

VA CAREGIVER SUPPORT PROGRAM: CORRECTING COURSE FOR VETERAN CAREGIVERS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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VA CAREGIVER SUPPORT PROGRAM: CORRECTING COURSE FOR VETERAN CAREGIVERS

Tuesday, February 6, 2018

COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The Committee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. David P. Roe [Chairman of the Committee] presiding.

Present: Representatives Roe, Bilirakis, Coffman, Wenstrup, Poliquin, Rutherford, Higgins, Bergman, Takano, Brownley, Kuster, O'Rourke, Rice, Sablan, Esty.

OPENING STATEMENT OF DAVID P. ROE, CHAIRMAN

The CHAIRMAN. Good morning. The Committee will come to order.

Welcome and thank all of you all for joining us for today's Full Committee hearing on the Department of Veterans Affairs Family Caregiver Program.

The Family Caregiver Program was created by Congress in 2010 to support severely wounded post-9/11 veterans and their caregivers. Approximately 4,000 caregivers were expected to be approved for the program at the time. VA ended up with more than 22,000 approved caregivers; that is a 550-percent increase over what was expected.

Needless to say, significantly higher than expected demand for the program has created setbacks. There has been miscommunication, confusion, and frustration from veterans, caregivers, and VA employees alike concerning practically every aspect of this program, from eligible to determinations, to clinical appeals, revocations, and more. To the Department's credit, they are well aware of those issues and have taken steps in the last year to address them.

I am particularly glad that, following a 6-year wait, a formal directive was published last June containing guidance on how the program should be administered. I applaud the Secretary and Ms. Kabat at the National Caregiver Program lead for the actions they have taken, and I am fully supportive of their ongoing efforts to include the request for information that was issued in early January to solicit public feedback on how to modify the program to better serve veterans and their caregivers.

That said, serious issues still remain to be resolved, including, as seems to be in every VA program, long-standing, critically important IT issues. I support expanding the Family Caregiver Program to pre-9/11 veterans, but I believe that before doing so we must ensure that the program is working as intended.

I have had the opportunity over the years to get to know caregivers who have provided life-saving care on a daily basis to the veterans in their lives, and I have been a caregiver for my elderly parent in the past and so I have some understanding of what this involves. And my heart goes out to them for the time, health, money, and personal aspirations that they have sacrificed to be there for their loved ones. The selfless devotion that it takes to be a caregiver knows no age or era, and what caregivers of post-9/11 veterans have been experiencing over the last 17 years is old hat to what the caregivers of pre-9/11 veterans have been experiencing for, in some cases, decades.

I am a Vietnam-era veteran myself and I am well aware that I and my fellow brothers and sisters in arms are not getting any younger, neither are our caregivers. However, I share this Administration's concern that the significant expansion of the Family Caregiver Program cannot be discussed or supported without an honest conversation about finding the right balance between clinical appropriateness and cost.

I also share the Obama Administration's concern that expansion of the Family Caregiver Program under current budget framework would compromise resources needed to meet VA's core mission of providing high-quality care to our Nation's veterans.

Those are the very high stakes and they should give us all pause. Accordingly, I feel strongly that any legislation to improve and expand the Family Caregiver Program should be developed, proceed through regular order, and passed on its own merits. Today's hearing is my commitment to Members and stakeholders that we will have that debate. No veteran and no caregiver from any generation is well served by having access in name only to a program that has the deficits that this one does and as ill-prepared as this one is to accept a sudden influx of new beneficiaries with complex, widely differing care-giving needs from those veterans that the program is currently serving.

I hope that today's hearing will shed light on the way ahead, and I hope that those in this room will be able to work together to make sure that this program is working well and then, finally, serving all.

The CHAIRMAN. I now yield to Ranking Member Brownley for any opening statements that she may have.

OPENING STATEMENT OF JULIA BROWNLEY, MEMBER

Ms. BROWNLEY. Thank you, Mr. Chairman, and thank you for accepting I think many requests from our colleagues and our veterans service organizations and veterans nationwide to hold this hearing to discuss the improvement and the potential expansion of the VA Caregiver Program.

In the early 2000s, our Nation saw a wave of young veterans returning home from Iraq and Afghanistan, many who were severely

wounded. So, in 2010, Congress passed the Veterans Omnibus Health Services Act and created the Caregiver Program.

We all know the Caregiver Program's mission is critical to the care of our veterans, but the program has experienced its share of issues. We have seen some veterans and caregivers be mistakenly dismissed from the program, we have heard stories of staff misconduct and veteran mistreatment. I think everyone in this room can agree that the Caregiver Program has its flaws, but it is not an excuse to abort the mission, to give up on getting it right, or to abandon the veterans whose welfare depends on the Caregiver Program.

When we take a step back, I think it is easy to see that whether it is a lack of staff, lack of IT, or lack of direction, each of these issues ties back either directly or indirectly to a lack of resources. Yet instead of requesting adequate funding in the Administration's budget request, the Administration assures us that this year is the year that VA will get it right. However, our veterans have yet to see the Caregiver Program they need.

Late last year, President Trump said, "We will not rest until all of American's great veterans can receive the care they so richly deserve." But in a memo sent to our Senate colleagues by the White House, the Administration explicitly states, "The Administration cannot support a costly expansion of the Caregiver Program without further engagement with Congress on fiscal constraints."

Mr. Secretary, I would like to give credit where credit is due. When I learned of the VA's request for information regarding potential improvements to the Caregiver Program, I was pleased VA had engaged veterans and caregivers in this process. I am concerned, however, that the VA may attempt to justify cuts or changes to the program at the expense of our most vulnerable veterans rather than working to improve and expand the program. I ask you to review our concerns in full, which have been submitted as a comment by the minority side of the Committee.

And I would ask, Mr. Chairman, if we could add that to the record.

The CHAIRMAN. Without objection.

Ms. BROWNLEY. Thank you.

So, today I am looking forward to taking a close look at this program, what is working, what is not, and having that important discussion.

Ultimately, I am confident that the data will show us that the VA and the taxpayers will save money in the long run by expanding the Caregiver Program. We will do that by spending the money VA already spends on long-term care more wisely. Most importantly, expanding the Caregiver Program would allow veterans of all eras to make the choice that works best for their well-being and for their family's well-being.

As PVA says so eloquently in their testimony, "What is a more fundamental element of veterans' choice than the choice to receive quality care at home from the people they trust the most?"

One such veteran family I would like to recognize here today is Kimberly Cole and her husband, Scott, who depend on the Caregiver Program. After facing inconsistencies and roadblocks with the program, and the difficulty of recognizing mental health trauma,

Ms. Cole has come here to offer her perspective. She has submitted a statement for the record outlining her suggestions for improving the Caregiver Program that I encourage everyone to read, and I thank her for her work.

I would also like to thank each of the almost 300 veterans and caregivers that engaged in the VA's request for information with the intent to improve the program.

I look forward to the Secretary's comments, as well as the comments of the veterans service organizations, and I hope today's discussion will lead to bipartisan support and to the expansion of the program, so that it may better serve veterans of all eras. This is the right and just thing to do, and we can do better.

Before I close, Mr. Chairman, I just wanted to make a statement that Mr. Walz can't be here today, that is why I am sitting in this seat, but he intends to submit questions for the record.

So, with that, I yield back, Mr. Chairman.

The CHAIRMAN. I thank the gentlelady for yielding.

And I am honored, we are honored today to be joined by our first panel by the Honorable Dr. David Shulkin, Secretary of the Department of Veterans Affairs.

Secretary, thank you for being here and thank you for the incredible job you are doing for our Nation's heroes.

The Secretary is accompanied by Margaret Kabat, the Acting Chief Consultant for Care Management, Chaplain and Social Work Service; and Dr. Richard M. Allman, the Chief Consultant for the Geriatrics and Extended Care Service.

Thank you all for being here and thank you for your service to our veterans.

Mr. Secretary, you are now recognized for as much time as you may consume.

STATEMENT OF THE HONORABLE DAVID SHULKIN M.D.

Secretary SHULKIN. Okay. Thank you, Chairman Roe, and Members of the Committee.

And I do want to recognize, Congresswoman Brownley, that Congressman Walz is not able to be here, but he has been great steward and champion on this issue.

I think that, you know, I also do want to recognize the caregivers and the veterans who are with us here today. This is a really important issue and it is one of the reasons why I always say that we have the very best Committee in the House, not only because of the leadership, but because we tend to focus on the issues. And I think everybody here can agree, this program is really important, it makes a difference in people's lives, and we all agree that we want to get this right and that is what we are discussing. And the way that you all work together in a bipartisan way makes me proud and really honored to work with all of you. So, thank you for that.

The Caregiver Program, as Congresswoman Brownley said, it was passed in 2010. We began implementing it within 90 days in 2011. And what it provided was the ability for us to support caregivers and eligible veterans with training, benefits, and services, and that is really what I am going to be talking about here today.

Last year alone, we had more than 400 VA staff dedicated to this program; about 350 of them are Caregiver Support Coordinators. They work in all of our VA Medical Centers and they support about 26,000 family caregivers today. There are about 30,000 who have been served in this program since we began working it in 2011.

The program includes a monthly stipends; access to health care coverage, which is so important; mental health services, again, critical; counseling, caregiver training, and respite care.

I think it is important, though, that VA leads the country in an unprecedented way in providing a program like this. And in every program where you are leading the way, where there is really no roadmap, we have to periodically review it and see if we can improve it, eliminate the inconsistencies on how we might be able to improve it, but also potentially expand it going forward, so that we can make this valuable service accessible to other veterans and their caregivers.

Last April, it became very clear to me, as both the Chairman and Congresswoman Brownley have mentioned, that we had inconsistencies in this program; that it wasn't working the way that we thought it should, that there were rates of revocations that were in the very, very high levels than other programs that didn't have that, and that was really unacceptable. So, after I was made aware of that, I made a decision last April to pause the program in revocations. I did not want caregivers being taken away their benefits and their needed services until we could make sure that this program was working right.

That pause took about 3 months and during that time we conducted listening sessions with our veterans and their caregivers, and a number of internal and external groups, some of whom that you are going to get to hear from today. And as a result of that strategic pause, we made a whole bunch of decisions that we think improved the program: we looked at the appeals process, we put up a new Web site, we changed our procedures; most importantly, we trained all of our staff across the country to have a consistent way of looking at this program. And, as a result, our revocations dropped from 237 a month before the pause to 192 a month after the pause, or a 20-percent decrease.

Last month, as the Congresswoman said, in order for us to even get more input into how we can make this program work better, and these are really additional issues for VA to take a look at, not for Congress, we published a notice in the Federal Register where we had eight specific questions that we wanted to get feedback from people that this program matters to, and that comment period ended last night. So we are now going to start reviewing all those comments and make sure that we really understand the feedback that we are getting on how to improve the program. So this is still a work in progress.

What we are trying to do is to still further improve the consistency in the Caregiver Program and see how we can better support family caregivers going forward.

When we launched the program 7 years ago now, it was the first of its kind that it was incredibly innovative, and we have to continue to make this an innovative program that works. And, in that regard, I believe we must expand caregiver support to all eligible

veterans who need it. So, let me say that again, I am in favor of expanding this benefit to those that are pre-9/11. So, regardless of any age, regardless of when they served, this is an important program, but we have to do it in a way that is very thoughtful. We have to do it from what we have learned is working in our current program and how we can benefit those that need it most.

So this is really about our fulfilling our commitment to those who have served and being good stewards to taxpayer resources.

Last year, we spent about \$500 million on the post-9/11 Caregiver Program. By expanding it to the pre-9/11 veterans, I think we can have a much bigger impact. We can do this in a cost-effective way and help those by focusing on those who need the benefit the most. And I am not in favor of revoking this from those who currently have the benefits, I think that would be a mistake, this is about learning how we can do this better going forward.

We know that, as veterans age, the cost of long-term care and those with serious injuries are going to increase dramatically. And so if you take a look at the screen, we have prepared a chart. The blue line at the top is what we project given our current spend, our current program, we are going to be spending in future years on long-term care services. This is mostly institutional care, think about it as nursing home care and assisted care.

But if we do the Caregiver Program correctly and if we figure out the best way to help those who want to remain in their homes, we think that we can make a big difference in the cost impact of this program on taxpayers, and we think that we can improve the lives of veterans. So this is one of the reasons why we think it is important to expand this program, but do it in a thoughtful way.

We know that veterans who are able to stay in their homes with caregiver support have better well-being, healing, positive outcomes, both physical and mental. For example, if we are able to change the eligibility requirement for veterans of every generation who are at the highest risk, we think we can expand caregiver support in a less costly and more cost-effective way than simply expanding it using the exact same criteria that we have now.

Let me just say that the caregivers that we have are veterans' spouses, but they are also parents, brothers, sisters, children of veterans, sometimes friends, neighbors, and Members of the community, and they are people that know and love their veterans. That is the primary reason why we think a huge majority of veterans are better off in their homes with caregivers than the alternative.

We have recently established a Caregiver Survivor Federal Advisory Committee, which just had its first meeting last October, and we are so fortunate that Senator Elizabeth Dole has agreed to chair that. This is a really important advisory committee. You all know how busy she is, so her agreeing to do that was a big deal.

We have recruited lots of other distinguished Members who are knowledgeable about this topic. Some of them are here with us today.

We are also really excited that VA is going to be able to share our expertise and what we have learned about caregivers through the Caregiver RAISE Act, the Recognize, Assist, Include, Support, and Engage Family Caregivers Act, that President Trump just recently signed into law.

We know we have a lot more work to do and more decisions to make about how we can support these selfless individuals, our caregivers who devote their time and lives to caring for our veterans. When compiled with all this Federal Register information that we are just getting and input from our caregiver advisory board, we hope we can work to provide advice to make the Caregiver Program better and more efficient in the future.

Mr. Chairman, that concludes my testimony today. We look forward to any questions.

[THE PREPARED STATEMENT OF SECRETARY SHULKIN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Shulkin, for your testimony. And I will now yield myself 5 minutes.

And we are going to stick real closely to the 5 minutes, because we are going to have votes at 11:30 today. So we certainly want to get through your testimony as quickly as we can.

I want to begin by also stating what you said, that I support the expansion of the program. What I would like to see us do is not a Choice again, and we talked about this before we came in. In the Choice program, we had six ways to get non-VA care, and then we put the Choice program on top of it.

Right now, the VA has, the best I can understand this and I spent a lot of time reading this in the last couple days, is that VA does have support services, many services for pre-9/11 veterans, which include—and I am just looking at the request, it is about almost—it is around \$3 billion, and it is the community nursing home, state home domiciliary, state home nursing, VA community living centers, institutional obligations, adult daycare, community residence care, home hospice, home respite care, home telehealth, home-based primary care, homemaker/home health aide, purchased skilled home care, spinal cord injury and disability home care, state adult day health care, VA adult day health care. Those are all programs that now are available under you all's purview, am I correct, for pre-9/11 veterans? And the thing that the Caregiver Program would have it, correct me if I'm wrong, would be the stipend and the health benefit, the CHAMPVA, am I correct? That is really all we are talking about.

Secretary SHULKIN. Yeah. Mr. Chairman, you have it exactly right. VA provides an incredible array of services to help support veterans, particularly the pre-9/11 veterans, it is what makes VA unique. It is why when people talk about privatization of VA, they don't understand, this isn't available to outside, and so we are very proud of that.

What we are talking about now is adding that one piece that has been missing for our pre-9/11 veterans and that is caregiver support, because these caregivers are unbelievably burdened and to provide them with what you are talking about, both a small stipend, counseling support, if they need it, training, education, a caregiver support telephone line, that is what we are really talking about now.

The CHAIRMAN. Well, they have all of that except the stipend and the CHAMPVA. Do you have any idea about what numbers, because we missed it by 400 percent the last time that we did this—

Secretary SHULKIN. Yeah, yeah.

The CHAIRMAN [continued]. —in 2010, do you have any numbers that might be relevant?

Secretary SHULKIN. Yes. We think that, first of all, last time, boy, did we miss it, but we were starting a program with no experience, no one had ever done it before. Now we actually have pretty good data and we have developed a model.

If we were to simply expand it and use the exact same criteria that we do today for determining post-9/11 caregivers, we think that in 10 years we would have about 188,000 pre-9/11 caregivers. Remember, today we have 26,000, so we would expand that to 188,000 if we use the same criteria. If we used a criteria that would be a little bit more discriminatory, in other words, we used tiers, those that are in Tier 3 are our most severely ill or injured veterans, we think that number would be 40,000, 40,000 additional caregivers in the pre-9/11 group.

The CHAIRMAN. Well, it actually turned out that your estimate on the Tier 3 was pretty close. It was about 5,000-plus—

Secretary SHULKIN. Yes.

The CHAIRMAN [continued]. —and you had estimated about 4,000.

A question on the slide that you had up there, and I think I understand where you got your data now. You are assuming, the assumption of the savings is that you will not have these folks institutionalized. Could you explain to me—

Secretary SHULKIN. Yes.

The CHAIRMAN [continued]. —how or why the VA's nursing home is \$400,000 per year? Where I live, it is about 75. Why is it four times as much inside the VA as it is outside?

Secretary SHULKIN. Well, the number that we used for that model was about \$104,000 a year and I think that that is on average how much we are paying into our state nursing homes, I think that is a better number. The 400,000 number—

The CHAIRMAN. Where did that come from?

Secretary SHULKIN. I think this is the inability of VA to separate out the overhead costs and all of the other costs associated with the VA system. The number that we feel comfortable using is 104,000.

And so what you see in the delta there is the cost of all those wraparound services if we keep somebody in their home, which is about \$30,000 a year less expensive than putting them into a nursing home.

The CHAIRMAN. And I am about done, so just to hang onto this. But the question I have is, would we look at this whole package, this plethora of programs that we have, is there a way to consolidate those some, so that we can use those resources in this Caregiver Program?

Secretary SHULKIN. Yeah—

The CHAIRMAN. And, again, I am out of time. So I am going to yield to Ms. Brownley.

Secretary SHULKIN. Yes, if it is okay to answer, absolutely. These are all a package of services. And we have established this year what is called a moonshot and the moonshot would be that we believe that no veteran should have to ever leave their home because of one of these severe illnesses or injuries if they don't want to, if

they want to remain in their home. And the way we would accomplish that by setting that as our goal is through this whole wrap-around series of services to support somebody in their home, including caregiver support, but not duplicating; there shouldn't be duplication of those programs.

The CHAIRMAN. I yield now 5 minutes to Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman. And I really do want to associate myself with your comments that I believe, you know, as we did in terms of community care, we had all these different programs and then we laid Choice on top of it, we shouldn't be doing the same thing, that there are resources. The key, though, is that veterans pre or post have the choice. And I think in most instances the veteran will choose in-home care, because they are with the people that they trust and that gives them the very best quality of life.

And, Mr. Secretary, I appreciate you making it very clear in your statement that all veterans from every era, pre- and post-9/11, should receive caregiver services, if they need it. So I agree that it is inequitable the way we are approaching this.

My concern is—and when you talk about the moonshot, my concern is like when are we going to get there? Because I don't want to study this to death. I think, you know, we are pretty clear, despite some of the flaws in the program, that it is a successful program, there is high veteran satisfaction with the program. It is clear that there is a cost savings here.

And so I am interested in knowing when, and if you can give us a timeline in terms of when we can rectify this inequity and move forward with a program that we know serves our veterans—

Secretary SHULKIN. Yes.

Ms. BROWNLEY [continued]. —well and properly.

Secretary SHULKIN. Yeah, I am going to try to do this very short. As you know, when the Act passed in 2010, it required the Secretary to come back in 2 years to give a recommendation on when we could expand this to the pre-9/11. That was a difficult challenge back then because of the cost of expanding this program. I think we are seeing that same issue here.

And what we want to try to do, working with you and working with the Senate, is to try to figure out, is there a way to learn what we have experienced in the past to design this program, so it really does what we want it to do and get on with expanding it. The Senate has this included in their version and I think that there is an opportunity for all of you to have a discussion about that. We would like to participate in that discussion to help design this program well.

I think the key point, if I had to boil it down to one issue, Congresswoman, it is that every one of the programs the Chairman mentioned, the home care, the respite, the aide and attendance program, the homemaker program, all uses a clinical criteria of three activities of daily living, the Caregiver Program uses one activity of daily living.

So, if we could get some consistency on clinical criteria, and reasonable people can discuss this. That is why we put it in the Federal Register, we want to hear everybody's thoughts. But if we could come up with consistency, we think we could expand this pro-

gram. It is the right thing to do, but let's do it in a clinically appropriate way.

Ms. BROWNLEY. So, consistency is the barrier in terms of moving ahead on this, that is the only barrier—

Secretary SHULKIN. I think it is—

Ms. BROWNLEY [continued]. —from your perspective?

Secretary SHULKIN [continued]. —yes.

Ms. BROWNLEY. I would really like it if you could give us, you know, a firmer timeline. So if that is what we need to do to give that to you, fine, but if we give that to you, then what do you see as the timeframe?

Secretary SHULKIN. As soon as you guys pass a law on this, giving us the authority to do it. We would like to see it with clinically appropriate criteria to do it in the right way, but this is really your decision; the Senate and the House have to come to agreement on this.

Ms. BROWNLEY. Okay. So in terms of, you know, moving forward here in the short term, I think you have sort of laid out in your testimony some of the areas that need to be fixed. We have just talked about consistency, but there is also IT and a number of other things, the number of Caregiver Support Coordinators, properly trained, et cetera.

Can we expect to see a request for full funding for the Caregiver Program to address these issues from the Administration?

Secretary SHULKIN. We currently have in the upcoming budget a request for continuing the current Caregiver Program. Once we were to have authority to expand—

Ms. BROWNLEY. I am not talking about expansion right now—

Secretary SHULKIN. Yeah.

Ms. BROWNLEY [continued]. —I am talking about the issues that need to be addressed, that that is going to cost some money, whether it is IT, whether it is additional training—

Secretary SHULKIN. Yeah.

Ms. BROWNLEY [continued]. —whether it is more supervisors, is that included in the budget request?

Secretary SHULKIN. I think it is, but let's have Meg, who runs the program, tell us.

Ms. KABAT. Yes, the current budget request does reflect all that we need to do. There was some substantial growth early on, the numbers were doubling in 2015–2016, and we have seen really a steadying of the current need. We have been averaging about 24,000 for the past 2 years. So we don't have that huge increase that we need, because about 80 percent of our budget is the stipend payments that go to caregivers.

Ms. BROWNLEY. Thank you. I need to yield back. I have more follow-up questions, but I know we are on a strict timetable. I apologize.

The CHAIRMAN. General Bergman, you are recognized.

Mr. BERGMAN. Thank you, Mr. Chairman, and thanks, Dr. Shulkin and the rest of you, for being here.

I am a Marine, I am pretty simple. You know that, we have talked before. Ready, aim, fire. Okay? Not ready, fire, aim. You are asking us to fire before I have heard you aim.

You know, does the VA have the ability, because, Dr. Shulkin, I heard you say that the inability of the VA to do something, does the VA, as it is currently structured with the people on board assigned to this task, do they have the ability to assess what has worked and what has not worked already with the population that we have, the post-9/11 veterans?

Secretary SHULKIN. Yeah, I believe that we do. I believe, at least it is my belief, that we do not right now have consistency of the clinical criteria and it would be my recommendation that we fix that, so that this program can be targeted to those that would get the most benefit from it. But Dr. Allman is our clinical chief, and so do you feel like we know enough about how to fix this?

Dr. ALLMAN. Yes, Secretary Shulkin, I think we do indeed have—we have field expertise and expertise within—

Mr. BERGMAN. Can you put a cost? So the criteria you have developed to fix this, because in your graph you are obviously going to take the savings, you are counting on the savings from expanding the program, okay? Can you take the criteria that you have developed to fix the program, can you attach a dollar figure to them now?

Dr. ALLMAN. Well, the estimate that we had was by 2030, I believe, we would be saving about—or cost avoiding \$2.5 billion. Clearly, the cost is going up—

Mr. BERGMAN. But it is one thing to cost avoid, it is another thing to cost—you are going to have to hire clinicians if we change the clinical criteria, tighten up all these specs and standards, are you able to tie a cost to that?

Dr. ALLMAN. I think we have the staff, the people with the ability to carry out this program, if Congress gives the ability for—

Mr. BERGMAN. How long is it going to take to—the public comment just closed at midnight—how long is it going to take to assess the responses and the data that you have gotten from that public comment? How long?

Ms. KABAT. So we have staff who have been collecting the data as we go through. As with other Federal Register notices, there are many comments that do not respond directly to the questions. In fact, about a third of them are very short and state that the program—

Mr. BERGMAN. How long is it going to take?

Ms. KABAT. For us to go through all those comments?

Mr. BERGMAN. Yes—

Ms. KABAT. Well, we already—

Mr. BERGMAN [continued]. —how long?

Ms. KABAT [continued]. —I expect it to take about 6 to 8 weeks to get to the point where we can identify some specific recommendations. Now, those recommendations are about our current program, they are not about—

Mr. BERGMAN. That's okay, that's okay. It is taking the data that you have asked for and assessing the data, and then applying it to what we are going to move forward to try to accomplish. Because what you are asking us to do is to put more money into an unproven program. I am a pilot, I have done experimental aircraft flying and all of those kinds of things, you don't put an aircraft into service until you know that it is safe to fly, and I would suggest

to you the same thing with this program. Not only the number-one criteria is to make sure, whether we expand the program or not—and, by the way, I support expanding the program—is that we have to ensure that it works for our veterans. And I get a little antsy at times not seeing the data to support, whatever clinical criteria, is the why of, you know, what we are doing.

And I guess I—because I know my time is going to run short here—has over the last few years in our attempt to provide this home care to the post-9/11 veterans, has that increased the size of the VA bureaucracy?

Secretary SHULKIN. We have about 400 staff working on this program now.

Mr. BERGMAN. Did we hire new to do that?

Secretary SHULKIN. Yes.

Mr. BERGMAN. So we created 400 more positions—

Secretary SHULKIN. Yeah.

Mr. BERGMAN [continued]. —to do this? Okay.

I know my time is running short here. I am just going to yield back the 30 seconds, because we are behind schedule.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Takano, you are recognized.

Mr. TAKANO. Thank you, Mr. Chairman.

