

**THE LEGISLATIVE PRIORITIES OF
THE BLINDED VETERANS ASSOCIATION**

PRESENTED BY

**NEIL APPLEBY
NATIONAL PRESIDENT**

**BEFORE THE HOUSE AND SENATE
COMMITTEES ON VETERANS' AFFAIRS**



MARCH 4, 2004

TABLE OF CONTENTS

I. Introduction

II. Critical Issues

III. Background

IV. Current Services

A. Blind Rehabilitation Centers

B. Visual Impairment Services Team (VIST)

C. Computer Access Training (CAT)

D. Blind Rehabilitation Outpatient Specialist (BROS)

E. Visual Impairment Services Outpatient Rehabilitation (VISOR)

F. Visual Impairment Center To Optimize Remaining Sight (VICTORS)

V. Effects of VERA on Rehabilitation

VI. Oversight

VII. Department Of Veterans Affairs FY2005 Budget Request

VIII. Independent Budget

IX. Prosthetic Service

X. VA Research

XI. CARES Phase II

XII. Other Legislative Priorities

XIII. Conclusion

I.

Introduction

Mr. Chairman and members of these distinguished Committees, on behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to present BVA's legislative priorities for 2004. These Committees are known for being the most bi-partisan in Congress. We sincerely hope this trend continues into the second session of this 108th Congress as we all work toward the same goal: caring for America's veterans.

The Blinded Veterans Association is the only congressionally chartered Veterans Service Organization (VSO) exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. Later this month, BVA will celebrate its 59th year of continuous service. We are especially proud of the close working relationship and strong support we have enjoyed from these Committees through the years. Together we make a substantial difference in the quality of life for the men and women who have sacrificed so much for our freedom.

BVA and its members are strong ambassadors for VA's blind rehabilitation programs. Throughout our 59 years of service, BVA has closely monitored VA's capacity to deliver high-quality rehabilitative services in a timely manner. When problems or concerns have been identified, BVA has worked diligently with VA and these Committees to resolve any service delivery deficiencies.

II. Critical Issues

We are happy to report that positive changes are happening within VA blind rehabilitation. Progress is progress, no matter how slowly it might be occurring.

Mr. Chairman, last year BVA voiced grave concerns about the over 2,500 blinded veterans awaiting entrance into one of 10 VA Blind Rehabilitation Centers (BRC) across the country. Thanks to the leadership of Senator Bob Graham, Ranking Minority Member of the Senate Veterans Affairs Committee, and Representative Rob Simmons, Chairman of the Subcommittee on Health of the House Veterans Affairs Committee, the General Accounting Office is now investigating the waiting list for blind rehabilitation. We are thankful to Senator Graham and Chairman Simmons for listening to our concerns and taking action. While the waiting list has not been reduced, BVA is glad to know it is being analyzed to understand why the list is so long, what type of veterans are on the list, and what type of alternatives may be available for blinded veterans.

Due to the increasing age of our veteran population and the known prevalence of age-related visual impairment, the Visual Impairment Advisory Board (VIAB) has identified the need for a uniform national standard of care. The VIAB is an interdisciplinary board that includes providers, the Blinded Veterans Association, research, and network representatives. There is a need to develop a continuum of care that augments the services already in place for legally blind veterans by including veterans who have a severe vision loss, but are not yet legally blind.

VIAB presented a proposal before the Health Systems Committee of the National Leadership Board (NLB) asking all Veteran Integrated Service Networks (VISN) to implement a full continuum of care for visually impaired and blind veterans. The Committee received the proposal very positively and requested that a gap analysis be conducted. The gap analysis determines what services are currently available along the continuum of care in each VISN. It also includes an assessment of the gaps in the delivery of such services. An estimate of the cost of filling in such gaps is formulated once the analysis is complete. The VIAB does not dictate to the VISNs how this continuum of care should be implemented. While BVA would point to successful models of unique and successful programs within VA across the country, VISNs may meet its needs in the best way for its area. It is time for all blind veterans to receive the right service, at the right place, at the right time.

