N
22	664	San Diego Vet Center	San Diego	CA	0618V	N	N
22	691	San Luis Obispo Vet Center	San Luis Obispo	CA	0619V	N	N
22	691	East Los Angeles Vet Center	Commerce	CA	0623V	N	N
22	600	North Orange County Vet Center	Garden Grove	CA	0624V	N	N
22	605	San Bernardino Vet Center	San Bernardino	CA	0637V	N	N
22	664	San Marcos Vet Center	San Marcos	CA	0642V	N	N
22	691	Ventura Vet Center	Ventura	CA	0643V	N	N
22	600	South Orange County Mobile Vet Center	Mission Viejo	CA	0869MVC	Y	N
22	501	Hopi Outstation	Hotevilla	AZ	5162OS	N	Y
22	691	Sepulveda Outstation	Sepulveda	CA	6051OS	N	Y
22	501	Chinle Mobile Vet Center	Chinle	AZ	0882MVC	Y	N
22	664	San Marcos Mobile Vet Center	San Marcos	CA	0883MVC	Y	N
22	678	Yuma Mobile Vet Center	Yuma	AZ	0885MVC	Y	N
23	437	Bismarck Mobile Vet Center	Bismarck	ND	0819MVC	Y	N
23	437	Fargo Mobile Vet Center	Fargo	ND	0820MVC	Y	N
23	618	Brooklyn Park Mobile Vet Center	Brooklyn Park	MN	0821MVC	Y	N
23	568	Rapid City Mobile Vet Center	Rapid City	SD	0823MVC	Y	N
23	636	Lincoln Mobile Vet Center	Lincoln	NE	0825MVC	Y	N
23	437	Grand Forks Outstation	Grand Forks	ND	4061OS	N	Y
23	437	Minot Vet Center	Minot	ND	0404V	N	N
23	636A6	Des Moines Vet Center	West Des Moines	IA	0405V	N	N
23	437	Fargo Vet Center	Fargo	ND	0406V	N	N
23	618	St. Paul Vet Center	Saint Paul	MN	0416V	N	N
23	618	St. Cloud Outstation	St. Cloud	MN	4391OS	N	Y
23	568	Rapid City Vet Center	Rapid City	SD	0423V	N	N
23	636	Omaha Vet Center	Omaha	NE	0424V	N	N
23	438	Sioux Falls Vet Center	Sioux Falls	SD	0425V	N	N
23	636	Lincoln Vet Center	Lincoln	NE	0427V	N	N
23	438	Sioux City Vet Center	Sioux City	IA	0428V	N	N
23	618	Duluth Vet Center	Duluth	MN	0429V	N	N
23	636A8	Quad Cities Vet Center	East Moline	IL	0430V	N	N
23	636A8	Cedar Rapids Vet Center	Cedar Rapids	IA	0431V	N	N
23	618	Brooklyn Park Vet Center	Anoka	MN	0439V	N	N
23	437	Bismarck Vet Center	Bismarck	ND	0446V	N	N
23	636A8	Cedar Rapids Mobile Vet Center	Cedar Rapids	IA	0854MVC	Y	N

2026 Budget Request Justification – For Congressional Justification Narrative

Authority for action

- 38 C.F.R. Part 59, Grants to States for Construction or Acquisition of State Homes
- P.L. 95-62, State Veterans' Home Assistance Improvement Act of 1977
- P.L. 98-528 §105, The Veterans' Health Care Act of 1984
- P.L. 99-576 §224, The Veterans' Benefits Improvement and Health Care Authorization Act of 1986
- P.L. 99-576, The Veterans' Benefits and Services Act of 1988
- P.L. 102-585 §403, The Veterans' Health Care Act of 1992
- P.L. 106-117 §207, The Veterans' Millennium Health Care and Benefits Act of 1999

Purpose

The State Home Construction Grant program (SHCGP) is regulated in 38 C.F.R. Part 59. The program provides funding up to 65% of construction or renovation costs for state Veterans homes (SVH), which are owned and operated by states. Applications must be received by April 15 of each calendar year to be listed on the following fiscal year's annual Priority List. VA is required by 38 U.S.C. § 8135 to fund projects in the order of their ranking on the annual Priority List. The Department's highest priority is to protect Veterans from conditions that threaten the lives and safety of residents of an existing facility.

2025 Planned Accomplishments

In 2025, the program anticipates obligating funding for 6 grant projects with total estimated obligations of $198.8 million.

Implementation Plan

Per 38 C.F.R. § 59.50, Priority List, VA must follow the prioritization in ranking of projects in a specific order. Finalization of the 2024 Priority List and confirmed appropriated amounts will determine the order of disbursement of awards to states.

States must submit an initial application by April 15 of each year to be considered for the following fiscal year's priority list. States must complete the entire grant application by August 1 of the fiscal year to be considered for a final grant award.

- States 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 is completed by the

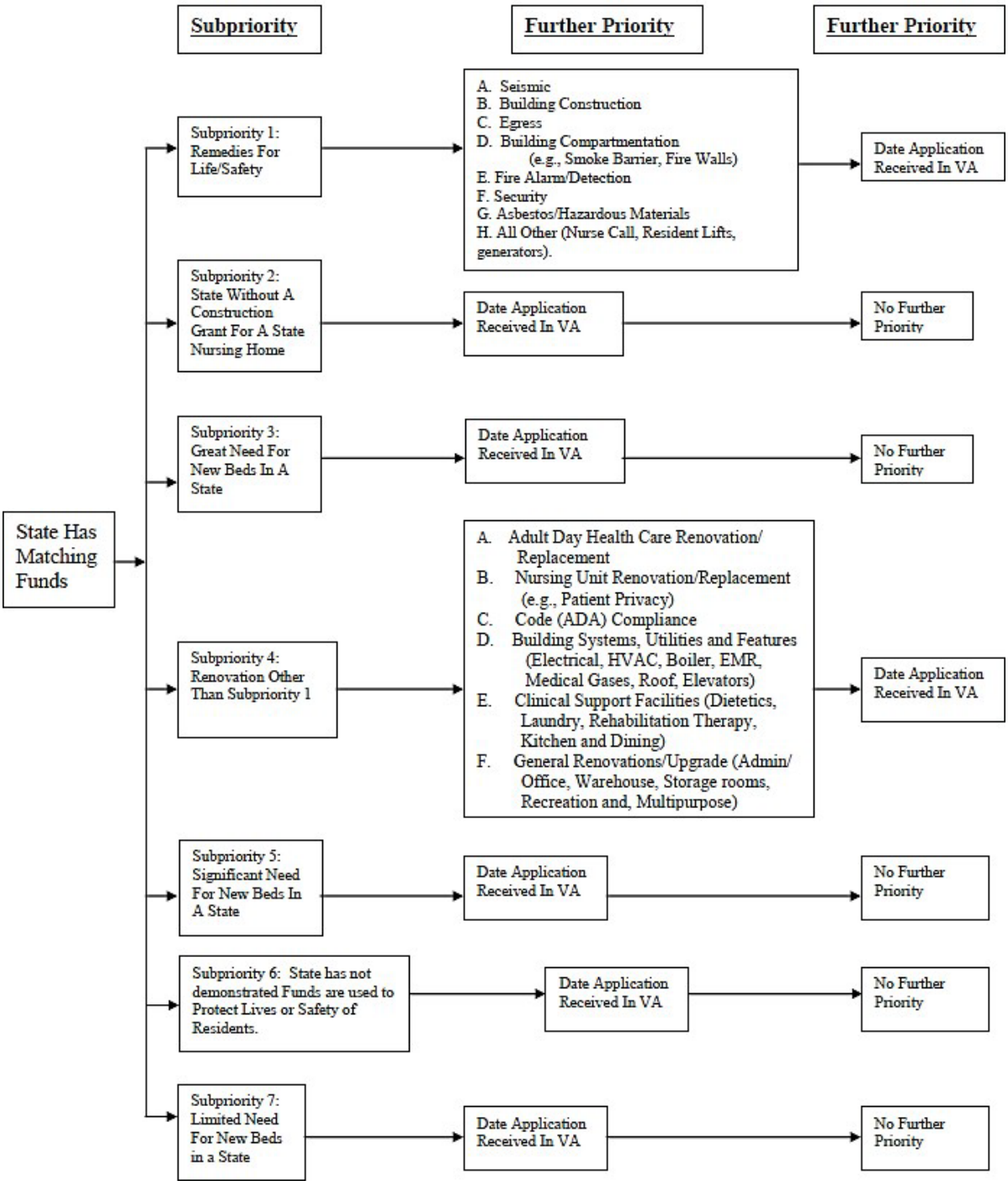
following June 30 deadline. States unable to complete a grant offered for an award may request a deferment to the following year for reconsideration.

- States must meet all requirements for a grant not later than 180 calendar days after the date of conditional approval.
- If a state that has obtained conditional approval for a project does not meet all requirements within 180 calendar days after the date of conditional approval, the Secretary will rescind the conditional approval, and the project will be ineligible for a grant in the fiscal year in which the state failed to fully complete the application. The funds that were conditionally obligated for the project will be de-obligated.

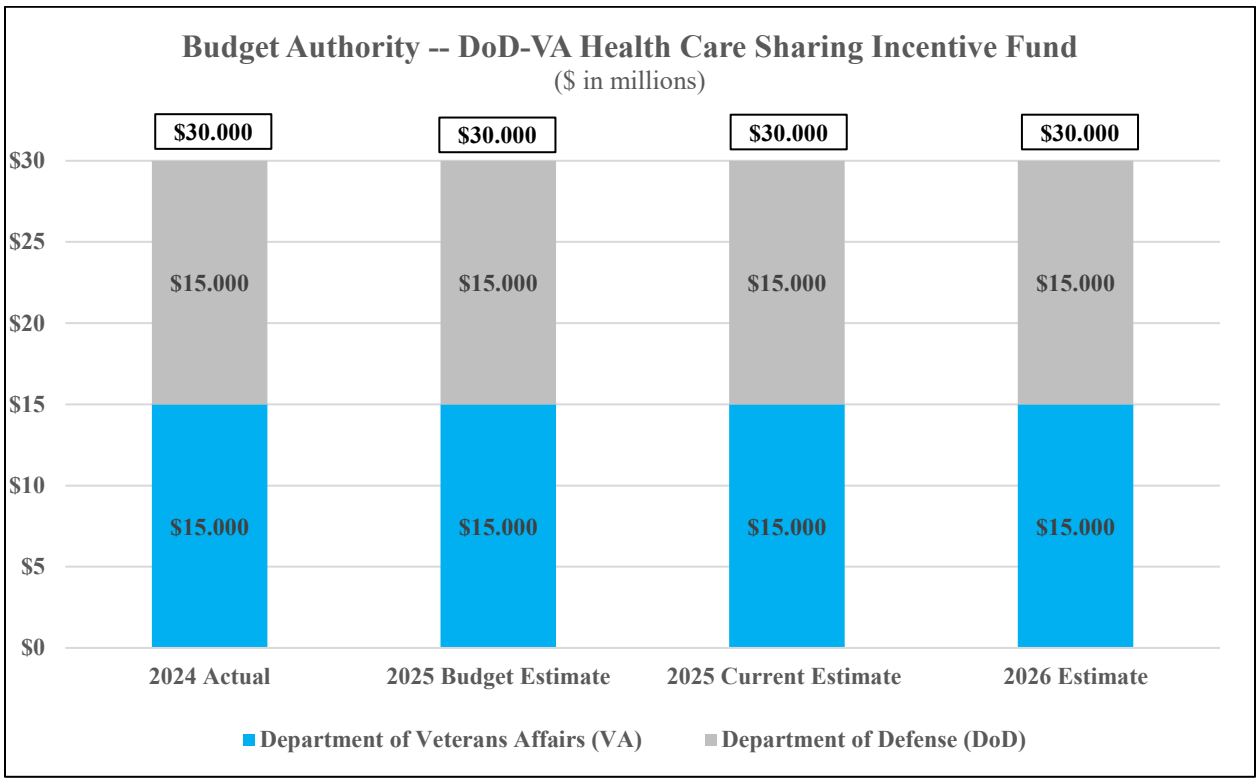
2026 Budget Request

The 2026 budget request, matched with state funding, is based on the 2025 construction priority listing for projects ranked with highest priority in accordance with 38 C.F.R. § 59.50. VA requests $171.0 million for state home expansion, which includes construction of new facilities as well as remodeling of existing structures The request also supports furnishing for domiciliary, nursing home, and adult day health care. VA is required by 38 U.S.C. § 8135 to prioritize state grant applications. Funding will support essential life-safety renovation projects to help ensure quality care for Veterans and assist SVH facilities with meeting code requirements for the Americans with Disabilities Act. Any remaining resources will be used to support new construction and non-life safety renovation projects.

Prioritization for Priority Group 1



DoD-VA Health Care Sharing Incentive Fund



Funding contributions anticipated from VA and DoD.

Program Description

Congress created the DoD-VA Health Care Sharing Incentive Fund, regularly referred to as the Joint Incentive Fund (JIF), between the DoD and the 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. Each Secretary is required to contribute a minimum of $15 million from the funds appropriated to that Secretary's Department in accordance with 38 U.S.C. § 8111(d). The DoD-VA Health Care Sharing Incentive Fund became effective on October 1, 2003. The Continuing Appropriations and Ukraine Supplemental Appropriations Act, 2023, (P.L. 117-180 § 103) amended 38 U.S.C. § 8111(d)(3) to extend the program to September 30, 2026. The funds are available until expended.

Administrative Provision

An administrative provision related to the JIF is 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.

2025 Projects

JIF funding is an initial investment in the project to facilitate mutually beneficial exchanges of health care resources, with the goal of improving access to high-quality and cost-effective health care provided to beneficiaries of both Departments. JIF funding is designed and programmed to cover start-up costs during the initial two-year JIF financial support period, after which time sustainment funding will be provided by the designated Departments, as appropriate. The approval and implementation of the following list of anticipated projects is subject to availability of funds and may execute over multiple years. Additional projects may be selected at a later date.

- ***Walter Reed National Military Medical Center / VA Puget Sound Health Care System (HCS) - Three-Dimensional (3D) Printing Quality Management System Enhancements:*** This project expands 3D printing base capabilities to a scaled solution that can be utilized across the VHA and the Military Health System (MHS). There is a clear demand for these products, evidenced by increased clinical orders and stakeholder feedback. DoD and VA patients will benefit from these solutions, therefore improving direct patient health care outcomes while decreasing costs.
  Funding: $7.9 million (DoD: $4.1 million; VA: $3.8 million)

- ***Uniformed Services University / VA Salt Lake City HCS - Assessing Infrasound Exposure During Combat Weapons Training:*** This project conducts research into the threat of micro-concussions from exposure to combat weapons training by assessing whether high intensity represents a viable alternative or compounding mechanism to underlying reports of adverse health effects after sub-concussive blast exposure. Results will be used to determine links between cumulative exposure histories, physiological biomarkers, and neurological measures of harm among personnel in heavy weapons training. Assessments contribute value by reducing harm and care costs, and improving military readiness by informing new safety standards, training procedures, and clinical care guidelines. **Funding: $2.1 million** (DoD: $1.5 million; VA: $650,000)

- ***Naval Medical Center San Diego / VA Office of Mental Health and Suicide Prevention - Early Intervention for Service Members with Emerging Psychotic Disorders:*** This initiative aims to hire specialized VA liaisons with expertise in psychosis to support development of a program for DoD Service members experiencing psychosis to transition into evidence-based care for psychotic disorders within VA. A feasibility pilot will assess the effectiveness of this model. **Funding: $1.3 million** (VA: $1.3 million)

- ***Uniformed Services University / Michael J. Crescenz VA Medical Center (VAMC) - Imaging Radiation Induces Pathology Surveillance:*** This project will build a surveillance tool designed to decrease redundant radiation exposure for Service members and Veterans who are often exposed to acute doses of radiation when treated for various traumatic injuries, chronically exposing them to an increased risk of pathologies and malignancies. Generalized linear models will be used to determine the relationship between injury severity scores and radiation exposure, identify variables that predict pathology, provide understanding of when a patient has received too much imaging radiation (or redundancy in imaging studies), as well as track radiation exposure over time indicating a patient may be at risk of a systemic pathology.
  Funding: $859,808 (DoD: $416,431; VA: $443,377)

- ***Martin Army Community Hospital (ACH) / Veterans Integrated Service Network (VISN) 23 - Joint National Subspecialty Ophthalmology Network Virtual Eye Care Services:*** This proposal intends to set up two telehealth eye care access points, staffed by VA, to improve access to eye care for DoD beneficiaries, military personnel, and Veterans in the Martin ACH and Fort Benning / Columbus, Georgia catchment area (part of the VA Central Alabama HCS). In addition, it will provide a range of virtual eye care services through telehealth technology to optimize quality and safety while standardizing costs. **Funding: $1.2 million** (DoD: $512,000; VA: $714,242)

- ***Joint Pathology Center / VA Pathology Center - Military Working Dogs (MWD): Sentinels for Deployment Related Health Implications:*** This proposal creates a MWD pathology database to facilitate retrospective studies of MWD diseases and comparative studies between MWDs and their human counterparts. Both pathology centers will leverage data to develop, house, and maintain a MWD database as a consolidated source of demographic, deployment, and health-related information.
  Funding: $2.0 million (DoD: $1.7 million; VA: $301,370)

- ***Walter Reed National Military Medical Center / Washington, DC VAMC - Decision Support Algorithm for Hemodialysis (HD) Access Management:*** The proposal intends to construct HD vascular access management algorithms and perform practice-pathway modeling. It will identify areas in which the MHS and VHA regional collaboration can result in optimal resource utilization for HD vascular access management. In addition, it will be used to provide recommendations to enhance performance on quality improvement measures, optimize implementation of interventions that achieve best-practices, and reduce costs associated with community care referrals for HD vascular access management. **Funding: $5.0 million** (DoD: $2.5 million; VA: $2.5 million)

- ***Walter Reed National Military Medical Center / Martinsburg VAMC - Otolaryngology Virtual Health Program:*** This proposal seeks to create an opportunity for Veterans seeking care at Martinsburg VAMC who require ear, nose, and throat evaluations, surgical care, radiation therapy, and post-op care to be treated at Walter Reed National Medical Center. This referral process would increase the complexity and acuity of cases treated by DoD surgeons and thereby contribute to a ready medical force.
  Funding: $1.8 million (DoD: $810,000; VA: 948,745)

- ***Uniformed Services University / Phoenix VA HCS - Photobiomodulation Treatment and Prevention of Influenza:*** This project plans to demonstrate the clinical utility of an integrative medicine approach that utilizes newly approved safe light (424 nanometer purple light) technology to enhance local human immune system attributes and treat the patient without pharmaceuticals. The effort will validate the efficacy and efficiency of this innovative technology and inform DoD and VA clinical practice on a large scale by rapidly transitioning it in-vivo to operational use by incorporation into clinical practice via the Uniformed Services University based Military Primary Care Research Network.
  Funding: $4.5 million (DoD: $2.1 million; VA: $2.4 million)

