VA | U.S. Department of Veterans Affairs

Office of the Secretary
Washington DC 20420

In Reply Refer To: **00REG**

March 4, 2020

Subject: Economic Regulatory Impact Analysis for RIN 2900-AQ48(P), Program of Comprehensive Assistance for Family Caregivers Improvements and Amendments under the VA Mission Act of 2018.

I have reviewed the attached Regulatory Impact Analysis and determined the following:

1. VA has examined the economic, interagency, budgetary, legal, and policy implications of this regulatory action and determined that the action is an economically significant regulatory action under Executive Order 12866.

2. This rulemaking will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act, 5 U.S.C. 601-612.

3. This rulemaking is not likely to result in the expenditure of $100 million or more by State, local, and tribal governments, in the aggregate, or by the private sector, in any one year, under the Unfunded Mandates Reform Act of 1995, 2 U.S.C. 1532.

4. This rulemaking is considered an EO 13771 regulatory action.

5. Attached please find the relevant Regulatory Impact Analysis documents.

(Attachment 1): Agency's Regulatory Impact Analysis, dated March 4, 2020.
(Attachment 2): Assumptions & Methodologies Assessing Regulatory Impact of § 71.20 Eligible Veterans and Service Members and § 71.25 Approval and Designation of Primary and Secondary Caregivers, dated March 4, 2020.

Approved by:
Michael Shores
Director
Office of Regulation Policy & Management (00REG)
Office of the Secretary

(Attachment 1)

Regulatory Impact Analysis for RIN 2900-AQ48(P)

Title of Regulation: Program of Comprehensive Assistance for Family Caregivers Improvements

Purpose: To determine the economic impact of this rulemaking.

Statement of Need: The Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L 111-163) established 38 U.S.C. 1720G, which directed the Department of Veterans Affairs (VA) to establish a Program of Comprehensive Assistance for Family Caregivers (PCAFC) and a Program of General Caregiver Support Services (PGCSS). Both programs are managed by the VA's Caregiver Support Program (CSP) Office. On June 06, 2018, the President signed into law the VA Maintaining Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 or the VA MISSION Act 2018 (P.L. 115-182). The VA MISSION Act of 2018 will fundamentally transform elements of the Department of Veteran Affairs' (VA) healthcare system to include expansion of the PCAFC within the CSP (38 U.S.C. 1720G; 38 CFR Part 71).

The intent of this rulemaking is to implement changes required by section 161 of the VA MISSION Act of 2018, improve PCAFC, and to ensure consistency in how PCAFC is administered across VA.

Summary: In preparation for such expansion, VA proposes to revise its regulations that govern the PCAFC, which provide certain medical, travel, training, and stipend benefits to designated family caregivers of certain veterans and servicemembers who were seriously injured in the line of duty on or after September 11, 2001. This rulemaking would update the regulations by (1) updating the scope of the program specific to residency requirement, (2) revising and creating definitions, (3) expanding the scope of eligibility to all service eras, (4) changing the stipend payment calculation, (5) clarifying the time at which adjustments in stipend payments for Primary Family Caregivers would take effect, (6) requiring annual reassessment of eligibility for the program, (7) revising the process for revocation and discharge from the program and providing for an extension of benefits in certain instances, (8) removing the requirement that monitoring must occur at the eligible Veteran's home, and (9) updating the terminology for monitoring visits and the purpose of such visits.

Benefits: The proposed rulemaking implements Sections 161-163 of the MISSION Act of 2018, by expanding the CSP specifically the PCAFC. This program will serve all service era Veterans' family caregivers by providing stipend payments, enhanced respite care, mental health services, benefits travel, and CHAMPVA to those who are eligible.

Additionally, the proposed rulemaking will strengthen consistency and validity within PCAFC by revising eligibility requirements and revising definitions for clarity. PCAFC will be able to address the unique needs of eligible veterans regardless of service era.

This proposed regulation would require participating family caregivers and their eligible veterans participate in annual reassessments, wellness visits, and engage in all requirements of the program. We would revise the process for revocation and discharge from PCAFC.

This rulemaking would also make several improvements to PCAFC and would update the regulations to comply with the recent enactment of the VA MISSION Act of 2018, which made several changes to the program's authorizing statute. The proposed changes would allow PCAFC to address the needs of eligible veterans of all eras and standardize the current program to focus on veterans with moderate and severe needs.

Estimated Impact: VA has determined that in addition to benefits, there are both costs and transfers associated with this rulemaking. Some portions of the following analysis rely upon assumptions that may change, due to difficulty predicting how many Veterans are going to elect to participate in the CSP, the severity of their caregiving needs, and for which services they will elect to utilize within and outside of VA.

The estimated costs of the proposed revisions to 38 CFR Part 71 are $66.9 million in FY 2020 and a total of $755.5million over five years. The estimated transfers of the proposed revisions to 38 CFR Part 71 are $72.5 million in FY 2020 and $4.4 billion over five years. The net budget impact is estimated to be $140.3 million in 2020 and $5.1 billion over five years.[1] The impacts of the rulemaking are outlined in Table 1.

This rulemaking is likely to be considered an EO 13771 regulatory action if finalized. VA has determined that the net costs are $755.5 million over a five-year period (FY2020-FY2024) and $146 million per year on an ongoing basis discounted at 7 percent relative to year 2016, over a perpetual time horizon.

[1] An indirect cost of the proposed rule would be increased distortions in the labor markets taxed to support federal government programs and activities. Such distortions are sometimes referred to as marginal excess tax burden (METB), and Circular A-94—OMB's guidance on cost-benefit analysis of federal programs, available at https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A94/a094.pdf—suggests that METB may be valued at roughly 25 percent of the estimated transfer attributed to a policy change; the Circular goes on to direct the inclusion of estimated METB change in supplementary analyses. If secondary costs—such as increased marginal excess tax burden is, in the case of this proposed rule—are included in regulatory impact analyses, then secondary benefits must be as well, in order to avoid inappropriately skewing the net benefits results, and including METB only in supplementary analyses provides some acknowledgement of this potential imbalance.

Table 1. Estimated Impact of Rulemaking on the Caregiver Support Program

	Definitions for § 71.10 and § 71.15	§ 71.20 Eligible Veterans & Service Members; § 71.25 Approval & Designation of Primary & Secondary Caregivers (Case Management)	§ 71.30 Reassessment of Eligible Veterans & Caregivers	§ 71.40 Wellness Visits	§ 71.47 over payment recovery	Additional Program and Administrative Costs	Subtotal Costs	§ 71.20 Eligible Veterans & Service Members; § 71.25 Approval & Designation of Primary & Secondary Caregivers (Transfers)	§ 71.40 Caregiver Benefits (Transfers)	§ 71.45 Revocation & Discharge of the Family Caregiver (Transfers)	Subtotal (Transfers)	Total Budget Impact
2020	$0	$18,300,000	$0	$0	$0	$48,573,389	**$66,873,389**	$26,043,220	$32,440,972	$13,971,859	**$72,456,051**	**$139,329,440**
2021	$0	$66,699,600	$8,052,181	$0	$0	$41,889,646	**$116,641,427**	$394,041,400	$115,603,363	$24,090,260	**$533,735,022**	**$650,376,450**
2022	$0	$91,466,722	$10,816,286	$2,228,898	$0	$45,066,615	**$149,578,521**	$810,177,213	$23,477,855	$27,896,361	**$861,551,429**	**$1,011,129,950**
2023	$0	$128,579,060	$15,773,384	$6,446,821	$0	$46,833,782	**$197,633,048**	$1,239,901,907	$17,877,373	$36,578,583	**$1,294,357,863**	**$1,491,990,911**
2024	$0	$149,059,442	$18,552,959	$8,733,848	$0	$48,400,171	**$224,746,420**	$1,550,888,581	$13,270,025	$39,457,087	**$1,603,615,694**	**$1,828,362,114**
5-Yr Total	**$0**	**$454,104,824**	**$53,194,811**	**$17,409,568**	**$0**	**$230,763,603**	**$755,472,805**	**$4,021,052,321**	**$202,669,588**	**$141,994,150**	**$4,365,716,059**	**$5,121,188,864**

Each section of 38 CFR Part 71 impacted by the rulemaking is further discussed below providing supportive explanation that justifies the costs and/or savings associated with the regulatory action.

§ 71.10 Purpose and Scope and § 71.15 Definitions

Alternative Policy

VA proposes to specify that only those veterans residing in a State as defined by 38 U.S.C 101(20) are eligible to participate in PCAFC. VA also proposes to include new definitions of domestic violence (DV); financial planning services; in need of personal care services; institutionalization; intimate partner violence (IPV); joint application; legacy applicant; legacy participant; legal services; monthly stipend rate; need for supervision, protection, or instruction; overpayment; and unable to self-sustain in the community. VA also proposes to revise the definitions of in the best interest, inability to perform an activity of daily living (ADL), primary care team, and serious injury. VA proposes to remove the definitions of combined rate and need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury, which will be addressed later in this analysis.

VA also considered not changing and creating basic terms in the current § 71.15 and keeping the current regulation. Defining new terms and changing current terms to reflect current practice and adhere to the laws outline in the MISSION Act of 2018 will provide additional detail that allows VA to increase consistency in implementation across medical centers.

Assumptions and Methodology

There would be no costs or savings (i.e., $0) associated with the proposed changes to § 71.10 and § 71.15.

VA is merely further defining the scope of the program and defining terms (i.e., *DV, IPV, long-term institutionalization*) as they will be used in later sections concerning requests for revocation and/or discharge of Veterans or family caregivers and extension of benefits due to intimate partner violence.