Mr. Secretary, in your pre-hearing question responses you suggested that to expand the Caregiver Program you would need legislative authority, you reiterated that position in your answer to Ms. Brownley, Ms. Brownley's question, but in the past you have suggested that you could expand the Caregiver Program under your own authority, you have made public statements to that effect. Can you clarify your position?

Secretary SHULKIN. Well, I think that we do need additional legislative authority and appropriations to be able to expand to the pre-9/11 population. I believe the 2010 Act was for post-9/11 veterans.

Mr. TAKANO. But you have made prior public statements to the effect that you believe that you could expand this program under your current authority as Secretary.

Secretary SHULKIN. Yeah, I think that, as I—

Mr. TAKANO. Were you in error? Were those erroneous statements?

Secretary SHULKIN. I think that what I was trying to say was, was not on the legal legislative issue, but that if we have the right consistency of clinical criteria, that that would allow us to take current resources and expand them to veterans who need them of any age.

Mr. TAKANO. So by adjusting these criteria, you do have the authority to expand the Caregiver to pre-9/11 recipients?

Secretary SHULKIN. Let's try to clarify this, because I don't want to have a confusion.

Ms. KABAT. I think it is important to note that there are all kinds of different programs that provide support to caregivers. Dr. Roe mentioned many that provide home and community-based services, we also within the caregiver—

Mr. TAKANO. Excuse me, I just want to cut in. I just want to get a straight answer about your authority.

Ms. KABAT. We—

Mr. TAKANO. So I just heard the Secretary say that if he were to adjust the criteria that he does have the authority to expand the Caregiver Program to pre-9/11 individuals.

Ms. KABAT. We do not have the authority to provide stipends directly to—

Mr. TAKANO. Wait a minute, you are now parsing the words about stipends. Do you have the authority or do you not?

Ms. KABAT. It is the Program of Comprehensive Assistance within the Caregiver Support Program. We do not have the authority—

Mr. TAKANO. More comprehensive, but—

Ms. KABAT. Correct.

Mr. TAKANO [continued]. —if you were to adjust the criteria, you could?

Ms. KABAT. Other services, but—

Mr. TAKANO. Well, I'm—

Ms. KABAT [continued]. —not the Program of Comprehensive Assistance.

Mr. TAKANO [continued]. —taking your answers—I mean, you have made previous public statements to the effect that you could, Mr. Secretary. You have added that if you adjust the criteria that you can. So you do have a certain amount of discretion to expand under your own authority right at this moment the program.

I just want to know whether the White House, the Budget Director, or any other person in this Administration has put undue pressure on you to change, you know, the tune here.

Secretary SHULKIN. No, no. I apologize that there is confusion, but I think that right now there shouldn't be confusion. The Comprehensive Caregiver Program, we cannot expand that to pre-9/11 veterans without legislation. We provide a number of services to older veterans, but not this particular program.

Mr. TAKANO. Okay. And the key word is comprehensive.

Secretary SHULKIN. Yes.

Mr. TAKANO. You are able to offer less than comprehensive services like—

Secretary SHULKIN. Yes.

Mr. TAKANO. Okay. Well, in your response to pre-hearing questions from this Committee, you discussed the cost of expanding eligibility to pre-9/11 veterans. In the response, you suggested it could be as much as \$3 billion annually. In the past, CBO has suggested that such expansion would cost \$3.4 billion over 5 years. And just last year before this Committee, you suggested the CBO score, quote, “was not an accurate reflection on the true cost, because I believe we are going to save money, but not by institutionalizing people,” end quote.

Can you please explain the discrepancy between your estimate and that of past CBO scores?

Secretary SHULKIN. Well, the CBO came up with the score on the Senate bill. I think you are right, I think it was about \$3.4 billion over—was it a 10-year period or—

Ms. KABAT. It is 5 years—

Secretary SHULKIN [continued]. —five-year period.

Ms. KABAT [continued]. —and that is because that particular legislation rolls in eligibility.

Secretary SHULKIN. All right. And what I have said in the past, and that is what we showed the slide is, is that I do believe that if you create the right criteria and consistency of criteria with our other programs that there will be cost savings that CBO did not consider.

Mr. TAKANO. All right. I appreciate that response. The other questions I have to submit are going to make me run over time and I will yield back the balance of my time.

Secretary SHULKIN. Thank you.

The CHAIRMAN. Vice Chair, Mr. Bilirakis, you are recognized.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

And, Mr. Secretary, thank you for your outstanding work on behalf of America's heroes, I really appreciate it, and I want to thank the staff for being here as well.

I also want to thank you for your quick response with regard to our veterans at Bay Pines, I appreciate that so very much.

Mr. Secretary, I have a couple questions. Do you have a legislative proposal to improve or expand the program?

Secretary SHULKIN. The current law has the criteria of one activity of daily living in the law, so it does not give us the ability to change that criteria.

Mr. BILIRAKIS. Okay. Can we work with you on a legislative proposal?

Secretary SHULKIN. Absolutely.

Mr. BILIRAKIS. Okay. It is very important to us. Again, we want to make sure we get that as soon as possible to Congress and we want to work together—

Secretary SHULKIN. Thank you.

Mr. BILIRAKIS [continued]. —to get this done, because I am also a supporter of the pre-9/11 veterans, that they need the care.

And also I have a proposal, a concept, the Hero's Ranch concept that I would like to discuss with you as well.

Secretary SHULKIN. Okay.

Mr. BILIRAKIS. You know, again, the veterans should have a choice, but if they don't have the caregiver available, a qualified caregiver, I don't want to see them in a nursing home, you know. So, again, it is a quality-of-care issue.

All right, a couple questions here. Again, in your testimony you mentioned that VA heard concerns about the inconsistent implementation of the program, which led to the strategic review in April 2017. What were the immediate actions that were taken in response to those concerns?

Secretary SHULKIN. We looked at the policies and procedures and refined them, we then went out and did training for all 350 Caregiver Support Coordinators throughout the country. We met with caregiver groups and their families and veterans and talked to them about the program. We published a new Web site which had clarity on it and, when we rolled it out, there was greater consistency in decision-making, as evidenced by a 20 percent reduction in revocations around the country.

Mr. BILIRAKIS. Okay. I have heard from stakeholders in my district that there are still inconsistencies in communication and process with regard to the clear eligibility requirements. Why has effective communication between VA and caregivers about eligibility

been such a challenge for this program? Again, I hear it from constituents on a regular basis.

Secretary SHULKIN. Well, I think what we are learning is you can never communicate enough and we just have to constantly be working at doing this better. One of the reasons why I established a Family Caregiver Advisory Committee was exactly for this. How do you find better ways to communicate? How do we find better ways to hear the feedback?

And that Committee, as I mentioned, met for the first time in October, Senator Dole chairs it. And I think we are learning a lot from that exactly how to do a better job with communication.

Mr. BILIRAKIS. Yeah. And we want to assist in getting the word out as well—

Secretary SHULKIN. Yes.

Mr. BILIRAKIS [continued]. —so please include us.

Secretary SHULKIN. Thank you.

Mr. BILIRAKIS. Again, how many enrolled caregivers have been disqualified or removed from the program and, again, for what reasons?

Secretary SHULKIN. Yeah. It is currently now at about 192 a month, so we are probably on a run rate of 1500 a year. I am just trying to do the math quickly. And the reasons why are—the good reasons why would be because the veteran has gotten better and doesn't need the services, doesn't meet the criteria, that would be the good reason. The bad reason would be because the initial decision wasn't the appropriate one.

And so in these evaluations, which are done in multi-disciplinary teams, they are coming up with these decisions. And we give the family and the veteran or the caregiver the right to appeal it, because we don't always get the revocations right, that is why I paused it. And I agree with what you are hearing, we still have a ways to go to make this program work better.

Mr. BILIRAKIS. Okay. How long does it take, maybe the—on the average, maybe somebody else can—

Secretary SHULKIN. Yes.

Mr. BILIRAKIS [continued]. —answer this question—Ms. Kabat, on the average, how long does it take, the application process? And the appeals process, because that is very important as well.

Ms. KABAT. So about 85 percent of our applications are approved or denied within 120 days. And really we have just a handful of sites who are not in that group, so we have targeted a lot of intervention and support and assistance to those particular sites who are struggling with that timeliness beyond the average for the other sites.

Mr. BILIRAKIS. Yeah, we have got to do better. Again, you know, time is of the essence.

So thank you very much, again, for thinking outside the box, Mr. Secretary, and again putting our veterans first. I appreciate it very much.

I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Ms. Esty, you are recognized.

Ms. ESTY. Thank you, Chairman Roe, and to the Ranking Member for holding today's hearing.

I am one of the sponsors of and authors of an expansion bill, and I appreciate your coming here today. And I really want to thank the VSOs, who have been very strongly in favor of this, advocating for veterans and their families for equity and parity and recognizing.

And I will tell you, mine is one of those districts with a lot of Korea and World War II veterans, with aging caregivers who have been doing this for decades, and, frankly, I think it is unfair and unwise not to give them the support and assistance that they deserve to have, particularly at this time. So I appreciate with your focus, but I want to drill down on what that really looks like.

Dr. Shulkin, you have talked about Tier 3, so I want you to do two things. Can you discuss what Tier 3 is? And I want you to answer this question: are you suggesting or do you think we should be restricting the post-9/11 to Tier 3? If you had your druthers, if you were talking about the best way to serve, would you recommend, is that what you are suggesting, that we focus on those most in need? And the expansion should not be by era, but the expansion should be by severity? Because that is a really important thing for us to discuss with limited resources.

And I think, in fairness to veterans and their families, they should understand what exactly you would be calling on us to do, because if we are going to look to expand to those most severely, that is a really important distinction. We would have to authorize that here in Congress.

Secretary SHULKIN. Absolutely.

Ms. ESTY. And I want to get my handle around that and it is not clear to me that that—if that is only for one era—

Secretary SHULKIN. Right.

Ms. ESTY [continued]. —why would you not be actually asking us for all eras? Thank you.

Secretary SHULKIN. Well, thank you. And what I am doing is just giving you my best advice, because this is your decision. I do believe that, first of all, we should not be removing caregiver support from people who have already been granted that benefit. So I am not suggesting revocations. But moving forward, if we were to expand, I believe that my recommendation would be to move towards criteria that would be Tier 3, which is three activities of daily living or cognitive dysfunction. Cognitive dysfunction would be a separate category.

And the reason why I say that—and Dr. Allman is here as the expert—is that every other one of our programs using three activities of daily living as the criteria; the state Medicaid programs in your states that offer caregiver services uses three ADLs as their criteria, Medicare uses for nursing home determinations three ADLs. So if we want consistency, I believe, and the best use and impact in the area of not unlimited resources, I believe that would be my best recommendation, but I do not support withdrawing services from those who have already been granted them.

Ms. ESTY. And could you repeat again for us your best estimate if we were to do expansion to all eras—

Secretary SHULKIN. Well, we have—

Ms. ESTY [continued]. —of how many would be Tier 3? I know you have talked a little bit about what those numbers are.

Secretary SHULKIN. Right. We have about 26,000 now that are post-9/11 and we would have approximately 40,000 pre-9/11.

Ms. ESTY. And the savings on the chart that you showed us, those savings are predicated on the assumption that those Tier 3 veterans would otherwise be in a much more expensive institutionalized setting that would in fact be paid for by taxpayers, is that correct?

Secretary SHULKIN. That is correct.

Ms. ESTY. And is that assuming some of those are in VA facilities and some are in other facilities?

Secretary SHULKIN. Yes, yes. Yeah, community nursing homes, state nursing homes, and VA facilities, yes.

Ms. ESTY. Okay. And are those assumptions over the chart you are looking at, is that based on inflation rates that we have seen in nursing homes?

Secretary SHULKIN. Yes, that is a good question.

Ms. ESTY. I mean, it is a very important question because—

Secretary SHULKIN. No, that is a good question.

Ms. ESTY. Dr. Allman?

Secretary SHULKIN. Yes, best we can. But you are right, they have been climbing pretty high, yeah.

Ms. ESTY. Is that correct, Dr. Allman? Do you know if that is projecting out what we have seen over the last few years?

Dr. ALLMAN. Yeah, the numbers were adjusted for inflation, so they are in 2030 dollars.

Ms. ESTY. But based on the inflation rate for nursing homes or on the general inflation rate? Because those are two very different rates.

Dr. ALLMAN. It was just the general inflation rate, as I recall.

Ms. ESTY. So that could well be much higher than that, is that correct?

Dr. ALLMAN. Correct.

Ms. ESTY. Okay. Thank you.

I yield back.

The CHAIRMAN. I thank the gentlelady for yielding.

Mr. Rutherford, you are recognized for 5 minutes.

Mr. RUTHERFORD. Thank you, Mr. Chairman.

And, Mr. Secretary, thank you for everything that you have been working very hard to do to improve medical care for our veterans. I know how much they appreciate that.

I would like to first begin with a request. Could I get some of the backup data for the chart that we have up here? Because one of the things that I am a little confused about, I did a little math here and Tier 1 with these stipends, just the stipend amount, is \$4.5 million, Tier 2 is \$11.8 million, and Tier 3 is \$12.9 million, for a total of \$29.2 million. And there is a delta on the chart of 2 million, but I don't know what that represents. Can we get the backup data—

Secretary SHULKIN. Sure.

Mr. RUTHERFORD [continued]. —for that, to make sense of that?

Secretary SHULKIN. The very easy math, but we absolutely will get you the model, is we are using a nursing home costs 104,000 a year, and these wraparound services that the Chairman talked about, including caregivers, about \$30,000 a year less than that.

Mr. RUTHERFORD. So a \$74,000 delta?

Secretary SHULKIN. Yes.

Mr. RUTHERFORD. Oh, okay. Yeah, I would like to see that.

Secretary SHULKIN. Yeah, we will get you that.

Mr. RUTHERFORD. Thank you. And so my next question is, is it true that, as the testimony from the Elizabeth Dole Foundation claims, that individual VISNs have the autonomy to run the Family Caregiver Program as they see fit? Has anybody addressed that comment?

Ms. KABAT. No, that is not accurate. As Dr. Roe said, we published a directive, which is the national policy that all VISNs are required—all medical centers are required to follow. We have a lot of different ways that we provide oversight from the national office, including site visits, as well as some data analytics. So, certainly I will follow up with the Elizabeth Dole Foundation about that specific comment.

Mr. RUTHERFORD. Good. Thank you.

Also the—when we established the graduated-tier system, did that complicate the execution of this program by actually bringing more people in than we originally anticipated or Congress anticipated?

Ms. KABAT. I think that having the three different tiers is very difficult and confusing, it is confusing for caregivers and veterans. We did our best in establishing a tool that is used by VA clinicians and now we are, by the end of this year we will have actually 90 percent of our sites using a multi-disciplinary approach, because it is so very complicated, not just the eligibility, but also establishing that tier level.

Mr. RUTHERFORD. Right. And I think the eligibility issues, Mr. Secretary, that you talked about is, you know, when you look at Tier 3, that is pretty much what everybody had projected, and then it turned out to be something completely different.

Let me ask this: should the determination of eligibility for stipend payments be restricted only to those caregivers giving the 40 hours of treatment in Tier 3, understanding that all of these other programs are available for caregivers who may only be spending 10 hours a week? That doesn't seem like a lot of time, and yet they have a lot of opportunity to get assistance through these other programs. What is your opinion on that, I guess?

Secretary SHULKIN. Do you have a thought on that?

Ms. KABAT. Sure. I think it is certainly care-giving occurs on a continuum. At one end, you have a family member that you may start calling twice a day because you are concerned about them, way up to the high levels of care in which a caregiver is providing a lot more than 40 hours of support a week, and including special diets, tube feeding, all of those kinds of things. And we really want to be able to provide support to every caregiver along that entire continuum and I think the key is where we target the comprehensive assistance.

We need to make sure that we continue to provide all the other kinds of supports that we have, the wraparound services, training, and education, all of those things, but to determine where that line is where we move to that comprehensive group.

Mr. RUTHERFORD. Well, my time is up, but I would like to go on record, I support expansion of the program, but I think, as General Bergman said, you know, we really need to do this in a smart way.

Secretary SHULKIN. Absolutely. Thank you.

Mr. RUTHERFORD. Mr. Chairman, I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

And, Ms. Rice, you are recognized. They have called votes. So we will get through yours and then we will have to come back, I apologize.

Miss RICE. Thank you, Mr. Chairman.

Secretary SHULKIN. No problem.

Miss RICE. Secretary Shulkin, very quickly. Caregiver assistance is one of the biggest issues that comes up in my district, as I am sure everyone on this panel will say, and so I would just like to reiterate what my colleague Mr. Bilirakis was saying in terms of doing the outreach to have them understand exactly what they need to do in order to avail themselves of these services. So, I appreciate your focus on that.

Forgive me if I missed this. Were you able to figure out a dollar figure in terms of the savings that you—because the VSOs have well documented the savings, obviously, and you have testified here today about keeping people out of facilities and in their home—over the next 5 years, if you were to expand the program to pre-9/11, have you been able to come up with a number of what the savings, the long-term savings would be to the taxpayer, basically?

Secretary SHULKIN. Yeah. If we expand the program with the exact same criteria that we are using right now, I do not believe that there will be significant cost savings. And the reason is, we have studied this in the current caregivers that we have and costs actually went up, because I believe that our criteria right now is not focused on those who need it the most.

If we go, as Congressman Esty was asking my opinion, to the consistent criteria used in the industry, it will save upwards of 2 and a half billion dollars by 10 years, probably about half of that by 5 years.

Miss RICE. And that has got to be done legislatively?

Secretary SHULKIN. That would have to be done—

Miss RICE. Yes.

Secretary SHULKIN [continued]. —legislatively.

Miss RICE. So just one last question. The Elizabeth Dole Foundation pointed out that the VA has taken several steps to address the persistent inconsistencies with implementing and operating the Caregiver Program at the regional, local level, but that the program still lacks a level of centralization. I am just curious, Mr. Secretary, what steps you are taking to kind of centralize that as requested?

Secretary SHULKIN. Well, I shared that same concern, which is why I paused the program in April this year. I said no more revocations until we are sure we have program oversight. Meg Kabat, that leads it, was responsible for telling me when she was ready to start the program up again with the appropriate program oversight. And we believe we have good program oversight now, a consistent directive. Is it perfect? No, but it is a lot better than it was.

Miss RICE. So, I lied. One quick question. I totally support your position that there shouldn't be any revocations to people who currently have qualified for this service.

Secretary SHULKIN. Right.

Miss RICE. Going forward, though, if we were to make this legislative fix, they would not suffer, the people who already have it would not suffer and—

Secretary SHULKIN. We would continue to support those that are eligible under the current criteria. I don't think you can just pull the wool out of people that you have already made a commitment to.

Miss RICE. Right.

Secretary SHULKIN. But we also have a commitment to the pre-9/11 veterans. I think everybody in this room so far has been in agreement with that. And so the issue is whether we would just continue our current criteria or whether we would accept industry standards for criteria and adopt new ones going forward, and, you know, that would be my recommendation.

Miss RICE. Thank you very much, Mr. Secretary. I yield back.

The CHAIRMAN. I thank the gentlelady for yielding.

Dr. Wenstrup, you are recognized.

Mr. WENSTRUP. Thank you, Mr. Chairman.

Just a quick, multi-faceted question, I guess, but if you could explain the purpose of the Family Caregiver monthly stipend, the purpose of the aid and attendance benefits, sort of the difference between the two, and should one offset the other.

Secretary SHULKIN. Yeah, yeah, yeah, that is a great question. I am going to—Meg is more familiar.

Ms. KABAT. Sure. So the stipend is paid directly to the family caregiver, so that is one significant difference, because aid and attendance is additional money that is in the veteran's compensation or pension check, because that veteran requires the, quote, "aid and attendance" of another person. In neither circumstance is there any requirement to use the funds in any specific way, there is no oversight of how those funds are being used. Historically, the aid and attendance benefit, I think there is language around that that talks about getting assistance in order to remain at home, but there is no tracking of that that goes on.

So the difference is really who receives the money.

Mr. WENSTRUP. So might they be compensating for the same care?

Ms. KABAT. Well, the stipend, as the Comprehensive Assistance Program, was really money that was paid directly to caregivers and in recognition of the sacrifices that they had made, it was not meant to be income replacement or anything like that.

Mr. WENSTRUP. Okay. Thank you.

I yield back.

The CHAIRMAN. We will adjourn until after votes and, again, I apologize.

[Recess.]

The CHAIRMAN. I will gavel the meeting back to order. And just a couple of things as Members make their way back to the dais, that, first of all, I thought our first, before the interruption, was extremely helpful to me to focus where this program is going, could

and should become. And I think one of the things you pointed out, Mr. Secretary, is that if we would apply the Tier 3 eligibility criteria, the same as other different agencies do, you narrow it down to those most in need, I think we need to work on the IT part, a phase-in for people who might be going to nursing home care would be first in the queue. I think if we do those things and we get a better estimate of what they cost, I think that is something that we could carry to the Congress and get passed; I really believe it is.

So, have I pretty well summarized what you have—what your thoughts are on this?

Secretary SHULKIN. You have, Mr. Chairman.

The CHAIRMAN. Well, Mr. O'Rourke, you are recognized for 5 minutes.

Mr. O'ROURKE. I appreciate it, Mr. Chairman.

Mr. Secretary, good to see you. Thanks for being here. And Mr. Chairman, thanks for convening this hearing. I know that every time we have a joint, House-Senate listening session with the veteran service organizations, this is at the top of the agenda, and so I love the fact that we are

trying to make some progress on it and I appreciate the Secretary's effort and focus and attention on this.

And I wanted to ask a couple of questions about eligibility going forward for pre-9-1-1 veterans and caregivers. You mentioned that under one scope of the program, you could up to eight—188,000 pre-9-1-1 caregivers and under a more restricted scope, you could have just 40,000. I wanted to get your thoughts about what happens to those other 148,000 caregivers if they are not eligible for this program, and then you may want to, in your answer, talk about—you are trying to harmonize with other eligibility criteria for Medicaid, for example.

You may also want to think about Department of Defense, which I think has a more expansive set of eligibility requirements and talk about how we take care of those other 148,000 families.

Secretary SHULKIN. Yeah. No—thank you, Congressman.

First of all, it is very confusing when all these different departments, all that work for the same employer, the Federal government, have different eligibility criteria. So, it would be—I think we would be doing a service to move towards what is a reasonably, clinically appropriate criteria across the board.

The difference between the 40,000—let's talk about the Tier 3 and the 188,000, which was the projection, if we current—if we use the current criteria of one ADL. The 148,000 that you talk about, they are eligible for all of the other services that the Chairman had mentioned. They are eligible for home care visits, primary care-directed visits. Assistance with respite care. General caregiver support services, just not the comprehensive program.

Mr. O'ROURKE. So, just to—sorry to interrupt—

Secretary SHULKIN. Yeah, no problem.

Mr. O'ROURKE [continued]. —I just want to make sure I understand. Apples-to-apples would not be eligible for a caregiver stipend, caregiver counseling and mental health services, caregiver medical care, additional respite care, and reimbursement of travel expenses?

Secretary SHULKIN. I think that is right. That is the comprehensive program that you are talking about.

But today we support 250,000 older veterans with these wrap-around services. So, we are really doing a lot today, but you have it correct, Congressman.

Mr. O'ROURKE. Yeah, but it excludes those.

Secretary SHULKIN. Right.

Mr. O'ROURKE. In reading some of the DoD eligibility criteria, while I don't think it explicitly describes post-traumatic stress disorder, it describes difficulty with sleep regulation, requires assistance or supervision, as a result of delusions or hallucinations, difficulty with recent memory, self-regulation issues. And I am concerned, and I am sure you are as well, that if we too narrowly constrain eligibility, we will be missing the opportunity to help pre-9-11 veterans and their caregivers deal with very serious issues.

You are the first Secretary that I know of, who has made reducing veteran suicide a priority. We know 20 a day will take their lives today every day until we get a handle on this. And I believe the largest cohort are not post-9/11 veterans; it is pre-9/11, I think it is the Vietnam-era of service. So, if we are going to exclude them from eligibility and the caregivers in their lives from this kind of help, what will happen to them?

Secretary SHULKIN. Well, first of all, one of the criteria that we would propose, besides the three ADLs, is any type of cognitive type of dysfunction. So—

Mr. O'ROURKE. Okay.

Secretary SHULKIN [continued]. —that would absolutely need to be in there.

Secondly, today, our Caregiver Program has a very high incidence of mental health issues and post-traumatic stress; 89 percent of our current 26,000 caregivers in the comprehensive program have a co-morbidity in a high percentage of the mental health. So, we are very sensitive to that, and I do think this fits in with providing as much support as possible to help reduce, not only suicide, but also the burden of mental illness and mental health issues.

Mr. O'ROURKE. Thank you. I appreciate that.

Mr. Chairman?

Mr. ROE. I thank the gentleman for yielding.

Mr. Poliquin, you are recognized for 5 minutes.

Mr. POLIQUIN. Thank you, Mr. Chairman, very much.

Mr. Shulkin, it is always good to see you. Thank you very much for being here, and please continue—I know you will—your great work for our veterans.

My questions, sir, relate to the post-9/11 veterans that are currently eligible for the program. Mr. Shulkin, my parents are 89 and 87 and they live in a little apartment in an assisted-living place and we need additional home care help for my mom, who is a retired nurse. My father is a little bit stubborn, but he gets it and she gets it.

We all know how vitally important it is to keep our seniors, our veterans at home as long as we can, such that they can recover fully and keep them out of hospitals and other medical facilities. So, this is a great program that I completely support. Especially in

the rural parts of Maine, where you don't have access—and I know you were up in Brewer County—

Secretary SHULKIN. Right.

Mr. POLIQUIN [continued]. —not long ago, and we don't have a lot of options up there. You know, if you are one of our great heroes and you are missing a limb, it is very different from helping take care of mom and dad, but they need to learn how to dress and walk and shower and cook and all these other things, so, I am very, very supportive of this program.

However, I am also mindful, Mr. Shulkin, that you might have not have been here for this hearing, it was last October. There was a terrific veteran, one of our great heroes named Brendan O'Byrne, and I quote, "Being an active member of society is the ultimate sign of healing from combat and we should all be striving for it."