- ***Joint Pathology Center / Richmond VAMC - Protecting and Enhancing a National Resource: DoD-VA Collaboration to Save Pathology Archival Materials for Clinical Care, Education, and Research:*** This project intends to save archival pathologic materials from several DoD and VA facilities and hold them in perpetuity at the Joint Pathology Center (JPC) for advances in clinical care, education, and research. In addition, it will integrate data from the DoD JPC repository with data from the electronic health records maintained by VA, to create a more complete, easily accessible information record on these cases that will allow collaborative teams to discover, substantiate, validate, and implement superior models of care.
  Funding: $3.8 million (DoD: $2.7 million; VA: $1.1 million)

- ***Joint Pathology Center / Washington, DC VAMC - Pulmonary and Environmental Pathology Registry:*** This project proposes to create a VA/DoD Pulmonary and Environmental Pathology Registry of pathologic materials and associated clinical data by creating a unique registry dedicated to identifying the pulmonary diseases affecting military readiness and Veteran health, particularly those due to preventable environmental and military relevant exposures.
  Funding: $4.0 million (DoD: $3.1 million; VA: $913,668)

- ***Womack Army Medical Center (AMC) / Fayetteville VAMC - Robotic Surgery Access:*** This project expands the current joint robotic surgery program by acquiring and implementing a multi-faceted robotic surgical access package. The expansion of this surgical capability and capacity will greatly improve access to care and enhance surgical approaches to both the Fayetteville VAMC and Womack AMC beneficiary populations.
  Funding: $3.6 million (DoD: $3.6 million)

- ***William Beaumont AMC / El Paso VAMC - Photobiomodulation Therapy for Pain Management:*** The goal of this initiative is to implement Photobiomodulation therapy in the William Beaumont AMC Pain Clinic for Soldiers along with a new cohort of Veterans referred by El Paso VAMC and assess its effectiveness in treating low back pain as determined by the Defense and Veterans Pain Rating Score and complementary surveys. Clinical staff will be expanded to deliver this innovative care, and analytics personnel will be integrated into care delivery while maintaining prioritized care for normal operations of the clinic. Complementary therapies (non-pharmacological modalities of acupuncture, yoga, physical therapy, chiropractic therapy, and massage) will be included as variably prescribed standards of care, with a focus on physical therapy for the clinical trial. **Funding: $4.5 million** (DoD: $4.2 million; VA: $288,925)

- ***William Beaumont AMC / El Paso VAMC - Surgical Coordination Team:*** This proposal intends to establish a Surgical Coordination Team to facilitate communication and patient referrals, improving communication with VA staff, educating Veterans about William Beaumont AMC surgical services, and developing joint training for surgeons. The team members will also address access to care, transportation, and follow-up care issues, ensure proper coding and billing, and enhance training opportunities for William Beaumont AMC's Graduate Medical Education participants.
  Funding: $3.9 million (DoD: $3.6 million; VA: $288,176)

- ***DoD / VA National - Moral Injury Resource and Treatment Center Collaboration:*** Moral injury syndrome (MIS) is a constellation of psychological and behavioral sequalae resulting from challenges to deeply held values or beliefs and is associated with more treatment-resistant posttraumatic stress disorder symptoms and poor rehabilitation outcomes. This project expands upon earlier VA successes in treating MIS by training and implementing the program at The National Intrepid Center of Excellence to treat more Service members and Veterans, with the capacity to rapidly scale to a national program. **Funding: $3.5 million** (DoD: $1.2 million; VA: $2.3 million)

VA-DoD Health Care Sharing Incentive Fund Crosswalk

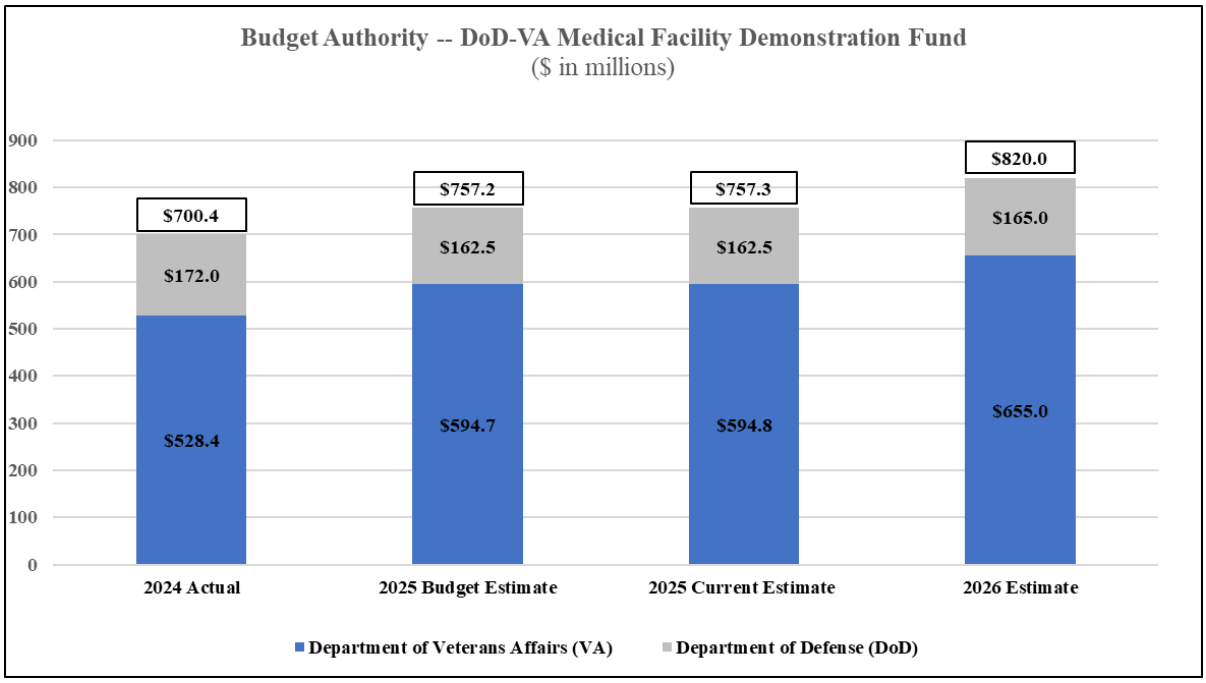
$ in thousands

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Estimate	2025-2026 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
Unobligated Balance (SOY): No-Year	$105,887	$109,787	$102,890	$102,890	$0
Adjustment to Unobligated Balances Brought Forward	($223)	$0	$0	$0	$0
Unobligated Balance (EOY): No-Year	($102,890)	($113,687)	($102,890)	($102,890)	$0
Recovery Prior Year Obligations	$6,391	$0	$0	$0	$0
Obligations	$39,165	$26,100	$30,000	$30,000	$0
FTE:					
VA Civilian*	29	31	25	25	0
DoD Personnel**	55	50	50	30	(20)
Total FTE	84	81	75	55	(20)

*Data source: VA Financial Management System. VA assumes a steady-state number of full-time equivalents (FTE) through the budget years.

**Data source: DHA. 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



Financial Highlights

(dollars in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate /1	2026 Estimate /1	2025-2026 Increase/ Decrease
Appropriation, Transfers From:					
Medical Services	$397,454	$384,926	$384,926	$416,125	$31,199
Medical Support & Compliance	$30,996	$42,193	$42,193	$47,819	$5,626
Medical Facilities	$40,570	$66,021	$66,021	$79,322	$13,301
Medical Community Care	$51,291	$93,500	$93,500	$103,500	$10,000
Subtotal, VA Medical Care Contribution	$520,311	$586,640	$586,640	$646,766	$60,126
VA Information Technology	$8,085	$8,085	$8,188	$8,188	$0
Subtotal, VA Total Contribution	$528,396	$594,725	$594,828	$654,954	$60,126
Department of Defense (DoD) /2	$172,000	$162,500	$162,500	$165,000	$2,500
Total Appropriations /3	$700,396	$757,225	$757,328	$819,954	$62,626
Collections /4	$10,957	$17,336	$17,336	$17,336	$0
Reimbursements /5	$9,104	$12,000	$12,000	$12,000	$0
Unob. Bal. (SOY)	$7,508	$0	$26,231	$0	($26,231)
Unob. Bal. (EOY)	($26,231)	$0	$0	$0	$0
Recovery Prior Year Obligations	$42	$0	$0	$0	$0
Lapse	($4)	$0	$0	$0	$0
Obligations	$701,772	$786,561	$812,895	$849,290	$36,395
Other DoD Contributions:					
MERHCF DoD reimbursement (Included Above)	*$6,293*	*$8,050*	*$8,050*	*$8,050*	*$0*
DoD "Stay Navy" (Excluded from Total Obligations) /6	*$11,477*	*$11,477*	*$11,477*	*$11,477*	*$0*
FTE:					
Civilian	2,536	2,491	2,593	2,593	0
DoD Uniformed Military /7	826	826	826	826	0
Total FTE	3,362	3,317	3,419	3,419	0

1/ The 2025 and 2026 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 comply with P.L. 111-84 which established this fund. P.L. 114-223 authorizes contributions from Medical Community Care beginning in 2017.

2/ This line reflects only the non-expenditure transfer of appropriations from the Defense Health Program (097-0130) budget account. This transfer amount may be impacted by the actual amount of the Medicare-Eligible Retiree Health Care Fund (MERHCF) reimbursement (as both sources of funding are used to pay for health care services delivered to DoD beneficiaries at the JALFHCC). The MERHCF actual reimbursement for 2024 and estimates for 2025 and 2026 is displayed in the section on *Other DoD Contributions* and are included in the "Reimbursements" line.

3/ Total Appropriations and Obligations exclude the "Stay Navy" contribution and MERHCF reimbursement.

4/ Reflects estimated medical care collections.

5/ Includes estimated MERHCF reimbursement from DoD.

6/ Non-add for Personal Services Contract funded by DoD for the East Campus.

7/ The 2025 and 2026 Estimates are from the 2024 Navy Manning Plan. Estimates do not reflect the number of DoD Uniform Military full-time equivalent (FTE) subject to Reconciliation in the JALFHCC Joint Areas.

Funding Highlights
The 2026 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). The financial needs are determined by a health care workload analysis and an assessment of the Non-Recurring Maintenance (NRM) requirements for Electronic Health Record Modernization (EHRM), Medical Community Care costs, and salary rate increases. In 2026, the facility anticipates executing additional NRM projects to support EHRM effort.

Program Description
On May 27, 2005, the VA/ DoD Health Executive Council signed an agreement to integrate the North Chicago VA Medical Center (NCVAMC) and the Navy Health Clinic Great Lakes (NHCGL). This landmark agreement created an organization composed of all the medical and dental components on both VA and Department of Navy property under the leadership of a VA Senior Executive Service Medical Center Director and a Navy Captain (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 an RSA.

The integrated organization (JALFHCC) is comprised of two campuses, West and East Campuses. The West Campus has 48 buildings on 94 acres of land between Green Bay Road and Buckley Road in North Chicago, Illinois. The East Campus has four medical facilities on Naval Station Great Lakes, Illinois. There are two Community Based Outpatient Clinics in Evanston and McHenry, Illinois and one in Kenosha, Wisconsin. The JALFHCC has 303 available beds and treated 889,877 outpatient encounters and 3,188 inpatient admissions in 2024.

The JALFHCC began using a single unified budget in 2011 to operate the integrated facility and execute funding using the VA Financial Management System. An account under the Department of Veterans Affairs, “Joint Department of Defense - Department of Veterans Affairs Medical Facility Demonstration Fund” (referred to as the “Fund”), was effective beginning in 2011 (4th Quarter).

VA and DoD determine the JALFHCC expenses that can be attributed to VA and DoD based on cost, workload, and the consumption of resources by each Department’s beneficiaries. This reconciliation model is used as the basis for preparing future budgets. The reconciliation methodology uses agreed-upon full costing methods and execution data to determine the costs attributable to each Department. The reconciliation methodology uses industry standard measurements such as Relative Value Units and Relative Weighted Products for the determinations of workload values to be compared to VA’s Decision Support System full costs. Both Departments will continue to work together to improve upon an equitable reconciliation process and ensure respective Department financial controls are implemented.

Administrative Provisions

VA is proposing continuing the following administrative provisions for 2026 in accordance with P.L. 111-84, National Defense Authorization Act (NDAA) for Fiscal Year 2010, as included in the President's Budget:

SEC. 218. *Of the amounts appropriated to the Department of Veterans Affairs for fiscal year 2026 for "Medical Services", "Medical Community Care", "Medical Support and Compliance", "Medical Facilities", "Construction, Minor Projects", and "Information Technology Systems", up to $654,954,000, 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 A of Public Law 118-42 is repealed.*

SEC. 219. *Of the amounts appropriated to the Department of Veterans Affairs which become available on October 1, 2026, for "Medical Services", "Medical Community Care", "Medical Support and Compliance", and "Medical Facilities", up to $739,918,000, 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. 220. *Such sums as may be deposited to the Medical Care Collections Fund pursuant to section 1729A of title 38, United States Code, for healthcare provided at facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110–417; 122 Stat. 4500) shall also be available: (1) for transfer to the Joint Department of Defense—Department of Veterans Affairs Medical Facility Demonstration Fund, established by section 1704 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111–84; 123 Stat. 2571); and (2) for operations of the facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110–417; 122 Stat. 4500): Provided, That, notwithstanding section 1704(b)(3) of the National Defense*

Authorization Act for Fiscal Year 2010 (Public Law 111–84; 123 Stat. 2573), amounts transferred to the Joint Department of Defense—Department of Veterans Affairs Medical Facility Demonstration Fund shall remain available until expended.

Also, in accordance with Public Law 111-84, NDAA 2010, DoD is proposing the following general provision, for 2026, as included in the President's Budget:

Section 8044. *From within the funds appropriated for operation and maintenance for the Defense Health Program in this Act, up to $165,000,000 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.*

Authorities to use this Fund terminates on September 30, 2026.

Health Care Sharing

The Department of Veterans Affairs (VA) procures medical services to strengthen the medical programs at VA medical centers (VAMC) and to improve the quality of health care provided to Veterans under title 38, United States Code. Contracting officers are authorized under 38 U.S.C. § 8153 to sole source directly to educational institutions when that institution is affiliated with a VA Residency Program, and the health care resource required is a commercial service, the use of medical equipment or space, or research. As a result, VA purchases medical care services from its academic affiliates, as well as other community partners, and the obligations associated with this activity are reported as Services Purchased by VA. The bulk of these contracts are for providing Veteran care through our Community Care Network (CCN), locum tenens physicians and so forth, to fill in gaps when there are no VA physicians available, or the internal VA workload is heavy. Services procured through this program are performed by academic affiliate providers at VAMCs, as well as at the community partner's facilities through CCN. The VA statute also enables the opportunity for VA to collect reimbursements by providing medical care services, equipment, or space to its academic affiliate partners. The obligations associated with this activity are reported as Services Provided by VA.

This authority is a critical component of VA's education and training mission. As one of four statutory missions, VA conducts an Education and Training Program for health profession students and residents to enhance the quality of care provided to Veteran patients within the Veterans Health Administration (VHA) health care system.

Although VA relies on several title 38, United States Code authorities for procuring services outside VA, the following information discusses activities conducted by VA's Office of Acquisition Logistics and Construction and VHA Office of Procurement and Logistics pursuant to 38 U.S.C. § 8153.

Health Care Sharing Obligations and Reimbursements

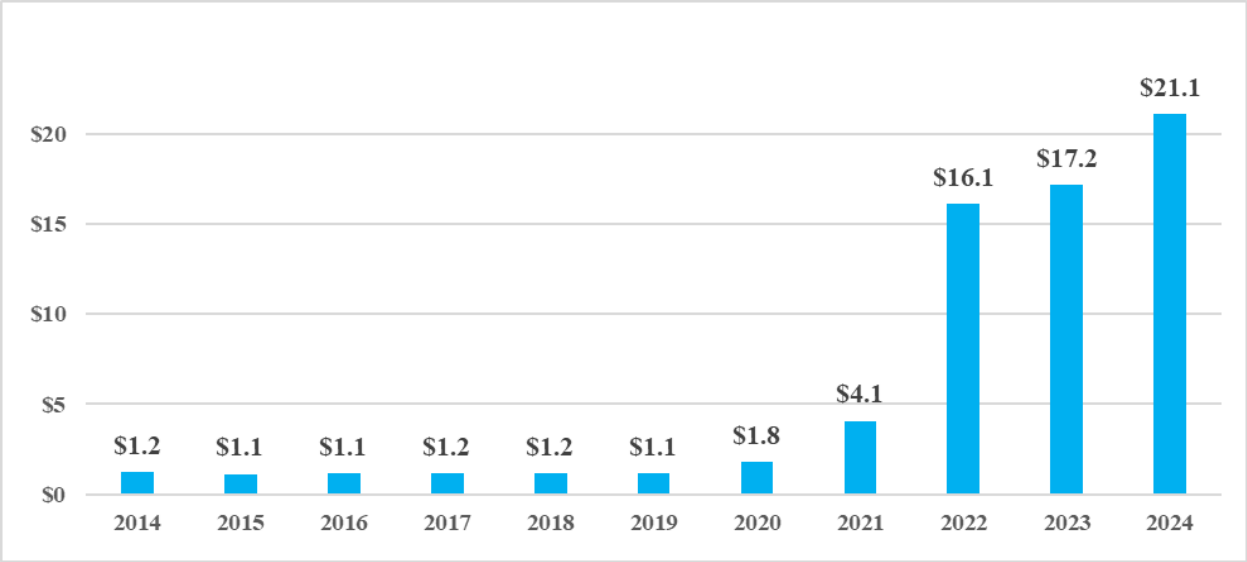
($ in thousands)

Description	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Advance Approp.	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
Services Purchased by VA:								
Medical Service (0160) VHA Contracting Obligations.....	$577,763	$779,779	$577,763	$779,779	**$577,763**	**$577,763**	$0	$0
Medical Service (0160) National Contracting Obligations /1.....	$20,416,077	$17,303,006	$22,457,685	$17,303,006	**$22,457,685**	**$22,457,685**	$0	$0
Medical Service (0160) Obligations Total.....	$20,993,840	$18,082,785	$23,035,448	$18,082,785	**$23,035,448**	**$23,035,448**	$0	$0
Services Provided by VA:								
Medical Service (0160) Reimbursements /2.....	$75,627	$68,812	$83,190	$68,812	**$84,190**	**$84,190**	$1,000	$0
Medical Service (0160) Obligations and Reimbursements Total...	$21,069,467	$18,151,597	$23,118,638	$18,151,597	**$23,119,638**	**$23,119,638**	$1,000	$0

1/ Includes Department-wide national contracting data.
2/ Estimated reimbursements are based on historical execution of reimbursement amounts.

Chart 1 presents the growth of the Health Care Resource Sharing Program. The bars represent the total health care resource services procurements and reimbursements since 2014.

Chart 1. Health Care Resource Sharing Program
($ in millions)



Source: VA, Annual Report on Sharing of Health Care Resources, 2024.