§ 71.20 Eligible Veterans and Service Members & § 71.25 Approval and Designation of Primary and Secondary Caregivers

Alternative Policy

VA proposes to restructure § 71.20 to accommodate three groups of Veterans and servicemembers based on new eligibility criteria, add new language to reflect the service era expansion requirements of the MISSION Act of 2018, create a transition plan to assess all approved family caregivers prior to the first final effective rule with new eligibility criteria, remove use of the Global Assessment Function (GAF) score and 100 percent service connected rating for that injury and awarded special monthly

compensation as part of the eligibility criteria, and revise paragraphs based on definitions outlined in § 71.15.

An alternative policy approach, leaving the current regulation unchanged, was considered. Without the changes, the program would not comply with the laws outlined in the MISSION Act of 2018. Additionally, the GAF scoring system is no longer recognized as a valid practice tool according to the Diagnostic & Statistical Manual of Mental Disorders, 5th Edition (DSM-5), and VA does not use it to determine if individuals are eligible for PCAFC.

In § 71.25, VA proposes to replace, remove, and insert terms and phrases to provide clarity about submitting applications, conducting clinical evaluations, what eligibility criteria to use based on date of application, required personal care services, timeframes for in home assessments, and ongoing approval for the designated family caregiver.

An alternative policy approach, leaving the current regulation unchanged was considered. However, failing to do so would cause confusion, create inconsistency and fail to meet new requirements outlined in section 161(a)(5) of the VA MISSION Act of 2018 the proposed changes are necessary.

Assumptions and Methodology

There would be no costs or savings (i.e., $0) associated with the proposed changes to remove the GAF scoring system as outlined in § 71.20 and § 71.25 to be consistent with the DSM-5. VA is proposing to revise language in § 71.20 and § 71.25 that will allow greater focus on the individual needs of the veterans without any financial impact.

VA is projecting a transfer cost of $26 million in 2020 and $4 billion over five years as displayed in Table 2 for the new eligibility criteria. The stipend cost of the expanded population, displayed in table 3 below, is set at the rates described under the proposed § 71.40 discussed later in this impact analysis. Table 4 details the other associated health costs from the program eligibility expansion. Table 5 shows the estimated Tier 1 stipend costs for Post-9/11 Veterans projected to be no longer eligible under the new eligibility standards. The estimates for Table 5 are prior to the extended eligibility described later in this RIA under § 71.40. Cost assumptions for the model underpinning the below analysis proceed Table 5.

VA is projecting a case management cost of $18.3 million in 2020 and $454 million over five years as displayed in Table 6.

Table 2: Cost Estimate of New Eligibility Criteria

Fiscal Year	Increased Stipends from Pre-9/11 Veterans	Other Health Care Costs of Pre-9/11 Veterans	Reduced Stipend Costs of Post 9/11 Veterans	Adjustment for the Rate Change captured in table 10	Total Transfers Impact from the New Eligibility Criteria
2020	$36,947,101	$14,682,711	($21,951,989)	($3,634,603)	$26,043,220
2021	$437,547,399	$54,514,303	($69,455,922)	($28,564,380)	$394,041,400
2022	$797,266,901	$90,256,254	($67,886,096)	($9,459,846)	$810,177,213
2023	$1,187,549,829	$128,198,997	($69,243,818)	($6,603,101)	$1,239,901,907
2024	$1,470,856,975	$152,709,093	($72,041,268)	($636,219)	$1,550,888,581
5-Yr Total	**$3,930,168,205**	**$440,361,358**	**($300,579,092)**	**($48,898,150)**	**$4,021,052,321**

Table 3: Cost Estimate of Expanding Stipends

Fiscal Year	Pre-Vietnam	Vietnam	Post-Vietnam	Total Expanded Unique Sponsor Counts	Pre-Vietnam	Vietnam	Post-Vietnam	Total Stipend Payment
2020	3,353	5,430	0	8,783	$14,167,983	$22,779,118	$0	$36,947,101
2021	11,391	19,915	0	31,306	$159,905,544	$277,641,856	$0	$437,547,399
2022	15,744	29,861	3,342	48,947	$271,445,750	$511,441,453	$14,379,698	$797,266,901
2023	17,184	35,329	12,748	65,260	$330,044,046	$674,231,021	$183,274,761	$1,187,549,829
2024	16,378	36,704	19,865	72,947	$346,985,014	$772,888,716	$350,983,246	$1,470,856,975
5-Yr Total					**$1,122,548,336**	**$2,258,982,164**	**$548,637,705**	**$3,930,168,205**

Table 4: Cost Estimate of other Health Benefits to the expanded population

Fiscal Year	Sponsor Count	CHAMPVA	Mental Health	Respite Care	Total Cost of Other Health Benefits
2020	8,783	$3,361,460	$295,957	$11,025,295	$14,682,711
2021	31,306	$12,266,440	$1,131,545	$41,116,319	$54,514,303
2022	48,947	$19,942,041	$1,976,977	$68,337,236	$90,256,254
2023	65,260	$28,097,136	$3,024,421	$97,077,441	$128,198,997
2024	72,947	$33,269,455	$3,747,243	$115,692,395	$152,709,093
5-Yr Total		**$96,936,531**	**$10,176,142**	**$333,248,685**	**$440,361,358**

Table 5: Tier 1 Stipend Cost for post 9/11 Veterans based on New Eligibility Criteria

Fiscal Year	Sponsor Count	Monthly Tier 1 Stipend Cost	Months	Cost
2020	7,624	$720	4	($21,951,989)
2021	7,624	$759	12	($69,455,922)
2022	7,624	$742	12	($67,886,096)
2023	7,624	$757	12	($69,243,818)
2024	7,624	$772	12	($72,041,268)
5-Yr Total				**($300,579,092)**

Please see Attachment 2 for a further detailed explanation of the assumptions and methodology used to assess § 71.20 Eligible Veterans and Service Members & § 71.25 Approval and Designation of Primary and Secondary Caregivers. Details on the rate change impact can be found in § 71.40.

As a result of the of the expanded eligibility, additional case managers are necessary to serve the enrolled Veteran and caregiver. The FTE amounts displayed in table 6 maintains a ratio of 1 staff to 48 Veterans, as guided by a VA workforce analysis that sought the optimal appropriate level of support.

Table 6: Case Management Cost for post 9/11 Veterans based on New Eligibility Criteria

Fiscal Year	Increased Case Management for Pre-9/11 Veterans FTE	Reduced Case Management for Post-9/11 Veterans	Net FTE Impact	Cost per FTE	Total Case Management Cost Impact from the New Eligibility Criteria
2020	183		183	$100,000	$18,300,000
2021	652		652	$102,300	$66,699,600
2022	1,020	(146)	874	$104,653	$91,466,722
2023	1,360	(159)	1,201	$107,060	$128,579,060
2024	1,520	(159)	1,361	$109,522	$149,059,442
5-Yr Total					**$454,104,824**

§ 71.30 Reassessment of Eligible Veterans and Family Caregivers and § 71.35 General Caregivers.

Alternative Policies

In § 71.30, VA proposes to redesignate this section, which is the section that describes who is a caregiver for purposes of part 71, as new § 71.35; and new § 71.30 to institute mandatory reassessments, including monthly stipend rate, for continued eligibility for PCAFC on an annual basis, or other frequently based on a clinical determination and revocation for noncompliance in reassessments.

VA considered not requiring an established timeline for reassessments of Veterans and family caregivers. VA also considered requiring annual reassessments for all participants without exception. However, VA does not believe this would be in the clinical best interest of all Veterans and family caregivers. A Veteran's need for personal care services may change over time, possibly affecting an increase or decrease in personal care needs. Currently, there is no standardized or consistent requirement for eligibility reassessments across VA, as some facilities conduct reassessments while others do not. Additionally, there is no standard timeline for when such reassessments should occur. Therefore, requiring annual reassessments would create consistency across the program and ensure that all sites are conducting these reassessments on a standard timeline. Assessing for ongoing eligibility and determinations of level of need would ensure that VA is supporting eligible Veterans and family caregivers by offering the most appropriate level of care and support needed.

Assumptions and Methodology

The estimated costs of the proposed revisions to § 71.30 would have no cost in 2020 and cost $53.195 million over the next five years as displayed in table 7

Table 7: Cost Estimate of Reassessment of Eligible Veterans & Caregivers

Fiscal Year	Annual Urban Site Reassessment Costs	Rural Site Reassessments	Total Cost of Reassessments
2020	$0	$0	$0
2021	$4,307,879	$3,744,302	$8,052,181
2022	$6,392,488	$4,423,798	$10,816,286
2023	$10,164,508	$5,608,876	$15,773,384
2024	$12,259,004	$6,293,955	$18,552,959
5-Yr Total	**$33,123,879**	**$20,070,931**	**$53,194,811**

The total number of Registered Nurse (RN) FTE needed in an urban facility was found by determining the total number of hours needed to reassess family caregivers in an urban setting. According to a staffing model produced by VA Manpower Office, it showed that 117 VA facilities out of a total 135 VA facilities are considered located in an urban setting, which is approximately 87 percent of all facilities. It is assumed that the ratio of Veteran sponsors is equal to the ratio of facilities, meaning 87 percent of total Veteran sponsors in a fiscal year is located within an urban setting. The total hours in an urban setting were found by multiplying the number of needed for reassessment by the total number of Veteran sponsors. It is believed that approximately 4 hours per Veteran sponsor is needed to conduct an annual reassessment. This factors in drive time, time spent with family caregiver and Veteran, administrative time, case coordination, and follow up. This number was then divided by 2,087 (numbers of hours for 1.00 Full Time Equivalent {FTE}) to determine total FTE needed each fiscal year. There are 62.00 RN FTE currently in the program and this was deducted from the total leaving us with the total FTE need for expansion. A RN II Step 5 salary plus benefits (23 percent) to determine total costs with a 2.3 percent inflation in out years. Table 8 details the costs of reassessments at urban sites.