The independent Capital Asset Realignment for Enhanced Services (CARES) Commission released recommendations to Secretary Principi in mid-February. While BVA still has concerns about the accelerated timeline of Phase II of the CARES process, and the omission of data for crucial segments of the veteran population, BVA does feel the Commission listened to BVA and blinded veterans who testified across the country. The Commission recommends the establishment of new BRCs in VISN 16 and VISN 22. Another recommendation put forth by the Commission states, "VA should develop new opportunities to provide blind rehabilitation in outpatient settings close to veterans' homes." BVA is encouraged that VA has already agreed to fund the gap analysis requested by the Health Systems Committee of the NLB. We hope that this recommendation by the independent CARES Commission will reinforce the need for timely implementation of a full continuum of services for all visually impaired veterans.

BVA strongly supports the concept of mandatory funding for VA health care. As a member of the Partnership for Veterans Health Care Budget Reform, our membership will be actively working to educate local members of Congress on this important issue. The Partnership supports moving VA health care from a discretionary to a mandatory funding method. This would neither change current eligibility requirements nor create a new entitlement benefit.

Mandatory funding and implementing a full continuum of care for blind and visually impaired are inextricably linked. The lack of predictability and accountability of the budget process allows only the status quo to be maintained. If VISNs are receiving their budgets almost half way through a fiscal year, and are not sure when the next year's funding will be passed by Congress, why would they invest in any type of new initiative?

III. Background

We are all aware of the aging veteran population and the increasing need and demand for health care services associated with aging. Mr. Chairman, aging is the single best predictor for blindness or severe visual impairment. As the overall population of veterans ages, more and more veterans are losing their vision, requiring rehabilitative services. Because of all the other chronic medical problems associated with aging, more and more members of our blinded veteran

population are either unable or unwilling to leave home to attend a comprehensive residential BRC. Also preventing many of these veterans from leaving home is the change in roles within their families. Spouses of these veterans have developed serious health problems and are often disabled themselves, relying on the veteran for their care. Consequently, the blinded veteran who has been the recipient of care has been forced into becoming the caregiver.

It seems obvious to BVA that VA Blind Rehabilitation Service (BRS) needs to develop an aggressive strategic plan to address the needs of older veterans who are unable to attend the BRC program. Unfortunately, the current reimbursement model for resource allocation serves as a definite disincentive for providing services locally. With respect to the allocation model, if the local VAMC refers a veteran to the BRC, the local VAMC will not have to pay for any services delivered or the prosthetics prescribed. Should the VAMC provide service locally, however, the VAMC must for pay for the care.

IV. Current Services

Mr. Chairman, I will now briefly describe each of the services offered by VA BRS and the challenges each is facing. We believe strongly that each of these services is an essential component of a full continuum of blind rehabilitation services that VA should strive to provide.

A. Blind Rehabilitation Centers

VA currently operates 10 BRCs across the country. The first blind center was established at the VA Hospital at Hines, IL in 1948. Nine additional BRCs have been established and strategically placed within the VA system. The sites include VA Medical Centers in Palo Alto, CA (1967); West Haven, CT (1969); American Lake, WA (1971); Waco, TX (1974); Birmingham, AL (1982); San Juan, PR (1990); Tucson, AZ (1994); Augusta, GA (1996); and West Palm Beach, FL (2000). The mission of each BRC is to address the expressed needs of blinded veterans so they may successfully reintegrate back into the community and family environment. To accomplish this mission, BRCs offer a comprehensive, individualized, adjustment-training program along with those services deemed necessary for a person to achieve a realistic level of independence. The environment is residential, but located within a VA facility, in order to provide medical services to blinded veterans while they participate in the rehabilitation process.

As stated before, over 2,500 blinded veterans await admission into one of these 10 BRCs. Many of these veterans may not even need to attend a residential BRC. Unfortunately, a majority of even the simplest services are not made available at a local level. In order to preserve the integrity of these BRCs, outpatient, and localized services must be provided.

B. Visual Impairment Services Team (VIST)

The mission of each VIST program is to provide blinded veterans with the highest quality of adjustment to vision loss services and blind rehabilitation training available. To accomplish this mission, VIST will establish mechanisms to maximize identification of blinded veterans and

offer review of benefits and services for which they are eligible. The VIST was created in order to coordinate the delivery of comprehensive medical and rehabilitative services for a blinded veteran. The "teams" were created in 1967. In 1978, VA established six full-time VIST Coordinator positions. Currently, the VA system employs 92 full-time Coordinators that serve as the case managers for an estimated 35,000 blinded veterans. VA researchers estimate there may be over 100,000 blinded veterans nationwide.