VA Health Care Facilities and Sharing

Traditionally, large VAMCs are more likely to have more extensive sharing arrangements. The referral system of medical practices enhances the size of these sharing programs as patients flow from smaller hospitals and clinics to tertiary care centers. The diversity of sharing arrangements is also influenced by the specialized capability of larger academic medical centers to manage difficult medical care problems. VAMCs in small metropolitan areas rely heavily on sharing agreements to provide health care resources not available at the VA facility.

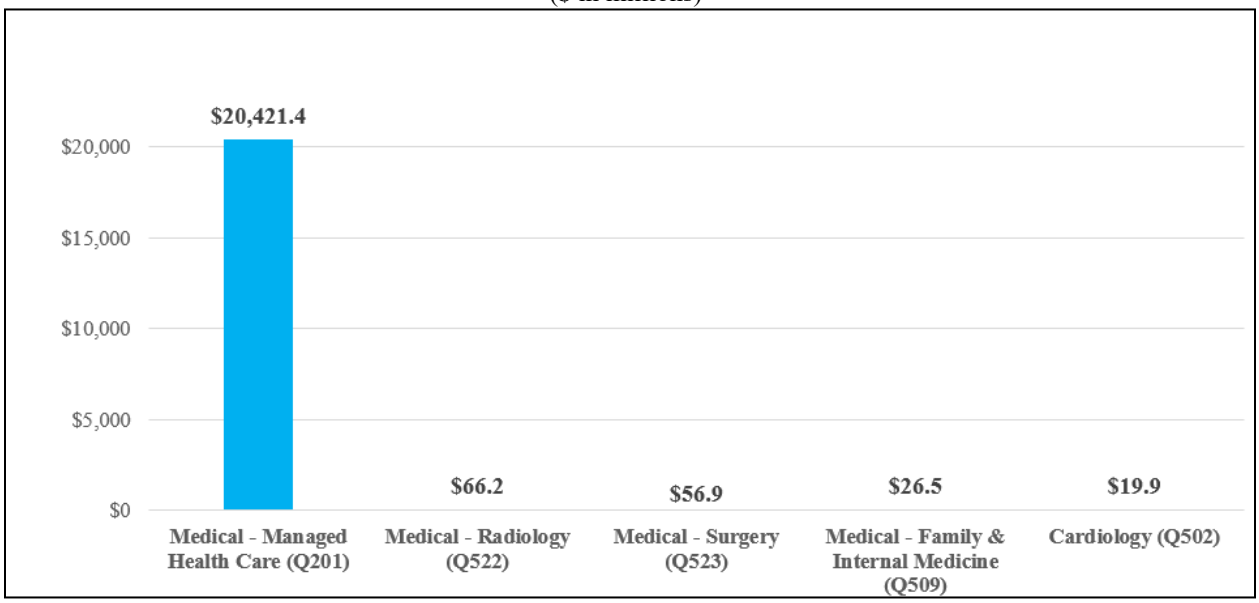
Procurements

The procurements are primarily in the following areas: managed health care, radiology, surgery, family and internal medicine, and cardiology. 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 2024. These categories account for $20.6 billion of total VA purchases of $21.0 billion in obligations that year.

Chart 2. Common Health Care Resources Procured

($ in millions)



Source: VA, Annual Report on Sharing of Health Care Resources, 2024.

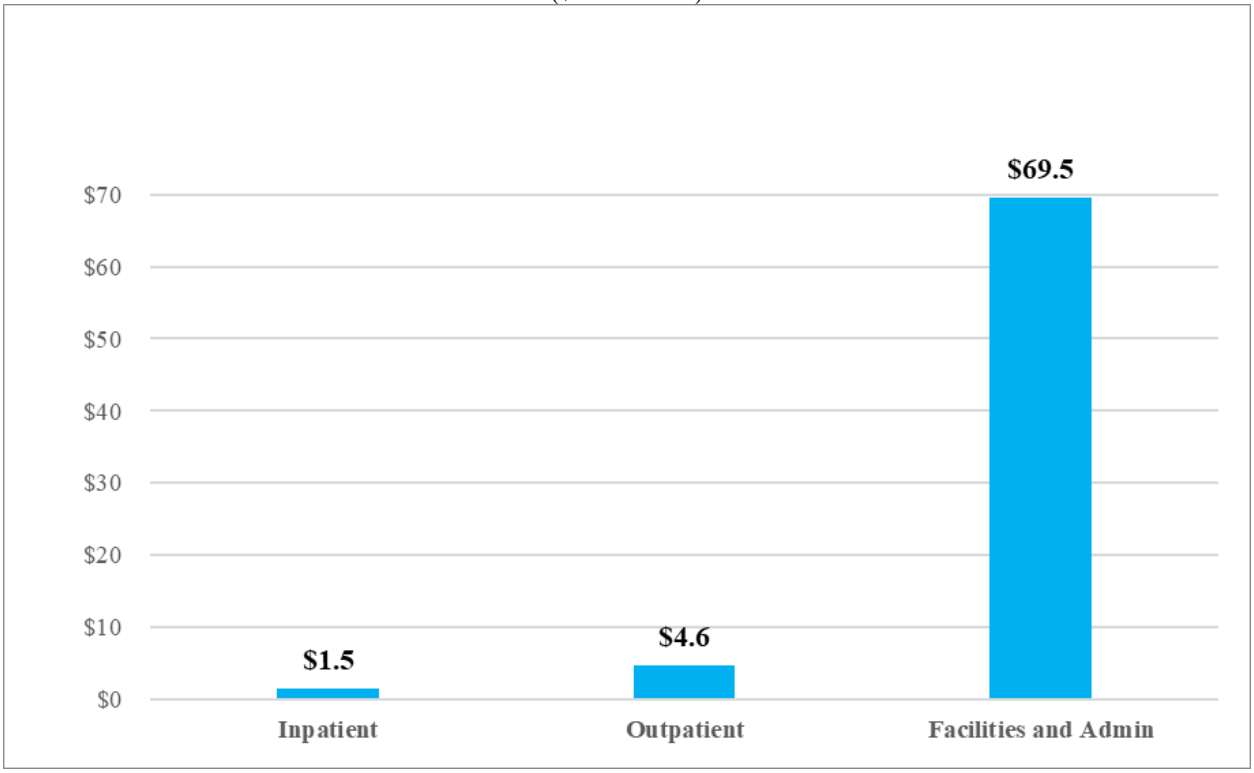
Reimbursements

VA provides a limited number of resources to affiliated medical colleges, community hospitals and other sharing partners such as State Veterans Homes. VAMCs that have particular resources not fully utilized for the care of Veterans may share these resources with other community entities. Such resources are more cost effective when shared. The reimbursements received from these sharing agreements are retained by the VAMC and are used to enhance services and support.

Chart 3 presents total reimbursements in 2024 from affiliated medical colleges, community hospitals and other sharing partners.

Chart 3. Reimbursements from Health Care Resource Sharing

($ in millions)



Source: VA, Annual Report on Sharing of Health Care Resources, 2024.

VA / DoD Sharing

VA and the Department of Defense (DoD) are authorized under 38 U.S.C. § 8111 to enter into sharing agreements for the mutually beneficial coordination, use, or exchange of health care resources, with the goal of improving access, quality, and cost effectiveness of health care services provided by VA and the Military Health System to the beneficiaries of both Departments.

VA / DoD Sharing Obligations[12] and Reimbursements

($ in thousands)

Description	2024 Actual 1/	2025 Budget Estimate	2025 Current Estimate	2026 Advance Approp.	**2026 Revised Request**	**2027 Advance Approp.**	+/- 2025-2026	+/- 2026-2027
DoD-Provided Services Purchased by VA								
Medical Community Care (0140) Obligations.....	$168,569	$119,715	$123,626	$127,335	**$131,155**	**$135,090**	$7,529	$3,935
VA-Provided Services Purchased by DoD								
Medical Services (0160) Reimbursements.....	$84,700	$83,214	$87,241	$89,858	**$92,554**	**$95,331**	$5,313	$2,777

1/ Itemized detail of DoD-Provided Services Purchased by VA in 2024 is as follows:

Obligations	
(8321) Army.....	$91,127
(8322) Air Force.....	$60,064
(8323) Navy.....	$17,211
(8324) Defense Health Agency.....	$167
Obligations Total.....	$168,569

1/ Itemized detail of VA-Provided Services Purchased by DoD in 2024 is as follows:

Reimbursements	
DoD Sharing - All Other.....	$23,387
DoD Sharing - Inpatient.....	$68
DoD Sharing - Outpatient.....	$11,870
CHAMPUS - Inpatient.....	$0
CHAMPUS - Outpatient.....	$6
CHAMPUS - All Other.....	$0
TRICARE - Inpatient.....	$5,279
TRICARE - Outpatient.....	$8,333
TRICARE - All Other.....	$551
TRICARE - Pharmacy.....	$12
TRICARE - Active Duty Dental.....	$13
DoD Disability Evaluation - IDES.....	$6
DoD Spinal Cord Injury - Inpatient.....	$1,263
DoD Spinal Cord Injury - Outpatient.....	$75
DoD Spinal Cord Injury - Other.....	$287
DoD Brain Injury - Inpatient.....	$30,092
DoD Brain Injury - Outpatient.....	$792
DoD Brain Injury - Other.....	$2,666
DoD Blind Rehab - Inpatient.....	$0
DoD Blind Rehab - Outpatient.....	$0
DoD Blind Rehab - Other.....	$0
Reimbursements Total.....	$84,700

[12] In 2024, the VA / DoD Sharing Program experienced an improvement in military treatment facilities use of DoD's new billing system resulting in 2023 health care claims being filed by DoD. In 2025, the Program expects to return to the standard trend.

Table 1 displays 189 active sharing agreements[13] with 3,226 services offered between 77 VA and 98 DoD facilities nationwide in 2024, an 77% increase in the number of services offered in agreements since 2023.[14]

Table 1. 2024 VA / DoD Health Care Resource Sharing Summary

VISN	Shared Service Type	Provider	Number of Services Offered
0 (VACO)	Administration and Support	DoD/VA	1
		VA	2
	Ancillary Services	DoD	1
0 Total			**4**
1	Clinical - Professional Skills Development and Maintenance	VA	1
1 Total			**1**
2	Administration and Support	DoD	2
		VA	1
	Ambulatory Care Services	DoD	5
		DoD/VA	2
		VA	19
	Ancillary Services	DoD/VA	5
		VA	8
	Clinical - Professional Skills Development and Maintenance	DoD/VA	1
		VA	1
	Dental Services	DoD	1
	Inpatient Services	DoD	1
2 Total			**46**
4	Administration and Support	VA	1
	Ambulatory Care Services	DoD	57
	Ancillary Services	DoD	8
	Clinical - Professional Skills Development and Maintenance	VA	3
	Inpatient Services	DoD	40
4 Total			**109**

[13] Excluding the DoD / VA Health Care Sharing Incentive Fund and the Joint DoD / VA Medical Facility Demonstration Fund.

[14] The VA / DoD Sharing Program has been systematically engaged in assessing and improving the quality of fiscal data to be compliant with U.S. Treasury G-Invoicing mandate, as well as in VA's transitions to the new Integrated Financial and Asset Management System and Electronic Health Record. In addition, VA is in the process of standardizing several VA / DoD resource sharing and fiscal processes to improve data capture and reliability. VA will continue to monitor the factors affecting the quality of data and expects to see fluctuation over the next several years.

VISN	Shared Service Type	Provider	Number of Services Offered
5	Administration and Support	DoD	15
		DoD/VA	2
	Ambulatory Care Services	DoD	9
		DoD/VA	46
		VA	1
	Ancillary Services	DoD	3
		DoD/VA	6
	Clinical - Professional Skills Development and Maintenance	VA	2
	Dental Services	VA	1
	Inpatient Services	DoD	2
		DoD/VA	27
	Other and Military Unique	DoD	1
		VA	1

VISN	Shared Service Type	Provider	Number of Services Offered
Total			**116**
6	Administration and Support	DoD	7
		VA	1
	Ambulatory Care Services	DoD	136
		DoD/VA	1
		VA	1
	Ancillary Services	DoD	48
		DoD/VA	1
	Clinical - Professional Skills Development and Maintenance	VA	3
	Dental Services	DoD	6
		VA	1
	Inpatient Services	DoD	107
		DoD/VA	2
		VA	2
6 Total			**316**
7	Administration and Support	DoD	18
		DoD/VA	2
		VA	1
	Ambulatory Care Services	DoD	105
		DoD/VA	12
		VA	6
	Ancillary Services	DoD	31
		DoD/VA	10
		VA	2
	Clinical - Professional Skills Development and Maintenance	VA	5
	Dental Services	DoD	6
	Inpatient Services	DoD	85
		DoD/VA	4
		VA	1
	Other and Military Unique	DoD	2
7 Total			**290**

VISN	Shared Service Type	Provider	Number of Services Offered
8	Administration and Support	DoD	11
		VA	5
	Ambulatory Care Services	DoD	72
		VA	4
	Ancillary Services	DoD	22
	Clinical - Professional Skills Development and Maintenance	VA	4
	Dental Services	DoD	3
	Inpatient Services	DoD	48

VISN	Shared Service Type	Provider	Number of Services Offered
8 Total			**169**
9	Administration and Support	DoD	8
	Ambulatory Care Services	DoD	5
		VA	2
	Ancillary Services	DoD	4
	Clinical - Professional Skills Development and Maintenance	VA	1
	Inpatient Services	DoD	1
9 Total			**21**
10	Administration and Support	DoD	4
	Ambulatory Care Services	DoD	10
		VA	2
	Ancillary Services	DoD	3
		VA	4
	Clinical - Professional Skills Development and Maintenance	DoD/VA	1
		VA	5
	Dental Services	VA	3
	Inpatient Services	DoD	58
	Other and Military Unique	VA	1
10 Total			**91**
12	Ambulatory Care Services	VA	1
	Ancillary Services	VA	1
12 Total			**2**
15	Administration and Support	DoD	2
		VA	1
	Ambulatory Care Services	DoD	24
		VA	98
	Ancillary Services	DoD	8
		VA	26
	Clinical - Professional Skills Development and Maintenance	VA	3
	Dental Services	VA	5
	Inpatient Services	DoD	24
		VA	53
	Non-Clinical - Professional Skills Development and Maintenance	VA	1
15 Total			**245**

VISN	Shared Service Type	Provider	Number of Services Offered
16	Administration and Support	DoD	5
		DoD/VA	4
		VA	12
	Ambulatory Care Services	DoD	56
		DoD/VA	1
		VA	6
	Ancillary Services	DoD	13
		VA	4
	Clinical - Professional Skills Development and Maintenance	DoD/VA	1
		VA	5
	Dental Services	DoD	2
		VA	1
	Inpatient Services	DoD	14
	Other and Military Unique	DoD	1
		DoD/VA	1

VISN	Shared Service Type	Provider	Number of Services Offered
16 Total			**126**
17	Administration and Support	DoD	2
		VA	2
	Ambulatory Care Services	DoD	349
		VA	2
	Ancillary Services	DoD	104
		VA	1
	Clinical - Professional Skills Development and Maintenance	VA	4
	Dental Services	DoD	20
		DoD/VA	1
	Inpatient Services	DoD	270
	Other and Military Unique	DoD	2
17 Total			**757**
19	Administration and Support	VA	1
	Ambulatory Care Services	DoD	4
		DoD/VA	48
		VA	23
	Ancillary Services	DoD	18
		DoD/VA	1
	Clinical - Professional Skills Development and Maintenance	DoD/VA	1
		VA	7
	Dental Services	DoD	1
	Inpatient Services	DoD	8
		DoD/VA	8
	Non-Clinical - Professional Skills Development and Maintenance	VA	4
19 Total			**124**

VISN	Shared Service Type	Provider	Number of Services Offered
20	Administration and Support	DoD	24
		DoD/VA	1
		VA	4
	AIDS	DoD	1
	Ambulatory Care Services	DoD	135
		DoD/VA	22
		VA	4
	Ancillary Services	DoD	58
		DoD/VA	8
		VA	1
	Clinical - Professional Skills Development and Maintenance	VA	3
	Dental Services	DoD	10
	Inpatient Services	DoD	98
		DoD/VA	18
		VA	3
	Mammography	DoD	2
	Other and Military Unique	DoD	1
		DoD/VA	1

VISN	Shared Service Type	Provider	Number of Services Offered
20 Total			**394**
21	Administration and Support	DoD	8
		DoD/VA	1
		VA	7
	Ambulatory Care Services	DoD	53
		DoD/VA	4
		VA	22
	Ancillary Services	DoD	14
		VA	7
	Clinical - Professional Skills Development and Maintenance	VA	2
	Dental Services	DoD	2
	Inpatient Services	DoD	41
		DoD/VA	3
		VA	5
21 Total			**169**
22	Administration and Support	DoD	1
		DoD/VA	4
		VA	17
	Ambulatory Care Services	DoD	90
		DoD/VA	4
	Ancillary Services	DoD	6
		DoD/VA	6
		VA	4
	Clinical - Professional Skills Development and Maintenance	DoD/VA	2
		VA	5
	Dental Services	DoD/VA	1
	Inpatient Services	DoD	80
		DoD/VA	6
	Other and Military Unique	DoD/VA	3
22 Total			**229**

VISN	Shared Service Type	Provider	Number of Services Offered
23	Administration and Support	DoD	1
		VA	2
	Ambulatory Care Services	DoD/VA	1
	Ancillary Services	DoD	1
		VA	4
	Clinical - Professional Skills Development and Maintenance	VA	7
	Inpatient Services	VA	1

VISN	Shared Service Type	Provider	Number of Services Offered
23 Total			**17**

Medical and Prosthetic Research

Table: Appropriations and Other Resources

(Dollars in thousands)	2024 Enacted	2025 Estimate	2026 Request	2026 Request - 2025 Estimate
Medical and Prosthetic Research Appropriation	$943,000	$934,682	$943,000	$8,318
Cost of War Toxic Exposure Fund (TEF)	$56,285	$59,000	$57,000	-$2,000
Intramural Research Total (VA Appropriations)	**$999,285**	**$993,682**	**$1,000,000**	**$6,318**
VERA Research Support (Medical Care Support)[1]	$836,400	$787,950	$850,000	$62,050
Extramural Funding (Other Federal and Non-Federal Resources)	$511,413	$496,800	$496,800	$0
Reimbursements	$56,285	$82,000	$82,000	$0
Total Budgetary Resources	**$2,403,383**	**$2,360,432**	**$2,428,800**	**$68,368**
Federal Employment Distribution (cumulative)[2]				
Medical and Prosthetic Research Appropriation[3]	3,703	3,707	3,565	-142
Cost of War Toxic Exposure Fund (TEF)	93	164	213	49
Total FTE	**3,796**	**3,871**	**3,778**	**-93**

1. Through the Veterans Equitable Resource Allocation (VERA), Research Support includes funding from the Medical Services, Medical Support and Compliance, and Medical Facilities Appropriations to support Research.
2. Medical and Prosthetic Research updated the FTE methodology to reflect cumulative FTE instead of non-cumulative. Cumulative FTE is consistent with the definition of full-time equivalent (FTE) employment in OMB Circular A-11
3. Includes Direct and Reimbursable FTE.
4. The FY 25 Appropiation Estimate contains a planned transfer of $8.3 M from the Medical Research to the Medical Services Appropiation.