Table 8: Cost Estimate of Reassessing at Urban Sites

Fiscal Year	Urban Sites	Unique Sponsor Counts	Urban Sponsors	Total Urban Hours	Additional RN FTE Needed	Cost per FTE	Total Costs
2020*					N/A		N/A
2021	117	56,666	49,299	197,197	32	$132,599	$4,307,879
2022	117	65,444	56,936	227,745	47	$135,649	$6,392,488
2023	117	81,110	70,566	282,262	73	$138,769	$10,164,508
2024	117	88,970	77,404	309,617	86	$141,960	$12,259,004
5-Yr Total	**468**	**292,190**	**254,205**	**1,016,821**	**239**		**$33,123,879**

**Reassessment occur on an annual basis, therefore this RIA will not show a cost for changes to the reassessment process in 2020.*

The total number of Registered Nurse (RN) FTE needed in a rural facility was found by determining the total number of hours needed to reassess family caregivers in a rural setting. According to a staffing model produced by VA Manpower Office, it showed that 18 VA facilities out of a total 135 VA facilities are considered located in a rural setting, which is approximately 13 percent of all facilities. It is assumed that the ratio of Veteran sponsors is equal to the ratio of facilities meaning 13 percent of total Veteran sponsors in a fiscal year is located within a rural setting. The total hours necessary in a rural setting were found by multiplying the number of hours needed for reassessment by the total number of Veteran sponsors. It is believed that approximately 8 hours per Veteran sponsor is needed to conduct an annual reassessment. This factors in drive time, time spent with family caregiver and Veteran, administrative time, case coordination, and follow up. This number was then divided by 2,087 (numbers of hours for 1.00 FTE) to determine total FTE needed each fiscal year. A RN II Step 5 salary plus benefits (23

percent) to determine total costs with a 2.3 percent inflation in out years. Table 9 details the costs of reassessments at rural sites.

Table 9: Cost Estimate of Reassessing at Rural Sites

Fiscal Year	Rural Sites	Unique Sponsor Counts	Rural Sponsors	Total Rural Hours	# Additional RN FTE Needed	Cost per FTE	Total Costs
2020*					N/A		N/A
2021	18	56,666	7,367	58,932	28	$132,599	$3,744,302
2022	18	65,444	8,508	68,062	33	$135,649	$4,423,798
2023	18	81,110	10,544	84,354	40	$138,769	$5,608,876
2024	18	88,970	11,566	92,529	44	$141,960	$6,293,955
5-Yr Total	**72**	**292,190**	**37,985**	**303,877**	**146**		**$20,070,931**

**Reassessment occur on an annual basis, therefore this RIA will not show a cost for changes to the reassessment process in 2020.*

§ 71.40 Caregiver Benefits

Alternative Policies

The proposed changes in 71.40(b)(2) would result in changes to multiple modifications, including transitioning "90-day monitoring visits" to "wellness contacts" in order to clarify the purpose of the visits and to allow flexibility in the setting of the contacts; reduction in the number of wellness contacts per year; removal of redundant words to avoid confusion; and transition to a two-level tier system. There will also be a transition in monthly stipend rate calculation from Bureau of Labor Statistics (BLS) combined rate to Office of Personnel Management's (OPM) General Schedule (GS) 4 Step 1 level, divided by 12, in the eligible Veteran's geographic area of residence; plan to address those that will receive an increase or decrease as a result of the stipend rate transition; revising the definition of determination for monthly stipend rate from fixed hours to a percentage of annual salary; inclusion of three cohorts of primary family caregivers; twelve month transition for current participants no longer eligible based on the new eligibility proposed; creation of thirty day notice of family caregiver and Veteran relocation; sixty day due process notice for those no longer eligible; addition of financial planning and legal services; removal of 45 day criteria for processing of applications, and redefining submission of joint applications.

VA considered not changing the wording of "90-day monitoring", the number of wellness contacts and flexibility in care settings, however, the visits are resource intensive, inconsistently completed, and are often viewed as burdensome by the Veteran and family caregiver. The Office of Inspector General (OIG) conducted an audit that confirmed the resource intensive and burdensome practice of these visits. See VA OIG Report, Program of Comprehensive Assistance for Family Caregivers: Management Improvements Needed, Report No. 17-04003-222, dated August 16, 2018, pp. 11-13.

VA considered keeping the three-tier level system, however a transition to a two-tier level system is necessary to be consistent with the definitions proposed in § 71.15 and the eligibility criteria proposed in § 71.20.

Two alternative policies were considered in determining stipend rate calculation. The first alternative considered was to keep the current combined rates to determine the stipend amounts. This would cause some geographic regions to receive more than double the national median pay for a home health aide due to BLS rates and a decision by VA that does not allow for a decrease in stipend payments. The other alternative considered was transitioning the stipend rate to a lower GS annual rate. Calculating several of OPM's GS Annual Rates, showed that each was not consistent with the pay of a home health aide.

VA considered not including a reassessment of current participants with new eligibility criteria and maintain current stipend rates; however, it is necessary in order to comply with the laws as set forth in the MISSION Act of 2018.

VA considered not revising the definition of determination for monthly stipend rate from fixed hours to a percentage of annual salary. VA has found that reference to a set number of hours creates significant confusion and discord among caregivers who feel the hours needed to provide care goes well beyond the number of hours determined.

VA considered not adding a paragraph that would describe the criteria that would be used to determine whether a primary caregiver will receive a stipend, however, it is needed to provide clarification based on the definition of "unable to self-sustain in the community" as proposed in § 71.15.

VA considered leaving out financial planning and legal services as a new benefit in the proposed rulemaking, however, it is necessary as outlined in section 161a of the MISSION Act of 2018.

Assumptions and Methodology

The estimated costs of the proposed revisions to § 71.40 would be cost neutral in FY 2020 and a total of $17.4 million over five years. The estimated transfers of the proposed revisions to § 71.40 would be $32.4 million in FY 2020 and a total of $220 million over five years.

BLS Rate to GS Gate Methodology

Step 1: Which private industry is the most comparable to VA Caregivers?
The "Home Health Aide" occupation reported by BLS is the most representative of VA Caregivers.[2] Home health aides, "Provide routine individualized healthcare such as changing bandages and dressing wounds, and applying topical medications to the

[2] BLS Code 31-1011

elderly, convalescents, or persons with disabilities at the patient's home or in a care facility. Monitor or report changes in health status. May also provide personal care such as bathing, dressing, and grooming of patient."[3]

Step 2: How to measure the private market wage for Home Health Aides?
The Occupational Employment Statistics program is the only comprehensive source of regularly produced occupational employment and wage rate information for the U.S. economy, as well as States, the District of Columbia, Guam, Puerto Rico, the U.S. Virgin Islands, and all metropolitan and nonmetropolitan areas in each State. Therefore, VA has chosen to use the OES data for our analysis.[4] The national median annual wage for a home health aide was $24,200 in 2018.

To measure the private market wage, we used the median annual wage reported by Bureau of Labor Statistics in their Occupational Employment Statistics release at a national level. The median is a better measure of wages for your "average" home health aide because it is not skewed by outliers like the mean. While VA would have liked to use a measure of income that is post tax and post employer contributions since the Caregiver stipends are non-taxable, but this data is not available at the MSA level by NAICS code on an annual basis.

Step 3: How much higher are private wages than the national median in areas that receive GS locality pay adjustments?
Assumptions made to answer this question are as follows:

- The time period for this analysis is from 2012 to 2018, the latest data available from BLS.
- The MSAs considered GS locality adjusted areas are areas that received locality adjustments in all years of analysis.
    - Findings therefore exclude Birmingham, Corpus Christi, Omaha, San Antonio, and Virginia Beach since they are not deemed GS Locality Adjusted Areas in all years.
    - Analysis excludes Alaska and Hawaii because the entire state is deemed a locality area, but only small portions of the states are represented by MSAs. It would be inaccurate to equate the behavior of MSAs to the behavior of the entire state.
- Analysis excludes Laredo in 2013 average because MSA level data is not available from BLS in 2012.
- In cases where a GS locality named multiple cities, the first city named on the GS adjustment was mapped to the MSA data from BLS. GS localities therefore do not align perfectly to MSAs called out in this analysis.

Of the 44 locality adjusted areas analyzed, 24 areas had a median private sector wage that was less than the national median wage in 2018 and 20 that were above. The

[3] https://www.bls.gov/oes/current/oes311011.htm

[4] https://www.bls.gov/oes/oes_ques.htm#overview

Huntsville area had a local wage that was the furthest below the national median (24 percent below). The Sacramento area had a local wage that was the furthest above the national median (50 percent above). Other areas where the local median was more than 20 percent above the national median were Boston (25 percent above) and Las Vegas (27 percent above).

Step 4: How much are the GS locality pay adjustments?

Assumptions made to answer this question are as follows:

- The time period for analysis is from 2012 to 2018.
- GS locality adjusted areas considered are areas that received locality adjustments in all years of analysis.
- Analysis excludes Alaska and Hawaii.
- These results do not include the overall increase made to the entire GS scale in each year, only the published locality adjustment rate.