A few of the VA VIST Coordinators have been very aggressive and have identified local resources capable of delivering needed services to blinded veterans in their homes. Regrettably, only a few are managing such dynamic VIST programs; the majority relies on the VA BRC. If the veteran is unable to attend that program, he/she goes without service. Mr. Chairman, this is unacceptable. Given the increasing numbers of severely visually impaired and blinded veterans, BVA believes and has always maintained that any VA facility that has 100 or more blinded veterans on its rolls should have a full-time VIST Coordinator. Lack of service provision is due to local facility management seeking to avoid costs. Once again, the reimbursement allocation model serves as a significant disincentive. BRC managers also contribute to this lack of service delivery because of the traditional belief that the only place a blinded veteran can receive high quality rehabilitative services is at the VA BRC. Consequently, they have insisted that BRS policy be extremely restrictive in this regard. This culture must change.

C. Computer Access Training (CAT)

As a result of the FY 1995 VA Appropriation with the special funds earmarked for VA BRS, monies were made available to establish Computer Access Training (CAT) programs at the five major BRCs. The demand for admission to these programs has dramatically increased to the point that an eligible blinded veteran may have to wait a year or more for admission.

Having to admit a blinded veteran into a VA BRC for this specialized computer training, which includes housing the blinded veteran in a hospital bed, is unnecessarily expensive. Local training would eliminate this expense, and, at the same time, be more responsive to meeting the veteran's needs. Unfortunately, this is a prime example of the Veterans Equitable Resource Allocation (VERA) model providing a disincentive for local managers. If a VISN provides local training and recommended equipment, that VISN is responsible for paying for those services. Referral to a VA BRC enables a VISN to avoid those expenditures. Furthermore, VERA encourages referral to the BRC because the veteran then qualifies for the high or complex reimbursement rate. Locally provided services are only reimbursed at the basic rate. This saves the facility those costs but significantly and unnecessarily adds to the overall system expenses. Regrettably, the VA BRS response to the increasing demand for CAT programs is expanding the number of BRC beds dedicated to CAT. It should also be noted that this expansion of CAT beds is at the expense of basic adjustment to blindness beds, resulting in longer waiting lists and times for admission to the basic adjustment program. VERA also provides an incentive for increased CAT beds. The CAT program tends to be shorter than the basic program. CAT therefore moves more veterans more quickly through the training program and realizes greater revenue or reimbursement at the complex care or high rate.

D. Blind Rehabilitation Outpatient Specialist (BROS)

The other highly specialized outpatient program offered by BRS is the Blind Rehabilitation Outpatient Specialist (BROS) program. This relatively new approach to the delivery of VA blind rehabilitation services is for those blinded veterans who cannot or will not attend a residential blind rehabilitation program. A major shortcoming of VA blind rehabilitation in the past was the lack of follow-up with veterans that had completed the residential program. VA BRS did not possess the workforce to carry out effective follow-up to assess how effectively the veteran had transferred the newly learned skills to his/her home environment. Thanks to Congress earmarking \$5 million for BRS in the FY 1995 VA Appropriation, BRS was able to establish 14 new BROS positions in 14 different facilities around the system. Since that time, six additional positions have been established. Although this is a relatively small number of professionals, the creation of the BROS positions provides VA with an excellent opportunity to evaluate the effectiveness of the rehabilitation approach.

The BROS is a highly qualified professional who, ideally, is dually certified; that is, having a dual masters degree both in Orientation and Mobility as well as Rehabilitation Teaching. In the absence of such dually credentialed professionals, masters level blind rehabilitation specialists should be selected for these positions and receive extensive cross training at one of the BRCs. This training prepares these individuals to provide the full range of rehabilitation services in the veteran's home environment. The delivery of such outpatient rehabilitative service may prove to be cost efficient for those veterans who have rehabilitation needs but who are unable to attend the residential program. Many of these individuals may be at risk and must not be denied essential rehabilitative services. The rapidly growing older blinded veteran population, as mentioned previously, is clearly the therapeutic target for this type of service delivery. Additionally, the highly skilled professionals conduct comprehensive assessments of the newly identified blinded veteran's needs to determine if referral to a residential BRC is warranted. If this proves to be the case, the BROS may also provide some initial training before admission, thus potentially reducing the length of stay in the BRC. VA BRS has collected functional outcome data, through the outcomes project, for this new program. Given that there are relatively few active BROS, sufficient data does not currently exist to unequivocally validate this treatment approach. However, current data trends do strongly suggest that this is a viable approach of service delivery that is deserving of expansion. Clearly, given the rapidly aging veteran population and the increased prevalence of blindness associated with aging, there certainly will be an increasing number of severely visually impaired and blinded veterans who will be at risk but who are unable or unwilling to attend a residential BRC.