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, $943,000,000, plus reimbursements, shall remain available until September 30, 2027: 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 Research Discretionary and Mandatory Appropriation Requests

To fulfill the commitment of the Department of Veterans Affairs (VA) to provide superior health care to Veterans, the Office of Research and Development (ORD) requests $1 billion in 2026, an increase of $6 million above the 2025 estimate, in total appropriated resources to fund the VA intramural medical research program. This amount is comprised of the following:

Discretionary Appropriations: A request of $943 million in the Medical and Prosthetic Research Appropriation, equal to the 2025 enacted level, and an increase of $8 million above the 2025 estimate due to the $8 million transfer to Medical Services included in the 2025 estimate.

Mandatory Appropriations: A request of $57 million, a decrease of 3% or $2 million below the 2025 enacted level, from the Cost of War Toxic Exposures Fund (TEF) to support medical and other research relating to exposure to environmental hazards.

Details on VA Research Funding Sources

VA Research uses a combination of VA appropriated resources and other resources to deliver on our promise to improve Veterans' health through medical research. The details below provide further explanation of the funding sources depicted in the Appropriations and Other Federal Resources table on the previous page:

- **Intramural Research:** ORD uses VA appropriations, including Medical and Prosthetics Research Appropriation and the TEF, to support research merit awards (studies), research career scientist awards, career development awards, research infrastructure, and overall capacity building for the Research Enterprise. **The total 2026 intramural research estimate is $1 billion.**
- **Veterans Equitable Resource Allocation (VERA), Research Support:** VA Research at VA Medical Centers (VAMCs) is further supported through VERA Research Support Allocations. Funding through the VERA model is distributed through VA Medical Care Appropriations, including Medical Service, Medical Support and Compliance, and Medical Facilities. The allocation is intended for use by the facilities in support of VAMC costs associated with research, including protected time for clinicians to conduct research, research equipment maintenance contracts, biomedical maintenance support, research infrastructure costs (both space and personnel), other general and direct administrative support for committees, and other expenses for research compliance and oversight. VERA is also used to support the Quality Enhancement Research Initiative (QUERI), which is part of the ORD organization but funded through the Medical Services Appropriation. **The 2026 VERA estimate is $850 million.**
- **Extramural Funding:** VA Researchers independently apply for and receive extramural funding from private and federal grants by leveraging VA research capabilities. This funding is typically managed at the local level at individual VAMCs, largely through 78 VA affiliated non-profit research corporations (NPCs) or a university affiliate. **The 2026 estimate for extramural funding is $497 million**.
- **Reimbursable Resources:** VA Research also earns collections and reimbursements. This resource includes interagency agreements with other Federal partners (within VA and outside), reimbursements from the Medical Care appropriation, and reimbursements from NPCs and university affiliates. **The 2026 estimate for reimbursable resources is $82 million**.

Legislative Authorizations and Requirements

1. **38 USC 7303: Functions of Veterans Health Administration: Research Programs**

   Provides overreaching authority for ORD to contribute to the Nation's knowledge about disease and disability among Veterans.

2. **38 USC 7381: Office of Research and Development (P.L. 117-328)**

   Establishes the ORD to serve Veterans through a full spectrum of research (including pre-clinical, clinical, and health systems science), technology transfer, and application.

3. **Sergeant First Class Heath Robinson Honoring our Promise toddress Comprehensive Toxics (PACT) Act of 2022 (P.L. 117-168)**

   ORD is the designated lead for:

   - Section 501: Interagency working group on toxic exposure research.

4. **Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022 (P.L. 117-328)**

   ORD is the designated lead for:

   - Section 181. Inapplicability of Paperwork Reduction Act,
   - Section 182. Research and Development (amendments),
   - Section 183. Expansion of Hiring Authorities for certain classes of research occupations, and
   - Section 184. Comptroller general study on dedicated research time for certain personnel of the Department of Veteran Affairs.

   ORD provides key support for:

   - Section 102. Department of Veteran Affairs treatment and research of prostate cancer.

5. **Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (P.L. 116-171) (Hannon Act)**

   ORD is the designated lead for:

   - Section 204(a). Department of Veterans Affairs study of all-cause mortality of Veterans including by suicide. This section specifically concerns the effects of opioids and benzodiazepines;
   - Section 301. Study on connection between living at high altitude and suicide risk factors among Veterans;
   - Section 305. Precision medicine mental health initiative;
   - Section 306. Statistical analysis and data evaluation by Department of Veterans Affairs; and

- Section 704. Use by the Department of Veterans Affairs of commercial institutional review boards in sponsored research trials.

ORD provides key support for:

- Section 405. Joint mental health programs by the Department of Veterans Affairs and Department of Defense;
- Section 702. Partnerships with non-Federal Government entities to provide hyperbaric oxygen therapy for treatment of post-traumatic stress disorder and traumatic brain injury;
- Section 705. Creation of Office of Research Reviews within the VA Office of Information and Technology;
- Section 101. Strategic plan on expansion of health care coverage for Veterans transitioning from service in the Armed Forces; and
- Section 201. Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP).

6. **Comprehensive Addiction and Recovery Act of 2016 (CARA) (P.L. 114-198)**

ORD has responsibilities in:

- Title IX: Subtitle A—Opioid Therapy and Pain Management
  - Sec. 913. Review, investigation, and report on use of opioids in treatment by Department of Veterans Affairs.
  - Sec. 931/932. Expansion of research and education on and delivery of complementary and integrative health to Veterans.

7. **John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act) (P.L. 115-182)**

ORD has responsibilities in the study and evaluation of the following through the Health Systems Research QUERI:

- Section 506. Program on establishment of peer specialists in patient aligned care teams settings within medical centers of Department of Veterans Affairs.
- Section 401. Development of criteria for designation of certain medical facilities of the Department of Veterans Affairs as underserved (e.g., rural health).
- Section 152. 1703E. Center for Innovation for Care and Payment pilot studies.

8. **Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act (P.L. 118-210)**

ORD has responsibilities in:

- Section 107. Strategic plan on value-based health care system for Veterans Health Administration and pilot program.

9. **Foundations for Evidence-based Policymaking Act (P.L. 115-435)**

ORD has responsibilities in:

- Title I, Section 101(a)(b). Agency evidence-building plan and evaluation plan.

VA Research Mission

For 100 years, VA Research transformed the lives of Veterans and all Americans through health care discovery and innovation. VA Research is part of the nation's largest integrated health care system and fosters collaboration with university affiliates, other federal agencies, nonprofit organizations and private industry.

ORD takes an enterprise approach to drive VA's research mission and the Administration's priorities related to:

- Improving Veterans' health and well-being through basic, translational, clinical health services and rehabilitation, genomic and data science research, and 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;
- Assuring a culture of professionalism, collaboration, accountability, and the highest regard for research participants' safety and privacy; and
- Highlighting how research-driven efforts provide value to the Veteran care experience beyond general expectations of the role of scientific activities.

VA Research Strategic and Cross-Cutting Clinical Priorities

VA Research leverages the input from various stakeholders to establish our Strategic and Cross Cutting Priorities. Our stakeholders include the National Research Advisory Council, Veterans Service Organizations, Veterans, their providers, families, and caregivers, Congress, and the Administration.

VA Research priorities for bringing better care to Veterans span prevalent diseases and conditions as part of military service and life experiences and unique opportunities for which VA is best positioned to address given its enterprise capabilities and integration within the VA healthcare system. ORD organized efforts to highlight a Veteran-focused approach to its work and summarized below.

VA Research's Three Strategic Priorities	Cross Cutting Clinical Priorities- Legislative and Agency priorities
1. Increasing Veterans' access to high-quality clinical trials 2. Increasing the substantial real-world impact of VA research 3. Putting VA data to work for Veterans	1. Traumatic brain injury (TBI) 2. Posttraumatic stress disorder (PTSD) 3. Military environmental exposures 4. Pain/opioid use disorder 5. Cancer, with a focus on precision oncology 6. Suicide prevention 7. Preventing Veteran homelessness 8. Veteran timely access to care – digital health/artificial intelligence 9. Well-being including physical/mental health and chronic disease care

Table: Medical Research Funding Resources

(dollars in thousands) Description	2024 Actuals	2025 Enacted	2026 Request	2026 Request - 2025 Enacted
DISCRETIONARY RESOURCES				
Medical and Prosthetic Research Appropriation	943,000	943,000	943,000	0
Transfer to:				
Medical Services (0160) from Medical and Prosthetics Research	0	(8,318)	0	8,318
Discretionary Budget Authority Total	**943,000**	**934,682**	**943,000**	**8,318**
Reimbursements	56,285	82,000	82,000	0
Unobligated Balance (SOY)				
No-year	4,305	5,354	4,500	(854)
2-year	83,016	86,761	111,500	24,739
3-year (24-26)	0	1,916	1,000	(916)
3-year (25-27)	0	0	2,000	
3-year (26-28)	0	0	0	
Unobligated Balance (SOY) Subtotal	**87,321**	**94,031**	**119,000**	**24,969**
Unobligated Balance (EOY)				
No-year	(5,354)	(4,500)	(4,500)	0
2-year (Annual Appropriation)	(86,761)	(111,500)	(100,000)	11,500
3-year (24-26)	(1,916)	(1,000)	(2,000)	(1,000)
3-year (25-27)	0	(2,000)	(1,000)	1,000
3-year (26-28)	0	0	0	0
Lapse	4	0	0	0
Unobligated Balance (EOY) Subtotal	**(94,035)**	**(119,000)**	**(107,500)**	**11,500**
Prior Year Recoveries	38,172	50,000	50,000	0
Total Obligations	**1,030,744**	**1,041,713**	**1,086,500**	**44,787**
Discretionary Full-Time Equivalents (FTE)				
Direct FTE	3,551	3,555	3,413	(142)
Reimbursable FTE	152	152	152	0
Total FTE	**3,703**	**3,707**	**3,565**	**(142)**
MANDATORY RESOURCES				
Cost of War Toxic Exposure Fund (TEF)				
5 Year (P.L 118-5, 24-28)	46,000	-	-	-
5 Year (P.L. 118-5, 25-29)	-	59,000	-	-
TEF (Request)	-	-	57,000	2,000
Mandatory Budget Authority Total	**46,000**	**59,000**	**57,000**	**(2,000)**
Unobligated Balance (SOY)	226	26,719	40,000	13,281
Unobligated Balance (EOY)	(26,719)	(40,000)	(30,000)	10,000
Prior Year Recoveries	21	-	-	-
Total Obligations	**19,528**	**45,719**	**67,000**	**21,281**
Mandatory Full-Time Equivalents (FTE)	**93**	**164**	**213**	**49**

Research Priorities for 2026

The 2026 request is based on where VA Research's investment can make the greatest impact to Veterans' health and well-being. It also considers the relative resource needs consistent with the overall balance for all needs across VHA.

Suicide Prevention

The ORD Suicide Prevention Actively Managed Portfolio (SP AMP) funds cutting-edge research to understand and prevent suicide among Veterans. This portfolio covers a wide range of studies, from preclinical to clinical and health services research. It includes diverse methods and approaches such as genetic analysis, pharmacological and non-pharmacological treatments, innovative technologies, and observational and epidemiological studies. Additionally, it emphasizes risk identification and the impact of community factors like family, caregiver support, education, public service announcements, recreation, housing, geospatial location, and employment on suicidality.

ORD suicide prevention research has already led to the adoption of many suicide prevention strategies within VA, including:

- Supporting Patients after Discharge from the Emergency Department

  An intervention that involves completing a safety plan while in the Emergency Department. The patient then receives weekly provider contact until the patient is engaged in mental health care. The intervention was associated with a 45% reduction in suicidal behavior in the 6 months following Emergency Department discharge.

- Improvements in the Adoption of Standardized Suicide Risk Screening and Evaluation (VA Risk ID)

  The VA Risk ID is a VHA-wide effort to implement a national, standardized process for suicide risk screening and evaluation, using high-quality, evidence-based tools and practices.

- Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET)

  REACH VET is a VA-developed predictive model that utilizes patient record information to inform Suicide Prevention Coordinators of Veterans who may benefit from enhanced clinical care, outreach, and risk assessment. REACH VET implementation is associated with greater treatment engagement and safety plan documentation with fewer mental health admissions, emergency department visits, and suicide attempts.

- National Veterans Financial Resource Center (FINVET)

  VA research demonstrated that financial well-being is related to better mental health and lower risk of suicide. In response to these findings, the Office of Suicide Prevention created FINVET to provide a one-stop website that makes it easier for Veterans to find money resources, boost financial literacy, and navigate their financial journey.

- VA Department of Defense (DoD) Clinical Practice Guidelines (CPG)

CPG for Patients at Risk for Suicide uses evidence-based information to guide health care providers in suicide prevention. ORD research informed recommendations on (1) suicide risk identification, (2) predictive analytics, (3) screening and assessment, (4) risk management and treatment, and (5) pharmacological and other somatic treatments. For example, modifications to recommendations on the use of lithium for suicide prevention is entirely based on VA-funded clinical trial.

- Caring Contacts

  Caring Contacts is an evidence-based suicide prevention intervention which sends short, caring messages to Veterans at risk of suicide. This intervention is shown to increase Veteran engagement in services and is used to engage Veterans who call the Veterans Crisis Line.

- Lethal Means Safety programs

  VA research shows Veteran preference for lockbox firearm storage led to rollout of lockbox distribution program for at-risk Veterans receiving care in VA facilities. VA research established the efficacy of developing out-of-home storage networks and the Office of Suicide Prevention is expanding the program across multiple Southern states.

2026 Planned Activities

- **Suicide Prevention Precision Health Research Resource:** The Suicide Prevention AMP, in collaboration with the VHA Office of Suicide Prevention, will begin development of the VA Enterprise for Suicide Prevention – Precision Health Research Resource. This platform will enable VA-wide suicide risk phenotyping, test interactions between phenotypes and interventions, and launch clinical trials to validate precision medicine hypotheses from observational studies. Collected data will leverage Artificial Intelligence (AI)/machine learning (ML) to identify risks and enhance precision psychiatry in suicide prevention. Furthermore, integrating survey and real-time assessments will support suicidality surveillance and provide a central resource to address Veterans' needs.
- **The Study to Assess Risk and Resilience in Servicemembers – Longitudinal Study (STARRS-LS):** Continue the DoD)/VA researcher-in-residence program, which provides VA investigators access to data collected as part of DoD's STARRS-LS and collaboration with the STARRS-LS investigative team. This program enables VA researchers to better understand the risk factors for Veteran suicide during the transition from military service.
- **Lethal Means Safety Approaches to Suicide Prevention:** The Suicide Prevention AMP is requesting research applications that seek to advance lethal means safety counseling, messaging, and other strategies that limit access to lethal means during periods of suicidality. The 2024 VA/DoD Suicide Prevention Clinical Practice Guidelines state that having a readily available firearm increases suicide risk, and removing firearms can reduce this risk. However, more evidence is needed on the best ways to encourage voluntary firearm safety among Veterans.
- **Evaluate Implementation of Dialectical Behavior Therapy:** Launch new evaluation to support the sustainment of Dialectical Behavior Therapy, an evidence-based practice that targets chronic suicidality for individuals with borderline personality, as part of the national

Suicide Prevention 2.0 Clinical Telehealth Initiative.

- **Evaluate Caring Letter Intervention**: Complete national evaluation of centralized Caring Letters suicide prevention intervention, which is expected to reach approximately 30,000 VHA patients per year. 140 VA sites are participating in the program with about 20,000 Veterans enrolled and over 95,000 letters mailed.
- **Evaluate Use of VA-issued Tablets for Suicide Prevention:** Complete evaluation of VA-issued tablets for virtual health care, which shown that Veterans who received tablets had a 36% reduction in the likelihood of having a suicide-related emergency department visit.

2025 Activities

- In 2025, ORD supported 52 separate suicide prevention research projects. Projects range the full translational research spectrum, from bench to implementation studies. In 2025, 40 suicide-prevention clinical trials were active.
- As required by the Evidence Act of 2018, ORD is completing the FY 2026-2032 Learning Agenda and Annual Evaluation Plan. The plan highlights national initiatives addressing suicide prevention and leading to the development of VA-wide suicide prevention resources to support the use of predictive modeling data and community-level geospatial, environmental, and social determinants of health data and expansion of the national Suicide Prevention Trials Database.
- Expand national evaluation of the Veteran Sponsorship Initiative, which uses predictive analytics to identify transitioning service members and Veterans at high risk for suicide and connect them with peer sponsors, community services, and VA benefits and health care.
- Complete national evaluation of Caring Letters, an evidence-based suicide prevention program that has reached over 370,000 Veterans who contacted the Veterans Crisis Line. The program is well-suited for large-scale high-risk populations. This evaluation led to a centralized approach for Caring Letters, reducing administrative burden and workload for providers.
- Completed a national evaluation of suicide risk screening, creating evidence-based tools like a dashboard and toolkit. These tools have helped implement screening for over 6.8 million Veterans across 138 facilities. Additionally, the evaluation results are improving how suicide prevention screenings are conducted.
- Evaluated virtual mental health services among 16,236 Veterans who were recently discharged or released from active duty which showed that a 1% increase in virtual mental health visits was associated with a 2.5% decrease in suicide-related events.
- Conducted a national assessment, gathering feedback from over 100 VA leaders to identify gaps in suicide prevention evidence and knowledge translation. Planned data and evaluation initiatives to address these gaps, such as creating enterprise-wide data resources to enhance suicide prevention efforts.

Veteran Homelessness Research

Compared to their housed peers, Veterans experiencing homelessness have worse health outcomes, including premature mortality. In addition to having complex social needs, homeless

and homeless-experienced Veterans generally have high rates of chronic medical illness, psychiatric problems, and substance use disorders. Therefore, ORD investigators are partnering with VA's Homeless Program Office, National Center for Homeless Veterans, Office of Rural Health, QUERI, and other federal agencies, to build knowledge on: (a) tools and strategies for preventing homelessness; (b) promoting housing retention and economic security for current homeless-experienced Veterans; and (c) improving medical and mental health care for homeless and homeless-experienced Veterans.