So, my question to you, and where I want to go down this path, if I may, Mr. Secretary, is I know this program is designed to be temporary, to help our veterans adjust to their new situation, showing them compassion to help them adapt and get back into a regular routine and also for their caregivers, to then move on with their normal lives. So I want to make sure—I rather want to ask you the question, sir: Is this goal, as Mr. O'Byrne testified, to get back to an independent living and what have you, is that the goal of this program?

Secretary SHULKIN. Well, I think that should be the goal of all of our programs at VA, our benefits program and our health programs, to restore independence. That is what people want. Sometimes, of course, that is not going to be possible and I think that is the reason why you should separate out high-need people from those that can get on a program towards independence and then reevaluate whether the people need the continued support.

Mr. POLIQUIN. Do you—can you list, rather, any specific reforms to the program right now that may help to that end?

Secretary SHULKIN. Yeah. Yeah. Some of the things we did in our Strategic Pause, I am sure.

Ms. KABAT. Sure. One thing we did was we instituted something that we call our roles and responsibilities document. It is on our Web site. We wanted to make sure that we were being transparent about it, and it really describes what the requirements of the program are and also helps our caregiver support coordinator start the conversation that you are describing about, for some of our veterans, this is an intervention that may be short-lived, while the caregiver is receiving additional supports that comprehensive assistance, the veteran is also going to be receiving mental health treatment or occupational physical therapy, so that as that veteran increases their level of independence, the amount of that comprehensive assistance that the caregiver receives will decrease. So, that has been a significant change in our program.

We actually required that all of our caregivers and support coordinators go back and review that same document with all of our current participating, as well as any new participating.

Mr. POLIQUIN. Can you, Dr. Shulkin, comment on any potential obstacles that you are facing at the VA, with respect to achieving this goal that we can help you with?

Secretary SHULKIN. Well, I want to get the clinical criteria correct. I mean, I think that having different clinical criteria between these multiple programs is confusing and doesn't allow us to focus on those that need it the most.

Mr. POLIQUIN. Thank you, Mr. Chairman. I yield back my time. Thank you.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Higgins, you are recognized.

Mr. HIGGINS. Thank you, Mr. Chairman.

Secretary Shulkin, God bless you, sir. Thank you for your leadership. You continue to provide encouraging testimony. Many of us on this Committee have been advocates for expanding the Caregiver Program to pre-9-1-1 veterans for quite some time. For me, that is a year, since day one on this Committee.

Secretary SHULKIN. Uh-huh.

Mr. HIGGINS. And I am sensing a path forward, sensing a path forward, here, so let us forge forward and promise to arrive at a bipartisan conclusion that we can make this thing happen.

But let me just state that even in a world of unlimited resources and funding, would we not want to eliminate waste fraud and abuse?

Secretary SHULKIN. Absolutely.

Mr. HIGGINS. Thank you, sir. So, given that additional dynamic, where we certainly do not live in a world of unlimited funding and resources, should we not seriously investigate waste fraud and abuse where it does exist in the stipend program, the Caregiver Program for post-9/11 veterans, whereby that funding may be made available for deserving veterans, pre-9/11. Would you concur with that general assessment?

Secretary SHULKIN. Absolutely.

Mr. HIGGINS. Okay. Given that, how often are receivers of stipends supposed to be visited by, in some sort of supervisory role—

Secretary SHULKIN. Yeah.

Mr. HIGGINS [continued]. —a VA employee, to go to their home and observe their home and interview that subject; is that supposed to be quarterly?

Secretary SHULKIN. Yeah.

Ms. KABAT. Yes, it is quarterly.

Mr. HIGGINS. What is the reality, though?

Ms. KABAT. I don't have exact numbers. I can get back to you on the reality of that. That is something that we have really focused on.

And many caregivers are concerned that that is too frequent and so we have allowed, in certain circumstances—and I can provide you with those criteria—where that wouldn't be an in-person visit, but it would be telehealth or over the telephone. There is a requirement for an annual in-home, in-person visit, however.

Mr. HIGGINS. But, there are caseworkers assigned to individual veterans?

Ms. KABAT. Correct.

Mr. HIGGINS. This 46,000-number, they have corresponding?

Secretary SHULKIN. Yeah, we have 350 caregiver coordinators for 26,000.

Mr. HIGGINS. I'm sorry, for 26,000, yes, sir.

Well, there is—this particular program is just generally known to be rife with abuse. I mean, can you imagine, viewed from the prism of a soldier, can you imagine a soldier having, you know, a full vest, 10 magazines for his M4 and his fellow soldier having one magazine. Can you imagine any soldier that would not give his fellow soldier a few magazines from his—

Secretary SHULKIN. No, sir.

Mr. HIGGINS [continued]. —from his vest? Sure, of course we would.

So, it is troubling that waste fraud and abuse even exists and it is disheartening that it exists within a veteran population, but it does.

Secretary SHULKIN. Uh-huh.

Mr. HIGGINS. And in order for us to move forward as a body, can we seek your commitment, sir, that there will be a genuine effort to seek out unrighteous abuse of this program whereby that funding can be made available to the righteous, deserving veterans pre-9-1-1?

And may I ask, Madam, is social media used? If you have a veteran posting pictures of him hitting in a gym, deep-sea fishing, snow skiing, et cetera, he can probably feed himself and bathe himself.

Ms. KABAT. So, is your question, do we review social media?

Mr. HIGGINS. Yes.

Ms. KABAT. We do not currently review social media. We rely on an interdisciplinary approach made up of physicians, nurses, social workers, occupational physical therapy, mental health professionals to make a determination.

Mr. HIGGINS. As it should be, because the veteran's privacy should be completely preserved and respected; however, we do live in an era of social media, and this is available data. So, if you have a staffing issue that is causing us not to be able to investigate waste fraud and abuse, might I suggest that social media, perhaps, could be an avenue.

With that, Mr. Chairman, I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

And I would like to thank this first panel for your instruction. It has been very helpful. I will add, as a matter of fact, it cleared up a lot of things about how I think we can see a way forward.

I thank all three of you for being here and I apologize for the votes that came up in the middle; we couldn't help that, and with that, you all are dismissed.

I know you have a busy day in front of you, Mr. Secretary, and thank you so much.

Secretary SHULKIN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

There—joining us will be our second panel, as soon as the Secretary is able to leave.

Joining us on—excuse me—on our second panel this morning is Adrian Atizado, the Deputy National Legislative Director of Disabled American Veterans—welcome; Sarah Dean, the Associate Legislative Director for Paralyzed Veterans of America—also, welcome; and Steven Schwab, the Executive Director of The Elizabeth Dole Foundation.

Thank you all for being here, and Mr. Atizado, you are recognized for 5 minutes.

STATEMENT OF ADRIAN ATIZADO.

Mr. ATIZADO. Thank you, Mr. Chairman, Members of the Committee. I want to thank you for inviting DAV to testify on the VA Caregiver Program.

Since its inception several years ago, VA's Comprehensive Caregiver Support Program has been annually serving over 20,000 caregivers of severely injured veterans. And there is mounting evidence that the program is measurably supporting and improving the lives of family caregivers and their veterans.

According to an online caregiver survey DAV conducted last year, more than three-quarters of disabled veterans who currently rely on family caregivers would require institutional care now or in the near future if their loved one could no longer be their family caregiver.

Here's what one of the caregivers we surveyed, a 38-year old mother, with teenage children, who is caring for her severely disabled husband said, "We depend on the Caregiver Program more than you can imagine. I miss doing what I love—my career—but I love my husband and my children. My husband depends on me in so many ways that there are days that I am just so exhausted, but I continue on because I know he needs me."

Mr. Chairman, we are grateful that the Committee is holding today's hearing to examine how to improve and expand VA's Comprehensive Caregiver Support Program, and we offer a few recommendations on how to improve the program in our written testimony; however, there is no issue more important today than finally be correcting the gross unfairness and inequity that discriminates against veterans ill and injured prior to September 11, 2001, and their family caregivers.

In the audience today are DAV past national commander, Dennis Joyner, and his wife and caregiver, Donna, and DAV past national commander, Dave Reilly, and his wife and family caregiver, Yvonne. I would please ask that they raise their hands to be recognized.

Now, Mr. Chairman, the last time Dennis walked was on principal in Vietnam's Mekong Delta on June 26th, 1969. And he has been confined to a one-arm drive wheelchair ever since. While he led a successful rewarding career, it was greatly aided by the love, work, and sacrifice of his wife, Donna. When his good shoulder, his one good shoulder, finally gave out a decade ago, Donna was forced to retire from her full-time job to be his full time caregiver, but because Dennis was injured in Vietnam, Donna isn't eligible for VA's Comprehensive Caregiver Program.

Now, for Dave, after losing his arms and legs two decades ago, during his service in the Coast Guard as a rescue swimmer, each and every day begins and ends with the help and love of his wife and full-time caregiver, Yvonne. Despite the considerable progress Dave has made functioning with his prosthetic limbs, as a quadruple amputee, he will always rely on Yvonne for the many, many of his basic needs. Like Dennis and Donna, Dave and Yvonne are not eligible, because, he, too, is a pre-9-1-1 veteran.

But even if the date were changed, Mr. Chairman, Dave and Yvonne would likely not be allowed access to VA's Comprehensive Caregiver Program because he lost his limbs to a water-borne flesh-eating bacteria. It would be an illness and not an injury, and the law doesn't count illnesses.

Mr. Chairman, the most critical reform for Caregiver Program is extending eligibility to severely disabled veterans from all war eras. Research has shown that family caregivers delay, avoid, and in certain situations, can actually help transition veterans out of nursing homes at great cost savings to taxpayers. The Congressional Budget Office estimated to extend access to pre-9-1-1 veterans is about \$30,000 a year. Compare this to an average annual cost of over \$400,000 for a VA nursing home or \$110,000 for a community nursing home for disabled veterans.

Respecting a severely disabled veteran's choice to remain in their homes longer is not only economically smart, making more efficient use of VA and taxpayer funds, but it also allows the veteran to lead high-quality lives with respect and dignity and be an active member of society.

After a lifetime of caregiving, Gulf, Vietnam, Korea, and World War II veterans, many family caregivers are aging and their ability to continue in their role is declining.

With bipartisan support in the Senate, a growing support in the House, we believe now is the time to act. Mr. Chairman, DAV, along with virtually all the VSOs call on this Committee to take bold action, similar to what the Senate Veterans' Affairs Committee did last fall, pass legislation to expand eligibility for VA's program to veterans severely ill and injured, from all eras and their family caregivers. This concludes my testimony.

Thank you so much, and I would be happy to answer any questions you may have.

[THE PREPARED STATEMENT OF ADRIAN ATIZADO APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

Ms. Dean, you are recognized for 5 minutes.

STATEMENT OF SARAH DEAN

Ms. DEAN. Chairman Roe, Congresswoman Brownley, and Members of the Committee, Paralyzed Veterans of America thanks you for the opportunity to present our views before you today.

We are grateful for your interest in the improvements and potential expansion of the Caregiver Program. No group better understands the value of caregivers, more than PVA's members, veterans with spinal cord injuries or diseases, and most of PVA's members currently do or will rely on a caregiver.

Seven years ago, the VA set up a program that was the first of its kind in the United States. Recognizing the degree of injury endured by servicemembers returning home and the burden shouldered by their caregivers, Congress took bold action to enable VA to meet their needs. Based on the clinical determination of activities of daily living or need for supervision, the caregivers of certain veterans receive comprehensive critical supports to provide quality care at home.

For PVA members who are eligible, this program has enabled them and their families to better manage the new normal of their lives. The feedback we receive of the program has been crucial. It has given the caregivers the tools to manage the emotional, physical, and financial stresses of caring for someone with a severe disability.

As with any unique program, especially one of this scale and this integrated reach, challenges were encountered, but overall, and especially after the corrective actions of last summer, it is our belief that VA has done a commendable job addressing these issues and we see no reason why Congress should not take bold action again and enable the VA to meet the majority—the needs of the majority of veterans who rely on caregiver services, those catastrophically injured on or before September 10th, 2001.

PVA understands the costs associated with any expansion are significant and there likely will never be a projection that isn't, but as has been stated, not expanding will have considerable costs. We know that veterans who remain home receive a quality of life that they can't get in an institution and we know that support of caregivers reduce hospital admissions and medical complications.

In recent years, this room has seen a lot of discussion about veterans choice and care in the community. This Committee, for nearly four years, has shepherded reform efforts, so veterans are able to receive care that best meets their needs, in and outside of VA. So, I ask again, what could be more fundamental to that question or to that question than seeing that veterans are able to choose to stay home while receiving the care that best meets their needs.

According CVO, roughly 70,000 veterans who were catastrophically injured as a result of their service, are in need of critical supports right now, but for 7 years, Congress has said it costs too much. That is unacceptable. This is a clinically determined program. If the cost is significant, if it is the \$3.4 billion over 5 years, the Senate projection says, then that is what we owe, because that is the deal we made when they signed up.

I know of no other clinically determined support service for service-disabled veterans that cuts off access because of date and then is justified by Members of Congress because of costs. It is unconscionable to tell those injured that only some of you will be helped. We are the beneficiaries of their sacrifice. They served. They were injured. We do what we have to do make them as whole as possible.

This program is an imperfect solution to the perfect one of wholly healing these people, but for PVA members in the program, it has made all the difference in their lives. For our older veterans, who have been relying on their—the sacrifices of their spouses, and now their grandchildren, some for half a century, they need a difference made in their lives, too.

We stand ready and willing to help the efforts of this Committee on this issue and thank you for the opportunity to speak here today. I am happy to answer any questions.

[THE PREPARED STATEMENT OF SARAH DEAN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Ms. Dean. Thank you for your testimony.

Mr. Schwab, you are recognized for 5 minutes.

STATEMENT OF STEVEN SCHWAB.

Mr. SCHWAB. Thank you. Chairman Roe, Congresswoman Brownley, and Members of the Committee, I am pleased to be here today to offer the views of The Elizabeth Dole Foundation and the Department of Veterans Affairs' program of Comprehensive Assistance for Family Caregivers.

I will simply refer to such program as "the program" in my testimony. The Elizabeth Dole Foundation's mission makes us uniquely qualified to share our views on this subject. We are the only national organization exclusively focused on the military and veteran caregiver population, the 5 and a half million spouses, family members, and other loved ones, caring for wounded, ill, or injured veterans at home.

We call these caregivers "America's hidden heroes," since much of their work is being done behind the scenes, in the wee hours of the morning or late at night, with little support or fanfare. Senator Elizabeth Dole, herself, a caregiver to her husband, Bob, started the foundation six years ago to shine a light on the work caregivers do each day and to advocate for their support.

Mr. Chairman, our philosophy has always been to work hand-in-hand with the VA and other support organizations to determine what works for caregiver support and to provide host feedback on what doesn't, ensuring that caregivers' needs are heard, programs are truly responsive, and that they are built to serve them as they serve their loved ones. With the passage of the Caregivers and Veterans Health Services Act of 2010 and the establishment of the program of Comprehensive Assistance for Family Caregivers, the VA recognized caregivers for the invaluable work they do to assist in the rehabilitation and recovery of our Nation's veterans.

However, the implementation of the program has not been without its challenged, as has been discussed. Congress initially intended the program to serve a small number of caregivers, those supporting only the most catastrophically wounded post-9/11 veterans. Upon executing the program, the VA realized that many more caregivers needed this support than initially anticipated.

As we have discussed, the program now serves more than 26,000 caregivers; that is nearly three times the number of caregivers for which the VA initially planned. Because of this, the program has faced significant challenges as it accommodates the growing number of veterans' caregivers that qualify for the stipend program. Chief among these issues are unclear eligibility requirements, lack of accountability, and inconsistent implementation, which I expand upon in my written testimony.

Despite these challenges, we know that this is an important program for caregivers and we believe it should be available to all who need it, regardless of which era they served. We cannot let the pursuit of perfection delay us from doing what is right and that is ensuring that vets of every era have access to this program.

Mr. Chairman, Congress should act simultaneously to pass an expansion of the program to include service-connected illnesses and

pre-9-1-1 caregivers, while also addressing the issues of standardization and clarity. These efforts should not be a zero-sum game.

I would like to leave you with a story that illustrates why programs like this are so important. Jenny Beller is from Indianapolis. Her husband, Chuck, was exposed to Agent Orange while serving in Vietnam in his 20s, and as a result, he had a stroke when he was in his late 50s. The stroke rendered Chuck paralyzed and unable to speak.

As she grappled with her new reality as a caregiver, Jenny struggled with the demands of her job as a public attorney, while also slipping into debt. Jenny performs a juggling act that almost every caregiver around the country knows too well and many of them are watching us today. She balances career, finances, Chuck's medical appointments, bathing, dressing, cooking, and cleaning, all while trying to fit in time for her own health and well-being.

Jenny made the difficult decision to quit her job last year to care for Chuck full time, because, frankly, there is no one else out there better suited to do it. So, I ask you to consider Jenny. She cares for a pre-9-1-1 veteran with a service-connected illness who was left paralyzed and without the ability to speak after a sudden and traumatic event. For 7 years, she has devoted all of her time to Chuck's care at the expense of her income and career as a civil servant, ensuring that she can receive the help in the dignity of his own home, rather than in an institution, yet, as of today, Jenny is not eligible for the VA's program of comprehensive assistance.

Isn't it our duty, as stewards of those who have borne the battle, to offer her the same support as those who care for veterans just returning from war? The answer is a resounding yes. As RAND's research points out, the number one factor in a wounded warrior's recovery is a well-supported caregiver and it is programs like this that are the lifeline for people like Jenny and Chuck. The program needs to be expanded.

On behalf of Senator Elizabeth Dole and the caregivers we speak, I thank you, again, for the opportunity to be here today and to share our insights. I am happy to take questions.

[THE PREPARED STATEMENT OF STEVEN SCHWAB APPEARS IN THE APPENDIX]

The CHAIRMAN. I thank you for your testimony.

I will start now by asking a few questions. And just one, Mr. Schwab, on Jenny, you just referenced, did she use any of the other VA programs that I have referenced to begin with? Has she sought those out.

Mr. SCHWAB. I don't know in her particular case, but I know that there is an issue among many caregivers around clarity of eligibility for programs. The Secretary mentioned in his remarks that we have done a great deal of work across organizations and within VA to put information out there in a more proactive way. So, my hope is that folks like Jenny are aware of benefits.

But the issue is that Jenny still doesn't qualify, herself, for a program that post-9/11 veteran caregivers—

The CHAIRMAN. Well, I understand that; that is what this hearing is about. But my question is, did she—is she aware—and I think one of the things when I hold veteran town halls around the

country, is getting access to information that programs that are there right now functioning for people. I just wonder if this—I mean, there is at least a dozen programs here that maybe help her right now. If she's not using them, I would certainly ask her to reach out to VA and see if she can't do that.

Mr. SCHWAB. I would just like to say that it may very well be that Jenny is availing herself to certain programs, but I think the bottom line is still the unjust fact that Jenny doesn't qualify support—for support that post-9/11 caregivers do.

The CHAIRMAN. A couple more questions that I had. Should the veterans and family caregivers live in the same residence? Should they be—should that be a criteria?

Mr. SCHWAB. Is that a question for me?

The CHAIRMAN. Anybody. It doesn't matter.

Ms. DEAN. I believe under the comprehensive program, it is; that they have to live with the veteran or—

The CHAIRMAN. Have to live in the same residence.

Ms. DEAN [continued]. —if they are not a family member.

The CHAIRMAN. Okay. Cannot if they are not a family member. A family member could live outside and come in and help—a daughter or a son or someone?

Mr. SCHWAB. Mr. Chairman, if I could just add one—about a third of the Nation's 5 and a half million military caregivers are friends that live outside the home. So, there is a significant portion of the population that, in fact, provide care who aren't in the residence.

The CHAIRMAN. One of the things—and this the other support programs that I was bringing out that are currently available, what are your all—and anyone can grab this—what are your views on the other programs, such as adult daycare or veteran-directed home health care and how should they fit in or compliment the current program? And that is—this is one of the things that I was mentioning earlier, the way we provide non-VA health care was we had six ways and then we had a choice on top of that, now we are trying to get one way to do that.

Is that possible, to consolidate some of these and make the services better?

Mr. ATIZADO. Well, Mr. Chairman, that is actually a very good answer, and this is one thing that Secretary Shulkin had mentioned, is that the VA is doing very well at—actually, better than is seen in other health care systems, because VA tends to take care of the caregiver—I'm sorry—the veteran for their lifetime. They seen the longitudinal need of that veteran and so they provide a comprehensive array of services from primary care all the way to nursing home care and in between all of that are these home and community-based services that you were just referencing.

I do want to talk very briefly before we get into this about your question about caregivers knowing or not knowing about these services that you are referencing. The other thing that VA should be commended about is their desire to use literature research to inform their policy and, in fact, the research that they are doing on the Caregiver Program, which we fully support, they found when they compared caregivers who were in the comprehensive program versus a caregiver who is not, is that those caregivers in the com-

prehensive program are far more aware of the benefits and services that VA has to offer.

The CHAIRMAN. Uh-huh.

Mr. ATIZADO. That is a key difference in the nuance between the two programs.

Now, having said that, the availability of these services, as we all know from the Choice Program, is a variable, because they are predominantly paid for, or I should say, bought by VA. They use community providers for homemaker home health aid, for respite, for adult day health care. And because of the variability of availability across the Nation, so is the caregiver and the veterans's ability to access those services. It depends on where they live.

It is no fault, necessarily, of VA or the private health care system; this is the nature of the market. So, whether or not a caregiver is able to avail themselves of those services to support their veteran in their home depends on whether they are able to access that and where they live.

The CHAIRMAN. I would say a lot of that has—and you have just mentioned a problem in the health care system, where it depends on where you live and access. As, if you live in rural America, you are a lot less likely to have access to certain things than if you lived in urban America.

My time is expired. Ms. Brownley, you are recognized.

Ms. BROWNLEY. Thank you, Mr. Chairman.

My first question is to Mr. Atizado. So, we have—in these ongoing discussions around the current caregivers program, we have frequently heard concerns about the possibility of duplication of services and I wanted to know, if you could share with us if you agree with that or what are—what is your opinion?

Mr. ATIZADO. Well, thank you so much for that question, Congresswoman Brownley. I have to disagree with the perception that there is a duplication of services. It may appear on paper that some of these services are doing the same thing, but when it is actually applied to a specific veteran, the patient, and the family caregiver, they are quite distinct.

One of the key parts about the Caregiver Program, the Comprehensive Caregiver Program, is that it integrates all of these services. They have a support coordinator whose responsibility is to make sure that these needs, the caregiver and veteran's needs, are met in an integrated fashion.

When you are in the general Caregiver Program, it is not. So, I want to make a distinction about that.

And there was another comment earlier, I want to—I would like to speak to on this particular topic—there was a discussion about a benefit called Aid and Attendance. That is a benefit that was referenced that is paid to the veteran, which is wholly distinct from the modest stipend a caregiver gets in the Caregiver Program that is paid to the caregiver.

The reason why on paper this looks like a duplication of services is because it appears to be serving the same need and the difference is this, Congresswoman, Aid and Attendance benefit is a compensation to the veteran that is able to, as best as possible, distinguish a higher level of disability.

When a veteran is a 100-percent service-connected, like, I am sure the past national commanders behind me are versus somebody that is spinal-cord injured at the neck level and they are bound to a bed, they, too, are 100 percent, but their severity of need and disability is quite difference. And what Aid and Attendance does is recognizes that greater severity of disability above and beyond 100 percent.

And so I think what is most important here is that these services that Chairman Roe had mentioned, the home and community-based services, the Veteran-Directed Care, which is in our testimony and may have been discussed earlier, that these services be integrated in a sensible manner, rather than fragmented, which does lend to waste and abuse.

And so a Comprehensive Caregiver Support Program really fights against these fragmented services, integrate them in a smart way in supporting the caregiver and the veteran at home.

Ms. BROWNLEY. Thank you. And Ms. Dean, do you have anything to add?

Ms. DEAN. Only that, to recognize the function of a caregiver in this program is within the directive, it says that they are supposed to be providing supports that exceed what would generally be expected from a spouse, et cetera. So, they have agreed, under the physicians plan, that they will do X, Y, and Z, that is required to keep this veteran at home. They are there to serve a function. They aren't being paid to be a family member; they are doing work.

The other thing is that the stipend is capped at the understanding that they are only working a maximum of 40 hours a week and we all know that they probably are working a great deal more than that, but if they can manage, perhaps, only 40 hours a week, then they likely need to have a second job, and then that second job means that they are unable to do other things that maybe veteran-directed can then assist them with, like coming in and offering them respite care or coming in and shoveling the sidewalks or mowing the lawn or cleaning the gutters, doing things that they need that they can't possibly get to if they have a critical veteran who needs all their attention or if they are trying to juggle jobs and care.

Ms. BROWNLEY. Thank you. And I have limited time left, but I wanted to ask the question to the panel, so in your opinion in dealing with current challenges that we have talked about today, to the Caregiver Program, prevent it from being expanded to include all ages, all eras, I have a feeling I know the answer, but, you know, if, for the record, you could just state your opinion.

Mr. Atizado?

Mr. ATIZADO. So, clearly, we believe that VA can improve this program and expand at the same time.

Ms. BROWNLEY. The same time, very good.

And could you also comment about whether or not you believe that veterans with severe post-traumatic stress benefit from the Caregiver Program.

Mr. ATIZADO. Absolutely.

Ms. BROWNLEY. But you don't see any barriers to that, right, in terms of that not being a qualifier for being a part of the program?

Mr. ATIZADO. Well, it shouldn't be; it is now for post-9/11 veterans—

Ms. BROWNLEY. Correct.

Mr. ATIZADO [continued]. —so, we hope to carry that on, as the Secretary of Veterans Affairs had said earlier, the current eligibility criteria is—it should be carried forward. I believe he wants to tighten up a little bit. The way we would like to reform the eligibility criteria is to include illness.

Ms. BROWNLEY. Thank you. That message was loud and clear. I yield back.

The CHAIRMAN. I thank the chairlady for yielding.

Mr. Rutherford, you are recognized for 5 minutes.

Mr. RUTHERFORD. Thank you, Mr. Chairman.

Mr. Swab, the—on the eligibility issue, could you talk to whether you believe, for example, work outside the home by the veteran or the caregiver, whether that should impact on that eligibility?