GS Locality	**2018**	**2017**	**2016**	**2015**	**2014**	**2013**	**2012**
ALBANY-SCHENECTADY, NY-MA	16.5%	15.9%	14.2%	14.2%	14.2%	14.2%	14.2%
ALBUQUERQUE-SANTA FE-LAS VEGAS, NM	15.8%	15.4%	14.4%	14.2%	14.2%	14.2%	14.2%
ATLANTA--ATHENS-CLARKE COUNTY--SANDY SPRINGS, GA-AL	21.2%	20.7%	19.6%	19.3%	19.3%	19.3%	19.3%
AUSTIN-ROUND ROCK, TX	16.7%	16.0%	14.5%	14.2%	14.2%	14.2%	14.2%
BOSTON-WORCESTER-PROVIDENCE, MA-RI-NH-ME	27.5%	26.7%	25.2%	24.8%	24.8%	24.8%	24.8%
BUFFALO-CHEEKTOWAGA, NY	19.2%	18.7%	17.3%	17.0%	17.0%	17.0%	17.0%
CHARLOTTE-CONCORD, NC-SC	16.2%	15.7%	14.4%	14.2%	14.2%	14.2%	14.2%
CHICAGO-NAPERVILLE, IL-IN-WI	27.5%	26.9%	25.4%	25.1%	25.1%	25.1%	25.1%
CINCINNATI-WILMINGTON-MAYSVILLE, OH-KY-IN	19.9%	19.5%	18.8%	18.6%	18.6%	18.6%	18.6%
CLEVELAND-AKRON-CANTON, OH	20.1%	19.7%	18.9%	18.7%	18.7%	18.7%	18.7%
COLORADO SPRINGS, CO	16.6%	16.0%	14.5%	14.2%	14.2%	14.2%	14.2%
COLUMBUS-MARION-ZANESVILLE, OH	19.0%	18.5%	17.4%	17.2%	17.2%	17.2%	17.2%
DALLAS-FORT WORTH, TX-OK	23.4%	22.6%	21.0%	20.7%	20.7%	20.7%	20.7%
DAVENPORT-MOLINE, IA-IL	16.1%	15.6%	14.4%	14.2%	14.2%	14.2%	14.2%
DAYTON-SPRINGFIELD-SIDNEY, OH	18.1%	17.6%	16.5%	16.2%	16.2%	16.2%	16.2%
DENVER-AURORA, CO	25.5%	24.7%	22.9%	22.5%	22.5%	22.5%	22.5%
DETROIT-WARREN-ANN ARBOR, MI	26.3%	25.7%	24.4%	24.1%	24.1%	24.1%	24.1%
HARRISBURG-LEBANON, PA	16.2%	15.6%	14.5%	14.2%	14.2%	14.2%	14.2%
HARTFORD-WEST HARTFORD, CT-MA	28.2%	27.6%	26.2%	25.8%	25.8%	25.8%	25.8%
HOUSTON-THE WOODLANDS, TX	31.7%	31.0%	29.1%	28.7%	28.7%	28.7%	28.7%
HUNTSVILLE-DECATUR-ALBERTVILLE, AL	18.5%	17.8%	16.4%	16.0%	16.0%	16.0%	16.0%
INDIANAPOLIS-CARMEL-MUNCIE, IN	16.2%	15.9%	14.9%	14.7%	14.7%	14.7%	14.7%

KANSAS CITY-OVERLAND PARK-KANSAS CITY, MO-KS	16.1%	15.6%	14.5%	14.2%	14.2%	14.2%	14.2%
LAREDO, TX	17.4%	16.7%	14.6%	14.2%	14.2%	14.2%	14.2%
LAS VEGAS-HENDERSON, NV-AZ	16.5%	15.9%	14.6%	14.2%	14.2%	14.2%	14.2%
LOS ANGELES-LONG BEACH, CA	30.6%	29.7%	27.7%	27.2%	27.2%	27.2%	27.2%
MIAMI-FORT LAUDERDALE-PORT ST. LUCIE, FL	22.6%	22.1%	21.1%	20.8%	20.8%	20.8%	20.8%
MILWAUKEE-RACINE-WAUKESHA, WI	20.1%	19.6%	18.4%	18.1%	18.1%	18.1%	18.1%
MINNEAPOLIS-ST. PAUL, MN-WI	23.4%	22.7%	21.3%	21.0%	21.0%	21.0%	21.0%
NEW YORK-NEWARK, NY-NJ-CT-PA	32.1%	31.2%	29.2%	28.7%	28.7%	28.7%	28.7%
PALM BAY-MELBOURNE-TITUSVILLE, FL	15.9%	15.5%	14.4%	14.2%	14.2%	14.2%	14.2%
PHILADELPHIA-READING-CAMDEN, PA-NJ-DE-MD	24.6%	23.9%	22.2%	21.8%	21.8%	21.8%	21.8%
PHOENIX-MESA-SCOTTSDALE, AZ	19.1%	18.6%	17.1%	16.8%	16.8%	16.8%	16.8%
PITTSBURGH-NEW CASTLE-WEIRTON, PA-OH-WV	18.4%	17.9%	16.7%	16.4%	16.4%	16.4%	16.4%
PORTLAND-VANCOUVER-SALEM, OR-WA	22.5%	22.0%	20.7%	20.4%	20.4%	20.4%	20.4%
RALEIGH-DURHAM-CHAPEL HILL, NC	19.5%	19.0%	17.9%	17.6%	17.6%	17.6%	17.6%
RICHMOND, VA	18.8%	18.2%	16.8%	16.5%	16.5%	16.5%	16.5%
SACRAMENTO-ROSEVILLE, CA-NV	24.9%	24.1%	22.6%	22.2%	22.2%	22.2%	22.2%
SAN DIEGO-CARLSBAD, CA	27.9%	27.0%	24.7%	24.2%	24.2%	24.2%	24.2%
SAN JOSE-SAN FRANCISCO-OAKLAND, CA	39.3%	38.2%	35.8%	35.2%	35.2%	35.2%	35.2%
SEATTLE-TACOMA, WA	25.1%	24.2%	22.3%	21.8%	21.8%	21.8%	21.8%
ST. LOUIS-ST. CHARLES-FARMINGTON, MO-IL	16.5%	15.8%	14.5%	14.2%	14.2%	14.2%	14.2%
TUCSON-NOGALES, AZ	16.2%	15.7%	14.5%	14.2%	14.2%	14.2%	14.2%
WASHINGTON-BALTIMORE-ARLINGTON, DC-MD-VA-WV-PA	28.2%	27.1%	24.8%	24.2%	24.2%	24.2%	24.2%

<u>Step 5: In which regions do the private sector differential and the GS adjustment not align?</u>

Assumptions made to answer this question are as follows:

- The time period for analysis is from 2012 to 2018, the latest data available from BLS.
- The MSAs considered GS locality adjusted areas are areas that received locality adjustments in all years of analysis.
    - Findings therefore exclude Birmingham, Corpus Christi, Omaha, San Antonio, and Virginia Beach since they are not deemed GS Locality Adjusted Areas in all years.
    - Analysis excludes Alaska and Hawaii because the entire state is deemed a locality area, but only small portions of the states are represented by

MSAs. It would be inaccurate to equate the behavior of MSAs to the behavior of the entire state.

- Analysis excludes Laredo in 2013 average because MSA level data is not available from BLS in 2012.
- In cases where a GS locality named multiple cities, the first city named on the GS adjustment was mapped to the MSA data from BLS. GS localities therefore do not align perfectly to MSAs called out in this analysis.

The first step in this analysis was to take the difference between the GS adjustment and the private sector differential in each of the covered regions. In 6 of the 7 years considered, Boston had a higher private sector differential than GS adjustment. The GS adjustment in Sacramento was larger than the private sector differential from 2012 through 2015; however, from 2016 on, the private sector differential has been larger than the GS adjustment. Another area that drew attention was Las Vegas, where the private sector differential outpaced the GS adjustment by 10 percentage points in 2018.

To see a time trend and pinpoint areas where the GS adjustment is consistently below the private sector differential, these yearly data points were averaged over the time period from 2012 to 2018. This analysis showed that the Boston area is the only location where GS wage adjustments have not been enough to keep up with the private sector differential over the time horizon.

The 2018 national median wage in for home health aides was $24,200.[5] To map this to the latest GS scale, it needs to be inflated to December 2019 dollars, so these values are in the same terms. This was done using the CPI specific to “Care of invalids, elderly, and convalescents in the home.” This index measures the consumer price change in fees paid to individuals or agencies for the personal care of invalids, elderly or convalescents in the home including food preparation, bathing, light house cleaning, and other services over time.[6] Using this inflation measure, the 2018 median wage equates to $25,277 in December 2019 dollars. This payment maps to a GS 3-3 on the 2020 payment schedule.[7]

To identify which GS adjusted localities would experience a stipend payment at the GS 3 Step 3 that is less than the private rate, the locality adjusted pay rate was compared to the median wage rate in each location. This analysis shows that all GS adjusted regions receive more than the private sector median wage in the area under a GS 3 Step 3 besides Davenport, Las Vegas, and Sacramento.

[5] Wages reported by BLS are reported in May 2018 dollars.

[6] https://www.bls.gov/cpi/factsheets/medical-care.htm

[7] https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/2020/general-schedule/

	2018 BLS wage grown to 2020 Dollars	GS 3-3 Adjusted Rate	How much less is the GS 3-3 than the median BLS rate?
ALBANY-SCHENECTADY, NY-MA	26738.803	30147	
ALBUQUERQUE-SANTA FE-LAS VEGAS, NM	24263.375	29840	
ATLANTA--ATHENS-CLARKE COUNTY--SANDY SPRINGS, GA-AL	24232.04	31241	
AUSTIN-ROUND ROCK, TX	21067.252	30221	
BOSTON-WORCESTER-PROVIDENCE, MA-RI-NH-ME	31532.987	33019	
BUFFALO-CHEEKTOWAGA, NY	25903.215	30740	
CHARLOTTE-CONCORD, NC-SC	21547.715	30034	
CHICAGO-NAPERVILLE, IL-IN-WI	25266.08	32886	
CINCINNATI-WILMINGTON-MAYSVILLE, OH-KY-IN	24420.047	30829	
CLEVELAND-AKRON-CANTON, OH	22801.096	30899	
COLORADO SPRINGS, CO	25736.098	30121	
COLUMBUS-MARION-ZANESVILLE, OH	23699.353	30694	
DALLAS-FORT WORTH, TX-OK	21015.028	31962	
DAVENPORT-MOLINE, IA-IL	29934.926	29932	-$2.93
DAYTON-SPRINGFIELD-SIDNEY, OH	23072.662	30479	
DENVER-AURORA, CO	26738.803	32512	
DETROIT-WARREN-ANN ARBOR, MI	24252.93	32561	
HARRISBURG-LEBANON, PA	23908.25	29973	
HARTFORD-WEST HARTFORD, CT-MA	26592.575	33116	
HOUSTON-THE WOODLANDS, TX	20900.135	34095	
HUNTSVILLE-DECATUR-ALBERTVILLE, AL	19260.294	30650	
INDIANAPOLIS-CARMEL-MUNCIE, IN	24712.503	29901	
KANSAS CITY-OVERLAND PARK-KANSAS CITY, MO-KS	25286.97	29955	
LAS VEGAS-HENDERSON, NV-AZ	32034.339	30095	-$1,939.34
LOS ANGELES-LONG BEACH, CA	29746.918	33863	
MIAMI-FORT LAUDERDALE-PORT ST. LUCIE, FL	23511.346	31586	
MILWAUKEE-RACINE-WAUKESHA, WI	24754.282	30934	