2026 Planned Activities

- **Preventing homelessness**
    - Use data science tools—natural language processing, AI tools, and predictive modeling— for detecting housing instability in real-time, which will enable targeting resources towards preventing homelessness among Veterans. Specific activities include:
        - Expanding the Department of Energy (DOE) - Million Veteran Program (MVP) VA Homeless Screener Clinical Reminder to proactively address housing instability and homelessness among Veterans through further validation in VA national electronic medical record systems.
        - Researching integrating (non-VA) community (e.g., state) data with VA data for predictive modeling of housing insecurity.
    - Research how to optimize connecting at-risk Veterans to resources for improving economic security, including novel digital technologies, person-generated health data, and vocational and employment services.
    - Design and assess impact of community-based, organizational, or national-level interventions or policies for employment and financial stability/health among Veterans at risk of homelessness/housing instability.
    - Assess impacts of programs focused on community and/or caregiver/family support on housing and economic outcomes.
- **Promoting housing retention**
    - Adapt and test a validated psychosocial intervention to improve family connections among homeless-experienced Veterans.
    - Research and systematically apply psychosocial treatments that increase community integration among homeless-experienced Veterans transitioning from temporary to permanent housing.
    - Examine how changes in social networks predict substance use, housing status, and community integration to provide foundational evidence for interventions to sustain recovery and housing stability for homeless-experienced Veterans.
    - Conduct clinical trials that examine the potential for novel drugs to enhance motivation for social engagement, and thereby, community integration and housing stability, among homeless-experienced Veterans.

- Research using specialized brain imaging to develop and refine novel inter-brain connectivity—a factor predicting social connectivity and community integration—for use with homeless-experienced Veterans.

- **Improving medical and mental health care**
  - Develop and test an enhanced health care support program to sustain older homeless-experience Veterans living in non-institutional settings.
  - Research using homeless-experienced Veteran peers to increase homeless Veterans' engagement in mental health, substance use services, and chronic medical illness care.
  - Research approaches for improving the quality of mental health services delivered in primary care for homeless Veterans.
  - Evaluate national implementation of evidence-based practices to improve health outcomes for Veterans receiving VA provided case management.

2025 Activities and Accomplishments

- **Preventing homelessness**
  - Partnered with DOE and VA's MVP to develop the VA Homeless Screener Clinical Reminder, which identifies predictors of Veteran housing instability.
  - Researched models for screening and referring services for rural-dwelling Veterans to address unmet social and economic needs.

- **Promoting housing retention**
  - Implemented a case management practice across 32 sites for over 1,400 Veterans, increasing housing stability and decreasing hospitalizations among those with homelessness experience.
  - Evaluated Congressionally mandated legal services for over 5,000 Veterans, delivered in partnership with non-VA organizations, addressing housing, economic, and social issues. The resulting report and data dashboard enables the VHA Homeless Programs Office (HPO) to improve the initiative's scale-up, sustainment, and inform VA's report to Congress on its impact.
  - Evaluated VA's Grant and Per Diem Case Management (GPD-CM) program, which provides long-term transitional housing and supportive services for Veterans with homelessness experience, resulting in a report and knowledge translation playbook to enhance Veteran housing and health outcomes.

- **Improving medical and mental health care**
  - Evaluated the Homeless Patient Aligned Care Teams (H-PACT) model for delivering primary care to homeless and homeless-experienced, Veterans, describing Veteran outcomes and costs, to provide information for the HPO to utilize in optimizing H-PACT performance.
  - Evaluated the receipt of preventive health services in VA's HUD-VASH

programs to create resources for clinicians serving HUD-VASH Veterans and to help the VHA Homeless Programs Office monitor performance.

Precision Oncology

ORD established the foundations for high quality oncology care and improved access to care for Veterans. This effort included conducting multidisciplinary team-based translational studies, real-world data analyses to inform guidelines, clinical trials and overall building a learning health care system model that integrates clinical care and research. ORD has a history of landmark trials in cancer with increased emphasis on its ability to conduct and participate in large national clinical trials. These efforts are continuing not only in developing and executing studies that offer potential treatments based on biomarkers or molecular diagnostics in advanced disease but also in precision-based screening and early detection to help with prevention. Initial efforts for precision oncology targeted prostate and lung cancer, which are the two most common non-skin cancers in VA. Research is now expanded to include other cancers such as bladder, kidney, ovarian, breast, head and neck, and blood.

Starting in 2021, Congressional appropriations focused on cancer clinical trials and precision oncology by establishing new studies and cancer trials networks capable of providing more access to Veterans across the nation. In collaboration with VA's National Oncology Program, ORD established supporting infrastructure to provide a system of excellence in cancer care that incorporates clinical trials and research. This integrated network infrastructure helps to facilitate analyses to optimize treatment regimens using AI/ML and national clinical trials through clinical research centers to inform care for over 27,000 Veterans affected by prostate and other cancers. Additionally, the partnership enabled ORD to meet the requirements under the Cleland-Dole Act to increase its focus on prostate cancer, enabling researchers to conduct precision cancer studies across VA facilities to address the clinical needs of Veterans, establish new evidence for clinical care, while maximizing efficiency and strategic investments across the enterprise.

2026 Planned Activities

- Support recruitment of 23,520 Veterans in the precision-augmented lung cancer screening randomized trial. This study aims to refine United States Preventive Services Taskforce guidelines for lung cancer screening, to increase uptake of screening, and reduce disparities observed in black and younger Veterans.
- Sustain partnership activities with the DoD and the National Cancer Institute (NCI) aimed at expanding a biospecimen collection (at least 800 new cases) at 8 new Applied Proteogenomics Organizational Learning Outcomes sites in VA. In an effort to generate proteogenomic data to support development of new knowledge and evidence to improve Veteran care.
- Support development of a clinical and genomic data integration platform for AI to inform patient stratification into cohorts for improved care, treatment, response, and improved outcomes. This platform has potential to speed research and impact for over 50,000 Veterans diagnosed and treated for cancer in VA annually.
- Support a phase II biomarker directed clinical trial that combines chemotherapy and poly

(ADP-ribose) polymerase (PARP) inhibition in small cell lung cancer patients who failed treatment. Study will recruit 152 Veterans across 11 VAMCs. This novel approach could significantly improve treatment for small cell lung cancer patients with limited therapeutic options.

- Support development and validation of a prognostic (Precision Risk/Effectiveness Multi-omic Assessment) model that estimate the risk of prostate cancer-specific mortality compared to non-prostate cancer death with different treatments. The goal is to improve clinician treatment decision-making for hormone sensitive prostate cancer in Veterans.
- Provide support to extend the Phase 2/3 Standard Systemic therapy with or without PET-directed local therapy for OligoRecurrenT trial (STARPORT) to increase Veteran enrollment to reach its target of 374 patients across 17 VA sites. The outcome from this clinical trial has potential to change clinical practice and define the standard of care for Veterans with oligometastatic prostate cancer.
- Expand the clinical research centers (hub and spoke) to include six additional centers in six new VISNs where centers currently do not exist to enable systematic access to oncology care, clinical trials, and research.
- Initiate the development of an evidence-based precision screening tool (that include genetic, environmental, and clinical data) tailored to Veterans to predict prostate cancer risks with the goal of reducing prostate cancer morbidity, mortality, overdiagnosis and overtreatment. Study will also inform the United States Preventive Services Taskforce guidelines for prostate-specific antigen testing.
- Based on feasibility:
    - Support the initiation of clinical trials that: (a) shorten the course of consolidation immunotherapy in localized advanced lung cancer based on real-world Veteran clinical data to reduce toxicities and improve quality of life; and (b) potentiate immunotherapy with tyrosine kinase inhibition to improve the management and survival of patient with metastatic bladder cancer. The decentralized clinical trial model will be used where possible to increase Veteran access to new therapies and to fill unmet clinical needs while embedding AI tools into these trials to validate their ability to predict treatment response and outcomes. Approximately 970 patients will be enrolled in these trials.
    - Support study to understand the contribution of genetic, clinical and environmental and military exposure risk factors to the development of aggressive kidney cancer.
    - Sustain collaborative studies in multicancer early detection (part of a collaborative effort with the NCI).

2025 Activities

- Initiated research on military exposure and cancer to determine whether inherited gene mutations in combination with cancer-causing and cancer-promoting exposures alter susceptibility to bladder, lung, and prostate cancer.
- Continued research to determine the relative risk of Agent Orange exposure for prostate

cancer incidence, aggressiveness, and outcomes, and identification novel genomic mutational signatures associated with Agent Orange exposure.

- Initiated phased start-up of six clinical research hub and spoke sites (representing 38 VA facilities) to support increased access to clinical trials, research and care (include prostate cancer), which is part of a plan to establish one hub in each VISN to form an integrated network supporting systematic access to oncology care, clinical trials, and research.
- Activated three precision therapeutic clinical trial/studies (two lung and one prostate) aimed at establishing new evidence for improving Veteran cancer care.
- Stood up 12 clinical trial sites to participate in the collaborative multi-cancer early detection studies led by NCI.
- Enrolled 274 Veterans in the Phase 2/3 STARPORT trial designed to determine the best way to treat Veterans with oligometastatic metastatic prostate cancer to reduce death from treatment-resistance compared to standard treatment alone.
- Activated a safety and efficacy decentralized hybrid clinical trial comparing standard of care Bruton's tyrosine-protein kinase inhibitor (BTKi) alone versus combination BTKi and Venetoclax to treat chronic lymphocytic leukemia/small lymphocytic lymphoma, a cancer of white blood cells that is incurable. Study will enroll 114 Veterans.
- Supported Targeted Radiation with no Castration for Metastatic Castration Resistant Prostate Cancer (RESTORE), which is a phase II trial that leverages new imaging and precision radiotherapies to offer Veterans an effective treatment for lethal prostate cancer without the burden of ongoing testosterone suppression. Study will enroll 60 Veterans.
- Continued development of an AI-based algorithm to stratify Veterans with human papillomvirus-associated head and neck cancer into risk groups to enable personalized intensification or de-escalation of cancer treatment, improve outcome and establish new standard of care.
- Lung Precision Oncology Program (LPOP) completed over 681,204 low-dose computed tomography CT scans on 351,088 Veterans.
- Increase research activities in the LPOP network to include up to 108 active prevention, screening/detection and treatment clinical trials.
- Continued the use of imaging data to train ML tools to improve diagnostic capacity for earlier detection of lung cancer/stage.
- Completed three major projects using real-world data on Veterans with prostate cancer aimed at improving VA clinical pathway that doctors rely on to treat prostate cancer as well as National Comprehensive Cancer Network guidelines.

Traumatic Brain Injury (TBI)

TBI can cause lifelong disabilities, varying in severity based on the nature and frequency of the injuries. Combat and training during military service often result in undiagnosed TBIs, delaying necessary care and worsening neurobehavioral conditions, significantly impacting Veterans' quality of life.

Over 300,000 VA patients have diagnosed with TBI since the beginning of the post 9/11 conflicts. Symptoms include headaches, irritability, sleep disorders, visual and balance issues, memory lapses, slowed thinking, and depression. TBI affects cognitive function, behavioral health, sensory perception, motor skills, endocrine, and autonomic nervous system functions. Possible consequences are neurodegenerative disease, prolonged sensory deficits, substance misuse, and mental health issues. Most TBIs are mild and hard to diagnose. VA researchers are exploring ways to better detect, monitor, and treat TBI in Veterans.

Under the Hannon Act, Section 305, the ORD's Scott Hannon Initiative for Precision Brain and Mental Health (SHIPBMH) initiative will identify and validate biomarkers for depression, anxiety, PTSD, bipolar disorder, and TBI. SHIPBMH will utilize machine learning algorithms to integrate multiple biomarkers (neuroimaging, biofluids, EEG, and genetic and neurobehavioral assessments) to provide a clinically actionable diagnostic. through. This effort will leverage discoveries from ongoing research programs such as MVP, Long-Term, Impact of Military-Relevant Brain Injury Consortium - Chronic Effects of Neurotrauma Consortium, the Translational Research Center for TBI and Stress Disorders (TRACTS) and the new research area on the brain health effects of military occupational blast exposure.

SHIPBMH will also enhance the availability of deidentified data by collecting standardized data and sharing it openly through the Federal Interagency TBI Research system and VA Data Commons. An additional goal is to clinically translate SHIPBMH-identified targets.

ORD remains committed to developing tools and resources to improve TBI and related brain health diagnoses and monitoring for Veterans. This effort includes focusing on Veterans with a lifetime history of TBI, mental health conditions, and the complex interaction TBI and mental health symptoms. The goal is to more effectively treat Veterans through precision brain and mental health diagnoses.

2026 Planned Activities

- Complete four projects to fulfill the precision brain and mental health requirement of the Hannon Act, Section 305. These projects will develop machine learning algorithms to integrate multi-modal biomarkers for greater accuracy in diagnosis and tracking of brain health. Based upon the results of these projects, further opportunities for a larger scale effort will be announced, competed and funded at the end of 2026.
- Initiate a Cooperative Studies Program (CSP) clinical trial examining growth hormone replacement therapy in Veterans with mild TBI and adult growth hormone deficiency.
- To evaluate chronic TBI/brain health disorders, VA researchers will start the translational development of new TBI/Brain Health Positron Emission Tomagraphy (PET) ligands at our Missouri Open Field Blast Core and the Columbia VAMC PET ligand development team's project.
- Initiate study of the impact of TBI on multiple sensory systems, such as Veteran centric impairments of vision, hearing, balance, and sense of smell.
- Develop brain stimulation (e.g., magnetic, electrical, and electromagnetic modalities)

standards for clinical trials in treatment of TBI and brain health conditions. Currently, there are no consistent standards outside of transcranial magnetic stimulation used for treatment-resistant depression.

2025 Activities

- VA continued to support for the Long-term Impact of Military-relevant Brain Injury Consortium (LIMBIC). VA-DoD jointly funded longitudinal cohort of up to 3,000 post-9/11 Veterans and Service members with TBI and other brain health conditions. In 2025, the consortium will be in its extension year of its current five-year funding period.
- Established a TBI AMP that works in collaboration with the clinical program offices, align research priorities with clinical priorities.
- Established a Brain Health Coordinating Center and Clinical Research Sites, a collaboration between ORD and key clinical programs to improve research relevancy, clinical involvement, and implementation across range of brain health conditions.

Artificial Intelligence (AI) for Veterans' Health

VA's AI and emerging informatics organizational structure has evolved. The National AI Institute is now a subunit of the Digital Health Office and serves as the primary locus for all of VA's AI activities. Leveraging AI in Research to improve Veterans' well-being remains a priority:

- Supporting the President's AI executive orders and initiatives;
- Developing AI that improves the well-being of Veterans and working with VA clinical and operational partners to scale the technology, including the VHA Digital Health Office and the Chief AI Officer;
- Ensuring that Veterans are served by a research computing infrastructure that can put their data to work for them;
- Informing regulatory processes for AI in human research to reduce burden while protecting Veterans;
- Upskilling, recruiting, and retaining human resources with AI and emerging informatics skills; and
- Adhering to trustworthy AI requirements in ORD in collaboration with the VHA Digital Health Office and VA Chief AI Officer.

2026 Planned Activities

- Rationalize research AI computing infrastructure across the ORD enterprise to most efficiently and effectively meet research and operational needs.
- Collaborate with other Federal agencies (DoD, Department of Health and Human Services (HHS), the National Institute for Standards and Technology) on Veteran health-centric AI research and development.
- Expand and maintain key research AI capabilities to advance Veteran-centric

applications (e.g., diagnosis of interstitial lung disease, identification of actionable TBI/precision medicine biomarkers, and precision oncology applications).

- Maintain and streamline governance of research AI use cases, in accordance with the existing and emerging trustworthy AI requirements.
- Pilot an AI and emerging technology subcommittee to provide recommendations to the central Internal Review Board (IRB).
- Recruit and retain emerging informatics and AI human resources in VA Research, including exploration of affiliation agreements with technology-focused universities.

2025 Activities

- Establish integration group to coordinate AI work across units of ORD and provide ways for synergy and shared learnings.
- Launch VA Electronic Determination Aid AI to assist research use case owners in identifying whether their use case needs to be submitted through the VHA and Chief AI Officer trustworthy AI governance processes. Modifying data collected in the VA Innovation and Research Review System to capture the research projects that incorporate AI, including those funded by ORD and other sources.
- Educational programs to enhance trustworthy AI/ML information to support research and development across the enterprise.
- Provide subject matter expertise for translational AI research and development (R&D) and by evaluating novel AI R&D tools and solutions
- Develop expertise to support AI/ML research and development at VA.

Precision Health Research for Veterans

The goal of the MVP is to improve the health and well-being of all Veterans by understanding how genetics, lifestyle, military experiences, and toxic exposures affect health and using that knowledge to inform personalized or precision-health care approaches. To achieve this goal, MVP has four specific aims:

- **Turn research into real-world results for Veterans.** MVP will establish pathways to move scientific discoveries into clinical practice to deliver precision health care directly to Veterans. This includes, but is not limited to, advancing precision oncology and precision mental health and care for conditions related to military service.
- **Reach more Veterans and ensure all Veterans are sufficiently represented.** In November 2023, MVP reached its one million enrollee milestone; however, only 10% of the enrollees are women and approximately 25% represent racial minorities. MVP will continue enrollment and engagement to ensure access to new, evolving data from current and future generations of Veterans, which is critical for identifying emerging health challenges tied to different conflicts and deployments. MVP will focus on enrolling Veterans from communities historically underrepresented in research including women, racial and ethnic minorities, rural Veterans, younger Veterans and those with a range of military

experiences and health conditions from all service eras. This ensures that researchers have sufficient data to address health challenges faced by current and future Veterans.

- **Honor Veterans contributions by generating the most comprehensive research data possible.** MVP will securely generate the most comprehensive data possible from the donated blood samples, electronic health records and survey responses from participating Veterans to create the highest quality research-ready data.
- **Expand access to data to accelerate discoveries that benefit Veterans.** MVP will expand secure access to data for VA and non-VA researchers to expedite scientific discovery in areas that matter most to Veterans including precision oncology, precision mental health, military toxic exposures, chronic pain, and opioid use.

The goals of MVP align with the legislative requirements of PACT Act and Hannon Act, and the Administration's priority of improving the efficiency and effectiveness of healthcare services provided to Veterans, suicide prevention and reducing homelessness. MVP goals also align with VHA and ORD clinical priorities, including pain and opioid use, TBI, PTSD, suicide prevention, military toxic exposures, and precision oncology.

2026 Planned Activities

- Enhance recruitment/enrollment of Veterans from underrepresented populations such as women, racial minorities, rural Veterans, and younger Veterans.
- Develop and implement capabilities to use MVP as a platform to inform clinical trials. Using genetic and health information curated by MVP can help researchers pinpoint Veterans who could benefit from participating in clinical trials. This effort could also help with streamlining and accelerating clinical trial enrollment.
- Develop a plan and pilot expansion of biorepository capacity to store additional incoming MVP biospecimens. Securely storing these biospecimens will ensure current and future researchers can work on Veterans samples for years to come. It also allows for the opportunity for cutting edge biospecimen analyses as they are developed.
- Conduct new data collection (for example, images and military exposure data) to enhance information available for Veteran-specific research.
- Develop and pilot secure computing environments for access to deidentified MVP data for non-VA researchers to expand research opportunities that can accelerate improvements to Veterans' health care.
- Establish guidelines and procedures for use of cloud credits in the VA enterprise cloud for high-compute MVP data analyses. Using the enterprise cloud allows for computations on huge datasets like MVP that are not possible in other environments.
- Continue translating MVP discoveries towards clinical care and real-world impact for Veterans, especially in the areas of drug discovery and drug repurposing and polygenic risk score for predicting progression to metastatic prostate cancer.