Mr. SCHWAB. I think that each situation for every caregiver is different and as Meg Kabat mentioned earlier, there is a continuum of care and there are caregivers all along that continuum.

Some of the folks that I know that are in the program who spend 30 to 40 hours a week caring for their veteran have to work because they are the sole breadwinner for the family and many of them are doing that through work-at-home programs. Hilton has a terrific work-at-home program that hires a lot of caregivers to be reservation agents, and so they are putting in double duty. So, yeah, there is a significant percentage of caregivers who needed to both.

Mr. RUTHERFORD. Okay. That is kind of a good segue into my next question. Are you aware of any other government programs that could—that the veterans could access to assist in this caregiver need that they have?

Mr. SCHWAB. Well, Congressman, I think that is a great question, and the Secretary mentioned a new piece of legislation that the president just signed, the (RAISE) Family Caregivers Act, which empowers the secretary of HHS—it actually requires the secretary of HHS to bring an interagency strategy group together to begin to better organizing across the Federal government, benefits for family caregivers—

Mr. RUTHERFORD. Uh-huh.

Mr. SCHWAB [continued]. —and to enact and develop a national strategy for family caregivers.

So, I think we are going to see over the next year, a great deal of attention across the Federal government and among agencies to better organizing those services and support and coordinate them for veterans and family caregivers.

Mr. RUTHERFORD. Yeah, and that is kind of what, Atizado—

Mr. ATIZADO. Yes, sir.

Mr. RUTHERFORD [continued]. —I think that is kind of the point that you were making about the coordination of effort. And do you believe—and this is for all three Members—do you believe that there are offsets that we could find within VA through, you know, better coordination and integration of some of these programs?

Mr. ATIZADO. Mr. Rutherford, I would like—that is a great question, and I want to rephrase that question just a little bit. I think

the discussion here today is about how to spend the resources that VA has smarter so that you could use whatever is not used on other needs.

Mr. RUTHERFORD. Right.

Mr. ATIZADO. And so, to that point, I think the Caregiver Program speaks to that. All of these home and community-based services speak to that.

But one thing that I want to make sure doesn't get past this Committee, is that because VA buys a lot of these home and community-based services, they require an authority to do that, which, as many of you know, is a temporary authority. There is—the VA is now at risk of losing the ability to buy these services in the community because their provider agreement authority will cease to exist when the Choice Program terminates.

Now, having said that, I want to point out that these integration of services is working already today, Mr. Rutherford. I believe we have somebody in our audience from another federal agency that VA has collaborated with to establish what is called the Veteran-Directed Care Program. That is a very strong partnership between CMS and VA, and what they do is they utilize expertise at both, VA and CMS, to deliver services in the veteran's home.

And that is a great partnership and it has shown to save money; in fact, there was a facility—I want to say it is in Cleveland—that shows that they saved about \$100,000 just on one patient alone, just for that one program.

Mr. RUTHERFORD. Uh-huh.

Mr. ATIZADO. So, I think the smarter use of resources is what we are—we need to reframe our thinking about the costs of this program. It is a smarter use of resources.

Mr. RUTHERFORD. Thank you. Any other comments? Thank you.

And I see that Mr. Secretary is still here, so I want you all to know that I look forward to working with you on those provider agreements so that we don't have that lapse. And with that, my time is expired.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Ms. Esty, you are recognized.

Ms. ESTY. Thank you, Mr. Chairman. And to the three of you and to the veterans and caregivers you represent so ably, thank you. Thank you for your service and your passion and your tireless persistence so that we do better on this issue. I know several of the organizations have been working with me on the expansion legislation.

And I do want to note that both of the stories that you spoke of involved illness and the bill that we have introduced would cover illness. And I think it is really important, Mr. Secretary—and I want to thank you for staying, and I think that is really important that you stayed, and I want to thank you. Not everybody on the Committee could, but it is important that you hear from the VSOs as well, so thank you.

But I think, absolutely, we have to figure out a way to include illness. It is simply unjust and unfair not to include illness, so I think we do need to do that.

We are looking at—you heard the discussion about a better use of resources and that is critically important to meet those needs. There was discussion about the expansion, which I am fully in favor of to pre-9–1-1, where, frankly, many of those are hitting greater needs, escalating needs, not declining needs, and I do think we need to figure out some way to grapple with those, too, as we have seen suicide rates going up of Vietnam-era veterans.

People are experiencing now, later in life, different kinds of disabilities than, perhaps, they did earlier. So I think it is vitally important that we support families and help these wounded warriors.

I would like you, each, the three of you, to comment on the Secretary's proposal that we try to concentrate that focus through some mechanism of, as he described, Tier 3, which certainly the folks who talked about it, would be Tier 3, and a cognitive component. Now, ideally, I think we would want everyone to be fully covered in every respect, but trying to get your feedback, as we try to find a way forward with the limited resources that we have, what would you want to see a cognitive component to cover?

I am assuming yes on illness would have to be a part of that. Any part of that—any Tier 3 would need illness and not just injury. I would be fighting—will be fighting for inclusion of illness.

But can you talk about, given this population pool, what you would advise us, as we try to find a way forward.

Mr. SCHWAB. Thanks for that question, Congresswoman, and for all your support. You have been a terrific supporter of caregivers.

And I want to commend the Secretary, who has been on the record now, several times, that he has committed to expansion and we work with him on a regular basis at The Dole Foundation; he has just a terrific partner.

Specifically, on your question, and the notion of starting with Tier 3, I think it is encouraging that we are beginning to talk about pursuing expansion and I think it is really worth a thoughtful conversation and to explore a timeline on how we move beyond Tier 3 and make sure that all pre-9–1-1 caregivers who need and deserve support and this benefit, receive it.

So, we would want to have a thoughtful conversation around cognitive issues and we think illnesses should be included, and I have said that on the record, so, yeah, I think we are open to that thoughtful conversation.

Ms. DEAN. We certainly won't oppose any efforts to expand in any way, but—and if starting with Tier 3 is what we have to do to start, then we will absolutely support that.

I just think that—I just don't want to lose sight of the fact that if there is a clinical need for a caregiver, whether it is 10 hours a week or not, that that clinical need is still met, because it is a service-connected need and it is clinically determined, it still has to be met at some point.

So, if we start at Tier 3, it just won't be the end of the conversation, but we will support that.

Mr. ATIZADO. Congresswoman, first of all, I want to thank you for your bill and for championing the need to include illness and all pre-9–1-1 veterans into the Caregiver Program. And I would agree with my colleagues, for several years now, the DAV has been advocating for full expansion and as we know, as when we—when

we have such a lofty goal, incremental improvements is generally how things happen, so we are not averse to the Secretary's proposal.

Because I want to make sure that this Committee is sensitive to this urgency of having to do this. Every day we have members who are passing away and every day we have family caregivers who are impoverishing themselves and need help now. And so we are not lost on that, and so we want to move forward with this Committee, not only with whatever proposal it is able to provide—but to move that forward until everybody is equitably treated.

Ms. ESTY. Thank you very much.

The CHAIRMAN. I thank the gentlelady for yielding.

I think no further questions and the panel is dismissed. I thank you very much for being here; it has been very helpful.

And I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material.

Ms. Brownley, do you have any closing comments?

Ms. BROWNLEY. Thank you, Mr. Chairman.

I just want to thank everybody for being here. I think this has been a very, very productive hearing and I hope that we can follow up with another hearing or something so that we can kind of roll-up our sleeves and start working on some of the issues that are pretty clear that we need to work on.

I just wanted to highlight and get on the record, while the Secretary is here, as well, is so these coordinators, social workers, you know, I got some data to find out what the current ratios are to coordinator to veterans and I just wanted to point out in VISN 22 and several of their locations, that ratio is very, very high. And in Los Angeles, it is 1:21. In San Diego, it is 1:123—Los Angeles is 1:121. San Diego is 1:122. Long Beach is 1:360.

And Ms. Esty, in New Haven, it is 1:124. So, we need some work, given the existing program. I think in this hearing, we have heard how important the coordinators are in terms of accessing service, so we really need to focus on that right away, please.

And with that, I yield back.

The CHAIRMAN. I thank the gentlelady for yielding.

At first, again, thank you all for being here; I agree with her, it has been an incredibly productive hearing and it helped me focus on what is possible. You know, it is rare that I say anything good about the press, but they actually, as I was walking back over here, gave me some ideas for a pay-for for this in a question that they gave me. There is some possibilities there.

I would like to see us follow up with a roundtable. I have found those very helpful, where we can just sit around and have a free flow of information, not in such a formal setting, and where we can hash out the details that the Secretary mentioned.

And we will—we will ask the Secretary, would you provide us a framework of where you would like to see this to go. I would like to include the VSOs and our members, so that we can all be around that table and discuss that, along with any other people that would like to be there.

And I think, also, it brings in—I didn't—I sort of forgot about this—it has put some urgency on getting our Choice bill passed so

that we can get these contracts done. Thanks for pointing that out again.

And I think there is a way forward. There may not be a way forward to get everything everybody wants, just because of the constraints that we have now. We still haven't after, what are we, six months on—five months into the budget year, hammered out the caps for this fall of this year's budget. We are going to vote this afternoon on a continuing resolution.

So, I do—I begin to see a way forward with this Caregiver Program for our post-9/11. I happen to be one of those. I see my Vietnam-era brothers and sisters all the time at home and they explain this to me, so I certainly understand that.

I appreciate, and let me just finish by saying how much I appreciate what the caregivers do and have done, as you have said, in many cases, for decades, not just a year or five years, in Senator Dole's case, and, quite frankly, he, for me, is the epitome of the poster child. One of the true heroes I have is Senator Bob Dole. I have been in Washington, D.C. for 9 years; I have asked for one autograph, it was his. And he has the only one I have and there is a reason for that. To me, he is a true American hero and his wife, Ms. Dole, also.

So, I thank you for bringing that up, being an advocate, and I look forward to continue this work, and with that, the Committee is adjourned.

[Whereupon, at 12:43 p.m., the Committee was adjourned.]

A P P E N D I X

HONORABLE DAVID J. SHULKIN, M.D.

Good afternoon Chairman Roe, Ranking Member Walz, and Members of the Committee. I appreciate the opportunity to discuss the Department of Veterans Affairs' (VA) Caregiver Support Program, specifically the Program of Comprehensive Assistance for Family Caregivers (PCAFC). I am accompanied today by Ms. Margaret Kabat, Acting Chief Consultant for Care Management, Chaplain and Social Work Service, and Dr. Richard Allman, Chief Consultant for Geriatrics and Extended Care.

Introduction

Providing care for a family member is an issue facing many Americans, but being a caregiver to a Veteran presents unique challenges. Research has shown us that caregivers of Veterans differ from caregivers of non-Veterans in several areas. Caregivers of Veterans are often younger, provide care longer, and more likely to attend to complex care needs.

VA, in close collaboration with our Federal agency partners, leading national organizations, Veterans Service Organizations and other nonprofit partners in communities across the country, remains committed to promoting and enhancing Veteran wellbeing through the provision of unprecedented services and support to caregivers of Veterans who require the care and assistance of another.

VA recognizes the important role of caregivers and is proud to support caregivers through PCAFC, as well as the Program of General Caregiver Support. Last year, more than 400 VA staff, including 350 Caregiver Support Coordinators in VA Medical Centers across the country provided support and services to individual caregivers. In addition, 57,803 callers contacted the Caregiver Support Line; more than 8,000 caregivers accessed a variety of services and supports including telephone educational support, face-to-face classes, and peer support programs; and more than 2,000 caregivers participated in evidence-based clinical interventions. Also, VA provided services and support to more than 26,000 family caregivers through PCAFC last year, including a stipend paid directly to approve primary family caregivers. These stipend payments totaled approximately \$400 million and VA obligated approximately \$12 million for the Civilian Health and Medical Program of VA for eligible primary family caregivers. PCAFC is a clinical program that focuses on the needs of both the eligible Veteran/Servicemember and the eligible primary and secondary family caregivers. At its core, the program provides enhanced services for eligible participants which may include a monthly stipend; access to health care coverage; mental health services; and counseling, caregiver training, and respite care. It is this program that is the focus of my testimony today.

Strategic Review

In April 2017, VA launched a strategic review of the current state of PCAFC. VA heard concerns about inconsistent implementation of the program and took immediate action to identify challenges and implement change. This three-month review included a temporary suspension of specific types of revocations from PCAFC, listening sessions with a variety of internal and external stakeholders and internal audits.

Results from the review revealed a need for better communication between VA, caregivers and Veterans about eligibility determinations, discharges, and the clinical appeals process. Additional findings included a need for additional internal processes and procedures such as templated notification letters, documents for VA staff to use with caregivers to ensure consistency across medical centers, and additional staff training in both clinical topics such as communication with caregivers and staff safety as well as procedural topics regarding implementation of policy.

Since that review, VA has made significant advancements in communication about eligibility determinations; revocations and the appeals process; and internal

processes and procedures and staff training. Specifically, those advancements include:

- Increased communication and engagement with Veteran Service Organizations, Military Service Organizations, members of Congress, VA Veteran Integrated Service Network Directors, and other stakeholders.
- Redesigned the Caregiver Support Program Web site to include a section about connecting caregivers and Veterans to home and community based services.
- Published Veterans Health Administration (VHA) Directive 1152, Caregiver Support Program, and shared it with 80,000 subscribers to the Caregiver Support Program list-serve to promote transparency.
- Issued a new, standardized letter to be used by all VA medical facilities when communicating program revocations with Veterans and family caregivers.
- Implemented a new “Roles, Responsibilities and Requirements” document that reaffirms that all family caregivers are collaborative partners with VHA.

These efforts have improved the experiences of Veterans and caregivers participating in PCAFC, but VA recognizes there is more work to be done. Last month, with the goal of increasing the opportunity for public input in the decision making process, VA published a notice in the Federal Register seeking public comment on eight specific questions related to the administration of PCAFC. These questions were driven by feedback received during the strategic review. The public comment period closed at midnight, February 5, 2018. VA will be reviewing all comments received and will use the feedback to inform any updates or changes to the program and its implementing regulations.

Current State

In addition to PCAFC, VA offers many different programs to support caregivers of Veterans, including a peer support program where caregivers are connected to one another as well as education and training provided face to face, over the telephone, and on-line. VA also offers a series of diagnosis specific caregiver support programs; one example is our Resources for Enhancing All Caregivers Health program. This is specifically designed to support caregivers of Veterans with a variety of conditions including spinal cord injury, dementia, and post-traumatic stress disorder.

To supplement these support services that are offered directly to the caregiver, VA also offers services that are focused more on the Veteran. These services also assist the caregiver in providing the best care to the Veteran and help the caregiver stay informed, strong, and organized as they care for the Veteran they love. These programs include:

Adult Day Health Care (ADHC) Centers

ADHC Centers are a safe and active environment with supervision designed for Veterans to get out of the home and participate in activities. It is a time for the Veteran to socialize with other Veterans while the family caregiver gets some time for himself/herself. ADHC Centers employ caring professionals who will assess a Veteran's rehabilitation needs and help a Veteran accomplish various tasks to maintain or regain personal independence and dignity. The Veteran will participate in rehabilitation based on his or her specific health assessment during the day. The ADHC Centers emphasize a partnership with the family caregiver, the Veteran, and the Centers' staff members.

Home-Based Primary Care

Home-Based Primary Care (HBPC) is a program designed to deliver routine health care services at home when the Veteran has medical issues that make it challenging to travel. Services include primary care and nursing, managing medication, and dietary and nutritional assessment. HBPC can also include physical rehabilitation, mental health care for the Veteran, social work, and referrals to VA and community services. This program can help ease the worry and stress of having to bring a Veteran to and from a VA medical center for routine medical appointments.

Skilled Home Care

The Skilled Home Care service provides a medical professional at home to help care for a homebound Veteran. Some of the care a Veteran can receive includes basic nursing services and physical, occupational, or speech therapies. This service is generally appropriate for homebound Veterans, which means the Veteran has difficulty traveling to and from appointments and is in need of receiving medical services at home. The Skilled Home Care service is similar to HBPC, but it involves VA purchasing care for a Veteran from a licensed non-VA medical professional.

Homemaker and Home Health Aide Program

The Homemaker and Home Health Aide Program is designed to help a Veteran with personal care needs. The local VA medical center arranges for a home health aide who will assist at home on a regular schedule to allow the family caregiver to take care of their own needs.

Home Telehealth

The Home Telehealth program is designed to give ready access to clinical providers and care coordinators by using technology (e.g., telephone, computers) in the home. The program is beneficial for individuals who live at a distance from a VA Medical Center. Home Telehealth services can also include education and training or online and telephone support groups.

Respite Care

Respite care provides a much-needed break from the family caregiver's daily routine and care responsibilities so that they have some time for themselves. VA generally provides respite care to Veterans in need of such care for up to 30 days per year (or for more than 30 days, if needed). The care can be offered in a variety of settings including at home or through temporary placement of a Veteran at a VA Community Living Center, a VA-contracted Community Residential Care Facility, or an Adult Day Health Care Center. Respite care may also be provided in response to a family caregiver's unexpected hospitalization, a need to go out of town, or a family emergency.

Future State

VA is striving to improve consistency in PCAFC and identify how best to support family caregivers moving forward. Under current authority, determining eligibility for PCAFC is extremely complex and resource intensive; often requiring multiple treatment providers and assessments. VA's goal is to make the eligibility criteria more streamlined and easily understood by Veterans, caregivers and staff members. VA is also currently focusing on how to leverage the 350 Caregiver Support Coordinators in the field to reduce administrative burden and allow for interactions that focus on Veteran care.

VA is working to improve the PCAFC program by completing a three pronged approach that is based on stakeholder feedback and recommendations. The first aspect of the plan included a series of Rapid Process Improvement Workshops, which involved interactions with front line VA staff who interface with family caregivers on a daily basis. During these workshops we identified issues, immediately determined solutions and implemented them. The second component of this plan of action included a face-to-face Process Improvement Summit whereby internal and external stakeholders, including representatives from various Veteran and Military Service Organizations, were invited to share feedback and insights into potential improvement strategies. VHA leadership spoke at the event and two local caregivers shared personal stories of caring for a Veteran loved one. Finally, VA invited the public to provide input on the PCAFC through a Federal Register Notice, as discussed earlier.

Conclusion

When Veterans are unable to care for themselves, VA and its Federal and community partners must work together to ensure that the Veteran is receiving the appropriate care that they need. Sustaining the momentum and preserving the gains made so far requires continued attention and investments of financial resources. When the PCAFC launched in May, 2011 it was the first of its kind and incredibly innovative. It is critical that we continue to move forward and support the program in a well thought out and deliberate fashion.

Mr. Chairman, this concludes my testimony. My colleagues and I are prepared to answer your questions.

Prepared Statement of Adrian Atizado

Mr. Chairman and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this hearing of the House Veterans' Affairs Committee. DAV is a non-profit veterans service organization (VSO) dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. For many severely ill and injured veterans, leading such lives would be difficult if not impossible to achieve without the love, support and daily sacrifice of their family caregivers, and we appreciate the oppor-

tunity to discuss their needs and the Department of Veterans Affairs (VA) caregiver programs.

The Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) required VA to establish a program of comprehensive assistance for family caregivers (Comprehensive Program) of any eligible veteran who has a serious injury, including traumatic brain injury, psychological trauma, or other mental disorder, incurred or aggravated in the line of duty on or after September 11, 2001, and is in need of personal care services. Caregivers participating in the Comprehensive Program can receive certain medical, travel, training, support services, and financial benefits. The law also required VA to establish a program of general caregiver support (General Program) that provides limited services to caregivers of wartime veterans injured prior to September 11, 2001.

In addition, the law required the Secretary to review the program after two years and recommend whether it was feasible and advisable to expand eligibility to severely disabled veterans of earlier eras, such as World War II, the Korean, Vietnam and Gulf Wars. Unfortunately, despite early indications at that time that the program was improving the lives of eligible veterans and caregivers - and mounting evidence since that the program continues to materially support so many veterans and family caregivers - it still remains limited only to post-9/11 veterans.

Mr. Chairman, we are grateful that the Committee is holding today's hearing to examine how to strengthen and modify the existing caregiver program to become more efficient and effective and will offer a number of recommendations to improve it. However, there is no issue more important today than finally correcting the gross unfairness and inequity that discriminates against veterans ill and injured prior to September 11, 2001, as well as their family caregivers.

How can we look these men and women in the face - some of whom are here with us today - and tell them that their service and sacrifices do not merit equitable access to all caregiver benefits? How can we say that their spouses, parents, siblings, children, and close friends who also sacrifice to be their caregivers, do not deserve the same support as those caring for post-9/11 veterans? There is simply no defensible argument for maintain the arbitrary date placed into law, other than the cold financial calculation of saving money, which transfers the burden of caring for so many severely disabled veterans onto the shoulders of family caregivers, many of whom have carried that heavy responsibility for decades.

Mr. Chairman, today, DAV, along with virtually all of our VSO colleagues, call on this Committee to take bold and decisive actions, similar to what the Senate Veterans' Affairs Committee did last fall, and pass legislation that will end this inequity by extending eligibility for the full array of caregiver benefits and services to veterans from all eras.

In addition to those ineligible because they were injured before September 11, 2001, the law as implemented precludes disabled veterans who became severely ill, regardless if that occurred on or after that fateful day. As a result, thousands of post-9/11 veterans with catastrophic illnesses, such as those on the Congressionally-mandated Open Burn Pit Registry (P.L. 112-260) or those exposed in 2003 at Qarmat Ali, Iraq to a chemical known to cause lung cancer and respiratory problems. And if the cutoff date were changed but the program remained limited to veterans who suffered injuries, it would continue to exclude hundreds of thousands of veterans who suffer from chronic diseases associated with exposure to herbicides like Agent Orange, as well as those who are suffering from Gulf War Illness. Fairness for all veterans requires that the law recognize the hazards of military services by including not just those who suffered wartime injuries, but also those who suffer debilitating wartime illnesses.

Effectiveness of VA's Caregiver Support Program

For today's hearing, the Committee has indicated its interest in examining the Comprehensive Program for its effectiveness "in serving the highest-need veterans and their caregivers," the reforms needed to successfully expand eligibility including alternative approaches to expansion and opportunities to adopt best practices from other VA programs and benefits without duplicating services, and the public response to the Agency's request for public comment for any changes needed to increase consistency across the Comprehensive Program, as well as ensure it supports those family caregivers of veterans service members most in need. However, to discuss effectiveness of the program, we must first agree on the purpose and goal of the program.

When the legislation was being debated in Congress, the President's Commission on Care for America's Returning Wounded Warriors found that 21 percent of active duty, 15 percent of reserves, and 24 percent of retired or separated service members who served in Iraq or Afghanistan had friends or family members give up a job to

be with them as their caregiver. In doing so, they had to give up their health insurance and spend their savings at a time when they chose to stay home and selflessly care for the veteran. Congress recognized that even without a job or health insurance, and in very stressful situations, family caregivers worked to fulfill the nation's obligation to care for its wounded warriors at great personal cost. Both the VA Comprehensive and General Program, collectively referred to as the Caregiver Support Program, were created to mitigate this situation.

Last June, DAV released a comprehensive report on veteran caregivers entitled "America's Unsung Heroes" (www.dav.org/wp-content/uploads/Caregivers—Report.pdf) in order to document the challenges and needs of veteran caregivers of all eras. The report contained a qualitative online survey conducted by DAV, which received 1,833 validated responses from veterans and caregivers. The results of the survey offer a deeper look at the hurdles all veteran caregivers face, as well as the supports they receive and need to help care for their loved ones. This report provides a clearer picture of the lives of veterans' caregivers to help guide critical public policy changes in the coming years. We include findings of this report pertinent to the work of this Committee for this hearing.

In speaking to the effectiveness of the Comprehensive Program, the survey DAV offered veterans and caregivers participating in the program the opportunity to provide their perspective. The comments included below exemplify the views we received of the effectiveness and value of the Comprehensive Program:

Caregiver, Spouse, 38, teenage children

We depend on the Caregiver Program more than you can imagine. I miss doing what I love (my career) but I love my husband and my children, so it can be such a struggle some days. I have found that the older the children get the more strenuous it is at home as well, due to the typical "teenage" stuff, but it affects my husband and myself. My husband depends on me in so many ways that there are days when I am just so exhausted, but I continue on because I know he needs me. We need so much support so we can continue to better ourselves, our spouses, and our families as a whole.

Caregiver, Spouse, 39, teenage children

I am currently participating in the Caregiver program through the VA. I have been extremely thankful for this program because of the education provider gave me coping skills and helped me learn to achieve stability in our family that was most certainly not there before.

Veteran, 37, spouse is caregiver

If we are speaking of quality of life, it would be quite the contrast from living in fear and disparity, to living in hope and security. Even the most responsible and capable person can be reduced to a hopeless and destitute in the wake of traumatic events and experiences. Having a familiar face, who is educated in the fields in need, to help bring a positive daily expectation of life is my most precious commodity today. Recovery is possible, but I cannot fathom moving forward without the help provided by my spouse with the assistance of the caregiver program.

Mr. Chairman, these are the real life results of the current program indicating it is working as intended. But there is always room for improvement, which is why DAV has advocated from the program's inception to integrate a research component. Studies performed with the VA Caregiver Support Program could help find answers such as how to effectively support family caregivers of severely ill and injured veterans in a cost-effective manner and could better inform program managers, policy makers and the public.

To this end, VA should be commended for embarking on a research initiative and funding the VA Caregiver Support Program Partnered Evaluation Center in April 2014. This three-year collaborative partnership project was to evaluate the short-term impacts of the Comprehensive Program and the General Program along four aims: 1) assessing the program's impact on the health and well-being of veterans by examining health care encounters expected to be sensitive to caregiver support (potentially avoidable utilization); 2) assessing the impact of the both the Comprehensive and General Program on the health and well-being of family caregivers; 3) understanding how caregivers use and value components of both programs, and; 4) gain a preliminary understanding of the relationship between the cost of Caregiver Support Programs and their value to caregivers.

VA was able to compare a small number of caregivers enrolled and not enrolled in the Comprehensive Program and found that caregivers in the Comprehensive program felt more confident in their caregiving, were more aware of resources to help in their caregiving role and felt more confident in supporting their veteran.