MINNEAPOLIS-ST. PAUL, MN-WI	30812.293	31881	
NEW YORK-NEWARK, NY-NJ-CT-PA	25840.546	34264	
PALM BAY-MELBOURNE-TITUSVILLE, FL	25140.742	29853	
PHILADELPHIA-READING-CAMDEN, PA-NJ-DE-MD	25673.429	32233	
PHOENIX-MESA-SCOTTSDALE, AZ	25495.866	30719	
PITTSBURGH-NEW CASTLE-WEIRTON, PA-OH-WV	25224.301	30535	
PORTLAND-VANCOUVER-SALEM, OR-WA	26059.888	31645	
RALEIGH-DURHAM-CHAPEL HILL, NC	24743.838	30814	
RICHMOND, VA	23281.559	30676	
SACRAMENTO-ROSEVILLE, CA-NV	37382.1	32318	-$5,064.10
ST. LOUIS-ST. CHARLES-FARMINGTON, MO-IL	24681.169	30088	
SAN DIEGO-CARLSBAD, CA	30070.709	33187	
SAN JOSE-SAN FRANCISCO-OAKLAND, CA	29214.231	36172	
SEATTLE-TACOMA, WA	29767.808	32484	
TUCSON-NOGALES, AZ	25255.635	29970	
WASHINGTON-BALTIMORE-ARLINGTON, DC-MD-VA-WV-PA	29162.007	33369	

As stated in previous assumptions, the MSAs considered GS locality adjusted areas are areas that received locality adjustments in all years from 2012 to 2018. Findings therefore exclude Birmingham, Corpus Christi, Omaha, San Antonio, and Virginia Beach since they are not deemed GS Locality Adjusted Areas in all years. This analysis also excludes Alaska and Hawaii because the entire state is deemed a locality area, but only small portions of the states are represented by MSAs in BLS data. It would be inaccurate to equate the behavior of only a few MSAs to the behavior of the entire state.

In Davenport a GS 3 Step 4 is required to meet the median of the private sector's 2018 data after inflation. In Las Vegas this results in a GS 4 Step 2, and in Sacramento a GS 4 Step 4.

Step 6: Setting the Stipend for All Locations

In determining the appropriate GS grade and step for stipend payments, we assessed the 2018 BLS wage rates for commercial home health aides, which was the most current information available from BLS. To ensure an accurate comparison with the 2020 GS pay scale, we inflated the 2018 BLS home health aide wage rates to 2020 dollars. We found that for 2020, the BLS national median wage for home health aides is equivalent to the base GS rate at grade 3, step 3 (without a locality pay adjustment).

Our findings also reflect that the 2020 GS rate at grade 3, step 3 is representative of the BLS median wage for home health aides in nearly all geographic areas. While this is not true for every locality, this would mean that in most U.S. geographic areas for 2020, stipend payments based on the GS rate at grade 3, step 3 would be equal to or higher than the BLS median wage for home health aides in the same geographic areas.

For those geographic areas where the 2020 GS rate at grade 3, step 3 was less than the inflation-adjusted BLS median wage for home health aides, we considered applying a unique GS grade and step based on the median home health aide wage rate in each of those geographic areas. However, we determined that would not be appropriate or practicable. As noted above, VA has found that historically the BLS rates for home health aides have experienced drastic fluctuations across the country in both increases and decreases. Additionally, there has been variation in the level of growth from year to year across the U.S. and in each GS locality pay area, with some year's wages growing faster or slower than in the previous years. Therefore, point-in-time comparisons between the GS rates and the median home health aide wages in the future may reflect the same or other geographic areas where the median wage for home health aides is higher or lower than the applicable GS rate. It would not be practicable to adjust the GS grade and step for a particular geographic area every time there is new data reflecting a higher or lower median wage rate relative to the applicable GS rate. Moreover, wage data can fluctuate up or down in one year, but not indicate a continuing trend.

Because VA cannot predict over time which localities will have higher home health aide wage rates than the GS rate at grade 3, step 3, and which GS grade and step will be most equivalent to the median rate in those areas, we propose to use the slightly higher GS rate at grade 4, step 1 for all localities. Although there would still be certain areas where the 2020 GS rate at grade 4, step 1 is lower than the inflation-adjusted BLS median wage for home health aides, we reiterate that our findings are based only on the most current available data and could change when updated BLS data becomes available and based on changes to GS locality pay adjustments from year to year. Therefore, as discussed below regarding proposed § 71.40(c)(4)(iv), VA would periodically assess the monthly stipend rate, and if appropriate, VA would make adjustments through future rulemaking.

Therefore, we believe the GS rate for grade 4, step 1 is, to the extent practicable, not less than the annual salary paid to home health aides in the commercial sector, particularly after considering that the monthly personal caregiver stipend is a nontaxable benefit. To illustrate, the 2020 base GS rate for grade 4, step 1 (without a locality pay adjustment) is $26,915. The 2018 BLS national median annual wage for a home health aide was $24,200, which after accounting for inflation, equates to $25,277 as of December 2019.

Additionally, the GS rate for grade 4 is the mid-range in which VA hires and staffs nursing assistant positions (GS-0621). Nursing assistants perform similar work to that of a home health aide including nonprofessional nursing care work, providing support and observation, and monitoring behavioral changes. See OPM's Position

Classification Standard for Nursing Assistant Series, GS-0621 at https://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/standards/0600/gs0621.pdf.

Step 7: Will the GS wage track the private sector over time?

This section will analyze the relationship between the US median wage of home health aides and the GS schedule. While we cannot guarantee a future relationship, the analysis will show that overall the private sector median wage for home health aides and the GS system have grown at the same rate since 2012.

There are two buckets of wages necessary to distinguish when looking at GS wage growth. The first bucket are the localities that receive a GS locality adjusted payment. The second bucket is the "Rest of the US", or all areas that do not.

Due to data restrictions, it is impossible to recreate these exact buckets for private sector wages. Assumptions in the steps above have shown how the VA has mapped GS locality adjusted areas to BLS reported MSA areas so we will not revisit that here. When trying to compare the GS "Rest of the US" to BLS MSAs, we have two approaches we could take. The first is to equate the "Rest of the US" to all MSAs that we did not identify as locality adjusted MSAs. The pitfall of this approach is that the BLA "Rest of the US" leaves out the rural areas of the country captured in the GS "Rest of the US". In recent years, the US population living in rural areas has increased, and the divide between rural employment and urban employment has grown.[8] Thus, leaving rural areas out of the analysis does not paint a complete picture and likely skews patterns. The second approach is to compare the GS "Rest of the US" to the national level data for BLS. This approach is still a bit of an apples to oranges comparison but, in our opinion, is better than the first method. The analysis that follows uses the second approach and compares the BLS national data to the GS "Rest of the US" bucket.

[8] https://www.ers.usda.gov/webdocs/publications/90556/eib-200.pdf

		2013	2014	2015	2016	2017	2018	Average
GS Wages	Growth of GS Base Pay	0.00	1.00	1.00	1.00	1.00	1.40	0.90
	Growth of Wages in Rest of US (Base Schedule plus "Rest of US" locality adjustment)	0.00	1.00	1.00	2.34	5.95	3.46	2.29
	Average Growth of Wages across GS Adjusted Localities (Base Schedule plus Locality Adjustment)	0.00	0.98	0.98	2.76	8.29	4.35	2.89
BLS Wages	Growth of Median Wage Across US	0.96	1.71	2.53	3.10	2.70	4.27	2.54
	Growth of Wages in GS Adjusted Localities*	-0.98	2.84	2.02	3.77	2.98	2.20	2.14
BLS Wages	Median Wage in US	$ 21,020	$ 21,380	$ 21,920	$ 22,600	$ 23,210	$ 24,200	$ 22,388
	Average Median Wages in GS Adjusted Localities*	$ 22,264	$ 21,992	$ 22,566	$ 23,013	$ 23,902	$ 24,601	$ 23,056
Note	*Averages exclude Birmingham, Laredo, Omaha, San Antonio, and Virginia Beach since they are not deemed GS Locality Adjusted Areas in all years. Excludes Laredo in 2013 average because MSA level data is not available in 2012. Excludes Alaska and Hawaii. In cases where a GS locality named multiple cities, the MSA with the first city name was used. GS localities do not align perfectly to MSAs.							

From 2013 to 2018, BLS median wages across the US for home health aides grew an average of 2.5 percent per year while GS rates for the “rest of the US” grew an average of 2.3 percent per year. The growth of the median BLS wage at the national level is slightly understated in this case because the national level data includes GS adjusted localities that have grown slightly slower than the US as whole. In the GS adjusted localities, wages have grown an average of 2.9 percent per year and BLS wages in these same areas have grown an average of 2.1 percent per year. Our findings indicate that GS and BLS wage growth for home health aides have tracked closely in the past both at a national level and for GS adjusted localities. This leads us to presume that the caregiver stipend, regardless of which grade and step, will grow on a similar trajectory to median private wages for home health aides.