2025 Activities
The following MVP research activities will increase the amount and types of data available for research, expedite scientific discovery and expand opportunities to directly impact improved healthcare for all Veterans.

- Process genotyping of samples from non-European ancestries on the custom – genotype array and make data available to approved researchers. This new array highlights important genetic variants that have not previously been captured.
- Launch campaigns for focused recruitment and enrollment of underrepresented populations such as women, racial and ethnic minorities, and rural Veterans. Targeting recruitment into these specific Veteran populations could mean expanded data for research that impacts the healthcare of those Veterans.
- Begin projects focused on military experiences by developing and deploying the MVP toxic exposures survey to all living participants in MVP and initiating data curation. Military exposures data will help researchers understand their impacts and develop better clinical treatments.
- Partner with precision oncology and precision mental health initiatives to begin piloting collection of new data types, such as, images and military exposures. Clinical images, like computed tomography (CT) scans and magnetic resonance images (MRIs) contain valuable information that cannot always be captured effectively in written notes. Clinical images combined with genetic data and other clinical characteristics have the potential to accelerate discovery into cancer, brain disorders, and chronic diseases.
- Complete VA-DOE projects at the Oak Ridge National Laboratory. These collaborative studies have led to breakthroughs in VA clinical care, including improvements on the VA's REACH-VET application to reduce Veteran suicide.
- Initiate a pilot use case with MVP and the National Institute of Health (NIH) All of Us Research Program datasets for joint analytics, which involves keeping datasets in their original secure locations, but moving code/analytic tools across datasets in a privacy-preserving manner. This pilot will allow for combining datasets across organizations to accelerate scientific discoveries.
- Initiate clinical translational pilot projects focused on MVP discovery- informed drug repurposing opportunities and validation of a polygenic risk score for prostate cancer in a clinical trial. Drug repurposing is an efficient way to use existing medications to treat different conditions than initially considered. Polygenic Risk Scores can be a clinical tool to better identify Veterans at risk for diseases/conditions. This pilot could result in more effective screening and prevention, earlier disease identification, and better disease management for Veterans.

Psychedelic Assisted Treatment for Mental Health Conditions
VA is committed to safely exploring all avenues that promote the health of our nation's Veterans. This request supports research studying psychedelic compounds for mental health conditions. There is a rapidly expanding evidence base of preclinical studies and clinical trials supporting the use of psychedelic treatments for mental health conditions prevalent in the

Veteran population, including depression, PTSD, and addiction. Several psychedelic treatments including 3,4,-Methylenedioxymethamphetamine (MDMA) and psilocybin are in the pipeline with potential to be Food and Drug Administration (FDA) approved within the next two to five years. The evidence to date was generated by private sponsors. VA seeks to further evaluate the efficacy of these treatments in the Veteran population and the potential to effectively and safely deliver this care to our Veterans.

2026 Planned Activities
ORD will continue to solicit, review and fund approved psychedelic research proposals, assist investigators who are planning and conducting this critical research, and collaborate with the Office of Mental Health on proactively planning for potential future clinical implementation of psychedelic assisted treatment. ORD will continue to monitor active psychedelic studies that are conducted at VAMCs by VA researchers that are funded by external sources. This comprehensive effort will allow VA to continue to gather rigorous scientific evidence on the potential efficacy and safety of psychedelic compounds when used in conjunction with psychotherapy to treat Veterans.

2025 Activities

- Initiate the study of the potential of MDMA-assisted therapy as a treatment option for Veterans with PTSD and Alcohol Use Disorder.
- Begin a study to see how psilocybin affects brain cells, aiming to help Veterans with PTSD by making their brains more responsive to therapy. The results could mean using smaller doses of psilocybin, making treatment more practical and accessible for Veterans.
- Continue to monitor the results from active or recently completed psychedelic studies that are being conducted at VAMCs by VA researchers but are externally funded.

Table: 2026 Administration Priority Areas – Mandatory Funding

(Dollars in thousands)	2024 Enacted	2025 Enacted	2026 Estimate	2026 Estimate - 2025 Estimate	
				$	%
Military Occupations & Environmental Exposures	**46,000**	**59,000**	**57,000**	**(2,000)**	**-3%**
Medical and Prosthetics Research (non-add)	-	-	-	-	-
Toxic Exposure Fund (non-add)	46,000	59,000	57,000	(2,000)	-3%
Gulf War Veterans Illness (non-add)[1]	**15,226**	**16,000**	**16,000**	**-**	**0%**
Medical and Prosthetics Research (non-add)	-	-	-	-	-
Toxic Exposure Fund (non-add)	15,226	16,000	16,000	-	0%

1/ Gulf War Veterans Illness is included in Military Occupations & Environmental Exposures

Military Service Environmental Exposures (MSEE)

Military toxic exposures stem from environmental sources, occupational specialties, and related health outcomes observed in Veterans. Forty-five percent of Veterans who underwent a toxic exposure screen reported experiencing at least one toxic exposure during their military deployment and expressed concerns about potential health impacts for themselves and/or their children. The toxic exposures of greatest concern include burn pit fumes and ash, Agent Orange, firefighting foams, and industrial chemicals that accumulate in human tissue. Adverse health outcomes include disorders affecting major organ systems, particularly the cardiovascular, neurological, and digestive systems, as well as the skin and eyes. MSEE studies aim to: (1) inform drug treatments (pre-clinical studies); (2) identify Veterans at risk (epidemiology); and (3) develop bedside clinical treatments and individual exposure assessments.

Ensuring appropriate representation of Veteran populations and maintaining unbiased peer-review are crucial for the highest quality MSEE research. Studies focusing on specific deployments, women's health, and particular Military Occupational Specialties may necessitate the involvement of multiple VAMCs. ORD collaborates with cross-agency specialists from the HOME and the War Related Illness and Injury Study Centers.

Military Service Environmental Exposures Programs overseen by ORD

1990-91 Gulf War Research Program: This program was established in 2002 as outlined in Public Law 105-368 with the mission of understanding and treating the health consequences of military service in the Southwest Asia theater of operations during the 1990-91 Gulf War. Approximately 35% of Gulf War Veterans suffer from chronic multi-symptom illness also known as Gulf War illness (GWI). Veteran engagement and outreach are another unique aspect of this program whereby this aging cohort can voice experiences, health concerns, and trust issues.

Military Exposure Research Program: Exposure assessment at the individual level was identified as the major gap in the military exposures field. The mission of MERP is to establish a system-wide capability to advance military exposure assessments and understand the effects of military exposures on Veterans' health outcomes.

PACT Act, Section 501: ORD is responsible for the PACT Act, Section 501. In accordance with requirements, the Toxic Exposure Research Workgroup (TERWG) was created and recognized in 2023. This essential interagency workgroup comprises of eight federal agencies, including the

VA, DoD, HHS, Environmental Protection Agency, the White House Office of Science and Technology Policy, and other federal partners.

2026 Planned Activities

Gulf War Research Program

- Conduct outreach sessions with Gulf War Veterans to understand aging health concerns and emphasize research participation.
- Develop and advance strategies to understand GWI symptomology subgroups and create a roadmap to identify research gaps and needs.

Military Exposure Research Program

- Complete first year of operations of the Vietnam Veteran Air Force Health Study (also known as the Ranch Hand Study) in VA Science and Health Initiative to Combat Infectious and Emerging Life-Threatening Diseases (VA SHIELD). This study will include archiving and distributing biospecimens and associated data. Approved field investigators will be able to utilize the Ranch Hand Study.
    - Prepare a report on metrics of how the Ranch Hand database and biospecimens are shared to support research that benefits Vietnam Veterans who have been exposed to Agent Orange and dioxins.

PACT Act, Section 501

- Organize interagency tasks and research opportunities into phased categories, focusing early efforts on documenting foundational concepts like military chemicals, substances, and airborne hazards, with an emphasis on occupational and environmental factors.
- Identify, evaluate, and collate current inventories of research resources, such as cohort data and biorepositories, to support future research activities.

2025 Activities

Gulf War Research Program

- Prepared a new research funding notice to focus on key areas like organ system interactions, GWI subgroups, aging disorders (including dementia and Parkinson's), heart disease, autoimmune issues, and cancers.

Military Exposure Research Program

- Curate data and specimens of the Vietnam Veteran Air Force Health Study to evaluate generational, cancer, and other health concerns of this cohort, in consultation with Vietnam Veterans of America and other stakeholders.

- Expanded training resources offered by the MERP. These resources will include webinars, online resources, and optimized customer service activities to support VA field investigations (e.g., laboratory, epidemiology, and medical studies).

PACT Act, Section 501, Research Matters

- Assigned operational and research tasks in the strategic plan to four TERWG subgroups: Monitoring; Prioritization and Alignment; Biorepository and Bio sampling; and Risk Communication, Health Outcomes, and Access to Care.
- Initiated collaborative interagency research from the TERWG strategic plan, focusing on assessing military exposures and evaluating new technology to address gaps.

Research Areas of Continued Interest

Women's Health Research
ORD is essential in enhancing the health and care experiences of women Veterans, the fastest-growing group seeking VHA services. ORD researchers address a broad range of health issues affecting women Veterans across the lifespan and across scientific disciplines, including biomedical, clinical, rehabilitation, genomic, health systems, data science, and implementation research. As the number of women Veterans using VA care grows, their participation in medical research has increased as well. This involvement ensures that research findings are relevant and drive new interventions and practices that improve care for all women Veterans at VA.

Accelerating women Veterans research: ORD invests in its Women's Health Research Network (WHRN), which is critical to accelerate evidence-based practices and policies for women Veterans. VA WHRN helped build VA's capacity for women-specific medical research by supporting a national consortium of over 450 researchers and other stakeholders at 76 VAMCs. Over 100 research studies and evaluations in high priority topics have used this research network. Topics include suicide prevention, homelessness, traumatic brain injury, access to care, community care, rural health, and chronic disease (e.g., chronic pain, cancer, posttraumatic stress disorder, etc.).

Increasing participation in research: Increasing the involvement of women Veterans in research is crucial for ensuring optimal care at VA facilities. The Women's Enhanced Recruitment Program toolkit, first introduced in 2019, offers VA researchers tools and training to boost women Veteran recruitment in clinical trials. In 2025, the toolkit was updated with new resources, including guidance on incorporating trauma-informed care into research. ORD continues to promote the toolkit to more VA researchers.

Ongoing Activities

- Continue implementation of WHRN and expand access to clinical trials and innovative research opportunities aligned with the Secretary's strategic vision and legislative requirements, including women's access to care, suicide prevention, and military exposures.
- Continue to prioritize prosthetic and other assistive technology needs of women

Veterans.

- Research assessing the impact of virtual, evidence-based interventions among women Veteran VA users in three priority health areas: perinatal depression, prediabetes, and cardiovascular disease.
    - Reach Out Stay Strong Essentials (ROSE) - More than 700 women Veterans received services for ROSE, which is an intervention to prevent perinatal depression. More than 350 providers across 73 sites have been trained to deliver the intervention. 15

- A new study that will look at the relationship between military toxic exposures and cancer risk, including breast cancer, among military firefighters. The study will include a cohort of 5,783 women Veterans.
    - Researchers are fielding a Veteran-centered needs assessment in 30 VAMCs about menopause. The assessment will evaluate the needs of midlife women Veterans and inform clinical trials development and strategic policy planning to support the needs of perimenopausal and menopausal women Veterans.

Recent Activities and Accomplishments

- There are currently 1,310 women Veterans living with a major lower limb amputation who receive their care at the VA and this number continues to grow. A prosthetic foot-shoe design was completed and licensed to industry partners. This design was supported by a VA study where researchers developed a new system to 3D-print custom energy-storing prosthetic feet to fit shoes of any size and heel height, both of which have been problematic issues for women Veterans.
- VA investigators published the results of the first longitudinal, national survey of Veterans with a non-fatal suicide attempt to better understand differences between men and women Veterans in their psychosocial symptoms and suicidal thoughts and behaviors. 1,000 Veterans (570 women, 430 men) completed the initial survey. Psychological distress was a core contributor to suicide risk for both men and women Veterans. However, Women Veterans may need additional support in other areas as well. This study highlights a need for tailored suicide prevention strategies for women Veterans.
- A 2024 study examined factors contributing to women Veterans' decision to receive their health care with VA on a long-term basis or move to community care. One finding showed that women who saw a VA Women's Health Primary Care Provider in their first year of care had lower odds of leaving VA than those who saw a general Primary Care Provider. Identifying experiences that influence women's decisions to stay in or leave VA care will help inform high-quality care for women Veterans.

[15] Funded by VHA Quality Enhancement Research Initiative (non-research appropriation) to support ORD's response to the Foundations for Evidence-Based Policymaking Act of 2018 (Evidence Act; PL 115-435).

Pain and Opioid Use
Chronic pain is more prevalent and of a greater intensity in the Veteran population than in the general population according to the National Health Interview Survey. Chronic pain is often accompanied by coexisting mental health problems and overlapping painful conditions, which places Veterans at risk for harm from opioid medication, especially opioid use disorder (OUD). VA Research supports the generation of new knowledge to improve the prevention, diagnosis, and treatment of OUD, as well as the development and testing of innovative approaches for chronic pain management for Veterans. ORD created the Pain and Opioid Use-Actively Managed Portfolio (POU AMP) to better to respond to the legislative requirements of the CARA of 2016, the Hannon Act, and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment Act of 2018 (SUPPORT Act). This program is also responsible for responding to the White House initiative to *Stop Opioid Abuse and Reduce Drug Supply and Demand* through the Office of National Drug Control Policy, and the VA's Opioid Safety Initiative through VHA.

The Pain and Opioid Use Actively Managed Portfolio (POU-AMP) continues to work with its VHA clinical partners that include Pain Management, Opioid Safety, and Prescription Drug Monitoring Program (PMOP), Pharmacy Benefits and Management, Office of Patient Centered Care and Cultural Transformation (OPCC&CT), and Office of Mental Health (OMH) to identify areas of clinical need to address research gaps that provide data to inform clinical care.

Future activities
The POU-AMP will be supporting research in the following areas of clinical need:

- Spinal Cord Stimulation Data Analytics research using electronic medical records (EMR) and current procedural terminology codes over the last decade to discover trends and patterns of spinal cord stimulation as a treatment of chronic painful conditions among. The goal is to build predictive models of the therapy and opportunities for improved safety.
- Pharmacogenomics of response to opioid medications research of genomic data (i. e. VA MVP or other sources) and their correlation with EMR to identify and validate potential pain and opioid treatment targets and mechanisms among Veterans.
- Data analytics for high and low impact chronic pain research that combines data mining of EMR and qualitative questionnaires to obtain Veterans' experience with chronic pain and its treatment.
- Retrospective data analytics on Veterans who were on Long-term Opioid Therapy (LTOT) and were impacted by the Opioid Safety Initiative. Research on the outcomes of Veterans on LTOT who were forced to taper medication, and/or switched to buprenorphine, from the Veterans' and prescriber's perspective.

Current Activities

- In accordance SUPPORT Act, currently conducting a pre-clinical study to understand the long-term effects of co-use of fentanyl and xylazine.
- In support of the CARA, currently conducting an evidence-based clinical trial for chronic low back pain to facilitate non-pharmacological pain management. The study will see how

well combining Intermittent Theta Burst Stimulation and yoga helps with pain relief, function, medication use, self-confidence, quality of life, and overall well-being in Veterans. The findings will provide the OPCC&CT with strategies for managing chronic low back pain.

- In support of CARA, currently conducting an evidence-based study identifying best practices to facilitate a Whole Person approach to pain management. This study will be the first to examine how Whole Person Pain Care can be delivered in the absence of a formal team, using the lens of Relational Coordination. The results will inform PMOP and OPCC&CT, of Whole Person Pain Care for Veterans outside of traditional primary care teams.

Recent Accomplishments

- The VA/DoD/NIH Pain Management Collaboratory Assessing Pain, Patient Reported Outcomes and Complementary and Integrative Health Trial. The trial assessed effects of use of practitioner-delivered Complementary and Integrative Health (CIH) therapies alone compared to the combination of self-care and practitioner-delivered CIH therapies among Veterans with chronic musculoskeletal pain. The study was conducted at 18 VA Whole Health sites and recruited 18,000 Veterans and results are currently being analyzed.
- Opioid Education and Naloxone Distribution (OEND) Project. Since 2014, VHA distribution of more than 1. 4 million naloxone prescriptions to over 610,000 Veterans resulting in over 5,700 overdose reversals.
- Medications for opioid use disorder study: A study on the differences in medications for opioid use disorder receipt between rural and urban Veteran patients. Data from 66,842 Veterans diagnosed with OUD were analyzed and results found 27.4% from rural settings had a lower likelihood of receiving methadone and naltrexone for OUD treatment relative to urban patients, but greater likelihood of receiving buprenorphine.
- The Spinal Cord Stimulation (SCS) Data Analytics is a study that will establish the largest multi-site repository of SCS outcomes in the VA system using cutting-edge machine learning and natural language processing tools to extract both structured and unstructured data from VA records.

To better serve our Veterans, POU AMP is involved with the following committees and groups:

- NIH/DoD/VA Pain Management Collaboratory (PMC) Steering Committee;
- VA's Advisory Committee for the Pain/Opioid Consortia of Research with VA operational partners PMOP, OPCC&CT, OMH, and the Pain Management Collaboratory leadership;
- VHA's PMOP Field Advisory Board; and
- VHA's Opioid Education and Naloxone Distribution, Physical Medicine and Rehabilitation, OPCC&CT's Complementary and Integrative Health Connections.

Spinal Cord Injury and Disorders (SCI/D)

Approximately 17,000 new cases of spinal cord injury occur each year, of which several hundred involve Veterans. The VA Healthcare System provides care for up to 27,000 Veterans living with Spinal Cord Injury and Disorders (SCI/D), such as Multiple Sclerosis and Amyotrophic Lateral Sclerosis. These conditions can result in permanent neurologic changes leading to paralysis. ORD supports innovative research on SCI/D to repair and/or replace damaged tissue, restore lost function, and reduce secondary consequences, aiming to maximize function, independence, and social reintegration for Veterans.

Recent and future activities:

- The FDA favorably reviewed a pre-investigational new drug for cell-based therapy to repair injured spinal cords. FDA requested long-term safety studies, which are required prior to conducting clinical trials for effectiveness.
- Introduce innovative robotic rehabilitation technologies to VA clinics and continue developing new approaches, paired with cell therapy, to maximize functional recovery.
- Continue a multi-site study to identify blood and physiological biomarkers that predict recovery in Veterans with complete and incomplete SCI. The study aims to determine if these biomarkers and spasticity correlate with recovery. The results could also help inform the cell therapy clinical trial.
- Continue a clinical trial on bowel emptying for Veterans with spinal cord injuries. This study compares electrical stimulation of the rectum to the usual method of digital rectal stimulation to improve bowel emptying.