According to VA, the short-term impact of program participation includes an increase in utilization of VA primary, mental health, and specialty care, and long-term services and supports. However, the cause of increased utilization remains unclear as well as whether it will lead to better health outcomes and thus fewer health care costs in the long term.

VA also deemed it necessary in 2017 to extend VA-CARES with a long-term evaluation project. This project will examine the effect of the Comprehensive Program on a veteran's total health care costs at three years, conduct a formative evaluation of the application process to identify areas and approaches for improving consistency across VA, and examine potential changes in the level of stress of caregivers participating in the Comprehensive Program. DAV eagerly awaits the deliverables of this project in 2019.

Such commitment by VA recognizes the Caregiver Support Program embodies the most sweeping national support program for family caregivers. We urge Congress to support VA's efforts to leverage this first and only national program of its kind to better inform policy makers and other health care systems considering supporting family caregivers across the nation.

Understanding caregivers' burdens and needs can help identify those most at risk for health and mental health effects and support them appropriately. Effectively supporting caregivers can delay placing veterans in more costly care settings such as emergency rooms and nursing homes. It is imperative that Congress require and fund a military and veteran caregiver research strategic plan to monitor the health and well-being of family caregivers and the recipients of their love and support; to study current and innovative interventions, their availability, accessibility, and use in supporting family caregivers; and study military and veteran caregivers from a public health perspective.

Needed Reforms in the Comprehensive Program, VA

As has been reported, the need for comprehensive caregiver support services by family caregivers of severely injured veterans was greater than anticipated by Congress and the Administration when the Comprehensive Program experienced significantly higher than expected demand in the years following implementation. With insufficient resources and funding, and higher than expected demand, additional challenges emerged in the timely processing of applications, consistency in applying the eligibility criteria, lack of program staffing in central office and the field, inadequate Information Technology (IT) support, and other issues.

We applaud VA's efforts to address each of these challenges, to include amending regulations of existing programs such as ensuring service members undergoing medical discharge with a qualifying primary or secondary family caregiver is able to apply for the Comprehensive Program¹ and has access to VA's Home Improvements and Structural Alterations (HISA) Benefits Program², improving veterans and family caregiver experiences with State Home adult day health care programs³, and to ensure family caregivers would be able to maintain eligibility on behalf of a veteran in the VA Veteran-Owned Small Business Verification Program.

To improve Comprehensive Program operations, VA amended existing regulations in January 2015 to ensure veterans are notified in writing should a family caregiver request to no longer be the caregiver, extending from 30 to 45 days the time the family caregiver has to complete all required training, and a change in the stipend calculation to ensure that primary family caregivers do not experience unexpected decreases in stipend amounts from year to year.⁴ VA also continues to work on stabilizing the current IT supporting the VA caregiver support program and identifying and implementing a more permanent solution.

Since the interim final regulations⁵ for the Comprehensive Program were made final in January 2015, DAV had been strongly advocating that more consistent guidance be issued to the field governing local program operations including changing how VA historically treated family caregivers, clearer staffing responsibilities, consistent application of eligibility rules and discharge procedures for the Comprehensive Program, and greater transparency of calculating tier assignments. VA finally issued a program directive in June 2017.⁶

¹ 79 Federal Register 59562, October 2, 2014.

² 78 Federal Register 69614, November 20, 2013.

³ 80 Federal Register 34793, June 17, 2015.

⁴ 80 Federal Register 1357, January 9, 2015.

⁵ 76 Federal Register 26148, 26148

⁶ Veterans Health Administration Directive 1152, Caregiver Support Program, June 14, 2017.

This long overdue directive was distributed far and wide in the midst of a temporary suspension initiated in April⁷ of discharging or revoking caregivers out the Comprehensive Program and to conduct an internal review to evaluate the consistency of the program nationwide. We commend VA for the suspension and for conducting its review with input from stakeholders, including caregivers across the country, DAV and other VSOs. Upon its completion, VA reinstated full operation of the program in July⁸ making significant changes to the program to affect policy and execution moving forward. This change includes mandatory VA staff training of the new directive, standardizing program information, a Frequently Asked Questions webpage for the program and a document outlining the roles, responsibilities and requirements for Caregiver Support Coordinators, family caregivers and veterans participating in the Comprehensive Program.

Communications. Based on DAV's long-standing concerns regarding appropriate and meaningful communication with veterans and family caregivers in the Comprehensive Program, we are particularly interested in VA's recent changes to its communications with stakeholders, including a standard discharge letter to provide, in plain language, the reasons for discharging participants from the Comprehensive Program.

We recommend VA improve and standardize its Comprehensive Program decision letter. To ensure veterans and caregivers understand the reasons and bases of the decision, the letter should contain, at the minimum:

- Identification of the issues decided;
- A summary of the evidence considered (to ensure completeness of medical evidence);
- A summary of applicable laws and regulations;
- Identification of findings favorable to the applicant;
- In the case of a denial, identification of elements not satisfied leading to the denial;
- An explanation of how to obtain or access evidence used in making the decision; and
- Identification of the criteria that must be satisfied for a favorable decision.

With these basic elements included in VA's communication articulated with reasonable clarity, veterans and caregivers would be able to make a more informed decision to agree with or appeal the decision. This is particularly important because of certain limitations of the current clinical appeals process.

DAV identified early on the need for an independent mechanism through which: (1) a caregiver can appeal a clinical decision; (2) the decision can be carefully reviewed *de novo*; and (3) an unwarranted decision can be reversed, altered, or sent back to the clinical team with instructions to reassess or consider additional factors.

In this vein, we also applaud this Committee's work to address other issues in the Comprehensive Program in 2016 when it passed H.R. 3989, the Support Our Military Caregivers Act, which was intended to establish an expedited external review process for cases in which the veteran or family caregiver disagreed with VA's decision. Accordingly, DAV supported H.R. 3989.

Respite Care. When DAV survey participants were asked about the importance of respite care, nearly 60 percent indicated it is important or very important; however, only a small minority (seven percent) receives respite care, of which only three percent believe they are receiving enough respite, while the vast majority (93 percent) are not receiving any respite whatsoever.

The DAV survey found that approximately one of every three veterans with family caregivers also had children living at home; 20 percent had children younger than 18 living with them. As expected, this was principally the case for post-9/11 veterans where 67 percent had children at home, including just over a third of the post-9/11 households (34.3 percent) who had children under 12 years old. However, having children in the same household impacts respite care delivery to the caregiver, particularly if agencies are utilized and do not provide child care while caring for the veteran. That is, the caregiver is unable to truly experience respite if their caregiving responsibilities shift from the veteran to the children. Caregivers may not also be using this critical benefit due to unavailability of service in their community and because they are concerned about entrusting the health and well-being for their veteran to a complete stranger.

It is imperative VA identify local barriers to receiving respite care in the most convenient setting for the caregiver and veteran. We fully support VA's current efforts to use every means available, such as innovating an existing program, the Vet-

⁷ VA Press Release, "VA Announces Internal Review of Caregiver Program," April 17, 2017.

⁸ VA Press Release, "VA Caregiver Support Program Resumes Full Operations," July 28, 2017.

eran Directed Home and Community Based Services (VD–HCBS) to address this unmet need.

Stipend. Stipend funds under the Comprehensive Program are determined primarily using Activities of Daily Living⁹ and Instrumental Activities of Daily Living¹⁰ to assess the caregiver’s burden, which may not give adequate weight to caregivers of veterans with behavioral health issues, including those with severe post-traumatic stress disorder or traumatic brain injuries. These veterans may be able to handle daily tasks, but need constant supervision and support to ensure that they are not threats to themselves or others and require more assistance with managing the administrative tasks of daily living.

In addition, the condition of some severely injured veterans improves and declines over time, yet VA national policy is silent on how to mitigate the effect of tier reductions and subsequent stipend reduction. With tier reductions having the greatest potential for adverse effect, VA should revise the immediacy of the effective date for tier reductions/stipend reduction to lessen the financial impact on veterans and caregivers.

We note that if revocation of the designation of primary caregiver is due to improvement in the veteran’s condition, death, or permanent institutionalization, the family caregiver will continue to receive caregiver benefits for 90 days. We recommend VA apply this procedure of continuing the stipend rate for 90 days prior to reduction.

Needed Reforms in Comprehensive Program, Congress

In contrast to VA’s Comprehensive Program, DoD’s Special Compensation for Assistance with Activities of Daily Living (SCAADL) program covers injuries as well as illnesses. The program helps offset the lost income of the primary caregiver who provides nonmedical care, support and assistance for service members with catastrophic injury or illness, but does not provide health insurance, respite care, counseling, training or other benefits that accrue to caregivers under PCAFC. Program participants transitioning from military to VA benefits may be unprepared to deal with the significant differences in these programs.

In addition, VA is authorized to provide counseling, training and mental health services to members of the veteran’s immediate family, the veteran’s legal guardian and to the individual in whose household the veteran certifies as intending to live. In accordance with this law, these services are only provided for: 1) veterans receiving treatment for a service-connected disability if the services are necessary in connection with that treatment; and 2) veterans receiving treatment for a nonservice-connected disability if the services are necessary in connection with the treatment, the services began during the veteran’s hospitalization, and the continued provision of the services on an outpatient basis is essential for discharging the veteran from the hospital. Such restrictions in law and resulting policies may perpetuate the treatment of family caregivers as incidental to the care of veterans rather than as the primary recipient of such caregiver supports.

Needed Reforms in General Program

Severely ill and injured veterans of all war eras want the option to live at home with appropriate supports for them and their family caregiver. VA’s efforts to provide long-term care in home- and community-based settings will reduce the need for nursing home admissions and preventable hospitalizations. However, like many home- and community-based services that could support veterans and family caregivers, Government Accountability Office (GAO) reports have consistently described gaps in access and availability of these critical services.

VA should be commended for finally issuing a unified policy for providing long-term services and supports to include support services for caregivers of severely ill and injured veterans who are not eligible for the Comprehensive Program. VA offers a relatively robust and innovative set of home- and community-based services that support both the veteran and their family caregivers. The unified policy issued in October 2016 is a strong step towards addressing the long-standing issue of access and availability.

To execute this policy, VA must grow total spending for home- and community-based services. While there have been tremendous strides increasing spending on home- and community-based services as a ratio of total long-term services and sup-

⁹Basic and fundamental functions of daily living (ADLs) such as bathing, toileting, dressing, grooming, getting in and out of bed or chair, walking, climbing stairs, and eating.

¹⁰Functions necessary to live independently in the community such as shopping, house-keeping, managing money and medication, preparing meals, communicating with others, and driving or using public transportation.

ports spending-nearly doubling from 16 percent in FY 2010 to 31 percent in FY 2015, with commensurate decreases in the proportion of total long-term services and supports spending on nursing home care, going from 84 percent to 69 percent, VA must continue this effort if it is to provide appropriate supports for severely ill and injured veterans and their family caregivers and see the cost saving associated with such spending¹³.

Home Based Primary Care. Veterans and family caregivers would benefit from VA's Home Based Primary Care (HBPC) program, which has been shown to reduce total VA and Medicare costs by 12 percent. VA must continue to expand access to this program and make it available at all VA facilities.

Veterans-Directed Home & Community Based Services. Because of the eligibility restriction to the Comprehensive Program, the statutory requirement acknowledges VA must collaborate with other entities that support caregivers. DAV has also advocated for VA to take full advantage of Public Law 111-163, which states "the Secretary shall collaborate with the Assistant Secretary for Aging of the Department of Health and Human Services in order to provide caregivers access to aging and disability resource centers under the Administration on Aging of the Department of Health and Human Services."

The VD-HCBS is administered through a partnership with Health and Human Services Administration for Community Living (ACL) and has proven to be a program that can meet the needs of some of VA's most vulnerable populations, including many who would likely be placed in nursing homes without this option.

Through VD-HCBS, the veteran has the opportunity to manage a monthly budget based on functional and clinical need, hire family members or friends to provide personal care services in the home, and purchase goods and services that will allow him or her to remain in the home. We will hold Secretary Shulkin accountable for his commitment, made during his nomination hearing in February 2017, to expand access to the VD-HCBS program, to make it available at every VA medical center within the next three years.

A recent analysis of VD-HCBS participants' health care use in FY 2015 before and after enrolling in this program found 29 percent reduction in inpatient days of care, 11 percent reduction in emergency room visits and 14 percent reduction in other than home- and community based services. While not conclusive, it suggests clear potential of reducing health care costs.

However, this program, like many home- and community-based programs supporting veterans in their home, relies on provider agreements. VA currently has a temporary Choice Provider Agreement authority, which it is using to the greatest extent possible with the number of veterans served increasing 37 percent to 1,751 in fiscal year (FY) 2016. In FY 2016, 81 VD-HCBS providers have entered into VA Choice Provider Agreements with VAMCs and 30 new VD-HCBS providers have been approved to deliver VD-HCBS services to veterans, which has expanded access for veterans in over 130 rural and highly rural counties.

Provider Agreement Authority. To help VA provide these and many other cost effective home- and community-based services programs, Congress must enact legislation granting VA permanent authority to enter into provider agreements with community providers.

In addition, VA and Congressional oversight is necessary to continue implementing effective strategies based on measuring veteran and family caregiver needs for increased access to home- and community-based services, creating an appropriate balance with nursing home care, and ensuring veterans are able to stay in their own homes, with appropriate supports for them and their family caregiver for as long as possible.

DAV recommends VA monitor and publicly report progress of individual facilities and regional networks toward meeting performance measures that focus on rebalancing long-term care, which includes increasing the availability and access to home- and community-based services. VA should focus first on expanding HBPC and VD-HCBS, while leveraging opportunities under the Veterans Choice Program.

¹¹ "Toward a Model Long-Term Services and Supports System: State Policy Elements." H. Stephen Kaye, PhD, John Williamson, PhD, *The Gerontologist*, Volume 54, Issue 5, 1 October 2014, Pages 754-761. <https://doi.org/10.1093/geront/gnu013>; H. Stephen Kaye, "Gradual Rebalancing of Medicaid Long-Term Services and Supports Saves Money and Serves More People, Statistical Model Shows," *Health Affairs*, June 2012, <http://content.healthaffairs.org/content/31/6/1195>.

¹² Kali Thomas and Vincent Mor, "Providing More Home-Delivered Meals Is One Way to Keep Older Adults with Low Care Needs out of Nursing Homes," *Health Affairs*, October 2013, <http://content.healthaffairs.org/content/32/10/1796.full>

¹³ Carol V. Irvin et al., *Money Follows the Person 2014 Annual Evaluation Report*, Mathematica Policy Research, Washington, D.C., <https://www.mathematica-mpr.com/our-publicationsand-findings/publications/money-follows-the-person-2014-annual-evaluation-report>.

Need to Expand Eligibility to Comprehensive Caregiver Support Program

Mr. Chairman, as discussed above, the most critical reform to the program is expanding eligibility to veterans from all eras. Research has shown that family caregivers delay, avoid, and, in certain situations, can actually help transition disabled veterans out of, expensive nursing homes. Allowing severely disabled veterans to remain in their homes longer is economically smart and will more efficiently use VA and taxpayer funds.

As this Committee is aware, their Senate counterparts approved S. 2193, the Caring for Our Veterans Act of 2017, which includes provisions to improve and phase-in expanded eligibility for the Comprehensive Program for family caregivers. According to CBO, stage one of the expansion under this bill to eligible veterans who were injured during service on or before May 7, 1975, would carry an average cost per participant of \$30,000 in 2020. Stage two of the expansion to remaining eligible veterans—those injured during service after May 7, 1975, and before September 11, 2001, with an average cost per participant of \$29,000 in 2022.

The annual cost estimated by the Congressional Budget Office for each veteran severely ill and injured before September 11, 2001, to participate in the Comprehensive Program is about \$30,000 compared to the federal cost of nursing home care of over \$60,000 in State Veterans Homes (matched by equal or greater state funding), \$100,000 in community nursing homes, and about \$400,000 in VA nursing homes.

To those who are concerned about the cost of doing the right thing for all severely disabled veterans and their family caregivers, we cannot now turn our back on the obligation to care for those who fought to defend our way of life. The cost of veterans benefits and services is a true cost of war and must be treated as such. It is an obligation this nation must shoulder and share by supporting disabled veterans and their family caregivers.

After a lifetime of caregiving for Gulf, Vietnam, Korean and World War II veterans, many family caregivers are aging and their ability to continue in their role is declining. With bipartisan support in the Senate, and growing support in the House, now is the time to finally provide fairness to caregivers of veterans from all eras.

Mr. Chairman, we call on this Committee to expand eligibility for VA's comprehensive caregiver support program to veterans severely ill and injured from all eras and their family caregivers.

This concludes my testimony and I would happy to respond to any questions that you may have.

Prepared Statement of Sarah S. Dean

Chairman Roe, Ranking Member Walz, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to present our views pertaining to the Department of Veterans' Affairs Comprehensive Family Caregiver Program. PVA appreciates the Committee's interest in the improvement and potential expansion of this unique and critical program. No other group better understands the value of caregiver support than PVA members.

While the Department of Veterans Affairs (VA) provides essential health care services to severely disabled veterans, it is their caregivers that provide the day to day services needed to sustain their wellbeing. Caregivers are the most important component of rehabilitation and maintenance for veterans with catastrophic injuries. Their welfare directly impacts the quality of care veterans receive. The VA Program of Comprehensive Assistance for Family Caregivers (PCAFC) is one-of-a-kind in the United States. It is the only integrated program that is required to provide health care, a stipend, travel expenses, mental health care, respite care and injury specific training. Without these support services the quality of care provided by the caregiver is likely to be compromised and the veteran is more likely to experience frequent medical complications and require long term institutional care. Veterans who access PCAFC are medically stable enough to live outside an institution, but lack the functionality to care for themselves on an ongoing basis.

When the program started in 2011 it was estimated 4,000 veterans would apply. Over 45,000 applied, clearly demonstrating the critical need for the program. There are currently 22,000 participants. Given the unique nature of the program and the larger than anticipated demand, VA has encountered several complications including staff shortages, unclear procedures, and an antiquated IT system. Seven years later, after a comprehensive review in 2017 and the issuance of VHA Directive 1152,

we believe VA has done a creditable job enacting the intent of Congress. Those PVA members participating in the program have reported positively on their experience. Their caregivers are better equipped to serve the veteran and they experience fewer financial and emotional stresses because of the availability of respite, mental health care and a monthly stipend.

Improvements to the current program

Public conversations around the efficiencies of the program often do not include its function and design. It was clinically modeled for older, catastrophically injured veterans. It is equal parts temporary rehabilitation program and permanent long term care program. The experience of this program is inherently variable. Some post-9/11 veterans are in the beginning of their rehabilitative journey and are establishing a new normal. They may improve to the point of no longer needing assistance with activities of daily living. However, over time their health may slip, their injuries may exacerbate, and they may return to the program and fluctuate between tiers. Other veterans with more static conditions will remain a steady cohort of program participants. The majority of program discharges are because the veteran is no longer clinically eligible.

PVA notes there has been some inconsistency of admittance and revocation. We believe this is a result of fractured practices at the local level and the use of a sole clinician assessing eligibility. We encourage the use of multidisciplinary teams in eligibility assessments at every facility. Individual providers making the eligibility determination allow for a great deal of subjectivity. The use of multidisciplinary teams in assessments and tier assignments offers more objectivity and stricter adherence to the seven eligibility criteria.

For all the genuine concern regarding wrongful revocation, it is our understanding very few clinical appeals were successful. It appears that the manner in which the local facilities informed the veterans and caregivers of revocation was poorly done, with little warning, if at all. VA must give consistent, and transparent information to veterans regarding eligibility and tier reduction. In the news stories leading up to the suspension of revocations, one theme was explicitly clear; VA must do a better job conveying to the veteran and caregiver that this program is not an earned benefit. It is a medical service based on clinical need. We were pleased to see the updated Roles, Responsibilities, and Requirements form published in July 2017 helps to do just that.

As with any newly established program, it will have flaws. These were exacerbated by the lack of clear policy guidelines until June of 2017 when VHA Directive 1152 was issued, finally providing consistent policy to the field regarding eligibility and discharge requirements. For six years it was unclear who was operationally responsible for what program elements. Now clear lines have been drawn for the VA medical centers, VA primary care services and the Caregiver Support Coordinators.

PVA is pleased with the progress and continual improvement of this program. While there is debate as to how future eligibility and process should look, the program is executing the intent of the law with the authorities and resources it has. We believe the program has proven its value to the thousands of veterans and caregivers already served. Yet the majority of veterans who rely on caregivers to complete activities of daily living are not eligible.

End the Inequity: Caregiver Expansion

We know the ability of a veteran to remain home, with one's spouse and children, among friends and in a community, is critical to overall wellbeing. At the same time, we know caregivers have sacrificed their own health, their career opportunities, and their financial standing to care for veterans. Because these caregivers have stepped up, some for half a century, they have saved the taxpayer billions of dollars. It is unconscionable that the needs of one group of veterans and the work of their caregivers be recognized and supported, while another group continues to labor in the shadows, unacknowledged with no reprieve, after decades of service.

PVA understands the costs associated with expansion are significant. And in a time of warranted scrutiny of spending by VA, lawmakers are hesitant to support such an expense, no matter how just the cause. But perhaps what should be considered in a challenging budget environment is how much would be saved by delaying a veteran's entry into an institutional setting. If a caregiver can no longer afford it, or becomes ill, their veteran likely has no other option but to be placed in an institution. VA is obligated to pay the full cost of nursing home services for veterans for a service-connected disability. The cruel irony is VA is not allowed to delay such an admission by supporting their caregiver. Consider the long term cost savings for the taxpayer by delaying disabled veterans admittance to the following—

- Average Annual Cost per Veteran for VA Community Living Center: \$379,853.71
- Average Annual Cost per Veteran for Community Nursing Home: \$101,132.20
- Average Annual Cost per Veteran for State Veteran Nursing Home: \$56,042.52
- Average Annual Cost per Veteran for PCAFC: \$19,000

Congress continues to find excuses to deny access. It has never been more urgent for those excuses to stop. As the largest cohort of veterans ages, our Vietnam-era veterans, the demand for long-term care resources will grow significantly. Catastrophically injured veterans will require the most intensive and expensive institutional care. By providing their caregivers the means to keep them at home with family, they will live healthier lives, and delay higher costs.

The issue of caregiving will at some point touch all of us. What is unique for service-connected disabled veterans as a group, is that their experience with caregivers will last decades. The Bureau of Labor Statistics projects the home health aide industry to double to meet the need of aging baby boomers. Local agencies will not have sufficient staff to meet the needs of veterans who require a high level of care, but are not yet ready for institutional setting. For veterans like PVA's members, their family caregivers are already there, and they want to continue the job, if we can make it a viable option.

An estimated 40,000 veterans, and their caregivers, are in need of the clinical services of this program. If the cost of expansion is \$3.4 billion over five years (CBO, S. 2921) or \$3.1 billion over five years (CBO, S.2193), then that is what this country owes. Because we are the beneficiaries of their sacrifice. I suspect the majority of Americans would agree. Catastrophically injured, WWII, Korean, and Vietnam veterans, for more than half a century, have been living a life they couldn't possibly have planned for. Their caregivers, most often spouses and now grown children, gave up or never pursued careers and dreams of their own in order to care for their loved ones disabled in support of this nation. They have been made vulnerable, financially and physically, after decades of work. They have saved the taxpayer billions of dollars that otherwise would have been the burden of VA.

Congress will eventually pay for this care one way or another. If it isn't through the caregiver program it will be through overwhelmed home health programs, or high cost VA nursing homes that do not have the necessary capacity. The caregiver program is by far the most just, cost effective, and efficient course of action for the veteran and taxpayer.

Survey data suggests caregivers of pre-9/11 veterans perform more activities of daily living and instrumental daily living skills than post-9/11 caregivers. These caregivers are more likely to endure physical strain; maintaining a veteran with severe physical disabilities means they are bending and lifting for a duration that is likely to jeopardize their own health.

As hard as it has been, and as hard as it will continue to be if Congress does not act, the caregivers of veterans with spinal cord injuries are proud of what they've accomplished. For decades they have maintained the health and wellbeing of a population whose condition once meant a slow death. They have gained skills they never planned to need, they are the reason their children were raised with two parents at home, the reason neighborhoods and churches and family reunions stayed whole. They deserve a break.

Recent years have seen a great deal of discussion about veteran's choice and care in the community; that veterans should have more options for how and where they receive care. This committee has advanced those efforts, many were proposals far more costly than caregiver expansion. What is a more fundamental element of veteran's choice than the choice to receive quality care at home from the people they trust most?

In the seven years since this program began, the barriers to its expansion have always been cost. There will likely never be a projection that isn't significant. But it is what this nation owes and should pay without delay. Admittance to this program is based on clinical need. Denying one group of people a medical service because of era served, and then continuing to deny it because of potential cost is indefensible.

The program is an imperfect solution in place of the perfect solution of healing their wounds. Anecdotal examples of flaws in the program concern us less than the overwhelming degree of satisfaction and gratitude among our members who are currently in the program. As long as human beings are making decisions of eligibility and process there will be flaws. Let us not allow perfection to be the enemy of the good. The majority of PVA members and their caregivers will prefer something over nothing rather than wait for Congress to deem something perfect enough. Let them have better. Their health and the health of their families depends on it. You have

a moral obligation to do this. Cost and program imperfections are unacceptable excuses.

PVA would once again like to thank the Committee for the opportunity to submit our views on the programs affecting veterans and their caregivers. We look forward to working with you to ensure our catastrophically disabled veterans and their families receive the medical services and support they need.

Prepared Statement of Steve Schwab

Chairman Roe, Ranking Member Walz, and Members of the Committee, the Elizabeth Dole Foundation is pleased to present its views on the Department of Veterans Affairs' (VA) Program of Comprehensive Assistance for Family Caregivers (PCAFC, "the Program").

The Elizabeth Dole Foundation was founded in 2012, just two years after the VA established the Program, and we have followed its trajectory ever since. As the only national organization exclusively focused on the military and veteran caregiver population - the 5.5 million spouses, family members, and other loved ones caring for wounded, ill, or injured veterans at home - the Foundation is uniquely positioned to speak to their point of view. We thank you for the opportunity to provide this testimony.