The BROS program provides an excellent opportunity to test, refine, and validate the effectiveness of outpatient service delivery. It assists in determining which veterans can receive maximum benefit from this rehabilitation model. Even if providing services locally on an outpatient basis is the right thing to do, there are sufficient disincentives in VERA that discourage this approach. Currently, there are 20 BROS positions scattered around the system, and, based on their experience, many more such positions should be established. This is not likely to occur, however, given the current reimbursement model. Networks will have to provide the full time employee equivalent (FTEE) for these positions. It is important to note that the

reason the current positions exist is that they were funded through VA Central Office from funds earmarked in the VA FY 1995 Appropriation. We have conveyed this concern to VHA officials in the past. BVA understands that VERA is continually being refined. It appears that the revised model (VERA 10), as announced, will not remove the disincentive. However, we are encouraged to hear that efforts are currently underway to further refine VERA 10 to reimburse more equitably all components of a full continuum of blind rehabilitation services.

Mr. Chairman, BVA strongly believes that every VIST with a full-time Coordinator should have a BROS as a member of this vital interdisciplinary team.

E. Visual Impairment Services Outpatient Rehabilitation (VISOR)

In 2000, VA Stars and Stripes Healthcare Network 4 initiated a revolutionary program to deliver services: Pre-admission home assessments are complemented by post-completion home follow-up. An outpatient ten-day rehabilitation program called Visual Impairment Services Outpatient Rehabilitation Program (VISOR) offers Skills Training, Orientation and Mobility, and Low Vision Therapy. This new approach combines the features of a residential program with those of outpatient service delivery. A VIST Coordinator, with low vision credentials, manages the program. Staff consists of certified Orientation and Mobility Specialists, Rehabilitation Teachers, and Low Vision Therapists.

VISOR is currently located at the VAMC in Lebanon, Pennsylvania, and treats patients within Network 4. This “service outside the box” delivery model is noteworthy. Patient satisfaction with the program is 100 per cent, as reported by VA Outcomes Project. This delivery model should be considered for replication within each Network. The program uses hoptel beds to house veterans. The beds do not enjoy 24-hour nursing coverage and are similar to staying in a hotel. Emergency care is available within the VAMC.

The VISOR program is providing functional outcome data to the Outcomes Project and will afford the opportunity to compare functional outcomes derived from this approach to the more traditional residential BRC or the BROS. Early functional outcome data indicates that the approach is very effective. Profiles gathered from early data suggest that visually impaired elderly veterans, who are relatively free from the health burdens typically seen in veterans attending the traditional BRC and who have relatively high degrees of residual vision, benefit the most from this rehabilitation approach. There may be other models of service delivery not yet developed, and further research in this area must be encouraged. VA should not abandon its leadership role in the field of blind rehabilitation services. VA must continue to explore additional alternatives to addressing the needs of blinded veterans.

This model combines the benefits of the residential model with those of outpatient service delivery. Unfortunately, however, the program is reimbursed at the basic rate rather than the complex care rate. Although it may be arguable whether this model requires the high or complex rate of reimbursement, it clearly requires more than the basic rate. Local and Network

management will certainly resist establishing alternative models if they are not properly funded. This type of innovation should be encouraged rather than discouraged. Additionally, this new model of service delivery may prove to be an effective method for meeting the rehabilitative needs of an older visually impaired veteran population.