ORD Operational Units Supporting the VA Research Enterprise

ORD undertook a major effort to align the organizational structure of the office with its functions, with the goal of more effectively and efficiently fulfilling our mission. ORD aligned its structure to better support the entire VA research enterprise, serving not simply as funders of research but also as the strategic headquarters of the largest integrated biomedical research organization in the nation. There are now six units reporting to the Chief Research and Development Officer.

Strategy, Partnerships, Outreach, and Communications (SPOC)

This unit is charged with creating forward-looking strategies, governance processes for establishing priorities and programs, and measuring the impact of serving Veterans. It develops and maintains ORD's long-term strategy by anticipating future trends in strategic health care priorities and maintaining a proactive stance, to ensure the effective communication of ORD's strategy and vision and build a community among ORD's stakeholders, to enforce organizational alignment with strategic priorities and measure the success of ORD. SPOC is also charged with ensuring the protection of VA's intellectual property and commercialization efforts. SPOC supports centralized functions within ORD, such as Communications and the Technology Transfer Program.

Enterprise Protections, Regulatory, and Outreach Systems (EPROS)
EPROS is charged with ensuring the appropriate policies for the protection of human participants and animal subjects in VA conducted research as well as with developing and managing VHA's research regulatory policies and associated education and training. It develops, coordinates, and manages enterprise-wide access to central research repositories and digital research systems. EPROS is responsible for championing and solving the impacts on research for the transition to the federal electronic health record, encouraging the disclosure of inventions, supporting the review of multi-site research through the Central IRB, providing a centralized core for ethical, regulatory and educational programs for human and animal research, and providing key central systems for data and biospecimen management. The following sub-units are currently housed under EPROS: Central IRB, Central Policy and Regulatory, Research Education and Training, Research IT and Data Governance, Research Education and Training, and Central Veterinary Medical Office.

Office of Finance
Finance is charged with managing all aspects of budget, finance and accounting for ORD and the field and evaluating the strategic use of ORD's financial resources. This unit works to ensure ORD is operating with fiscal responsibility in supporting the VA Research Enterprise's mission of improving Veterans' lives through research. Finance supports centralized functions within ORD, such as budgeting and operations, and the Non-Profit Program Office.

Operations and Workplace Culture (OWC)
The OWC unit is responsible for centralizing internal ORD operations functions. It provides ORD staff with dedicated resources such as human resources, contracting, leadership development, talent management, and employee engagement that are rooted in solving problems efficiently and effectively so that the day-to-day ORD processes run smoothly. The OWC unit also strives to continually improve the efficiency of internal operations and ensure timely responses to external requests and requirements. The following sub-units are housed under OWC: Central Administration, Contracting, and Operations.

Investigators, Scientific Review, and Management (ISRM)
ISRM contributes to the VA Research Enterprise mission of improving Veterans lives by funding research originating out of VA clinical setting and patient-provider care experience, management of research portfolios, collaboration with stakeholders and the recruitment and retention of a diverse set of investigators. There are five AMPs in ISRM that are focused on research addressing Agency, Congressional, and Veteran priorities in partnership with clinical stakeholders: TBI, Precision Oncology, Pain/Opioid Use Treatment, Suicide Prevention, and Military Exposures/Gulf War. In addition, four ISRM Broad Portfolios support translational, interdisciplinary research in pre-clinical, clinical, and health systems/implementation science: Medical Health, Brain, Behavioral and Mental Health, Rehabilitation Research Development and Translation, and Health Systems Research (HSR).

In addition, HSR supports the VA QUERI program, whose mission is to improve Veteran health through the rapid translation of research findings into real-world practice. Supported in part through the VERA Research allocation, QUERI funds over 200 VA scientists working with over 100 VA clinical partners to apply quality improvement methods and a deep understanding

of Veterans' needs to quickly integrate research findings into routine practice, enhancing the quality and safety of Veteran care. QUERI also manages VHA's commitment to the Evidence Act and its Evidence-Based Policy Subcommittee, promoting collaboration on national evaluations of VA strategic priorities. QUERI distributed over 200 research-based strategies, supporting VA employees in providing evidence-based care to over 6.1 million Veterans and their families. HSR also supports the Evidence Synthesis Program (ESP), which provides comprehensive, impartial reviews of medical literature to guide evidence-based clinical practice and policy within the VA. ESP reports support quality improvement and guide future research. In FY 2024 ESP received 40 evidence review topic nominations (a 54% increase compared to FY 2023) and major findings informed care for Veterans with TBI, PTSD, chronic pain, military exposures and other conditions, as well as shaping clinical care guidelines for genomic medicine and chronic disease management.

Enterprise Optimization (EO)
EO is charged with supporting the execution of ORD's agenda, particularly as it relates to a national enterprise-wide approach toward planning for, coordinating, and managing the VA Research Enterprise resources and producing impactful scientific findings that translate to the health care system, such as Field Support, so that the field may execute the VA research strategy efficiently and successfully. It supports centralizing existing field resources and developing them to provide researchers with effective and accessible tools and resources. It will also work towards increasing the accessibility of VA scientific resources and products to ensure a cooperative approach and facilitation of innovative scientific research. Sub-units within EO that support centralized functions within ORD include Field Operations, the Partnered Research Program, the Cooperative Studies Program, and the Million Veteran Program.

Cooperative Studies Program (CSP)
CSP is responsible for planning and conducting large multicenter clinical trials and epidemiological studies. It serves as a foundational part of the VA national clinical research enterprise and seeks to advance the health and health care of Veterans through cooperative research studies that produce innovative, definitive, and effective solutions to Veteran and national health care problems.

Million Veteran Program (MVP)
MVP is a national voluntary research program that partners with Veterans receiving their care in the VA health care system to study how genes affect health. To do this, MVP is building one of the world's largest databases of genes and health by safely collecting blood samples and health information from over one million Veteran volunteers. With over one million Veterans enrolled, MVP is also one of the most comprehensive and racially and ethnically diverse cohorts in the world with over 180,000 Veterans of African descent and over 80,000 Hispanic Veterans.

Collaboration with Federal Agencies and Other Organizations
To expand the scope and impact of VA research, ORD collaborates whenever possible with others in the research community who share our mission of improving health care. Partnering with others with common research interests allows VA to leverage resources and expand the impact

of our nation's investment in research. Collaboration supports the swift transition of medical findings into strategies to improve life for Veterans and all Americans.

VA and DoD share a commitment to honor those who served our nation by providing them with the best health care available. In addition to ones described earlier, our other collaborative research projects cover a wide range of topics, including the long-term health effects of military service on Service Members, Veterans and family, military environmental exposure, TBI, polytrauma, prosthetics and amputation care, PTSD and other mental health issues, suicide prevention, and pain management. VA and DoD have agreements allowing for the transfer of medical record data to support research, among other activities, which is stored in a joint database maintained by ORD as the DoD/VA Infrastructure for Clinical Intelligence. VA and DoD are partnering in several development tasks to support research using Cerner tools.

VA also is a formal partner with DoD, the Department of the Army, and the National Institute of Mental Health (NIMH) in the third phase of the STARRS-LS. As study participants continue to transition out of the military, this collaboration seeks to link DoD and VA data to better study the pathways military Service Members take as they leave the military, with an overall goal of reducing military and Veteran suicide.

VA and DOE are collaborating in the VA-DOE Big Data Science Initiative, a partnership focused on the secure analysis of large amounts of digital health and genomic data from VA, including MVP, to help advance health care for Veterans and others, while also driving DOE's next generation supercomputing designs. Current collaborative projects include developing risk-prediction tools for suicide, lethal prostate cancer, and cardiovascular disease, as well as assessing the relationship between altitude and suicide. Eight new joint projects were selected in 2023 and launched in 2024. The topics included improving treatment for heart failure, improving the risk prediction of suicide, predicting negative side effects of antipsychotic medications for better management of care, Long COVID, enabling precision care for sleep disorders, improving lung cancer screening, improving precision treatment for lung cancer, and improving risk prediction and management of complications from diabetes.

VA and HHS are collaborating on diabetes management, patient safety, the use of health information data, the identification of strategies and designs for military environmental exposures research, characterization of Gulf War illness, and cancer clinical trials.

ORD 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 NCI and the National Institute on Aging (NIA), as described below. Through the Pain Management Collaboratory, VA collaborates with NIH and DoD on a series of trials of non-opioid treatments for chronic pain in Veterans and active-duty military members. NCI and VA Interagency Group to Accelerate Trials Enrollment sites enrolled more Veterans into NCI trials than sites that did not received dedicated funding for local clinical trials infrastructure, which highlighting the success of the program.

VA ORD through its CSP has an interagency agreement with the U.S. Food and Drug Administration to use real-world evidence/data to better inform medical policy on the use of

treatments. Efforts focus on leveraging the CSP Point of Care methodology which allows greater reach of Veterans in various settings (including rural ones) to evaluate therapies that are already available and to examine their comparative effectiveness.

ORD, through QUERI, actively collaborates with the NIH to provide national training in implementation research and health system science methods to promote translation of research findings into real-world health care settings through the Implementation Research Institutes sponsored by NIMH and NCI.

VA and NIA are collaborating on the VA-NIA Alzheimer's Disease Veteran-Centric Alliance Network for Health Care Excellence Initiative. This partnership is aimed at fast- tracking the development of new treatments and cures for Alzheimer's disease and related dementias (AD/ADRD) and to improve the care of Veterans with AD/ADRD and the well-being of their caregivers.

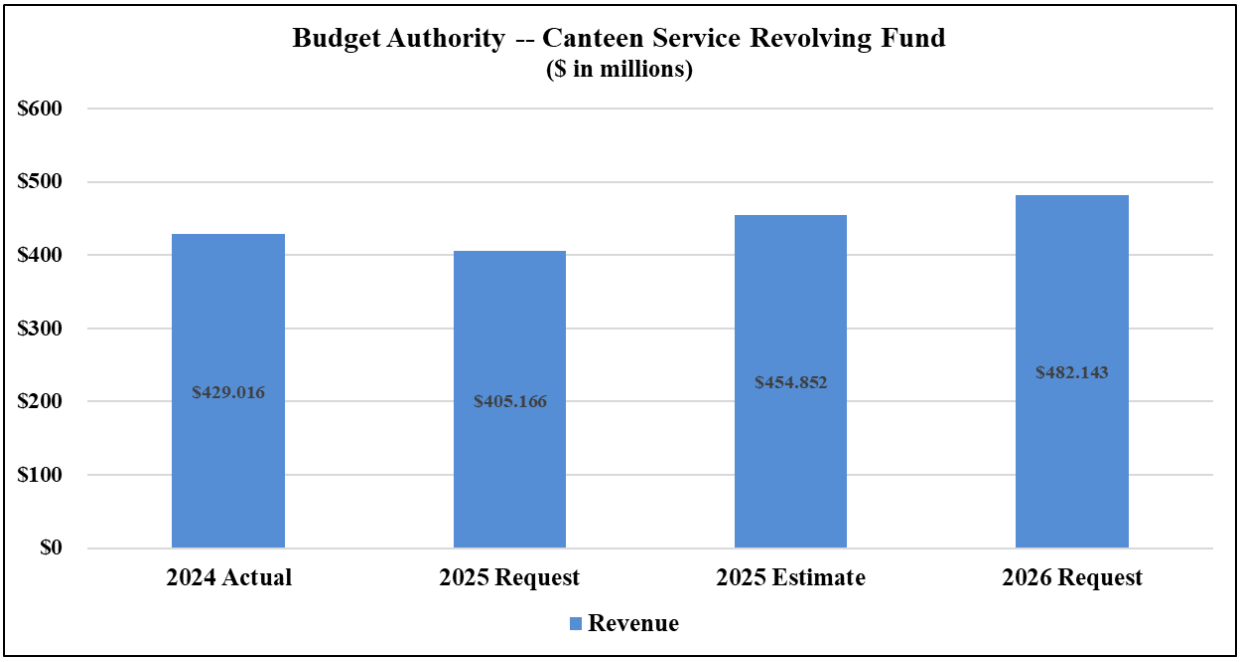
VA also fosters dynamic collaborations with its university affiliates and with nonprofit organizations and private industry.

Table: Obligations by Object Class

Direct Obligations			
(dollars in thousands)	2024 Actuals	2025 Estimate	2026 Request
11 Personnel Compensation	407,343	396,593	415,524
12 Personnel Benefits	158,565	157,948	165,487
13 Benefits for Former Personnel	75	75	78
21 Travel & Transportation of Persons	3,632	3,618	3,791
22 Travel & Transportation of Things	88	87	91
23 Rent, Communications, & Utilities	11,799	11,753	12,314
24 Printing & Reproduction	205	205	214
25 Other Services	341,000	328,116	343,778
26 Supplies & Materials	47,567	47,382	49,644
31 Equipment	13,486	13,433	14,074
32 Land & Structures	4	4	4
42 Insurance Claims & Indemnities	0	0	0
Total	983,764	959,213	1,005,000

Reimbursable Obligations			
(dollars in thousands)	2024 Actuals	2025 Estimate	2026 Request
11 Personnel Compensation	11,133	27,602	27,616
12 Personnel Benefits	1,129	2,799	2,800
13 Benefits for Former Personnel	-	-	-
21 Travel	3	8	8
22 Transportation of Things	-	-	-
23 Rent, Communications, & Utilities	-	-	-
24 Printing & Reproduction	-	-	-
25 Other Services	34,843	51,676	51,703
26 Supplies & Materials	-	-	-
31 Equipment	14	35	35
Total	47,123	82,119	82,162

Veterans Canteen Service Revolving Fund



The 2025 Estimate is based on updated projections for the Canteen Service.

Program Description

The Veterans Canteen Service (VCS) was established by Congress in 1946 to furnish reasonably priced meals, merchandise, and services necessary for the comfort and well-being of Veterans in hospitals and domiciliaries operated by the Department of Veterans Affairs (VA) (38 U.S.C. §§ 7801-10). It has since expanded to provide 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 million for the operation of the VCS and initially required the return of any excess funds to the U. S. Treasury. Enactment of the Veterans' Benefits Act of 1988 (Public Law 100-322) eliminated this requirement and authorized investment of such funds 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 high-quality service to customers is VCS's primary focus and priority. This philosophy is the catalyst for the organization's continued success.

Fund Highlights /1 (dollars in thousands)					
		2025			
Description	2024 Actual	Budget Estimate	Current Estimate	2026 Estimate	+/- 2025-2026
Total revenue.....	$429,016	$405,166	$454,757	$482,042	$27,285
Obligations.....	$408,000	$410,398	$454,757	$482,042	$27,285
FTE.....	2,100	2,200	2,100	2,100	0

[1/] The numbers in the chart above reflect an estimate of the activity during the Federal fiscal year (October – September), as the Veterans Canteen Service uses a retail industry fiscal year (February – January) used by similar private sector retailers to enhance their ability to compare their operations to their private sector peers.

The retail-calendar-fiscal-year reporting cycle has been adopted to better align VCS operations with the financial reporting structure of the retail industry. The calendar uses a (4-5-4) weekly cycle for the monthly reporting schedule. The 4-5-4 retail accounting calendar begins with February and divides the year into quarters. The first and last month of each quarter consists of four weeks each, and the middle month of each quarter consists of five weeks. Although the retail accounting calendar is used for management purposes, VCS will continue to report on a Federal fiscal-year basis.

Summary of Budget Request

VCS is a self-sustaining, revolving fund activity that obtains its revenues from non-Federal sources; therefore, no Congressional action is required. VCS is an independent agency within VA with control over its major activities, including collections, procurement, finance, and personnel management. VCS is implementing operational changes to ensure continuing self-sustainment. The operational changes include right-sizing staff expenses to current revenue levels, controlling costs by reducing inventory levels, and implementing targeted price increases. Operational adjustments will continue to be made until collections are sufficient to cover obligations.

Summary of Employment

For personnel management, VCS uses techniques generally applied in commercial retail chain stores, food, and vending operations. The key performance indicator (KPI) is salary expenses as a percent of revenue. Budgets for canteens and central office staff are established for this KPI annually. The KPI is monitored monthly through financial reports provided to the central office and canteen leadership, and it is benchmarked against the same period from the previous year and the budget targets. Contractors are an essential component of human capital required to maintain operations during the onboarding process. As such, contractor cost is part of this KPI.

The following chart reflects the full-time equivalent (FTE) employment for 2024-2026:

Summary of Employment

	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Estimate	+/- 2025-2026
FTE	2,100	2,200	2,100	2,100	0

Revenues and Expenses
(dollars in thousands)

	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Estimate
Sales Program:				
Revenue	$429,016	$405,166	$454,757	$482,042
Less Cost of Sales	($255,555)	($239,048)	($268,228)	($291,405)
Gross Income	$173,461	$153,963	$186,529	$190,637
Less Operating Expenses	($158,736)	($135,731)	($162,803)	($161,484)
Operating Income	$14,725	$18,232	$23,726	$29,153
Non-operating Expenses/Income	($20,807)	($17,827)	($21,374)	($21,210)
Net income for the year 1/	($6,082)	$405	$2,352	$7,943

1/ A net loss will be covered by the Reserve in the Canteen revolving fund which is shown in the Financial Conditions chart below on the line titled: *Cash with Treasury, in banks, in transit*.

Financial Condition

The schedule below reflects the anticipated financial condition of the VCS through 2026. Changes from year-to-year are the result of anticipated changes in revenues, obligations, and outlays previously portrayed.

Financial Condition
(dollars in thousands)

	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Estimate	+/- 2025-2026
Assets:					
Cash with Treasury, in banks, in transit	$92,656	$58,614	$93,937	$96,179	$2,243
Accounts receivable (net)	$39,437	$36,165	$39,982	$40,937	$955
Inventories	$16,020	$16,286	$16,241	$16,629	$388
Real property and equipment (net)	$24,310	$40,456	$24,646	$25,234	$588
Other assets	$194	$541	$197	$201	$5
Total assets	$172,617	$152,063	$175,003	$179,181	$4,178
Liabilities:					
Accounts payable including funded accrued liabilities	$34,206	$44,372	$34,395	$34,075	($320)
Unfunded annual leave and coupons books	$6,615	$7,085	$6,427	$6,747	$320
Total liabilities	$40,821	$51,457	$40,822	$40,822	$0
VHA equity:					
Unexpended balance:					
Unobligated balance	$0	$437	$0	$0	$0
Undelivered orders	$0	$0	$0	$0	$0
Invested capital	$131,795	$100,168	$134,181	$138,359	$4,178
Total Government equity (end-of-year)	$131,795	$100,605	$134,181	$138,359	$4,178

Retained Income
(dollars in thousands)

	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Estimate	+/- 2025-2026
Retained Income:					
Opening Balance	$33,884	$14,513	$27,652	$30,038	$2,386
Transactions:					
Net Operating Income	($6,082)	$405	$2,352	$7,943	$5,591
Net Non-Operating Gain	$0	$0	$0	$0	$0
Closing Balance	$27,802	$14,918	$30,004	$37,981	$7,977

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 (VAMCs). 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 received approval for the formation of nonprofit research corporations. Presently, 78 are active. Most of the corporations have indefinite, ongoing operations. However, the law permits NPC mergers, which may result in a decrease in the number of NPCs overall.