Budget Impact Methodology

Table 10: § 71.40 Summary of Budget Impact

Fiscal Year	Wellness Contacts (costs)	BLS to GS Rate change (transfers)	Delay in Stipend Rate Decrease (transfers)	17-Month Transition Period (transfers)	Financial and Legal Services (transfers)	Subtotal Transfers	Total Budget Impact
2020	N/A	$3,634,603	$7,236,273	$20,470,588	$1,099,508	$32,440,972	$32,440,972
2021	N/A	$28,564,380	$18,090,683	$61,411,765	$7,536,534	$115,603,363	$115,603,363
2022	$2,228,898	$9,459,846	$0	$5,117,647	$8,900,362	$23,477,855	$25,706,753
2023	$6,446,821	$6,603,101	$0	$0	$11,274,272	$17,877,373	$24,324,194
2024	$8,733,848	$636,219	$0	$0	$12,633,806	$13,270,025	$22,003,873
5-Yr Total	**$17,409,568**	**$48,898,150**	**$25,326,956**	**$87,000,000**	**$41,444,481**	**$202,669,588**	**$220,079,156**

In order to determine the total FTE and costs associated with wellness contacts, it is assumed that one contact will be via telephone or telehealth and the second incorporated as part of the annual reassessment outlined in § 71.30. Therefore, only

the FTE and costs associated with one wellness contact will be discussed here. The total wellness contact hours were found by multiplying the number of needed hours per wellness contact by the total number of Veteran sponsors. It is believed that approximately 4 hours per Veteran sponsor is needed to conduct a wellness contact. This factors in time spent with family caregiver and Veteran, administrative time, case coordination, and follow up. This number was then divided by 2,087 (numbers of hours for 1.00 FTE) to determine total FTE needed each fiscal year. There are 109.00 RN FTE currently in the program and this was deducted from the total leaving us with the total FTE need for expansion. A RN II Step 5 salary plus benefits (23 percent) to determine total costs with a 2.3 percent inflation in out years.

Table 11: Cost of Wellness Contacts

Fiscal Year	Unique Sponsor Counts	Hours per Wellness Contact	Total Hours	# Additional RN FTE Needed	Cost per FTE	Total Costs
2020*	33,831			N/A		N/A
2021*	56,666			N/A		N/A
2022	65,444	4	261,775	16	$135,649	$2,228,898
2023	81,110	4	324,439	46	$138,769	$6,446,821
2024	88,970	4	355,882	62	$141,960	$8,733,848
5-Yr Total		**12**	**942,097**		**$416,378**	**$17,409,568**

**2020 and 2021 do not require additional FTE to meet this criteria.*

Fiscal Year	Unique Sponsor Counts	Monthly Stipend total	Months	Total Cost
2020	7,624	$5,117,647	4	$20,470,588.24
2021	7,624	$5,117,647	12	$61,411,764.71
2022	7,624	$5,117,647	1	$5,117,647.06
2023	7,624	$5,117,647	0	$0.00
2024	7,624	$5,117,647	0	$0.00
5-Yr Total		**$20,470,588**		**$87,000,000**

The Congressional Business Office (CBO) has estimated an annual average cost of $130 per beneficiary that will receive financial planning and legal services. Using this estimate as the base assumption and adding a 2.3 percent inflation rate, it was applied to the number of total possible eligible Veterans based on projections provided by VA Enrollment and Forecasting. Table 15 shows the annual transfer costs of the financial planning and legal services.

Table 12: Total Transfer Costs of Financial Planning and Legal Services by Fiscal Year

Fiscal Year	Unique Beneficiary	Annual Cost per Sponsor	Total Costs
2020	33,831	$33	$1,099,508
2021	56,666	$133	$7,536,534
2022	65,444	$136	$8,900,362
2023	81,110	$139	$11,274,272
2024	88,970	$142	$12,633,806
5-Yr Total			**$41,444,481**

§ 71.45 Revocation and Discharge of the Family Caregiver

Alternative Policies

In 71.45, VA proposes to revise the current section to address both revocation and discharge from PCAFC and also revising the title to reflect this, redefining reasons for revocations for family caregiver and Veteran, redefining reasons for discharges for family caregivers and Veterans to include Domestic Violence (DV)/Intimate Partner Violence (IPV), effective dates of revocations discharges, establishing 60-day due process, extended benefits timeline for revocations and discharges, notifications of revocations and discharges, recoupment of overpayments.

VA considered not clarifying between revocation and discharge, however, believe such distinction supports PCAFC as a health care program designed to help Veterans achieve their highest level of health, quality of life and independence.

VA considered not including extended benefits and current clinical practices assist caregivers in finding alternative healthcare, as applicable, for 30 days past discharge request. Extending all family caregiver benefits for 30 days allows for a more consistent, cohesive transition process for caregivers, and would be fair, reasonable, and compassionate. It would also be consistent with the current transition period when the request for discharge is initiated by the Veteran or his or her surrogate.

VA considered not proposing to extend the benefit period for family caregivers to 90 days when the caregiver requests discharge is due to DV/IPV. Family caregivers may fail to request discharge for this reason due to the lack of financial transition and security. While the financial burden on VA will be minimal as this would be a small percentage of the population, not allowing for a 90-day transition period in such circumstances could result in a reason that family caregivers choose to stay in an unsafe environment. The proposed paragraph (g)(1) would be a critical change that will assist caregivers while transitioning to a safe environment.

Assumptions and Methodology

The estimated transfers of the proposed revisions to § 71.45 would be $14.0 million in FY 2020 and $142.0 million over five years.

According to data provided by the Office of Community Care (OCC), approximately 1.5 percent of the total family caregiver population has requested a discharge for all other reasons except outlined in proposed paragraph (g) of this section in the past 5 fiscal years. Of the 1.5 percent of family caregivers that requested discharge, 58 percent in Level 1 and 42 percent in Level 2. The totals per level were determined by utilizing an average level payment for one month and then multiplying this total by the total caregivers in each level. This logic was used to project the estimates for FY2020 – FY2024 in table 16 while assuming the number of family caregivers is constant.

Table 13: Transfer Costs of Caregivers Requested Discharges (excluding table 16)

Fiscal Year	Unique Sponsor Counts	# Requests	Tier 2	Tier 3	Level 1 Stipend (30 day, all other)	Level 2 Stipend (30 day, all other)	FY Total Stipend (30 day, all other)
2020	33,831	507	294	213	$5,939,200	$6,535,674	$12,474,874
2021	56,666	850	493	357	$10,334,143	$11,175,018	$21,509,161
2022	65,444	982	569	412	$11,951,258	$12,956,207	$24,907,465
2023	81,110	1,217	706	511	$15,108,409	$16,378,836	$31,487,245
2024	88,970	1,335	774	561	$16,904,062	$18,325,480	$35,229,542
5-Yr Total					**$60,237,072**	**$65,371,215**	**$125,608,287**

According to OCC, approximately 0.06% of the total family caregiver population has reported DV/IPV as the reason for discharge in the past 5 fiscal years. Of the 0.06 percent of family caregivers that reported DV/IPV, 58 percent in Level 1 and 42 percent in Level 2. The totals per tier were determined by utilizing an average tier payment multiplying this by 3 months (90 days) and then multiplying this total by the total caregivers in each tier. This logic was used to project the estimates for FY20 – FY24 in table 17 while assuming total family caregivers remain constant.

Table 14: Transfer Costs of Caregiver Requested DV/IPV

Fiscal Year	Unique Sponsor Counts	# Requests	Tier 2	Tier 3	Level 1 Stipend (90 day, DV/IVP)	Level 2 Stipend (90 day, DV/IVP)	FY Total Stipend (90 day, DV/IVP)
2020	33,831	20	12	9	$712,704	$784,281	$1,496,985
2021	56,666	34	20	14	$1,240,097	$1,341,002	$2,581,099
2022	65,444	39	23	16	$1,434,151	$1,554,745	$2,988,896
2023	81,110	49	28	20	$3,125,878	$1,965,460	$5,091,338

2024	88,970	53	31	22	$2,028,487	$2,199,058	$4,227,545
5-Yr Total					**$8,541,317**	**$7,844,546**	**$16,385,863**

§ 71.47 Collection of Overpayment

VA would collect overpayments as defined in § 71.15 of this section pursuant to the Federal Claims Collection Standards. Overpayment means a payment made by VA pursuant to this section to an individual in excess of the amount due, to which the individual was not eligible, or otherwise made in error. An overpayment is subject to collection action.

Assumptions and Methodology

This Impact Analysis assumes recovery of overpayments to be cost neutral. The benefit portions costed in other the proposed rule sections were estimated at their expected value. If overpayments take place in implementing the expansion, then the higher than expected value would be offset by the recovery. The workload associated with this section is expected to be met with existing staff.

Additional Program and Administrative Costs

Additional FTE are required to the oversee the program, process claims, and increase governance and oversite. The FY2020 cost is estimated to be $48.6 million and $230.8 million over five years.

The Caregivers VA Central Office will need 21 FTE for administration and support activities. This will be broken down into 5 FTE to support VA Medical Center (VAMC) Caregiver Support Program operations as and develop centralized eligibility and appeals teams and 16 FTE, consisting of 4 teams of 4 FTE, to support the new standardized PCAFC appeals process. Office of Community Care will require an additional 16 FTE in order to handle the increased claims processing workload that will result from this rulemaking. There will be 265 additional FTE in 2020 and 360 FTE by 2024 in order to standardize eligibility determinations at the VISN level by requiring each VAMC to have a dedicated program manager along with sufficient support at our Caregiver Support Line (CSL) and adequate Health Eligibility Center staff to maintain a five-business day application turnaround time.

Post-certification Information Technology costs are expected to cost $12.7 million in 2020 for development and about $2 million each year after for system maintenance.