F. *Visual Impairment Center To Optimize Remaining Sight (VICTORS)*

Another important model of service delivery that does not fall under VA BRS is the VICTORS program. The Visual Impairment Center To Optimize Remaining Sight (VICTORS) is a program operated by VA Optometry Service. This is a special low vision program designed to provide low vision services to veterans, who, though not legally blind, suffer from severe visual impairments. Generally, veterans must have a visual acuity of 20 over 70 or less to be considered for this service. This is typically a very short (five-day) inpatient program in which the veteran undergoes a comprehensive low vision evaluation. Appropriate low vision devices are then prescribed, followed by necessary training with the devices. Veterans who are in most need of these programs are those who may be employed, but, because of failing vision, feel they cannot continue. The VICTORS program enables these individuals to maintain their employment and retain full control over their lives. The VICTORS also performs a crucial preventative function as well. Unfortunately, Mr. Chairman, there are only three such programs currently within VHA. We submit that there is a critical need for many more such programs. In fact, expansion of the rehabilitative programs could further assist severely visually impaired (legally blind) or blinded veterans who have already attended a residential BRC and received low vision aids. The effectiveness of those aids could be reviewed and new prescriptions written when appropriate. This would avoid the necessity of readmission to the much more expensive BRC for such reviews and evaluations.

V. *Effects of VERA on Rehabilitation*

BRCs are admittedly resource intensive and costly. Currently, these programs are being viewed as potential moneymakers under the VERA model. As previously mentioned, BVA is pleased with the introduction of VERA 10. Instead of a blanket rate of \$42,000 for the higher reimbursement rate, BRC will now be reimbursed in Group 7 at \$29,737. BVA will be observing the implementation with a very watchful eye. A great deal of gaming occurred because of the high variance between the high and basic reimbursement rates.

BVA is extremely concerned about the abuses of the VERA currently taking place at the expense of the blinded veterans receiving services. At least two BRCs have established a very short one-to two-week program, while another BRC implemented a three-day program for vocational interests in order to increase the number of admissions, thus increasing the number of veterans who qualify for the high reimbursement rate. These so-called short programs certainly do not translate into comprehensive residential blind rehabilitation, nor should they qualify as complex care. Indeed, they do not require admission to a BRC at all. If these services are necessary, they should be provided either in a hoptel environment or, even more appropriately, in

the veterans' home areas. More focused outpatient programs (using hoptel beds) are not reimbursed at the higher rate. The incentive is to admit to the inpatient bed. When BRCs institute shorter programs, veterans are shortchanged. Programs such as VICTORS and VISOR admit a very focused population--veterans with high residual vision (usually macular degeneration) and few, if any, co-morbidities. Valuable time should not be taken from those blinded veterans needing full comprehensive residential blind rehabilitation at a BRC in the name of the almighty dollar.

A blinded veteran must spend at least one day in a BRC bed to qualify for the high reimbursement rate paid for complex care. Under the current methodology, the reimbursement rate goes to the veteran's host Network on a pro-rated basis. That is, if the BRC providing the blind rehabilitation is located in another Network, the cost of that care is allocated to that Network and the remainder of the high reimbursement rate remains within the veteran's home Network. It appears that Networks and/or facilities have discovered that if the length of stay in these programs is short enough, their cost is substantially reduced, therefore increasing a potential profit margin. This process then provides either the Network or facilities with funds to operate other programs and services.

The inability to track funds allocated to the Networks through VERA is another frustrating aspect of the funding issue. It is even more difficult, if not impossible, to track dollars allocated to the individual facility within the Network. Dollars allocated to the host facilities are not fenced or earmarked for blind rehabilitation. Consequently, facility directors and BRC managers cannot determine how much funding they have received to operate these special programs. The decentralized resource allocation practice apparently provides a lump sum to each facility from which they have the discretion and responsibility to operate all the programs and services assigned to that facility. Mr. Chairman, there must be a more clearly defined method for tracking these resources to insure that the specialized programs for which the Network and facilities are receiving the high reimbursement rate are indeed being utilized for those purposes. Theoretically, VERA provides Networks with sufficient funds to operate the special disabilities programs. Unfortunately, BRCs are continually required to share in facility FTEE reductions or freezes as a result of funding shortfalls. Field managers strenuously resist demanding this degree of accountability. They complain that this will infringe upon their flexibility as managers to establish priorities and carry out their assigned missions. This is an example of what Dr. Roswell referred to as the system being out of balance. Priority has been given to establishing greater capacity for outpatient services and new Community Based Outpatient Clinics (CBOCs) at the expense of tertiary care capacity.

Clearly, it is much more cost effective for the system as a whole to provide services locally, when appropriate, than to refer a veteran to a residential program some distance from his/her home. Unfortunately, local facility managers do not view this option as cost effective. Indeed, it is more costly than the reimbursement provided under VERA. BVA is not advocating wholesale contracting of services. Certainly, this is not in the best interest of all blinded veterans. We do recognize, however, that there is a growing segment of the blinded veteran population who, for whatever reason, cannot or will not attend a residential program while they still have needs that must be addressed.