All 78 NPCs received authority from the Internal Revenue Service Code of 1986, under Article 501(c)(3) or similar Code Sections. The fiscal years for these organizations vary, with most having year ends on September 30 or December 31. The table below reflects estimated revenues and expenses from 2023 to 2025.

Table: Contribution Highlights

($ in thousands)

	2023 Actual 1/	2024 Estimate 2/	2025 Budget Estimate	2025 Current Estimate	2026 Estimate	+/- 2025-2026
Contributions…	$325,428	$306,296	$313,417	$315,712	$329,100	$13,388
Expenses……	$325,428	$306,296	$313,417	$315,712	$329,100	$13,388

1/ The actual amounts for 2023 were reported by the NPCs in June and July 2024.
2/ The 2024 actuals will be reported by the NPCs in July 2025 as part of the annual reporting requirement in conjunction with the NPC Annual Report to Congress.

The following table is a list of research corporations that received approval for formation along with their actual 2023 contribution and estimates through 2026 from the non-VA Federal and private sources.

Table: Nonprofit Corporations

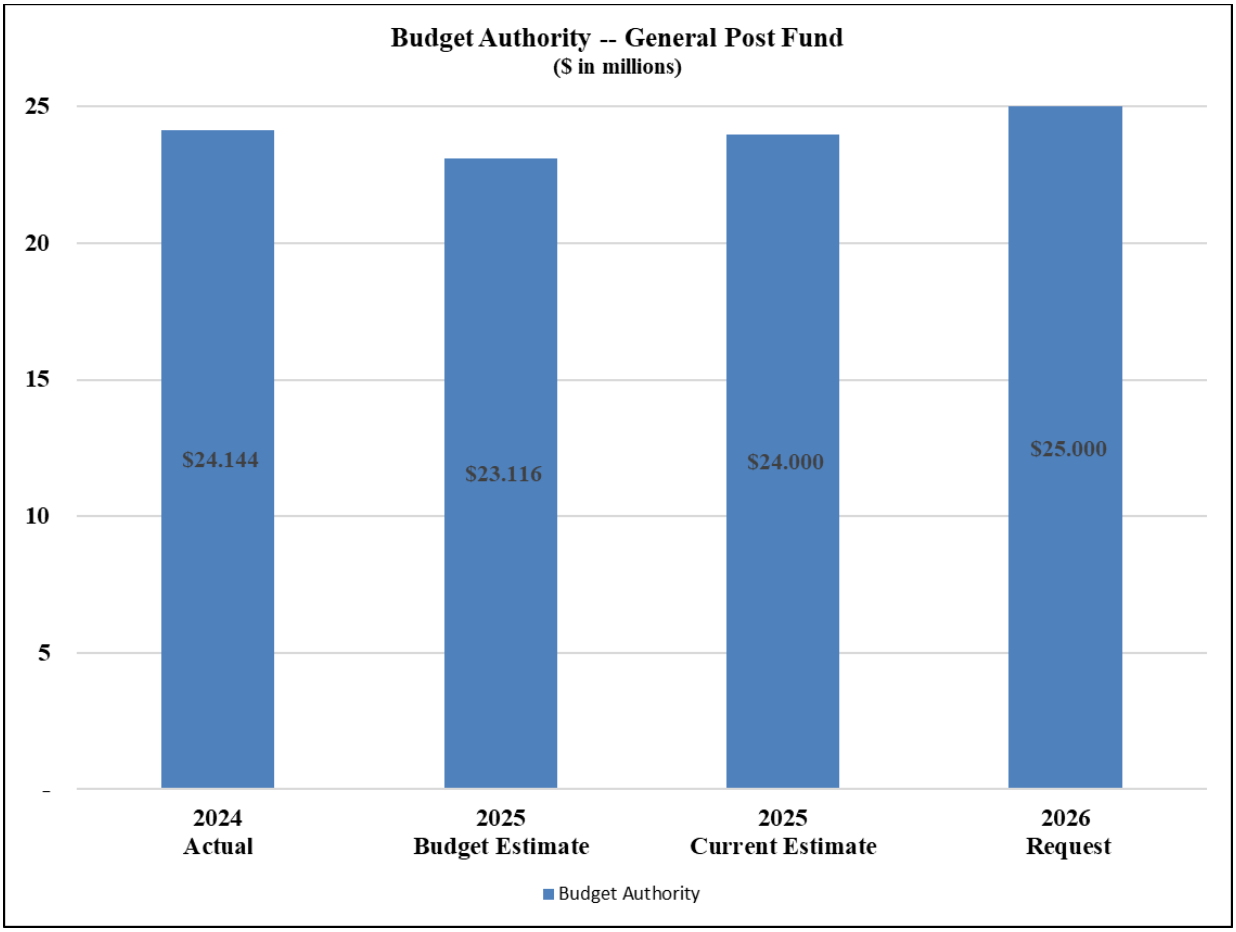
Nonprofit Corporations	City	State	Actual Revenues (Contributions) 2023	Estimated Revenues (Contributions) 2024	Estimated Revenues (Contributions) 2025	Estimated Revenues (Contributions) 2026
1. Albany Research Institute, Inc.	Albany	NY	3,390,000	608,000	648,000	633,000
2. Arizona Veterans Research and Education Foundation	Phoenix	AZ	2,116,000	2,100,000	2,300,000	2,500,000
3. Asheville Medical Research and Education Corporation	Asheville	NC	99,000	208,000	140,000	160,000
4. Augusta Biomedical Research Corporation	Augusta	GA	346,000	137,000	142,000	147,000
5. Baltimore Research and Education Foundation, Inc.	Baltimore	MD	6,994,000	7,000,000	7,350,000	7,718,000
6. Bay Pines Foundation, Inc.	Bay Pines	FL	2,362,000	1,200,000	1,200,000	1,200,000
7. Bedford VA Research Corp, Inc.	Bedford	MA	893,000	230,000	191,000	154,000
8. Biomedical Research and Education Foundation of Southern Arizona	Tucson	AZ	238,000	529,000	600,000	675,000
9. Biomedical Research Foundation	Little Rock	AR	1,665,000	1,500,000	1,650,000	1,650,000
10. Biomedical Research Institute of New Mexico	Albuquerque	NM	6,572,000	7,300,000	7,400,000	7,450,000
11. Boston VA Research Institute, Inc.	Boston	MA	17,109,000	13,000,000	13,000,000	13,000,000
12. Bronx Veterans Medical Research Foundation, Inc.	Bronx	NY	4,808,000	5,000,000	5,500,000	6,500,000
13. Buffalo Institute for Medical Research, Inc.	Buffalo	NY	842,000	620,000	530,000	580,000
14. Center for Veterans Research and Education	Minneapolis	MN	8,292,000	7,100,000	7,455,000	7,828,000
15. Central Texas Veterans Research Foundation	Temple	TX	1,096,000	1,081,000	600,000	600,000
16. Chicago Association for Research & Education In Science	Hines	IL	6,587,000	1,045,000	1,097,000	1,152,000
17. Cincinnati Education & Research for Veterans Foundation, Inc.	Cincinnati	OH	1,501,000	1,901,000	2,106,000	2,408,000
18. Cleveland VA Medical Research & Education Foundation	Cleveland	OH	4,391,000	4,610,000	4,841,000	5,083,000
19. Clinical Research Foundation, Inc.	Louisville	KY	331,000	350,000	325,000	335,000
20. Dallas VA Research Corporation	Dallas	TX	3,182,000	3,971,000	4,090,000	4,131,000
21. Dayton Veterans Affairs Research and Education Foundation	Dayton	OH	147,000	172,000	165,000	175,000
22. Denver Research Institute	Denver	CO	4,970,000	5,715,000	6,858,000	8,083,000
23. Dorn Research Institute, Inc.	Columbia, SC	SC	587,000	798,000	850,000	900,000
24. East Bay Institute for Research & Education	Sacramento	CA	1,603,000	1,300,000	1,500,000	1,800,000
25. Foundation for Advancing Veterans' Health Research, Inc.	San Antonio	TX	6,244,000	6,676,000	7,017,000	6,812,000
26. Foundation for Atlanta Veterans Education and Research, Inc.	Atlanta	GA	13,736,000	5,400,000	5,742,000	6,029,000
27. Great Plains Veterans Research Foundation	Sioux Falls	SD	92,000	125,000	140,000	150,000
28. Greater Los Angeles Veterans Research and Education Foundation	Los Angeles	CA	7,970,000	7,315,000	7,387,000	7,532,000

Nonprofit Corporations	City	State	Actual Revenues (Contributions) 2023	Estimated Revenues (Contributions) 2024	Estimated Revenues (Contributions) 2025	Estimated Revenues (Contributions) 2026
29. Houston VA Research and Education Foundation, Inc.	Houston	TX	818,000	300,000	350,000	400,000
30. Idaho Veterans Research and Education Foundation, Inc.	Boise	ID	718,000	650,000	675,000	750,000
31. Indiana Institute for Medical Research, Inc.	Indianapolis	IN	1,383,000	2,076,000	2,100,000	2,200,000
32. Institute for Clinical Research, Inc.	Washington	DC	4,583,000	5,600,000	6,000,000	6,500,000
33. Institute for Medical Research, Inc.	Durham	NC	20,757,000	22,000,000	24,000,000	26,000,000
34. Iowa City VA Medical Research Foundation	Iowa City	IA	669,000	400,000	400,000	425,000
35. Lexington Biomedical Research Institute, Inc.	Lexington	KY	643,000	200,000	200,000	200,000
36. Loma Linda Veterans Association for Research and Education, Inc.	Loma Linda	CA	3,465,000	3,750,000	4,125,000	4,375,000
37. Louisiana Veterans Research and Education Corporation	New Orleans	LA	306,000	363,000	399,000	435,000
38. Lowcountry Center for Veterans Research	Charleston	SC	3,055,000	3,433,000	5,780,000	6,358,000
39. Metropolitan Detroit Research and Education Foundation (MDREF)	Detroit	MI	77,000	200,000	225,000	250,000
40. Middle Tennessee Research Institute, Inc.	Nashville	TN	304,000	500,000	625,000	750,000
41. Midwest Veterans' Biomedical Research Foundation	Kansas City	MO	2,288,000	329,000	329,000	329,000
42. Mountain Home Research and Education Corporation	Mountain Home	TN	714,000	700,000	600,000	400,000
43. Narrows Institute for Biomedical Research, Inc.	Brooklyn	NY	3,794,000	200,000	200,000	200,000
44. Nebraska Educational Biomedical Research Association	Omaha	NE	983,000	750,000	773,000	796,000
45. North Florida Foundation for Research and Education, Inc.	Gainesville	FL	1,552,000	2,351,000	2,469,000	2,592,000
46. Northern California Institute for Research & Education	San Francisco	CA	52,613,000	57,677,000	59,407,000	61,189,000
47. Ocean State Research Institute, Inc.	Providence	RI	5,984,000	1,743,000	1,795,000	1,849,000
48. Overton Brooks Research Corporation	Shreveport	LA	264,000	340,000	345,000	350,000
49. Pacific Health Research and Education Institute	Honolulu	HI	865,000	1,200,000	500,000	500,000
50. Palo Alto Veterans Institute for Research	Palo Alto	CA	30,503,000	31,938,000	32,896,000	33,883,000
51. Philadelphia Research and Education Foundation	Philadelphia	PA	2,630,000	1,930,000	2,027,000	2,128,000
52. Portland VA Research Foundation	Portland	OR	9,727,000	10,028,000	10,329,000	10,639,000
53. Research! Mississippi, Inc.	Jackson	MS	158,000	165,000	200,000	215,000
54. Research, Inc.	Memphis	TN	1,165,000	700,000	720,000	740,000
55. Richmond Institute for Veterans Research	Richmond	VA	5,679,000	5,400,000	5,100,000	5,200,000

Nonprofit Corporations	City	State	Actual Revenues (Contributions) 2023	Estimated Revenues (Contributions) 2024	Estimated Revenues (Contributions) 2025	Estimated Revenues (Contributions) 2026
56. Salem Research Institute, Inc.	Salem	VA	1,601,000	1,800,000	2,000,000	2,200,000
57. Salisbury Foundation for Research and Education	Salisbury	NC	553,000	558,000	670,000	751,000
58. Seattle Institute for Biomedical & Clinical Research	Seattle	WA	20,870,000	21,750,000	22,000,000	22,000,000
59. Sierra Veterans Research and Education Foundation	Reno	NV	360,000	200,000	200,000	200,000
60. Sociedad de Investigacion Cientifica, Inc.	San Juan	PR	510,000	435,000	543,000	679,000
61. South Florida Veterans Affairs Foundation for Research & Education, Inc.	Miami	FL	3,018,000	360,000	360,000	360,000
62. Southern California Institute for Research and Education	Long Beach	CA	2,175,000	3,000,000	3,250,000	3,250,000
63. Tampa VA Research and Education Foundation, Inc.	Tampa	FL	3,447,000	3,500,000	3,700,000	3,900,000
64. The Research Corporation of Long Island, Inc.	Northport	NY	161,000	50,000	100,000	100,000
65. Truman VA Medical Research Foundation	Columbia, MO	MO	273,000	191,000	210,000	231,000
66. Tuscaloosa Research & Education Advancement Corporation	Tuscaloosa	AL	842,000	1,076,000	834,000	735,000
67. VA Connecticut Research & Education Foundation, Inc.	West Haven	CT	2,079,000	1,900,000	2,000,000	2,100,000
68. Veterans Bio-Medical Research Institute, Inc.	East Orange	NJ	2,389,000	2,150,000	2,150,000	2,000,000
69. Veterans Education & Research Association of Michigan	Ann Arbor	MI	2,391,000	2,200,000	2,420,000	2,662,000
70. Veterans Education and Research. Assn of Northern New England, Inc.	White River Junction	VT	3,427,000	3,598,000	3,958,000	4,089,000
71. Veterans Health Foundation	Pittsburgh	PA	3,357,000	3,213,000	3,534,000	3,887,000
72. Veterans Health Research Institute of Central New York, Inc.	Syracuse	NY	1,598,000	1,324,000	1,400,000	1,500,000
73. Veterans Medical Research Foundation of San Diego	San Diego	CA	15,913,000	16,500,000	16,500,000	17,000,000
74. Veterans Research & Education Foundation	Oklahoma City	OK	437,000	450,000	550,000	650,000
75. Veterans Research and Education Foundation of St. Louis	St Louis	MO	1,878,000	1,972,000	2,169,000	2,278,000
76. VISTAR, Inc.	Birmingham	AL	648,000	675,000	700,000	725,000
77. Western Institute for Veterans Research	Salt Lake City	UT	7,542,000	7,719,000	8,105,000	8,510,000
78. Wisconsin Corporation for Biomedical Research	Milwaukee	WI	437,000	390,000	400,000	410,000
Total			**339,766,000**	**316,925,000**	**331,146,000**	**345,255,000**

Note: The total revenues (contributions) reflected in the table above differ from the Budget Appendix and the Contribution Highlights table.

General Post Fund



The 2025 Current Estimate is based on an updated projection of receipts to the General Post Fund

Program Description

This trust fund consists of gifts, bequests, and proceeds from the sale of property left in the care of VA facilities by former beneficiaries who die leaving no heirs or without having otherwise disposed of their estate. Such funds are used to promote the comfort and welfare of Veterans at hospitals and other facilities for which no general appropriation is available. Donations from pharmaceutical companies, non-profit corporations, and individuals to support VA medical research can also be deposited into this fund (title 38 U.S.C., Ch. 83, Acceptance of Gifts and Bequests, and Ch. 85, Disposition of Deceased Veterans' Personal Property). The resources from this trust fund are utilized for the direct benefit of the patients.

Expenditures from this fund are for recreational activities and religious needs, specific equipment purchases, national recreational events, the vehicle transportation network, television projects, and other items as outlined in Veterans Health Administration Directive 4721, General Post Fund. In addition, P.L. 105-114 authorizes the receipts from the sale of a property acquired for transitional housing to be deposited in the General Post Fund and used for the acquisition, management, and maintenance of other transitional housing properties.

Summary of Budget Request

Operations of this trust fund are financed from fund receipts. Congress provided permanent, indefinite budget authority for this fund and no appropriation is requested.

Table 1: Fund Highlights

Fund Highlights
(dollars in thousands)

Description (dollars in thousands)	2024 Actual	2025 Budget Estimate	2025 Current Estimate	2026 Estimate	+/- 2025-2026
Budget Authority (permanent, indefinite).....	$24,144	$23,116	$24,000	$24,900	$900
Projected Receipts :					
Trust Fund and Donation.....	$19,311	$20,200	$20,100	$20,900	$800
Therapeutic Residences.....	$1,000	$700	$1,000	$1,039	$39
Total Projected Receipts.....	$20,311	$20,900	$21,100	$21,819	$719

Table 2: Changes from 2025 Budget Estimate

Changes From Original 2025 Budget Estimate
(dollars in thousands)

Description (dollars in thousands)	2025 Budget Estimate	2025 Current Estimate	Increase/ Decrease
Budget Authority (permanent, indefinite).....	$23,116	$24,000	$884
Projected Receipts:			
Trust Fund and Donation.....	$20,200	$20,100	($100)
Therapeutic Residences.....	$700	$1,000	$300
Total Projected Receipts.....	$20,900	$21,100	$200

Program Activity

Trust Fund and Donations

Estimates of trust fund obligations for 2025 and 2026 are $24.0 million and $24.9 million respectively. The obligations are consistent with the purposes for which proceeds from this fund may legally be expended (Comptroller General's Decision B 125715, November 10, 1955) and the intent of the donors. Donors usually specify that their donations be used for designated recreational or religious purposes, research projects, or equipment purchases (for example, televisions, medical equipment, and physical therapy equipment).

Compensated Work Therapy - Therapeutic Residences
Under 38 U.S.C. § 2032, funds received through the operation of the Therapeutic Housing Program are to be deposited in the General Post Fund. The Secretary has the discretionary authority to expend up to an additional $500 thousand from the fund above the amount credited to the fund in a fiscal year from proceeds of this program.

Table 3: Financial Actions and Conditions

Financial Actions and Conditions
(dollars in thousands)

Description (dollars in thousands)	2024 Actual
Balance beginning of year:	
Cash	$1,618
Investments	$139,892
Property, Plant, Equipment & Other Assets	$42,270
Total	$183,780
Increase during period:	
Cash	$256,339
Investments	$127,156
Property, Plant, Equipment & Other Assets	$538
Total	$384,033
Decrease during period:	
Cash	$233,607
Investments	$146,559
Property, Plant, Equipment & Other Assets	$2,267
Total	$382,433
Balance at end of year:	
Cash	$24,350
Investments	$120,489
Property, Plant, Equipment & Other Assets	$40,541
Total	$185,380

Department of Veterans Affairs
Office of the Assistant Secretary for Management
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