Table 15 highlights the FTE costs described above by FY.

Table 15: Additional Program and Administrative Costs

Fiscal Year	Claim Processors (FTE)	Administration and Support (FTE)	Eligibility Determiners, VAMC program	Total FTE	FTE Cost	Information Technology Cost	Total Cost

			Managers, Support Line (FTE)				
2020*	16	21	265	302	$35,873,389	$12,700,000	$48,573,389
2021	16	21	305	342	$39,889,646	$2,000,000	$41,889,646
2022	16	21	325	362	$43,020,615	$2,046,000	$45,066,615
2023	16	21	345	382	$44,740,724	$2,093,058	$46,833,782
2024	16	21	360	397	$46,258,973	$2,141,198	$48,400,171
5-Yr Total					**$209,783,347**	**$20,980,256**	**$230,763,603**

Paperwork Reduction Act (PRA): The Paperwork Reduction Act of 1995 (44 U.S.C. 3507) requires that VA consider the impact of paperwork and other information collection burdens imposed on the public. Under 44 U.S.C. 3507(a), an agency may not collect or sponsor the collection of information, nor may it impose an information collection requirement unless it displays a currently valid Office of Management and Budget (OMB) control number. This proposed rule contains provisions constituting a revised collection of information under 38 CFR 71.25, which is currently approved under OMB Control #2900-0768. The revised collections of information will be submitted to OMB for approval and also made available to the public for comment through a separate Federal Register (FR) Notice document that will be published in the Federal Register. The FR Notice will provide the public with an opportunity to comment on the revised information collections associated with this proposed rulemaking. A final FR Notice will also be published in the Federal Register once the revised collections of information are approved by OMB.

Accounting Statement and Table

Five Year Projection in Real Dollars (Annualized 3% & 7% Values)										
Category	***Transfers***									
Year Dollars		FY2020	FY2021	FY2022	FY2023	FY2024	Present Value		Annualized	
							3%	7%	3%	7%
Federal Annualized Monetized	*Low Est.*	na	na	na	na	na	$0	$0	$0	$0
	Pri. Est.	**$72.5**	**$533.7**	**$861.6**	**$1294.4**	**$1603.6**	**$3895.3**	**$3368.1**	**$825.8**	**$767.7**
	High Est.	na	na	na	na	na	$0	$0	$0	$0
From/To: & Period Covered:	***From:***	Federal Government			***To:***	Eligible Veterans			***Period Covered:***	FY2020 - FY2024
Notes:										
Category	***Costs ($s in Millions)***									
Year Dollars		FY2020	FY2021	FY2022	FY2023	FY2024	Present Value		Annualized	
							3%	7%	3%	7%
Federal Annualized Monetized	*Low Est.*	na	na	na	na	na	$0	$0	$0	$0
	Pri. Est.	**$67**	**$117**	**$150**	**$198**	**$225**	**$681**	**$597**	**$144**	**$136**
	High Est.	na	na	na	na	na	$0	$0	$0	$0
Notes:										
Category	***Benefits***									
Notes:										

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Date: March 4, 2020

(ATTACHMENT 2)

Assumptions & Methodologies Assessing Regulatory Impact of § 71.20 Eligible Veterans and Service Members and § 71.25 Approval and Designation of Primary and Secondary Caregivers

A updated assumptions specifically related to the PCAFC expansion specified in the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018:

- The pre-Vietnam and Vietnam service eras (Veterans injured in the line of duty on or before May 7, 1975) expansion start date will be June 1, 2020.
- The post-Vietnam service era (Veterans injured between May 8, 1975 and September 10, 2001) expansion start date will be June 1, 2022.
- There are several requirements for a Veteran to enroll in PCAFC and have a caregiver, one of which is that the Veteran must have a service connected serious injury. For these projections, “serious injury” is defined as having a minimum of a 70% service connected disability rating (SCD) and a daily need for personal care services.
    - These projections assume that current sponsors assigned a tier level 1 will not meet the daily need requirement, and that 2% of currently enrolled tier 2 and 3 sponsors will not meet the SCD requirement.
    - These projections assume that Veterans no longer meeting the serious injury requirement will transition out of the program over a 17-month period beginning June 1, 2020.
- The stipend payments will be now be based on the Federal General Schedule level 4, step 1 (GS-4 step 1). Currently stipend payments are based on a BLS payment calculation approach. The GS-4 step 1 fee schedule will increase each fiscal year consistent with 2019 VA Enrollee Health Care Projection Model (EHCPM) budget scenario BBA8 wage increase assumptions, specifically:

    - CY 2018: 1.9%
    - CY 2019: 1.9%
    - CY 2020: 0.0%
    - CY 2021+: 2.0%
    - There will be a 14-month transition for current sponsors, during which time no stipend payments will be reduced. The draft regulatory impact analysis document estimates the cost for this transition period to be $7.2 million in FY 2020 and $18.1 million in FY 2021.

The 100% reduction to tier 1 sponsors and 2% reduction to tier 2 and 3 sponsors is intended to reflect the revised eligibility requirements. It is assumed that tier 1 sponsors will not satisfy VA's intentioned requirement that Veterans have a daily need for

caregiver assistance, and the 2% of tier 2 and 3 Veterans will not meet the 70% service connected disability requirement. Some tier 2 and tier 3 sponsors may also not meet the daily need requirement, but for the purpose of this projection only tier 1 Veterans are excluded.

Methodology

Experience Basis – PCAFC Enrollment Data

PCAFC sponsor enrollment is projected by applying assumed enrollment probabilities to projected Veteran counts. These enrollment probabilities are developed using historical PCAFC enrollment experience by age band, gender, and service-connected disability level compared to the estimated pool of Veterans potentially eligible for enrollment. The enrollment probabilities used in the projection vary only by age band and gender. Service-connected disability level is used to develop the assumption for how enrollment probabilities increase with age. The final enrollment probabilities used in the projections only vary by age band and gender.

PCAFC sponsor enrollment has been declining since FY 2016 despite a growing number of Veterans who have separated since September 11, 2001. The decrease in sponsors may be the result of steadily declining PCAFC application approval rates along with more frequent benefit revocations for sponsors no longer meeting the eligibility requirements. There has not yet been stability in the sponsor enrollment rate.

Enrollment Probability Development

Using the actual PCAFC sponsor enrollment in the PCAFC and the estimated eligible Veteran pool as of the start of each fiscal year, raw enrollment probabilities were calculated by age band and gender. For each age and gender combination, if there were at least 500 PCAFC sponsors in the period[9], the final enrollment probability is based entirely on the raw probability. For age and gender combinations with fewer than 500 sponsors, the final probability is a combination of the raw probability and a manual probability rate.

The manual probabilities were developed first by calculating historical enrollment probabilities from the experience period by age band and service-connected disability rating. Again, any combination of age band and service-connected disability rating with a sponsor count exceeding 500 is assumed to be credible. Enrollment probabilities are assumed to increase with age at the same rate as FY 2017 home health user prevalence increased with age for Priority Level 1a VHA enrollees. This was accomplished as follows:

- First, enrollment rates were calculated for PCAFC sponsors with an SCD of 100% for age bands where there are at least 500 unique sponsors.
- Then, the average enrollment rate for these credible age bands was calculated. In FY 2018 this average enrollment rate was 9.4% constituting ages 25 through 59.

- The average home health usage rate for Priority 1a VHA enrollees was also calculated for these same age bands. This was 2.5%.
- Then, for the age bands considered not fully credible, the difference between the home health usage rate and the average home health usage rate was added to the average PCAFC enrollment rate for those age bands.
- For example, 11.0% of 80- to 84-year-old Priority 1a VHA enrollees used home health to some extent in FY 2017. As stated above, the average home health usage for ages 25-59 was 2.5%. This means that 8.5% more 80- to 84-year-olds Priority 1a VHA enrollees used home health than 25- to 59-year-old Priority 1a VHA enrollees. This 8.5% is added to the average PCAFC enrollment rate for 25-59-year-olds (which was 9.4%) yielding an assumed PCAFC enrollment rate of 17.9% for 80- to 84-year-olds who are 100% SCD.

Home health services were selected for developing the assumed sponsor enrollment probabilities by age band because the need and usage of home health services is assumed to be comparable to the need and usage of the services a Caregiver provides. As described above, the PCAFC enrollment probability was first calculated using PCAFC enrollment for sponsors with an SCD of 100%. Enrollment probabilities for sponsors with SCD of less than 100% were then calculated by applying observed enrollment rates from PCAFC enrollment for the lower SCD levels compared to the PCAFC enrollment for 100% SCD. After the enrollment probabilities are estimated for all ages and levels of service-connected disability, the enrollment probabilities are rolled up to the age band level using historical Veteran pool estimates.

Projected Eligible Veteran Pool

Projected enrollment probabilities are applied to the projected Veteran counts split by service era cohort. VetPop 2016 provided projected Veteran counts through FY 2045. Note that the total Veteran population is increasing for Post-9/11 service era Veterans due to new separations, while all other service eras are decreasing since any new Veteran is allocated to the Post 9/11 era cohort.

These projected Veteran counts for each service era are then allocated to service connected disability level and gender using a combination of the 2018 VetPop Proxy and VETSNET.

Projected Veteran Sponsor Development

The estimated number of Veterans that would become a Caregiver sponsor is initially calculated by multiplying the estimated Veteran pool counts by the enrollment probabilities. Several adjustment factors are then applied based on the assumptions previously listed for the new program.

For the pre-9/11 service era cohorts, a dampening factor is applied to account for assumed ramp-up during the first few years of enrollment. Specifically, for all pre-9/11 service era cohorts, the enrollment probabilities are dampened using factors of 40%, 70%, 90%, and 100% for the first four years (48 months) after enrollment begins. The ramp-up is applied by the number of months since enrollment began (rather than strictly

by the first through fourth fiscal years). For example, the count of Vietnam service era cohort sponsors is assumed to be 40% of a full population for June 1, 2020 through May 31, 2021. For the subsequent 12 months, the adjustment is 70% of a full population, and so forth.