Our understanding of the military caregiver population is data-driven; in 2012, we commissioned the RAND Corporation to conduct the first-ever needs assessment of military caregivers to better understand this hidden population and the challenges they face caring for our nation's wounded warriors. The findings of this comprehensive two-year study still drive the work of the Foundation today and the work of many of our partners. But while the 2014 landscape survey gave us critical insights into the military and veteran caregiver population, there is still so much that we do not know about supporting these hidden heroes in the long-term.

For the last six years, the Foundation and our Dole Caregiver Fellows, a remarkable group of military caregivers from diverse backgrounds and representing all 50 states, Puerto Rico, and Washington, D.C., have been on the forefront of communicating the caregiver population's experiences and concerns with the Program directly to the VA Central Office. We have worked with both the VA and military caregivers to understand the current systemic challenges, address them, and facilitate an open dialogue between the caregiver population and the VA. We also continually take the pulse on the ever-changing questions and concerns through our Fellows Program and online networks like the Hidden Heroes Caregiver Community; a safe, secure social network where caregivers can find peer support, seek advice, and share stories.

With the passage of the Caregivers and Veterans Omnibus Health Services Act of 2010 and the establishment of the PCAFC, veteran caregivers were finally recognized on a systemic level for the invaluable work they do to assist in the care, rehabilitation, and recovery of our nation's veterans. The 2014 RAND study, commissioned by the Foundation, found that military and veteran caregivers provide an annual \$14 billion in voluntary, uncompensated care for our nation's veterans and service members, and often shoulder physical, emotional, and financial strain to care for their loved one. Through the Program, qualifying veteran caregivers receive the support they need to take on the economic and personal costs that are intrinsic to caregiving, and in turn, veterans can receive the care they need at home from a loved one, rather than be institutionalized.

The implementation of the program has not been without its challenges. Congress initially intended the PCAFC to serve a small number of caregivers caring for only the most catastrophically wounded veterans. Upon executing the program, the VA realized that many more caregivers needed this program than initially anticipated, and the program expanded to serve the more than 26,000 caregivers that it does today - nearly three times the number of caregivers for which the VA initially planned. The VA uncovered a previously unaddressed need and soon found themselves deluged with veteran caregivers who had, until this point, been caring for their veterans without much support. Because of this, the implementation and administration of the PCAFC have suffered from growing pains as it attempts to accommodate the growing number of veteran caregivers that qualify for the stipend program.

Today, the Foundation has been asked to provide its insight into the challenges that have prevented the Program from giving the maximum level of support that these hidden heroes need. And while we are pleased to have the opportunity to provide our recommendations to help correct these deficiencies, the most significant

deficit is that only a limited number of veterans are eligible under the current law. It is unfair that pre-9/11 caregivers, who make up 80 percent of our nation's 5.5 million veteran and military caregivers, are barred from accessing the PCAFC because of their veterans' era of service or diagnosis with a service-connected illness.

We acknowledge that the Program is experiencing significant demand, and the Foundation remains committed to being a part of the solution. But we urge Congress not to overlook the millions of veteran caregivers barred from access to the program merely due to their era of service. Congress should act simultaneously to pass an expansion of the Program to include service-connected illnesses and all periods of service, while also addressing the issues of standardization and clarity. These efforts should not be a zero-sum game.

On November 29, 2017, the Senate Committee on Veterans' Affairs overwhelming passed the Caring for Our Veterans Act of 2017, which notably expands the Program to pre-9/11 caregivers. This change could - quite literally - improve the quality of life of millions of Americans. This legislation addresses the need to bolster the program and expands it in a phased, thoughtful manner - while the VA simultaneously implements an improved information technology system. We encourage the House Veterans' Affairs Committee to take up and pass this legislation.

RECOMMENDATIONS

1. THE VA SHOULD CONTINUE TO WORK TO IMPROVE CONSISTENCY AND ACCOUNTABILITY IN THE ADMINISTRATION AND EXECUTION OF THE PCAFC.

For several reasons, the implementation of the PCAFC has suffered from inconsistencies since its inception. Individual Veterans Integrated Service Networks (VISN), of which there are 18 across the country, have the autonomy to run their programs as they see fit. The result is that, although the PCAFC is a national program, there are many inconsistencies across VISNs in the implementation and operationalization of the program. The discrepancies have caused confusion and tension between caregivers, who hear from other caregivers in other parts of the country of the irregularities in the way the program is administered. And while the law is explicit about including traumatic brain injuries, psychological trauma, and other mental disorders in considering a veteran's eligibility, the lack of standardization often causes disparities in the assessment of this need. We've heard reports of caregivers removed from the program, despite a lack of change in their veteran's functioning levels. Without a standardized assessment tool or more explicit guidelines on the determination of eligibility, the VA is hard-pressed to explain to veterans and caregivers as to why they do not qualify for this program.

Much of this discrepancy stems from the reality that the caregivers witness firsthand the issues their veterans deal with on a day-to-day basis, such as not following a medication regime, driving erratically, forgetfulness that endangers their safety or the safety of others. But the review process - which can vary from VISN to VISN - does not always take the caregivers' knowledge into account. This kind of assessment is a difficult one. Understanding the full breadth of safety and supervision takes a combination of clinical assessments of the veteran, a records review that incorporates the notes and feedback of the primary care team and any outside providers, and a real conversation with the caregiver.

Last July, the VA took several steps to address the persistent inconsistency issues. We applaud the VA for devoting the time and resources required for such an extensive program review to ensure that the many voices of military caregivers are heard and that we as a nation can better meet the urgent needs of our veterans. We stand ready to work with the VA to provide guidance, direction, and insight into these demands. The steps taken by the VA in this review included; issuing a national policy directive regarding program operations, staff responsibilities, as well as veteran and caregiver eligibility requirements; developing a standardized letter used by all VA medical centers when communicating program discharges; and taking steps to demonstrate to caregivers that they should be collaborative partners with the VHA in ensuring overall care and well-being of veterans. The changes introduced increased standardization, but the Program still lacks centralization.

The lack of accountability has also led to variations in the way that the program is administered. Even with the development of a standard policy, the Caregiver Support Program Office cannot enforce its directive. They may only advise the local centers that they are in violation of the law or not in compliance with the VHA Directive. The new directive even notes that the Program is structured for each medical center to develop processes to carry out the Program. We understand that the ability of each medical center to self-determine its own needs is central to the operation of the VA system. When operational authority supersedes policy implementation,

however, it creates an inconsistent - and at times prejudicial - program environment for caregivers.

The Foundation as far back as three years ago began to hear concerning stories of caregivers unexpectedly dropped from the PCAFC. We started to collect these stories, mapped out the scope of the issue and helped to connect caregivers to essential resources to help them appeal these decisions. We referred the most grievous cases to the Department of Veterans' Affairs for further review and reevaluation, and in some instances, the program revocation overturned. We owe our work to the many caregivers who have stepped up, shared their experiences, and provided all of us the necessary insight into the challenges the Program was experiencing. We must continue to support those caregiver voices through the standardization of this critical VA Program.

2. Congress and the VA should work to more clearly define and communicate PCAFC program eligibility requirements.

PCAFC is the stipend program offered through the VA Caregiver Program. This is currently limited to eligible veterans injured in the line of duty on or after September 11, 2001. Eligibility for the program is a clinical determination that the program will significantly enhance the veteran's ability to live safely in a home setting, support the veterans' potential progress in rehabilitation, and create an environment that promotes the health and well-being of the veteran.

Under current law, the clinical determination is based off the veterans' need for personal care services from another individual for at least six continuous months based on A) an inability to perform one or more activities of daily living (ADLs), B) a need for supervision or protection based on a neurological or other impairment/injury, and/or C) is service connected for a severe injury that was incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001, has been rated 100 percent disabled for that serious injury, and has been awarded special monthly compensation that includes an aid and attendance allowance.

The current statutory language allows for broad interpretation of the eligibility requirements and subjective assessment - particularly for activities of daily living and the need for supervision or protection. While this provides for accommodation of a wide range of physical and cognitive issues, it also allows for variability of implementation that is both time-consuming to the care team making the decision, and often inconsistent concerning the veteran and caregiver.

We've heard cases where a caregiver moved from one part of the country where they had been determined eligible for the program, to another part of the country where they were found ineligible for providing the same support. The eligibility requirements should be clarified and standardized as much as possible, while still allowing clinicians their discretion to make a decision that will lead to the best outcome possible for the veteran. A focused look at how the eligibility requirements are defined and interpreted is required. The directive the VHA released in July provides the definitions for the individual activities of daily living and the need for safety and supervision. However, it does not provide guidance on the assessment and evaluation of those two particular eligibility criteria.

Standardized evaluation metrics and tools should be determined that allow individual medical centers and VISN leadership to establish processes that serve their specific local needs and prevent unfair variance in the national implementation of the program.

3. The VA, along with members of the veterans' community, should more effectively communicate to veterans and their caregivers the programs and services available to them.

It is essential that interested veterans and their caregivers have a good understanding that the Program is one vehicle for intervention and not the only option for support available under the VA's Caregiver Support Program. A confusion of the stipend program as a "benefit" rather than one part of a program meant to help facilitate the clinical need for a caregiver often contributes to frustration on the part of the caregiver. This misunderstanding about the Program results in significant demand and thus an increased strain on the Program.

Miscommunication of the intent of the Program leads to another issue as well. Eligibility for the PCAFC, or the lack thereof, can create resentment among caregivers who feel as though their caregiving role is being "ranked." There is a sense that those who qualify for the program are somehow "better" caregivers than those who are not - when nothing could be further from the truth. The fact is that caregiving occurs on a continuum, and while this program serves a specific portion of that continuum, this does not invalidate the selflessness or dedication of those caregivers

who do not participate. This incorrect assessment of the PCAFC is often due in part to a misunderstanding that the Program is a benefit program, rather than a program based on a clinical determination of the needs of the veteran. By emphasizing the true clinical nature of the program, we can help alleviate these misconceptions.

The Caregiver Support Program and the Caregiver Support Coordinators are essential in communicating available support to veterans and their caregivers. However, we must adopt a multi-tiered approach to disseminating information about all programs within the VA's Caregiver Support Program. The communications strategy should also explicitly set expectations and help caregivers understand the growing network of support - of which the PCAFC is just one part.

As a community - the Foundation, the Veteran Service Organizations, the VA, and others - must also provide additional guidance and awareness of other programs available for veteran and caregiver support - which are not eligibility restricted. Within the VA, these programs include in-home care, respite care, services to address mobility, physical rehabilitation, education and training, financial support, referral services, and other caregiver support services. (Table 1) We must also focus our attention on programs and resources outside the VA that can support military and veteran caregivers. Improving communication cannot be a VA problem; we must all work towards a culture of holistic support that meets caregivers where they are and addresses their needs in both the short- and long-term.

The Elizabeth Dole Foundation has taken steps at addressing this communications gap through our Campaign for Inclusive Care, in partnership with the Department of Veterans' Affairs. The campaign focuses on ensuring that veteran and military caregivers fully integrated as part of their veteran or service member's medical team. The Foundation is also working to develop a military caregiver journey map, which maps the key milestones that each caregiver faced along their journey. This map aims to shed light on some of the critical crisis and decision points that the military caregivers go through, and will assist in designing interventions to help caregivers in the future. Additionally, through our Hidden Heroes Cities Program, Dole Caregiver Fellows Program, and partnerships with other organizations, we are bringing awareness and support to caregivers on the community level.

Military and veteran caregivers are essential to the recovery and rehabilitation of our nation's wounded warriors. But they cannot do it alone. It is up to us to ensure that these selfless hidden heroes have the tools they need to facilitate that support. The Elizabeth Dole Foundation is committed to creating and strengthening a holistic system of support that will position these selfless men and women for the best possible outcome for their veteran and their family. We look forward to working with the VA and our partners to make this vision a reality.

TABLE 1

DEPARTMENT OF VETERANS' AFFAIRS CAREGIVER SUPPORT PROGRAM (CSP) LIST OF SERVICES TO SUPPORT VETERANS AND FAMILIES		
In-Home Care	Education and Training	Caregiver Support
Skilled Nursing	Financial Support	Caregiver Support Coordinators
Home Health Aide	Aid and Attendance	Peer Support
Home Based Primary Care	Family Caregiver Stipend – Post	Mentoring Program
Veteran Directed Home &	9/11	Building Better Caregivers™
Community Based Care	Information and Referral	Spouse Telephone Support
Respite Care	Caregiver Website –	REACH VA
Services to Address Mobility	www.caregiver.va.gov	Support Groups
Equipment	Caregiver Support Line –	
Home Modification	855-260-3274	
Automobile Modification		

Statements For The Record

THE AMERICAN LEGION

Chairman Roe, Ranking Member Walz, and distinguished members of the House Committee on Veterans' Affairs, on behalf of Denise H. Rohan, National Commander of The American Legion, the country's largest patriotic wartime service or-

ganization for veterans, comprising 2 million members and serving every man and woman who has worn the uniform for this country; we thank you for the opportunity to testify on the topic of the “Department of Veterans Affairs’ Program of Comprehensive Assistance for Family Caregivers.”

Veteran Caregivers have long proven critical to the livelihoods of disabled and severely wounded veterans. On a daily basis, veteran caregivers help veterans bathe and dress, administer medication, or removing barriers to free movement in the community, veteran caregivers are the difference between a veteran being limited by a disability and living productively. The passage of the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111–163), which provided caregiver support to those who only served post 9/11 and has exceeded original enrolment expectations has certainly shown us that there is a greater than anticipated need for this critical program.

The American Legion has long advocated that the Caregiver Program at the Department of Veterans Affairs (VA) be expanded to include all generations of veterans. All veterans, regardless of what era they served in, deserve equality in terms of benefits, including fair access to the Caregivers Program. If a member of the armed forces was harmed in the line of duty for their country, their benefits should not differ because they served in Vietnam, the Gulf War, or Korea and not in Iraq or Afghanistan. The American Legion calls on this committee to pass meaningful legislation that removes the arbitrary rule preventing equality among those veterans who have literally bled for this nation.

Background and Eligibility

On May 5, 2010, President Obama signed into law the Caregivers and Veterans Omnibus Health Services Act of 2010. Among other things, title I of the law established 38 U.S.C. 1720G, which requires VA to “establish a program of comprehensive assistance for family caregivers of eligible veterans,” as well as a program of “general caregiver support services” for caregivers of “veterans who are enrolled in the health care system established under [38 U.S.C. 1705(a)]. Among other things, the law authorized the Secretary to provide family caregiver services of an eligible veteran if the Secretary determines it is in the best interest of the eligible veteran to do so. The law defined an eligible veteran as any individual who-

“(A) is a veteran or member of the Armed Forces undergoing medical discharge from the Armed Forces;

“(B) has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval,

or air service on or after September 11, 2001; and

“(C) is in need of personal care services because of-

“(i) an inability to perform one or more activities of daily living;

“(ii) a need for supervision or protection based on symptoms

or residuals of neurological or other impairment or injury; or

“(iii) such other matters as the Secretary considers appropriate.”

The purpose of the 2010 caregiver benefits program was to provide certain medical, travel, training, and financial benefits to caregivers of certain veterans and servicemembers who were seriously injured in the line of duty.

VA initially estimated that roughly 3,596 veterans and servicemembers would qualify to receive benefits under the program during the first year, at an estimated cost of \$69,044,469.40 for FY2011 and \$777,060,923.18 over a 5 year period. VA distinguished between three types of caregivers based on the requirements of the law: Primary Family Caregivers, Secondary Family Caregivers, and General Caregivers.

A Primary Family Caregiver is an individual designated as a “primary provider of personal care services” for the eligible veteran under 38 U.S.C. 1720G(a)(7)(A), who the veteran specifies on the joint application and is approved by VA as the primary provider of personal care services for the veteran.

A Secondary Family Caregiver is an individual approved as a “provider of personal care services” for the eligible veteran under 38 U.S.C. 1720G(a)(6)(B), and generally serves as a back-up to the Primary Family Caregiver.

General Caregivers are “caregivers of covered veterans” under the program in 38 U.S.C. 1720G(b), and provide personal care services to covered veterans, but do not meet the criteria for designation or approval as a Primary or Secondary Family Caregiver.

On May 3, 2011, VA rolled out the program by issuing a National Press release entitled, VA to Take Applications for New Family Caregiver Program.. VA an-

nounced that it was opening the application process on May 9, 2011 for eligible post-9/11 Veterans and Servicemembers to designate their Family Caregivers.¹

In September 2014, the Government Accounting Agency issued its first report on VA's Caregivers program, Government Accountability Office (GAO) report-14-675, entitled, Actions Needed to Address Higher-Than-Expected Demand for the Family Caregiver Program.² According to GAO, Veteran Health Administration (VHA) officials originally estimated that about 4,000 caregivers would be approved for the program by September 30, 2014. However, by May 2014 about 15,600 caregivers had been approved—more than triple the original estimate.

In 2015, veterans and their caregivers began sharing reports where they were being cut from the Program of Comprehensive Assistance for Family Caregivers (PCAFC). On April 17, 2017, VA announced it would suspend revocations of benefits initiated by VA medical centers for the PCAFC, pending a full review of the program. The announcement came two weeks after media coverage revealed that some VA medical centers have been dropping Caregivers from the program at alarming rates, likely due to budget constraints.

The suspension of revocations would last three weeks, according to VA. Secretary of Veterans Affairs David Shulkin ordered the internal review. Secretary Shulkin stated the review was intended to “evaluate consistency of revocations in the program and standardize communication with Veterans and caregivers nationwide.”³

On July 28, 2017, the VA announced it was resuming full operations of the PCAFC. The resumption follows an April 2017 decision to temporarily suspend certain clinical revocations from the program to conduct a strategic review aimed at strengthening the program.⁴

VA's three-month review indicated a need for better communication about clinical revocations, improved internal processes and procedures, as well as additional staff training. Following the review, VA issued a new directive outlining staff responsibilities, veteran and caregiver eligibility requirements, available benefits and procedures for revocations from the program.

VA also conducted mandatory staff training on the new directive and implemented standardized communications and outreach materials to educate veterans and their caregivers about the program.

The new directive provided background on the Caregiver Support Program authorized by title I of Public Law 111-163, Caregivers and Veterans Omnibus Health Services Act of 2010, and Title 38 United States Code (U.S.C.) 1720G. The directive specified VA staff responsibilities for the implementation of the Program of Comprehensive Assistance for Family Caregivers and the Program of General Caregiver Support Services, collectively referred to as the Caregiver Support Program. The directive also described aspects of program operations, including the different kinds of caregivers, the eligibility of veterans for the program, the eligibility and requirements for caregivers, and the benefits available to caregivers.

Moving forward, in January of 2018 the VA announced it was seeking public comments on how it could further strengthen and improve the caregiver support through the PCAFC. The American Legion is looking forward to reviewing those comments in concert with VA and assisting in making the necessary changes to alter the program for the better.

Recommendations

The American Legion has long advocated and stood on the right side of providing those who have been disabled through military service the services and assistance needed to live as much a normal life as possible. Through our advocacy, and the support of this committee, legislation has been signed into law that created the current program, that does indeed provide quality support to those who are deserving. Without question there has been concern, but when necessary, the VA made the corrections to furnish the care and support needed by our nation's heroes.

1. National Standard: One concern that has not only been brought to the attention of The American Legion, but also the VA, and others is that each Medical Center Director has the authority to approve or deny veterans into the PCAFC. This means that there are 167 different standards of eligibility held by the 167 different VAMC (Veterans Affairs Medical Center) Directors. When there is not a national

¹ May 3, 2011 VA Press Release <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2088>

² GAO Report-14-675, <https://www.gao.gov/assets/670/665928.pdf>

³ VA Announces Internal Review of Caregiver Program <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2889>

⁴ VA Caregiver Support Program Resumes Full Operations - <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2933>

standard, or consistency, it leads to a system that is unfair, granting access or denial by dissimilar levels of eligibility, and that is not reasonable. Though VAMC Directors often express that each case brought to them for approval or denial should truly be decided on a case-by-case situation, The American Legion urges this committee to instruct VA to have a national standard, that is consistent, fair, and reasonable. Having a consistent base of eligibility for all VAMC's would approve those needing access to this critical program, all while preventing fraud and abuse the best VA can.

2. S. 591: In May of 2017, The American Legion testified before the U.S. Senate Committee on Veterans' Affairs in support of S. 591, the Military and Veteran Caregiver Services Improvement Act of 2017. This legislation, just as other legislation supported by The Legion, is a great step forward in expanding and improving the PCAFC.

3. S. 2193: In December of 2017, Chairman Johnny Isakson introduced the Caring for our Veterans Act, S. 2193. This bill, which was supported by The American Legion and other VSO's, would expand and improve the caregivers program, all while improving care from VA in general. The American Legion was proud to stand in support of this bill while attending and speaking at a press conference in support of the legislation.

4. Independent Audit: Lastly, The American Legion is concerned that VA's Caregivers policies were not clearly defined which led to ineligible veterans being enrolled in the program, and eligible veterans being dropped from the program, who were still in need of the services offered through the program. We recommend an independent audit of VA's Caregivers program to determine what is working or not working and what changes are required to improve the program.

Conclusion

Chairman Roe, Ranking Member Walz and distinguished members of this committee, The American Legion looks forward to working with this committee on how to best improve and expand PCAFC program. The original program received nearly triple the applications than the VA expected, highlighting a real need for veterans to have access to this life altering and lifesaving program. Veterans have a much better quality of life if they are at their home, instead of a VA or private care facility. Veterans prefer to live at home with a caregiver of their choice compared to inpatient care, and statistics have also shown that this route of care is even more fiscally responsible and feasible for the VA.

The American Legion thanks this committee for holding this important hearing and for the opportunity to explain the views of the 2 million veteran members of this organization. For additional information regarding this testimony, please contact Mr. Matthew Shuman, Director of The American Legion's Legislative Division at (202) 861-2700 or Mshuman@legion.org.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

KAYDA KELEHER, ASSOCIATE DIRECTOR
NATIONAL LEGISLATIVE SERVICE

Chairman Roe, Ranking Member Walz and members of the committee, on behalf of the women and men of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our remarks on how to improve and expand the Department of Veterans Affairs (VA) Program of Comprehensive Support for Family Caregivers.

Whether providing assistance to a veteran who served in Korea or Afghanistan, Caregivers help lower costs of care and increase the health and quality of life for veterans who were seriously injured in the line of duty. Family caregivers who choose to provide in-home care to severely disabled veterans truly epitomize the concept of selfless service. They choose to put their lives and careers on hold, often accepting great emotional and financial burdens. They do this recognizing their loved ones benefit greatly by receiving care in their homes, as opposed to institutional settings.

The VFW strongly believes the contributions of family caregivers cannot be overstated, and our Nation owes them the support they need and deserve. That is why the VFW strongly supported the Caregivers and Veterans Omnibus Health Services Act of 2010, which provided a monthly stipend, respite care, mental and medical health care, and the necessary training and certifications required for caregivers of severely disabled Post-9/11 veterans. We did so, however, with the understanding

that eligibility would be later expanded to include veterans of all eras. Severely wounded veterans of all conflicts have made incredible sacrifices, and all family members who care for them are equally deserving of our recognition and support. The fact that caregivers of previous era veterans are excluded from the full complement of program benefits implies that their service and sacrifices are not as significant, and we believe this is wrong.

One of the requirements of the Caregivers and Veterans Omnibus Health Services Act of 2010 was for VA to submit a report to Congress examining the feasibility of expanding eligibility for comprehensive caregiver benefits to those who care for severely injured veterans of previous eras. That report, issued in September 2013 and stated that expansion would be operationally feasible, so long as Congress gives VA the necessary funding to administer the programs and hire the required additional staff. Subsequently, the Secretary of Veterans Affairs and the members of this committee have publically supported expansion of this important program. It is past time for Congress to follow through and expand this important benefits.

Eligibility and Current Recipients

Current eligibility criteria requirements for acceptance into the caregiver program are rigorous. This is shown in the fact that there are currently only 22,000 participants in the program, which is less than three percent of the 1.06 million Global War on Terror veterans who have received a service-connected disability rating from VA \geq as of September 30, 2016. Additionally, 86 percent veterans who are enrolled in the caregiver program have a service-connected disability rating of 70 percent or higher. To be eligible, the veteran must have incurred or aggravated a serious injury while serving in the military on or after Sept. 11, 2001. Due to the serious injury the veteran must also now require assistance with the management of their personal care and functions involved in daily life. This assistance must be needed for a minimum of six continuous months based on a clinical decision, and then receive ongoing care from a Patient Aligned Care Team or another VA health care team which is in the best interest of the veteran. The veteran must also agree to receive ongoing care at home by the designated family caregiver, and those services provided by the caregiver may not be provided by any other individual or entity.

During the evaluation process VA also conducts a home visit to help the agency make a sound decision regarding eligibility that is not solely based on service-connected disability ratings or statements made by the veterans and/or their caregivers. During the assessment for eligibility process VA may request additional evaluations from behavioral health, occupational therapy, physical therapy and other medical specialty offices to assist in completing the assessment. If approved for the program, a designated caregiver must be an immediate family member or somebody who lives with the veteran full time and is at least 18 years of age. These individuals must also undergo training and be able to demonstrate the ability to assist their veterans.

For those who are approved for the program, VA then requires their medical centers to monitor all participants. This involves quarterly check-ups for monitoring, which are done through various platforms such as phone calls, clinic, telehealth and/or home visits.

The VFW agrees that the requirements for VA's caregiver program must be tough to assure only veterans who need the program are able to partake, though we do have some concerns. Aside from the VFW's strong support of expanding the caregiver program to veterans who served before Sept. 11, 2001, the VFW also supports expanding the eligibility criteria of "seriously injured" to "seriously ill or injured". According to the Code of Federal Regulations, VA defines a serious injury for participation in the caregiver program as, "any injury, including traumatic brain injury, psychological trauma, or other mental disorder, incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001, that renders the veteran or servicemember in need of personal care services."