VI. Oversight

Mr. Chairman, the last oversight hearing by the House Subcommittee on Health was held in 1998 to determine if VA was maintaining its capacity to provide specialized rehabilitative services to disabled veterans. BVA is convinced that a follow-up hearing is necessary, given the negative testimony suggesting that VA is falling far short of its legislative mandate. Capacity is not being maintained. Beds are not being fully staffed and blinded veterans are not being served in an efficient, timely manner.

VII. Department Of Veterans Affairs FY2005 Budget Request

The President's FY 2005 Budget Request is a prime example of the urgent need for mandatory funding. The gaming must end. BVA urges the members of these Committees to support mandatory funding. As in years past, we are deeply concerned that the FY 05 Budget Request will fall short, once again, of projected requirements to adequately address the health care needs of an aging veteran population. When budget gimmicks are backed out of the request, the remaining numbers are not quite as advertised. Clearly, there are proposed increases in nearly all accounts, and they are far better than in recent years. Nevertheless, they will hardly allow the Veterans Health Administration (VHA) to recover from this year's shortfall. As in past years, VA is being forced to rely more heavily on first-and third-party collections to substitute for appropriations. While members decry the Administration's reliance on third-party collections, Congress has failed to provide adequate appropriations to sufficiently fund the VA health care system. Responsibility for the constant under funding of VA health care through the discretionary process rests with both past and present Administrations and Congress. Public policy must clearly define for whom VA is to provide care and, once that policy has been established, Congress and the Administration must provide the necessary resources to care for those veterans. Mandatory funding appears to be the best approach to achieve this goal. The recent delay in FY 2004 funding makes an argument for mandatory funding even stronger. Operating at the FY 03 level for the first few months of the new fiscal year was devastating for VA.

VIII. Independent Budget

BVA is very proud to endorse the Independent Budget (IB), prepared by four of the major VSOs: AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars. This is the 18th consecutive year BVA has endorsed the IB. BVA, along with many other endorsers, participated in the preparatory sessions and gave input to the formulation of this extremely important document. We trust these Committees will read this document carefully as it contains many important and constructive suggestions regarding VA health care delivery. The IB outlines a clear blueprint for addressing VA medical care delivery, including policy decisions and funding. BVA believes these suggestions are very sound and should receive serious consideration as the budget process moves forward.

The increase over FY 2004 appropriations recommended for health care is, in our view, essential if VA hopes to keep pace with the increased costs in salaries, benefits, goods, and services utilized by VA. Additionally, the recommended funding level will also enable VA to more adequately fund the Congressionally mandated initiatives adopted last year. We also firmly believe this funding level is necessary if the special disabilities programs are to be protected. The recommended increase in VA medical and prosthetic research is also vital to VHA's mission. The funds are critical to VHA's ability to attract and retain clinicians who are also seeking the opportunity to conduct research.

IX. Prosthetic Service

BVA is very pleased with the outcome of the Prosthetic Clinical Management Program (PCMP) process as it impacts visually impaired and blinded veterans. The stated focus of the PCMP is the quality of prescriptions rather than solely on the dollars expended for the prescriptions. When the PCMP process was initially established as a mechanism to attempt to standardize prescription of prosthetic equipment, Veterans Service Organizations (VSOs) and other consumers were not included as members of the PCMP Work Groups. The PCMP Work Groups were designated to develop specifications for each item and to develop Clinical Practice recommendations (CPR's) for issuance of equipment.

The driving activity behind the PCMP is the establishment of work groups composed of clinicians to review the prescription practices associated with an individual prosthetic device. As the result of efforts by BVA, DAV, and PVA, consumers were allowed to be members of the Work Groups. Were it not for the fact that BVA had an opportunity to actively participate in the work groups related to Aids and Appliances for the blind, visually impaired and blinded veterans would not have fared very well. The work groups have been tasked with developing specifications for the device and recommendations for issuance. The intent of the specification development is to facilitate the establishment of national contracts for a device if the majority of the devices are procured from one vendor.

BVA has some reservations regarding the potential for standardization on the belief that one size fits all. Severely disabled veterans need to be treated as individuals with unique needs who might not always benefit from the more standard device. The opportunity must exist for clinicians to prescribe items not on national contract, even if they are more expensive, without fear of reprisal from local or Network management.