The number of stipend payments per sponsor is also assumed to increase over the first few years of enrollment. This is presumed to be primarily the result of sponsors enrolling uniformly throughout the fiscal year, so on average sponsors receive fewer than 12 stipend payments per year.

Tier Level Distribution

The PCAFC sponsor estimates are split into the three stipend tier levels using the distribution of tier level by age band experienced in FY 2018. FY 2018 experience was not deemed fully credible for sponsors under the age of 25 or over the age of 55, so the distribution of tier levels was extrapolated for those ages using the experience of the fully credible ages. In general, it is assumed that older sponsors are more likely to be assigned to tier level 3 than tier level 1, with tier level 2 remaining largely unchanged by age band.

Beginning with the MISSION Act enrollment requirements, the projections assume new sponsors come in at tiers 2 and 3 only. Current tier 1 sponsors are expected to transition off over 17-months.

Projected Stipend Development

The projected unique sponsor counts by tier are multiplied by the projected number of stipend payments per unique sponsor per year. For the pre-9/11 service era cohorts, the projected number of stipend payments per unique sponsor per year is assumed to ramp-up over time until a steady-state is reached. This is because for the first several years of enrollment for the pre-9/11 service eras, it is assumed that new sponsors entering the program will enter at a rate faster than sponsors will leave so the average length of active enrollment during the fiscal year will be lower than a fully stabilized program. Actual PCAFC stipend payment experience was used to develop the assumed number of stipend payments per unique sponsor per year, which increases from 6 in the first full year to 10.5 once the steady state has been reached.

Once the number of stipend payments has been projected, the projected cost per stipend per tier level is applied. This cost assumption is developed using the general schedule grade 4, step 1 (GS-4-1) cost structure.

The GS-4-1 cost structure provides an hourly rate of reimbursement. Since tier levels are associated with a percentage of full time work of a home health aid (25% = tier 1, 62.5% = tier 2, 100% = tier 3), the model develops average costs per tier level per month. Use of the GS-4-1 cost structure is expected to go into effect June 1, 2020. For

FY 2018 and 2019, the current stipend reimbursement rate is used, which is based on actual stipend payment rates in FY 2018 and 2.4% CPI-U trend into FY 2019[10].

Using the above process, an initial projected cost by fiscal year, service era cohort, age band, and tier level is developed. The FY 2018 and FY 2019 projected costs were then calibrated to actual costs experienced by the program. For FY 2018 this amount is known. For FY 2019, this amount was estimated by the PCAFC staff using stipend payment experience through February 2019. The adjustments required to calibrate to the FY 2019 experience were applied to all projection years and scenarios.

CHAMPVA Cost and Enrollment Projections

Background
PCAFC Caregivers are eligible for CHAMPVA medical coverage in the event they do not have other medical coverage. The majority of PCAFC Caregivers are also eligible for CHAMPVA medical coverage through the CHAMPVA program. For example, a spouse of a Veteran that is a PCAFC sponsor may be eligible through the CHAMPVA program. If this spouse is also the Caregiver for the Veteran, the spouse may also be eligible for CHAMPVA benefits through the PCAFC program.

A minority of Caregivers are only eligible for CHAMPVA benefits through the PCAFC program. For example, an unrelated person serving as a Caregiver would not otherwise be eligible for CHAMPVA. The CHAMPVA expense for the PCAFC program is limited to the Caregivers eligible for CHAMPVA only through the PCAFC program.

Projections
The cost of CHAMPVA benefits utilized by PCAFC Caregivers was projected using the recent CHAMPVA experience from FY 2018.

The projections reflect CHAMPVA usage changes by sponsor and Caregiver ages and how this translates into CHAMPVA eligibility. First, historical PCAFC eligibility by Caregiver relationship (spouse, child, parent, sibling, and other) was summarized by sponsor age band in order to understand how the distribution of relationship type changes as sponsors age. For example, younger sponsors may depend more heavily on parents and spouses whereas older sponsors may depend more heavily on children as Caregivers. For ages 65 and older, the distribution of these relationships was estimated.

Historical PCAFC eligibility is then summarized by Caregiver relationship and sponsor age band, limited to Caregivers eligible for CHAMPVA benefits as a primary Caregiver not otherwise eligible for CHAMPVA under the traditional CHAMPVA eligibility requirements. The Caregiver relationship distribution is applied to this data to estimate the percent of sponsors with CHAMPVA-eligible Caregivers by sponsor age band and

Caregiver relationship type. These percentages were then allocated to Caregiver age band to calculate the percentage of Caregivers eligible for CHAMPVA benefits by sponsor age band. These percentages are applied to the projected sponsor counts by age band to determine the projected Caregivers eligible for CHAMPVA by age band.

CHAMPVA benefit expense is expected to vary by age band. The cost differences by age band were developed using actual CHAMPVA cost data by age band for CHAMPVA spouses. The assumed CHAMPVA costs were set to $0 for ages 65 and older since nearly all Caregivers aged 65 and older are assumed eligible for Medicare coverage thereby disqualifying them for CHAMPVA benefits. The resulting cost relativity by age band was then applied to the projected CHAMPVA-eligible Caregivers by age band to determine the projected CHAMPVA cost. These costs were then calibrated by actual FY 2018 CHAMPVA expenses.

Mental Health and Respite Care Cost Projections

Caregivers are eligible for mental health benefits. Sponsors may also use respite services to give their Caregiver a temporary break from caring for their sponsor.

Mental Health

For the mental health cost projection, a 2018 utilization of services rate by Caregiver age band was estimated using information from the Milliman 2019 Health Cost Guidelines (HCGs). The FY 2018 cost per Caregiver by age band was calibrated to the FY 2018 mental health obligations and the utilization rates. This cost per age band per year was trended forward to all projection years using mental health office visit utilization and unit cost trends from the 2018 EHCPM projections. The projected cost per age band per year was applied to projected Caregiver counts by age band, service era, and fiscal year.

Respite Care

For the respite care benefits, utilization is linked to the sponsor, not the Caregiver, so FY 2018 respite care utilization was summarized for PCAFC sponsors. This experience was summarized by age band and tier level since respite care use increases with tier level. Ultimately, the respite care utilization rate was set only by tier level since there is not a clear relationship between respite care usage and age band in the current PCAFC population. Total FY 2018 respite care cost was paired with the tier relativity to calculate the respite care cost per sponsor in FY 2018. These costs were trended to projection years using the home respite care utilization and unit cost trends from the 2018 EHCPM projections.

Note that the FY 2018 respite care services obligations were significantly higher than prior years. This was because the PCAFC program began reimbursing respite care for sponsors of both primary and general Caregivers starting in FY 2018, rather than just primary Caregivers. The services were already being provided for sponsors of general Caregivers prior to FY 2017, but the PCAFC did not fund these services.

Considerations Regarding the Projections

There are a number of significant uncertainties regarding the future of the PCAFC regarding the population expected to enroll in the PCAFC. We have listed several of these uncertainties below, which may result in actual PCAFC enrollment differing significantly from the projections included in this exhibit.

1. Currently the PCAFC program is open to Veterans that separated Post-9/11. The MISSION Act expands the PCAFC to all service eras. These projections are built off of historical PCAFC enrollment data with adjustments. There are several changes to the program eligibility which are not explicitly reflected in these projections. The impact of this is unknown at this time. Some of these considerations include the following:
    a. In order for a Veteran to enroll under the proposed eligibility criteria, the Veteran must have a caregiver willing and able to care for the Veteran. Some Veterans may have the need for a caregiver, but may not have a caregiver available and thus may not enroll in the program. It is unclear if this issue may be more prevalent with older Veterans relative to younger Veterans.
    b. Older Veterans utilize nursing home benefits more readily than younger Veterans. Veterans may qualify for a caregiver, but this need may be met in an institutional setting including VA community living centers (CLC), state veteran homes (SVH), or community nursing homes (CNH). These projections do not reduce the count of Veterans by those who use or may use such institutional care.
    c. The severity of sponsor tier level need may vary by age resulting in significant changes in the distribution of PCAFC tier levels**.**
    d. Older Veterans may rely more or less on VA for daily assistance than younger Veterans, instead of assistance through the PCAFC.
2. PCAFC will pay a stipend payment to a caregiver for each Veteran. The stipend payment (per hour rate) may significantly impact the enrollment as it may induce some caregivers to agree to participate in the program if the stipend payment increases relative to historical levels or deter some caregivers from participating in the program if the stipend payment decreases relative to historical levels. This summary focuses on VHA enrollees, but the impact of the stipend payment rate may entice some Veterans not enrolled in VHA to enroll.
3. The ramp-up assumption may be faster or slower than what is assumed in these projections. It is unclear how quickly VA will process these applications and what the application approval rates will be at the start of the program.
4. The revised PCAFC program eligibility requires a Veteran have a daily need for assistance. These projections approximate this requirement by limiting eligibility to Veterans with a tier 2 or tier 3 Caregiver support level. The actual enrollment criteria may be more or less strict than this assumption.
5. While the overall Veteran population is <u>decreasing</u> each year, the segment of the Veteran population that is Priority 1a (70% or higher service-connected disability) is <u>increasing</u>. It is unknown how future increases to the Veteran pool will relate to future PCAFC enrollment.

Therefore, this model assumes growth in the Veteran pool does not result in corresponding growth in PCAFC enrollment.

6. VA expects publicity of the PCAFC to increase substantially compared to historical knowledge of the program, which may impact enrollment.
7. A Veteran's need for caregiver assistance is no longer required to relate to their reason for a service connected disability rating. It is possible that this will expand enrollment relative to current requirements.

Dated: March 4, 2020