This definition does not successfully define the inclusion of those who need the assistance of a caregiver due to debilitating illnesses which render a veteran unable to perform activities of daily living without the assistance of a caregiver, such as Parkinson's Disease and Amyotrophic Lateral Sclerosis (ALS). While VA has never considered non-mental health illnesses when determining eligibility for the caregiver program, the Department of Defense's Special Compensation for Assistance with Activities of Daily Living (SCAADL) program does. The SCAADL program does not distinguish between illness and injury for eligibility determination. Veterans who have recently transitioned from military service who were enrolled in the SCAADL program because of a serious illness are rightfully outraged when they are rejected from the VA program simply because they suffer from an illness instead of an injury. Including illness in VA's eligibility would allow for more equity between the two programs which are needed by the same population.

Quality of Life

It is not secret the majority of people requiring assistance for daily living prefer being at home, and our members are not afraid of letting the VFW know. There is a comfort in being surrounded by one's familiar setting and personal belongings and there is a sense of happiness having the opportunity to remain in proximity to loved ones. This is why those who have fought for our Nation rightfully deserve every opportunity to remain comfortably at home with their loved ones before being forced into an assisted living situation most do not want.

Cost

Aside from how important it is to improve the quality of our heroes' lives, it is also more cost effective. According to the Congressional Budget Office, the average annual cost per patient for the caregiver program is \$18,300. This is the average cost when adding together stipend payments and Civilian Health and Medical Program of VA coverage. For veterans not using the caregiver program but in need of assisted living, VA may offer them VA Community Living Centers, Community Nursing Homes or State Veteran Nursing Homes.

As of 2016, the cost of the latter three options is exponential. The State Veteran Nursing Homes average at \$56,042.52 per patient per year, Community Nursing Homes average at \$101,132.20 per patient per year and VA Community Living Centers average at \$379,853.71 per patient per year. This means the average veteran caregiver saves VA and our government anywhere from nearly \$38,000 per year to \$362,000 per year - all while maintaining a comfortable and higher-quality lifestyle for severely injured veterans. The VFW believes investing money in VA's caregiver program is not only the correct thing to do, but it is the financially responsible thing to do.

Revocations and Tier Reductions

Members of the VFW and VA's Caregiver Support Line hear on a nearly daily basis from veterans and their caregivers about their frustrations with the revocation of their eligibility and tier reductions. The VFW is thankful VA has worked on improving these issues, but there is still work that must be done.

The VFW understands there will be veterans who are able to graduate from the caregiver program - and not needing the program anymore should be viewed as a positive. The problem lies with the handling and communication of a veteran improving enough to not need the assistance of the program. Program stipends were never intended to be a permanent benefit for all caregivers in the program, yet VA must work to assure caregivers of veterans who have grown to be dependent on the caregiver stipend are able to obtain meaningful employment that prevents financial hardship. Through its Unmet Needs financial grant, the VFW has helped countless caregivers make ends meet because they were abruptly discontinued from the caregiver program and were unprepared to obtain employment that would replace the lost financial stipend.

That is why the VFW believes VA must provide services to better assist caregivers in transitioning from being on the program, to a different tier or completely off the program. While VA is currently providing a period of time after notification before the caregiver loses their monetary stipend, VA needs to educate these individuals about opportunities for vocational training, employment possibilities and health care options.

The VFW commends Representative James Langevin for his efforts to improve and expand the caregiver program through H.R. 1472, the Military and Veteran Caregiver Services Improvement Act of 2017, which would expand the caregivers program to wounded veterans of all eras. The VFW frequently hears member feedback regarding eligibility for this important program. Their message is clear: veterans of all eras deserve caregiver benefits. As an intergenerational veterans' service organization that traces its roots to the Spanish American War, this is not surprising.

Our members are combat veterans from World War II, the Korean War, the Vietnam War, the Gulf War, the wars in Afghanistan and Iraq, and various other conflicts. They rightly see no justifiable reason to exclude otherwise deserving veterans from program eligibility simply based on the era in which they served. Accordingly, we strongly urge you to swiftly consider and pass a bill to end this inequity.

WOUNDED WARRIOR PROJECT

Chairman Roe, Ranking Member Walz, and Members of the Committee,

Thank you for inviting Wounded Warrior Project (WWP) to offer our input to your discussion and review of the Department of Veterans Affairs' (VA's) Program of Comprehensive Assistance for Family Caregivers (the Program). We appreciate the forum to highlight the service and sacrifice of our country's military caregivers. Too often, these men and women serve in the shadows, rarely getting similar recognition as the injured veterans they care for. We are grateful for your focus on this deserving population and are pleased to offer the following statement for the record.

WWP's mission is to honor and empower wounded warriors. Through community partnerships and free direct programming, WWP is filling gaps in government services that reflect the risks and sacrifices that our most recent generation of veterans faced while in service. Advancements in battlefield medicine and body armor have saved more service member lives than ever before. While the road to recovery for these men and women can be long, a generation of caregivers has risen to help them meet the challenges along the way. As the needs of this community are great and growing, WWP's mission and corporate purpose indicates that our focus is related to family caregivers of veterans and service members who have been wounded, ill, or injured since September 11, 2001.

In 2010, our advocacy on behalf of this community helped pave the way for the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111-163). Our comments today follow from distinctions outlined on November 19, 2009, when bill sponsor, then-Senate Committee on Veterans' Affairs Chairman, and World War II veteran, Senator Daniel Akaka addressed the Senate chamber with the these remarks:

While it is correct that the caregiver provisions target the veterans of the current conflicts, I do not believe that constitutes discrimination. The reasons for this targeting, at the least, are three: one, the needs and circumstances of the newest veterans in terms of the injuries are different - different - from those of veterans from earlier eras; two, the family situation of the younger veterans is different from that of older veterans; and three, by targeting this initiative on a specific group of veterans, the likelihood of a successful undertaking is enhanced.

While we support and advocate for our fellow veterans of previous generations, each of Senator Akaka's distinctions remain salient today, more than eight years after these comments and nearly seven years since the Veterans Health Administration (VHA) launched the Program in May 2011 at each of its VA medical centers across the United States.

Recent research validates two of the Program's initial premises that - though not more "deserving" - the caregiving needs and family situations of post-9/11 veterans are different. RAND Corporation's 2014 report, *Hidden Heroes: America's Military Caregivers*, illustrates several demographic differences between pre- and post-9/11 family caregivers. Among the differences most relevant to the Program:

- **Relationship to caregiver:** Pre-9/11 caregivers are most often the care recipient's child (36.5 percent) whereas post-9/11 veterans are most likely to receive care from a spouse/partner/ significant other (33.2 percent) or a parent (25.1 percent)
- **Support networks:** Pre-9/11 caregivers are more likely to have a support network (71 percent) than post-9/11 caregivers (47 percent)
- **Effects on mental health:** More post-9/11 caregivers (38 percent) meet the criteria for probable depression than pre-9/11 caregivers (19 percent)
- **Access to health insurance:** Post-9/11 caregivers are more likely to be without health insurance (32 percent reported no coverage) than pre-9/11 caregivers (18 percent)

These points highlight how the Program has and continues to address post-9/11 family caregiver needs, and how Program components have hopefully driven down concerning statistics since the RAND report was published three years ago. To wit, while caregivers from all eras may be eligible for aid and attendance benefits, respite care, social support services, and training, the Program provides additional services to eligible post-9/11 caregivers, including a monthly stipend based on the amount and degree of personal care services provided to the veteran, access to the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) if they have no health insurance, mental health counseling, and an expanded respite care benefit. These benefits have been a crucial resource for post-9/11 caregivers, and with appropriate funding, could and should be made available to all generations of military caregivers.

While the Program's offerings address the needs of many post-9/11 family caregivers, its success has been tempered by substantial growth. From fiscal year 2013 to fiscal year 2015, the number of primary family caregivers enrolled in the Program

grew from 12,710 to 24,711. This growth was matched by increased spending, which grew from \$226M to \$454M in annual outlays over the same period, yet only modest increases in staffing. At the end of fiscal year 2013, the number of Caregiver Support Coordinators (CSCs) - those who administer the Program at the medical facility level - stood at 225. The CSC count grew to 267 by the end of fiscal year 2014, and was projected to grow to 328 for fiscal year 2016.

During this period of remarkable growth in Program participation, the U.S. Government Accountability Office (GAO) published a report in September 2014 concluding that "staffing shortages impeded timeliness of key functions and negatively affected services to caregivers despite actions taken to address them." Accordingly, GAO concluded that:

After three years of operation, it is clear that that VHA needs to formally reassess and restructure key aspects of the Family Caregiver Program, which was designed to meet the needs of a much smaller population. This would include determining how best to ensure that staffing levels are sufficient to manage the local workload as well as determining whether the timeliness and procedures for application processing and home visits are reasonable given the number of approved caregivers.

As the Committee is aware, even with its current scope serving only post-9/11 caregivers, VA has had significant challenges implementing the Program. In 2017, these challenges came to a head, and VA paused all revocations from the Program pending a complete review. Although VA has concluded its review, the impact of new VHA Directive 1152 ("Caregiver Support Program") and associated training have not become clear.

Like all Members of the Committee, and like all organizations who have testified or submitted statements for the record, we are deeply invested in the success of the Program. Family caregivers, including those of the pre-9/11 generation not currently eligible for the Program, help conserve state and federal agency resources by keeping seriously injured veterans at home, avoiding costly forms of care including institutionalization. In many cases, these caregivers sacrifice their own life experiences and successes, including careers, education, and retirement savings, in order to properly care for the veterans they support at home.

Though WWP's mission is to assist caregivers of the post-9/11 generation, we recognize caregivers of the pre-9/11 generation are no less deserving of praise, recognition, or access to vital services and benefits provided by the Program. WWP supports legislation that would improve the lives of pre-9/11 caregivers without harming caregivers of the post-9/11 generation. As such, WWP firmly believes that proposals to expand the Program must be accompanied by sufficient funding to cover additional staffing and information technology needed to properly administer the Program and meet the needs of the caregivers and veterans it serves. At this time, however, we would like to address several points about the Program raised during public comment on Federal Register announcement 2018-00004 ("Notice of Request for Information on the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers").

Appealing a Decision made by PCAFC:

One essential mechanism for consistency and fairness is a meaningful appeals process in which veterans can challenge erroneous eligibility and tier level determinations. Despite allegations of wrongful revocations that gave rise to VA's recent Program review, in our experience, successful appeals through the VHA system have been extremely rare. Given the nature of the Program, adjustments should be made to the clinical appeals process for review of eligibility and tier level determinations.

Require Communication with Caregivers:

Caregivers must be present and involved in assessments that give rise to change in tier level or revocation. Especially where mental health or cognitive challenges are involved, caregivers can provide the insight necessary to reach correct and comprehensive conclusions. Nonetheless, we have heard many accounts of caregivers who were not allowed to participate. While VHA Directive 1152 addressed this issue, we are waiting to see how effective the new instructions and staff trainings have been in encouraging and increasing dialogue between caregivers and the veteran's health care team.

Review Revocations and Tier Reductions:

We know you are aware of the many veterans and caregivers who have reported erroneous determinations, and that is why you are conducting this review. Given these reports, in the interest of fairness, we ask for review of all revocations and

tier reductions that have taken place since program inception. We understand that this would place a significant workload on program staff and therefore propose a triaged approach in which cases, where tier 3 veterans were completely revoked, are addressed first. An adjustment this dramatic should be extremely rare and suggests irregularities.

The Inclusion of “Illness” in Qualifying for Caregiver Assistance:

Another issue to be addressed in Program eligibility is the inclusion of the word “illness” in qualifying for caregiver assistance. Under § 71.15, a serious injury is defined as “any injury, including traumatic brain injury, psychological trauma, or other mental disorder, incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001, that renders the veteran or servicemember in need of personal care services.”

By excluding the term “illnesses” in the qualifying language for caregiver, a large population of post-9/11 and pre-9/11 veterans are precluded from a benefit they might well deserve. We see this as an inherent flaw in the access to much-needed care for veterans. Much like generational expansion, we believe the Program should grow to accommodate those with service-connected illnesses - particularly those linked to toxic exposures - provided such expansion is accompanied by proper funding.

Servicemember Eligibility:

WWP not only assists veterans but also current serving military members of the Armed Forces. There are instances where severely injured servicemembers do not qualify for Caregiver support due to the VA’s interpretation of “undergoing medical discharge.” Section 1720G indicates that servicemembers are eligible for benefits under the Program if they are undergoing medical discharge from the Armed Forces: “For purposes of this subsection, an eligible veteran is any individual who . . . is a veteran or member of the Armed Forces undergoing medical discharge from the Armed Forces.” 38 U.S.C. 1720G(a)(2)(A). With any expansion of the Program, we would request that the definition of “undergoing medical discharge” include families in need of a caregiver before receiving a medical discharge date by the Department of Defense. By considering eligibility at an earlier date, this would ensure that proper training opportunities are available for caregivers of the injured servicemember throughout the entire treatment of the servicemember. We feel that the sooner families can receive training on caregiver programs and techniques, the more successful families will be.

Overall Compensation for Caregivers:

Increasing the hourly cap of 40 hours a week and the hourly wage rate set by VA should also be addressed. Caregivers have continually indicated that 40 hours a week is not a fair representation of the amount of time it takes to assist a severely injured veteran requiring fulltime caregiver support. Additionally, VA calculates the hourly wage rate by using the 75 percent rate of pay established by the Bureau of Labor Statistics. We would ask Congress and VA to review these two data points to ensure that caregivers are being properly compensated for their time.

Improve Transition Services:

As program stipends were not intended to be a permanent benefit in all situations, there will certainly be cases where veterans are no longer eligible for the Program due to changed circumstances. Where this occurs, VA should provide transition services and education regarding health care options, employment possibilities, and vocational training. CSCs should be provided with a comprehensive list of transition services available in their community through VA, state veterans agencies, and the private and nonprofit sectors.

WWP Alumni Survey:

To provide context for the above, WWP draws data and insight from our longitudinal and most recent Alumni Survey. In 2017, we received 34,822 completed surveys that have helped draw data and insight about the more than 110,000 warriors registered for WWP programs and services. The information gathered gives us critical information about our alumni - the name we assign to our warriors - and their caregivers.

Of the alumni that responded to our 2017 survey, 7.9 percent indicated they were permanently housebound. All the survey participants were asked to indicate their current requirements for assistance from another person for a range of daily living activities. We found that four activities require more assistance than others. These

included doing household chores, managing money, taking medication properly, and preparing meals.

Among alumni who needed assistance, 61.8 percent needed help with three or more activities. The breakdown is as follows:

- One to two activities - 38.2 percent
- Three to four activities - 28.1 percent
- Five to eight activities - 24.6 percent
- Nine to all eleven activities - 9.1 percent

In addition, 27.5 percent of responding alumni reported a need for aid and attendance of another person. On average, almost one-fourth (24.7 percent) needed help for 10 or fewer hours per week. However, 25.4 percent needed more than 40 hours of aid per week. We highlight these important data points to give you a clearer understanding of the needs and circumstances of the current post-9/11 warrior using in-home care, as reflected by the information we have recently gathered.

Conclusion:

Wounded Warrior Project will remain diligent in addressing the needs and concerns of today's caregiver community. As the leader in assisting wounded servicemembers transition to civilian life, we are at the forefront of caregiver issues. We remain steadfast in our commitment to expanding the caregiver program without putting current caregivers at risk by expanding a program without appropriate funding.

Wounded Warrior Project thanks this committee for their diligence and commitment to our nation's servicemembers and veterans. We appreciate the efforts this committee has made in understanding and addressing the gaps in caregiver support. We are thankful for the ability to speak on behalf of our constituency and stand ready to assist when needed.

Sincerely,

Rene C. Bardorf

Senior Vice President of Government and Community Relations

footnotes

i 155 Cong. Rec. S11538 (daily ed. Nov. 19, 2009) Congressional Record, November 19, 2009, S11538

ii Terri Tanielian, et. al., Hidden Heroes: America's Military Caregivers, RAND Corporation, 2014, p. 34.

iii Id. at 40.

iv Id. at 75.

v Id. at 73.

vi Department of Veterans Affairs, FY 2015 Budget Submission, VHA-66; Department of Veterans Affairs, FY 2017 Budget Submission, VHA-99-100.

vii Department of Veterans Affairs, FY 2015 Budget Submission, VHA-11; Department of Veterans Affairs, FY 2017 Budget Submission, VHA-98.

viii Department of Veterans Affairs, FY 2015 Budget Submission, VHA-66; Department of Veterans Affairs, FY 2016 Budget Submission, VHA-104-05; Department of Veterans Affairs, FY 2017 Budget Submission, VHA-99-100VHA.

ix GAO, VA Health Care: Actions Needed to Address Higher-than-Expected Demand for the Family Caregiver Program, GAO-14-675, 18 (Washington, D.C.: September 2015).

x April Fales, et. al., 2017 Wounded Warrior Project Survey, Westat, 2017, p. 33 (available at <https://www.woundedwarriorproject.org/media/172072/2017-wwp-annual-warrior-survey.pdf>).

xi Id. at 35.

xii Id.

RAND

Supporting Military and Veteran Caregivers from All Eras

Insights from RAND's Research

Terri Tanielian

CT-487

Testimony submitted to the House Veterans' Affairs Committee on February 6, 2018

For more information on this publication, visit www.rand.org/pubs/testimonies/CT487.html

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Supporting Military and Veteran Caregivers from All Eras: Insights from RAND Research

Statement of Terri Tanielian¹
The RAND Corporation²

Before the Committee on Veterans' Affairs
United States House of Representatives

February 6, 2018

There are more than 20 million veterans living in the United States today, many of whom have service-connected conditions or disabilities that require ongoing support and care. Supporting these wounded, ill, and injured warriors are the nation's "hidden heroes"—caregivers who provide unpaid, informal support with activities that enable current and former U.S. servicemembers to live fuller lives. These caregivers are an essential, but often overlooked, component of the nation's care for returning warriors.

Starting in 2010, new federal programs were created to ensure improved support for caregivers; however, at the time, little was known about the characteristics and needs of this population. My comments today derive from three studies sponsored by the Elizabeth Dole Foundation and conducted by the RAND Corporation. In this statement, I highlight some of the notable findings and recommendations from this work in an effort to help the Committee consider specific opportunities to improve existing federally supported programs that support military and veteran caregivers.

Shaping Program Support Based on the Characteristics of Military and Veteran Caregivers

RAND's first study, *Hidden Heroes: America's Military Caregivers*,³ was the first to rigorously assess how many caregivers were aiding current and former servicemembers, the characteristics of these caregivers, the value they contribute to society, and the risks they face as a result of their caregiving roles. We estimate that there are 5.5 million military and veteran caregivers in the United States. Of these, 19.6 percent (1.1 million) are caring for someone who served in the military after the terrorist attacks of September 11, 2001 (post-9/11 caregivers).

¹The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of the RAND Corporation or any of the sponsors of its research.

²The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

³Rajeev Ramchand, Terri Tanielian, Michael P. Fisher, Christine Anne Vaughan, Thomas E. Trail, Caroline Batka, Phoenix Voorhies, Michael Robbins, Eric Robinson, and Bonnie Ghosh-Dastidar, *Hidden Heroes: America's Military Caregivers*, Santa Monica, Calif.: RAND Corporation, RR-499-TEDF, 2014. We use the term military and veteran caregiver to include both those caring for a current member of the military (including active-duty, reserve, and National Guard members) and those caring for a former member of the military (commonly referred to as a veteran).

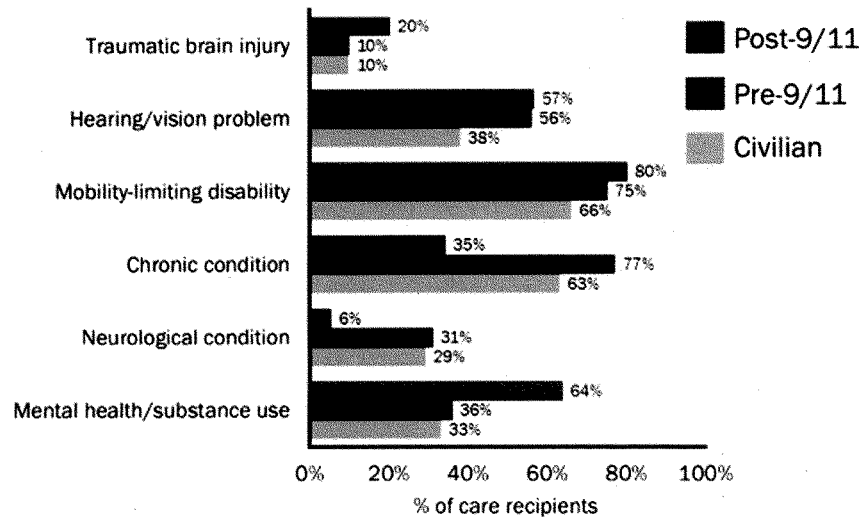
The remaining 4.4 million are providing caregiving support to veterans who served prior to September 11 (pre-9/11 caregivers).

We compared post-9/11 and pre-9/11 military and veteran caregivers with each other and with those providing care to nonveterans (civilian caregivers). Pre-9/11 military and veteran caregivers tend to resemble civilian caregivers in many ways. By contrast, post-9/11 caregivers differ systematically from the other two groups. Table 1 details some of the key differences among these populations, and Figure 1 highlights the variation in the types of conditions of their care recipients.

Table 1. Key Differences Across Caregiver Populations

	Post-9/11 Caregivers (%)	Pre-9/11 Caregivers (%)	Civilian Caregivers (%)
Caregiver characteristics			
Relationship to person being cared for	<ul style="list-style-type: none"> ☐ Spouse: 33 ☐ Parent: 25 ☐ Unrelated friend or neighbor: 23 	<ul style="list-style-type: none"> ☐ Child: 37 ☐ Spouse: 22 ☐ Parent: 2 ☐ Unrelated friend or neighbor: 16 	<ul style="list-style-type: none"> ☐ Child: 36 ☐ Spouse: 16 ☐ Parent: 10 ☐ Unrelated friend or neighbor: 13
Age 30 or younger	37	11	16
Married to and living with the care recipient	71	66	61
Employed	76	55	60
Have a support network (who share in the caregiving tasks)	47	71	69
Have health insurance	68	82	77
Have a regular source of health care	72	88	86
Met criteria for major depression	38	18.9	20.3
Assist with any activity of daily living	44	54	64
Assist with any instrumental activity of daily living	79	94	96
Spend more than 21 hours of care per week	33	27	37
Report having a child under age 18 living with them	39	20	27
Care recipient characteristics			
Have a disability rating from the U.S. Department of Veterans Affairs (VA)	58	30	n/a
Have a mental health or substance use disorder	64	36	33
Have a chronic condition, such as cancer, diabetes	35	77	63

Figure 1. Variation in Care Recipient Conditions, by Caregiver Population



Our study revealed that military and veteran caregivers provide critical assistance with activities that enable U.S. veterans to live more independently. It also documented that, while caregivers provide a valuable service to their loved ones and the United States, they also face unique challenges as result of their duties and may need an appropriate level of support to help reduce the burden. Understanding the differences between pre-9/11 and post-9/11 caregivers, and among other caregiver subgroups (for example, spouses and parents), is essential for targeting interventions that can most optimally support both caregivers and those for whom they are caring. For example, these caregivers may vary in terms of their demographics, rates of problems, and the nature of the conditions that they are caring for. Understanding and considering these differences can help ensure that educational content, benefits provided, and services offered can be tailored to specific subgroups. Doing so may improve the effectiveness of such interventions and increase the overall efficiency of programs.

VA Caregiver Support Programs

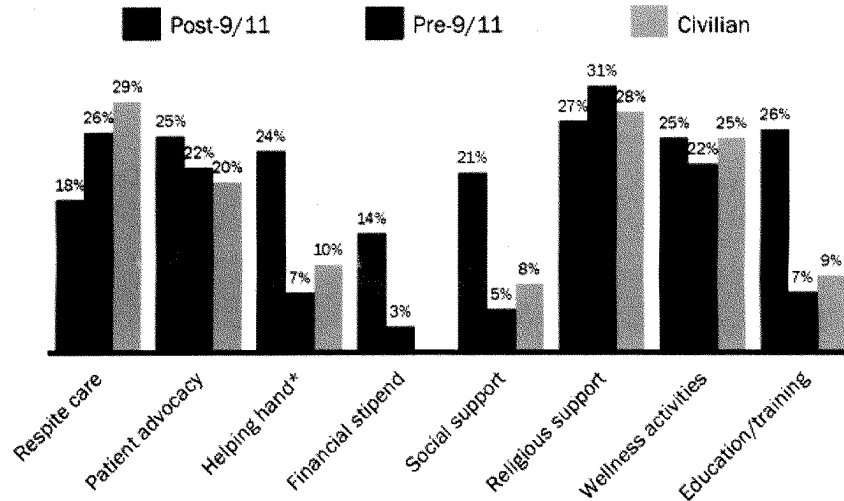
The Hidden Heroes report also examined the existing programs and policies that support military and veteran caregivers and highlighted gaps in that support landscape. We identified 120 organizations that were delivering services, resources, or other programs for these caregivers.

Among these organizations was the VA, which offers a wide array of services and benefits for military and veteran caregivers, including the Program of Comprehensive Assistance for Family Caregivers.

While our study documented the types of services offered through these organizations, we did not evaluate the efficacy or effectiveness of the services delivered. Thus, we do not have any data or findings to support specific recommendations for how to improve the VA's existing

programs that support caregivers. However, we did observe variation in eligibility for and utilization of available programs for caregivers (see Figure 2). For example, there is little uptake of stipends and social support for pre-9/11 military and veteran caregivers, while religious support is used by roughly one-fourth of all caregivers.

Figure 2. Program Utilization of Military and Veteran Caregivers



* Direct support, such as loans, donations, legal guidance, housing support, or transportation assistance.

Programs often have varying eligibility criteria or content areas of focus that may be applicable to only some subgroups of the caregiver population (e.g., those married to their recipients, those caring for someone over age 65). Understanding how all programs, including those that are publicly funded and those sponsored by non-governmental entities, align across these characteristics allows not just for identifying gaps in service availability for the subgroups but also for understanding redundancies and how to better integrate and coordinate across sectors.

Moving Forward to Create Better Support for Military and Veteran Caregivers

Based on the characteristics and needs of caregivers, we made several recommendations for improving the overall landscape of programs that support military and veteran caregivers. These recommendations, outlined in Hidden Heroes, called for strategies that would empower caregivers, create more-supportive environments (in the workplace and in health care settings), fill specific gaps in existing programs (e.g., expand respite care services, align eligibility criteria, and evaluate program effectiveness), and plan for the future (in terms of ensuring caregiving continuity for veterans and enabling research to continually inform programs and policies).


While the overall recommendations were broad in terms of their objectives, the variability and nuances across the different subgroups of caregivers highlight the fact that there is no one-size-fits-all solution that will serve the needs of all caregiver subgroups equally. Our findings and recommendations indicate that, in order to be optimally effective, programs and resources need to be tailored to the specific needs of different populations. For example, a program that is focused on helping a caregiver attend to the needs of a care recipient who experiences posttraumatic stress disorder will not be appropriate for a caregiver who is attending to the needs of someone with a spinal cord disorder, and vice versa. Similarly, programs and services primarily designed for individuals who are married to or living with their care recipient may not be suitable for caregivers who have different relationships or live elsewhere.

In 2017, RAND conducted a follow-on study to Hidden Heroes, titled Improving Support for America's Hidden Heroes: A Research Blueprint.⁴ The goal of this study

⁴Terri Tanielian, Kathryn E. Bouskill, Rajeev Ramchand, Esther M. Friedman, Thomas E. Trail, and Angela Clague, Improving Support for America's Hidden Heroes: A Research Blueprint.

Continued

was to identify a series of research priorities to more efficiently fill remaining knowledge gaps and improve policies and programs. I shared insights from that study with the Senate Special Committee on Aging in May 2017.⁵ In that study's report, we reiterated a recommendation we also made in *Hidden Heroes* that ongoing research is needed to inform improvements in the policies and programs that support military and veteran caregivers. This is especially true because caregiving is a dynamic responsibility, with specific tasks and demands that shift over time, and the impacts associated with it also wax and wane. The Blueprint also outlined ten priority questions, all of which, if pursued, could provide empirical evidence and guidance on how to most effectively expand and improve programs. Those priority questions, and the other recommendations made in that report, are also relevant to your considerations, particularly as you consider specific recommendations to improve VA programs.



print, Santa Monica, Calif.: RAND Corporation, RR-1873-TEDF, 2017. As of February 1, 2018: <https://www.rand.org/pubs/research—reports/RR1873.html>

⁵Terri Tanielian, “Creating Better Support for Our Nation’s Hidden Heroes: A Research Blueprint for Military and Veteran Caregivers,” Santa Monica, Calif.: RAND Corporation, CT-478, 2017. As of February 1, 2018: <https://www.rand.org/pubs/testimonies/CT478.html>

Federal Register Insert



Federal Register / Vol. 83, No. 4 / Friday, January 5, 2018 / Notices

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material shall be used to perform domestic Federal contracts for construction, with certain exceptions. VA policy is to not accept foreign construction material. However, if a bidder chooses to submit a bid that includes foreign material, VA will consider such bids if the material is specifically identified and the price of the material is provided. VAAR clause 852.236–89, Buy American Act, advises bidders of these provisions and requires bidders who want to offer foreign construction material to list the material and its price. Bidders who do not intend to offer foreign material do not need to submit any information under this clause. The information is required to allow VA to make an informed decision as to whether or not to accept a bid that includes foreign construction material. In actual practice, very few bidders ever offer foreign materials and, when they do, very few of those offers are accepted.

An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The **Federal Register** Notice with a 60-day comment period soliciting comments on this collection of information was published at 82 FR 142 on July 26, 2017, pages 34747 and 34748.

Affected Public: Business or other for-profit and not-for-profit institutions.

Estimated Annual Burden: VAAR clause 852.236–89, Buy American Act—22 hours.

Estimated Average Burden per Respondent: VAAR clause 852.236–89, Buy American Act—30 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: VAAR clause 852.236–89, Buy American Act—43.

By direction of the Secretary.

Cynthia Harvey-Pryor,

Department Clearance Officer, Office of Quality, Privacy and Risk, Department of Veterans Affairs.

[FR Doc. 2018-00002 Filed 1-4-18; 8:45 am]

BILLING CODE 8320-01-P

DEPARTMENT OF VETERANS AFFAIRS

Notice of Request for Information on the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers (PCAFC)

AGENCY: Department of Veterans Affairs.

ACTION: Request for information.

SUMMARY: The Department of Veterans Affairs (VA) is requesting information regarding its Program of Comprehensive

Assistance for Family Caregivers (PCAFC). Through PCAFC, VA provides certain medical, travel, training, and stipend benefits to designated family caregivers of eligible veterans and servicemembers who were seriously injured in the line of duty on or after September 11, 2001. This notice requests information and comments from interested parties to help inform PCAFC of any changes needed to increase consistency across the program, as well as ensure it supports those family caregivers of veterans servicemembers most in need.

DATES: Comments in response to this request for information must be received by VA on or before February 5, 2018.

ADDRESSES: Written comments may be submitted through <http://www.Regulations.gov>; by mail or hand delivery to the Director, Office of Regulation Policy and Management (00REG), Department of Veterans Affairs, 810 Vermont Avenue NW, Room 1068, Washington, DC 20420; or by fax to (202) 273-9026. Comments should indicate that they are submitted in response to “Notice of Request for Information on the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers (PCAFC)”. Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management (00REG), Department of Veterans Affairs, 810 Vermont Ave. NW, Room 1063B, Washington, DC 20420, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except Federal holidays). Please call (202) 461-4902 (this is not a toll-free number) for an appointment. During the comment period, comments may also be viewed online through the Federal Docket Management System at www.Regulations.gov.

FOR FURTHER INFORMATION CONTACT: Margaret Kabat, National Director, Caregiver Support Program, 10P4C, Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420, 202-461-6780 (this is not a toll free number).

SUPPLEMENTARY INFORMATION: The Program of Comprehensive Assistance for Family Caregivers (PCAFC) was established by Title I of Public Law 111-163, Caregivers and Veterans Omnibus Health Services Act of 2010, and is codified in section 1720G(a) of title 38, United States Code (U.S.C.). VA has been administering PCAFC

continuously since May 5, 2011 and has implemented this program through its regulations in part 71 of title 38, Code

of Federal Regulations (CFR). The purpose of PCAFC is to support family caregivers of eligible veterans (as defined in 38 U.S.C. 1720G(a)(2) and 38 CFR 71.20 to include certain servicemembers) through the provision of caregiver benefits, including training, respite care, counseling, technical support, beneficiary travel (in certain circumstances), a monthly stipend payment, and access to health care (if qualified) through the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). 38 U.S.C. 1720G(a)(3), 38 CFR 71.40.

For purposes of this notice hereinafter, the term “veteran” refers to veterans and servicemembers who apply for or participate in the Program of Comprehensive Assistance for Family Caregivers.

We are issuing this notice in order to solicit input on several components of the program, as further explained below. This notice and request for information serves as a means for VA to consult with key stakeholders on whether and how PCAFC should be modified to provide the highest quality care and support to veterans and their family caregivers in a consistent manner. We will use the information to inform any updates to this program and its implementing regulations. To the extent that there are any comments related to, or which would require changing, the relevant statutory authorities, those comments are outside the scope of this notice, as those would require Congressional action. The intent of this notice is for VA to garner input from the public on whether and how to change its regulations under the current statute.

This notice and request for information has a comment period of 45 days, during which individuals, groups, and entities may reply to the questions presented below. VA believes that 45 days is sufficient to provide comments, as the individuals, groups, and entities interested in this program likely have information and opinions readily available or can quickly compile and submit such information. Commenters are encouraged to provide complete but concise responses to the questions outlined below. Please note that VA will not respond to comments or questions regarding policy plans, decisions, or issues with regard to this notice. VA may choose to contact individual commenters, and such communications would serve to further clarify their written comments.

In order to improve PCAFC, we are seeking information on the following topics and issues:

HVAC Letter to Mr. Michael Shores

February 5, 2018

Mr. Michael Shores
 Director
 Office of Regulation Policy and Management
 Department of Veterans Affairs
 810 Vermont Ave. NW
 Room 1063B
 Washington, DC 20420

Dear Mr. Shores, April 23, 2019 April 23, 2019

We write this comment in response to the January 5, 2018, Federal Register notice seeking comments as to how the Department of Veterans Affairs can purportedly improve the Program of Comprehensive Assistance for Family Caregivers (Caregivers Program). We offer the following recommendations and comments regarding any potential changes being considered to the Caregivers Program. We want to strongly caution the agency against considering any modifications to eligibility that would lead to any decrease in benefits provided or number of beneficiaries served. Given our concern regarding eligibility, in particular, we tailor our recommendations and comments to that topic.

1. Should VA change how “serious injury” is defined for the purposes of eligibility?

a. Should the severity of injury be considered in determining eligibility to ensure VA is supporting family caregivers of Veterans most in need? If so, how should the level of severity be determined?

If Congress intended to scale-back eligibility for the Program based on the type of injury, it would have specified it in statute. The severity of the injury is assessed not by artificially grouping the type or cause of injury, but by its impacts on the veteran and the resulting caregiving needs. In particular, the Senate Report for P.L. 111–163, the Caregiver and Veterans Health Services Act of 2009, specifically expressed that eligibility be grounded in the veterans’ need for personal care services based on their ability to perform the independent activities of daily living or in their need for supervision or protection as a result of neurological or other impairments. These qualifications are not necessarily related to the type or mechanism of the injury, but rather the veteran’s ability to perform daily activities and other important functions without help.

Further, we do not support restrictions on eligibility absent congressional approval. It is VA’s job to implement the laws as Congress writes them, not to artificially narrow the law in regulations. As evidenced by our including an expansion of eligibility to veterans in the pre-9/11 service eras in an ANS Ranking Member Walz offered at a recent mark-up, and requiring studies on expanding the program to veterans of all eras in the enactment of the first caregivers legislation, expanding eligibility for the Caregivers Program is a priority for the Minority Members of the House Committee on Veterans’ Affairs. Had we intended to scale-back eligibility for the Program based on the type of injury, we would have done so prior to offering legislation expanding the number of eligible individuals.

b. How should VA define veterans who are most in need?

The Department should not attempt to create such a definition. Focusing on a purported scale of need is outside the intent of the law as written. Any new criteria based on this would artificially limit the eligible population when these types of restrictions appear nowhere in the statute. When we know that there are already few options for the delivery of care for severely disabled and injured veterans, we should seek to expand their care options not restrict them. Further, it is not the Department’s purview to create such artificial restrictions, contrary to current law. Rather, VA is obligated to request sufficient funds and other resources to fulfill its obligations under the law. Instead of attempting to limit eligibility or support, we expect the Department to submit a comprehensive budget request sufficient to cover all eligible veterans and caregivers, with services of the quality the American people demand for our veterans, and to prepare for future expansion of the program as clearly recommended by our Members and the veteran community.

c. Should eligibility be limited to only those veterans who without a family caregiver providing personal care services would otherwise require institutionalization? If so, how should this be determined?

Limiting eligibility to include only those veterans who would otherwise require institutionalization is antithetical to the principles of the original caregiver's program which was designed to help ease the burdens on caregivers who can provide a better environment and outcomes, not to supplant institutionalization. In fact, Congress specifically rejected a criteria of limiting eligibility to only those veterans who would otherwise require institutionalization in developing the final Caregivers and Veterans Omnibus Health Services Act.

VA is already obligated to provide institutional care for veterans in need of such care and meet one of the following criteria: a service-connected disability rating of seventy percent or more; a need for nursing home care for a service-connected disability; or a rating of sixty percent when either unemployable or permanently and totally disabled.

The intent of the law was not to replace institutionalization but support family members willing to sacrifice and provide the opportunity for the veteran to receive care at home. The law was designed to help keep veterans in the safest, most appropriate setting for their health and care needs. The need for institutionalization is not synonymous with the severity of illness or injury, and takes into consideration a number of factors that are not necessarily the same as a caregiver situation and would therefore be arbitrary if applied to Caregivers eligibility.

We are concerned that this solicitation's focus on eligibility, combined with the administration's recent concerns regarding "fiscal constraints" as noted in its recent redline document provided to the Senate Committee on Veterans' Affairs regarding S. 2193, Caring for Veterans Act of 2017, and emphasis on focusing resources on "Veterans who need it most", amounts to an attempt to justify cuts or changes to the Program at the expense of our most vulnerable veterans rather than an opportunity to assess the program's strengths and weaknesses. We urge the administration to consult with Congress on the nature of these issues before moving forward with any modifications to eligibility.

We appreciate your consideration of this comment. If you have any questions, please reach out to Ms. Megan Bland, Democratic Professional Staff Member, at (202) 225-9756 or via email at Megan.Bland@mail.house.gov.

Sincerely,

TIMOTHY J. WALZ
Ranking Member

MARK TAKANO
Vice-Ranking Member

JULIA BROWNLEY
Member of Congress

ANN M. KUSTER
Member of Congress

KATHLEEN RICE
Member of Congress

J. LUIS CORREA
Member of Congress

GREGORIO KILILI CAMACHO SABLAN
Member of Congress

Questions For The Record

HVAC to The Honorable David Shulkin

January 29, 2018

The Honorable David Shulkin
Secretary
United States Department of Veterans Affairs
810 Vermont Ave. NW
Washington, D.C. 20515

Dear Mr. Secretary:

In advance of your testimony at the upcoming Full Committee oversight hearing entitled, "A Caregiver Support Program: Correcting Course for Veteran Caregivers,"

please respond to the following - in writing - by no later than close of business on Friday, February 2, 2018.

1. On January 27th, three separate statements were issued on your behalf concerning the Family Caregiver Program. What is your position in comparison to the stated Administration's position? Does the program need to be improved or expanded? Does the program need to be improved before any expansion can be considered?

2. You state your desire for the Family Caregiver Program to "[focus] its resources on Veterans who need it most." Which veterans do you believe "need" the Family Caregiver Program "the most" and why? Do you think the eligibility criteria for the current Family Caregiver Program should be amended to better target these veterans? How?

3. You also state your desire to engage with Congress to "find the right balance between the scope of the benefit, including clinical appropriateness, and overall cost." Where do you believe that balance lies? What specific information do you need to make an informed decision whether to expand the Family Caregiver Program to pre-9/11 veterans in its current or amended form?

3. What are the fiscal implications - to include both cost savings and cost increases - of expanding the Family Caregiver Program as it exists today to pre-9/11 veterans and caregivers? Similarly, how many more veterans and caregivers would qualify for the Family Caregiver Program were it expanded, in its current state, to pre-9/11 veterans, how would the Program's budget and staff be impacted by such expansion, and how did you arrive at this estimate?

4. What other existing long-term, extended, geriatric or other programs or benefits serve pre-9/11 veterans and/or caregivers and, should the Family Caregiver Program be expanded to pre-9/11 veterans, how would you prevent duplication of those programs or benefits and/or incorporate them into the expanded Family Caregiver Program?

5. When is the Information Technology (IT) system for the Family Caregiver Program expected to be fully implemented and operational? What is the total cost of that system and how is it expected to be used? Once data is compiled via that system, how long would you need to analyze such data and determine potential program adjustments based on that data?

Your timely response to these questions for the record and your commitment to our nation's veterans are both very much appreciated. If you have any questions, please contact the Subcommittee on Health at (202) 225-9154.

Sincerely,
DAYID P. ROE, M.D.
Chairman

VA Responses to Pre-Hearing Questions

Feb 6, 2018, HVAC Hearing - Caregivers Program

1. On January 27th, three separate statements were issued on your behalf concerning the Family Caregiver program.

a. What is your position in comparison to the stated Administration's position?

Response: My opinion is the same as the Administration's position, which is that expansion of the Program of Comprehensive Assistance for Family Caregivers (PCAFC) is the right and equitable thing to do, but we can't responsibly support it without ensuring funds will be available.

b. Does the program need to be improved or expanded?

Response: We strongly support improving the Caregiver programs and focusing its resources on Veterans who need it most regardless of when they served. We are already working to improve the program. In January of this year, the Department published a notice in the Federal Register seeking public comment on ways to improve the Caregiver program. The public comment period closes on February 5, and we will use the feedback to inform future changes to the program.

c. Does the program need to be improved before any expansion can be considered?

Response: VA has made significant improvements over the past year and is currently working on additional improvements. VA cannot comment on whether or not expansion can happen at the same time.

2.You state your desire for the Family Caregiver Program to “[focus] its resources on Veterans who need it most.”

a.Which veterans do you believe “need” the Family Caregiver Program “the most” and why?

Response: We think the program’s eligibility criteria should target Veterans who would require a higher level of care, outside of their home were it not for the assistance of their family caregiver.”

b.Do you think the eligibility criteria for the current Family Caregiver Program should be amended to better target these Veterans? How?

Response: The eligibility should target those Veterans at risk for having to leave their homes in order to receive care.

3.You also state your desire to engage with Congress to “find the right balance between the scope of the benefit, including clinical appropriateness, and overall cost.”

a.Where do you believe that balance lies?

Response: The cost to expand the Family Caregiver Program under its current eligibility is more than \$3 billion annually. In order to ensure that we provide the additional supports and services available under the Family Caregiver Program to caregivers whose Veterans served Prior to 9/11, we may need to limit eligibility to those Veterans who cannot remain at home were it not for their family caregiver.

b.What specific information do you need to make an informed decision whether to expand the Family Caregiver Program to pre-9/11 veterans in its current or amended form?

Response: New legislation is required for VA to expand eligibility to pre-9/11 Veterans. VA would need to review the legislation closely and have confidence sufficient resources will be available to properly fund the program without compromising other core Veteran health care programs.

4.What are the fiscal implications - to include both cost savings and cost increases - of expanding the Family Caregiver Program as it exists today to pre-9/11 veterans and caregivers?

a.Similarly, how many more veterans and caregivers would qualify for the Family Caregiver Program were it expanded, in its current state, to pre-9/11 veterans, how would the Program’s budget and staff be impacted by such expansion, and how did you arrive at this estimate?

Response: Care Management and Social Work Services collaborated with the VHA Office of the Assistant Deputy Under Secretary for Health for Policy and Planning, VHA Finance and the Office of Community Care (formerly referred to as the Chief Business Office Purchased Care) Caregiver Support Division to develop a stipend budget projection model for the Program of Comprehensive Assistance for Family Caregivers. Data, methodology and assumptions from this mid-year FY 2016 model were updated in the spring of 2017. The model results have been expanded to include projections through fiscal year 2027 for Veteran sponsor counts, and total stipend expense by fiscal year for four different eras of Veteran service including: prior to the Vietnam War, Vietnam War, after the Vietnam War but before September 11, 2001, and after September 11, 2001. These projections are applicable for the expansion of the Program to all era Veterans with eligibility as the Public Law 111–163 is currently written, therefore projections and costing would be significantly different if the eligibility was changed to incorporate Veterans with a “serious illness” or if there were other programmatic changes for additional benefits and/or services.

Total Pre and Post 9/11 Projections Combined

Year	Veterans	Stipend Only	Total projections: Inclusive of current eligibility plus expansion to all eras (assumes stipend accounts for 85% of the entire budget)
2017	88,309	\$1,246M	\$1,466M

Total Pre and Post 9/11 Projections Combined—Continued

Year	Veterans	Stipend Only	Total projections: Inclusive of current eligibility plus expansion to all eras (assumes stipend accounts for 85% of the entire budget)
2018	130,371	\$2,022M	\$2,379M
2019	155,608	\$2,507M	\$2,949M
2020	165,807	\$2,787M	\$3,279M
2021	162,686	\$2,790M	\$3,282M
2022	155,742	\$2,716M	\$3,195M
2023	152,863	\$2,719M	\$3,199M
2024	150,169	\$2,725M	\$3,206M
2025	182,925	\$2,735M	\$3,218M
2026	182,723	\$2,757M	\$3,244M
2027	182,195	\$2,785M	\$3,276M

Methodology: Veteran counts are based on a combination of observed enrollment patterns in the current Program of Comprehensive Assistance for Family Caregivers and estimated enrollment patterns that would occur if the PCAFC program were expanded to pre 9/11 Veterans. Annual stipends per Caregiver sponsor (Veteran) and cost per stipend are assumed to remain consistent with those projected under the current Public Law 111–163.

Total sponsors estimated were split into the three stipend tiers using the distribution of tiers by age band, gender, and service-connected disability experienced under the current Caregiver Support Program.

Projected number of stipend payments was determined by multiplying the projected sponsor counts by tier by the average number of stipend payments per year projected for FY 2017 through FY 2027 under the current Caregiver Support Program.

Total stipend payments were multiplied by the expected cost per payment projected for FY 2017 through FY 2027 under the current Caregiver Support Program in order to determine the total projected stipend cost by service era and tier for FY 2017 through FY 2027.

The pool of eligible Veterans was estimated using both VetPop2014 and the VA/DOD Identity Repository (VADIR) database. The VADIR data was incorporated into this development since VetPop2014 does not have information by separation date, which was required to identify the post 9/11/2001 Veterans. Veteran counts from VADIR were limited to Veterans separating from active duty after September 11, 2001 and prior to the start of FY2012 through FY2015.

Enrollment probabilities were estimated based on the PCAFC data and Census Bureau data provided in the Public Use Microdata Sample (PUMS). The PUMS data includes information on Veterans by broad degree of disability categories, as well as needing assistance with three or more ADLs (activities of daily living). This modeling relied on the PUMS data for the change in assistance with ADLs by age.

Assumptions: Projections do not have a built in ramp up period. The probability of needing assistance with three or more Activities of Daily Living increases as a Veteran's age increases. Annual stipends per Caregiver sponsor (Veteran) and cost per stipend are assumed to remain consistent with those projected under the current Caregiver Support Program which is about 85% of the overall Program's operating budget.

5. What other existing long-term extended, geriatric or other programs or benefits serve pre-9/11 veterans and/or caregivers and, should the Family Caregiver Program be expanded to pre 9/11 veterans, how would you prevent duplication of those programs or benefits and/or incorporate them into the expanded Family Caregiver Program?

Response: VA purchases a mix of services that assist Veterans and caregivers when Veterans need assistance with activities of daily living or have cognitive impairments. These personal care services are: Homemaker/Home Health Aide (H/

HHa); Veteran Directed Care (VDC); Community Adult Day Health Care (CADHC); and, Home Respite.

These programs are currently available to Veterans and caregivers participation in the Family Caregiver Program. If the Family Caregiver Program is expanded to pre-911 Veterans, these programs would continue to be available to those participating in the Family Caregiver Program.

The amount of care provided will be established through the case mix instrument VA introduced in August 2017. The instrument assists VA providers in making a clinical decision on the amount of care (hours or days or a budget amount) needed for the Veteran to remain safely at home, based on the Veteran's need for personal care services. Duplication of service is avoided by having a standardized tool inclusive of all personal care services, based on a Veteran's need for care.

VA also provides Home Based Primary Care (HBPC) for Veterans with complex, chronic disabling conditions when routine clinic-care is not effective. This enables VA to provide comprehensive, longitudinal, and interdisciplinary primary care in the home when Veterans are unable to go to clinic. HBPC service provides primary care to Veterans and lowers caregiver burden by reducing the need for caregivers to arrange clinic visits and also by providing educational and emotional support to caregivers that is complementary to the Family Caregiver program.

These services do not duplicate those provided by the Family Caregiver program.

6. When is the Information Technology (IT) system for the Family Caregiver expected to be fully implemented and operational?

a. What is the total cost of that system and how is it expected to be used?

Response: The Caregiver Support Program is pursuing a two-pronged approach to enhance and improve its IT platform. The Caregiver Application Tracker (CAT) Rescue is a short term solution targeted on enhancing and stabilizing the current Caregiver Application Tracker (CAT) application. This project has encountered significant delays, and is currently targeting a June 2018 deployment. Product testing is currently underway. The success of CAT Rescue lays the foundation for the longer term solution, the Caregivers Tool, or Care-T. CAT Rescue provides robust error-checking features and moves the system into a data center with stronger disaster recovery and failover features. It also provides enhanced reporting functions for the Caregiver Program Office. Care-T is currently in the development phase and scheduled to deploy in September 2018.

CareT is designed to significantly enhance data integrity by instituting business rules and data validation. It has equivalent or enhanced features relative to the CAT Rescue application, including robust error-checking and strong disaster recovery and failover features. CARE-T will use a web-based architecture. It is designed to be scalable and capable of accommodating significant growth in numbers enrolled in the Caregiver program, including an expansion of eligibility of a pre-9/11 Veteran population. It is designed to be a more intuitive system for enhanced user experience, with interfaces designed based on the most likely inquiries for a given user population. CareT has role-defined data views, which will enable the tool to be used by Veterans, Caregivers, and VA staff administering the program alike, thus enabling its use as an interactive tool between these groups of users and enhancing the efficiency of communications between these groups. In short, CareT enables cleaner data collection, improved reporting, enhanced communication between Veterans, Caregivers, and VA staff administering the program, excellent reporting and audit tools, and improved data analytics for program managers.

Breakdown of total costing for CAT Rescue by fiscal year (contract and FTE costs)

Fiscal Year (FY)	Cost
FY12	\$4,211,352.76
FY13	\$137,000
FY14	\$137,000
FY15	\$1,793,274
FY16	\$1,135,897

Fiscal Year (FY)	Cost
FY17	\$1,550,952
FY18 Estimated	\$1,273,131
FY19 Estimated	\$547,000
FY20 Estimated	Zero. System retired

Breakdown of total costing for CareT by fiscal year (contract and FTE costs)

Fiscal Year (FY)	Cost
FY15	\$2,119,785
FY16	\$2,639,037
FY17	\$2,026,065
FY18 Estimated	\$1,105,640
FY19 Estimated	\$1,637,000
FY20 Estimated	\$1,692,000

a. Once data is compiled via that system, how long would you need to analyze such data and determine potential program adjustments based on that data?

Response: Despite the delays in implementing a new IT system, VA has made multiple, significant, program adjustments based on data that is available, stakeholder input, and continuous improvement processes. Program evaluation is also underway to inform program changes without this existing robust data mining capability in the Caregiver Application Tracker. The Caregiver Support Program has partnered with Health Services Research and Development to assist not in traditional research but quality improvement efforts. More recently the Program Office has pursued a contract to survey Veterans and Caregivers requesting their direct feedback about services and supports offered. In addition, in January 2018 the Program Office pursued a Federal Registry notice and has formally asked for public comment on a variety of program issues seeking input to potential program changes.