X. VA Research

BVA feels strongly that legislation should be initiated that would require the National Institutes of Health (NIH) to pay VA for the indirect cost of NIH-funded research grants. Currently, NIH pays for the indirect cost to almost everyone receiving NIH grants except for VA. Consequently, VA must utilize medical care dollars to cover the indirect costs. We believe this is grossly unfair to sick and disabled veterans in need of medical care. It is also unfair to a healthcare system already forced to operate with constrained funding. NIH has refused every

effort by VA to request payment for these indirect costs. Therefore, we believe that legislative action is required.

XI. CARES Phase II

As stated before, BVA has major concerns about the omission of data for crucial segments of the veterans' population. BVA does feel the Commission made a real effort to address the needs of blind veterans. BVA was very skeptical when the plans for CARES Phase II were initially rolled out last June. Originally, there was no plan to address the future needs of the special disability populations. Thanks to the effort of the VSO community, there was some inclusion of the needs of a few of VA's special disability populations. We trust that Secretary Principi will keep his promise to the VSOs. In a letter dated November 7, 2003, he stated the following, "I am committed to, and I commit to you and your members, no net reduction in VA's capacity to provide inpatient mental health and long-term care prior to completion of a comprehensive assessment of veterans' need for these services."

XII. Other Legislative Priorities

BVA believes these issues are vital to the survival of VA and to services and benefits for blinded veterans. Some of these issues are unique to veterans and others are applicable to all blind Americans.

- A.** BVA strongly encourages passage of legislation instituting mandatory funding of VA health care.
- B.** Authorizing VA to retain third-party collection should be viewed as a supplement to, and not as a substitute, for federal funding. Veterans and their insurance companies should not be required to pay for veterans' health care, as this is clearly a moral responsibility of the federal government.
- C.** BVA strongly supports the provision of a full Cost of Living Adjustment (COLA) for veterans receiving disability compensation and surviving spouses and dependent children receiving Dependency and Indemnity Compensation (DIC). Further, we support this COLA being made effective December 1, 2004. It is extremely important that disabled veterans or surviving spouses be able to keep pace with inflation due to the additional cost associated with severe disabilities. Fortunately, the rate of inflation has been quite low in recent years, although medical costs continue to rise. The increases place pressure on the disabled person's purchasing power. BVA is opposed to any attempt to means test the provision of service-connected disability compensation, or DIC benefits. The income of spouses of deceased veterans should have no bearing on the DIC benefit.
- D.** Medicare subvention is an issue critical to the future funding of VA health care programs. Considerable discussion of this issue has occurred over the years, with strong resistance

coming particularly from the House Ways and Means Committee, regarding a pilot Medicare subvention demonstration project for VA. We trust legislative language can be crafted this year to move this legislation rapidly through the 108th Congress. Authorizing VA to bill Medicare for services provided to certain veterans seems to be a win-win situation. VA benefits from the additional revenue to supplement core appropriations while the Medicare trust fund benefits because VA will be reimbursed at a discounted rate.

- E.** As the federal government seeks to strengthen homeland security, VA should receive an appropriate share of resources dedicated for this purpose. VA must be recognized as an essential component of homeland security and the role it can play, particularly in terms of responding with medical resources in times of national emergencies.
- F.** BVA encourages Congress to carefully scrutinize any proposed changes in the statutory definition of legal blindness. Such scrutiny will ensure that the SSA has the ability to update its listings to reflect current advances in measurement technology without altering the intent of the statute, which is to extend benefits and services to Americans facing severe vision loss. BVA supports a standard of no more than 10 percent of normal vision, as measured either in central or peripheral vision, with best correction in the better eye.
- G.** BVA urges members of these Committees to support House Concurrent Resolution (H. Con. Res.) 56, introduced by Ranking Member Evans. H. Con. Res. 56 expresses “that it is the sense of the Congress that each State should require any candidate for a driver’s license candidates to demonstrate, as a condition of obtaining a driver’s license, an ability to associate the use of the white cane and guide dog with visually impaired individuals and to exercise great caution when driving in proximity of a potentially visually impaired individual.” We are grateful to Congressman Evans for introducing this important resolution.
- H.** As mentioned previously, aging is the single best predictor of blindness or severe visual impairment. Veterans are not the only ones who are growing old and losing their sight. BVA encourages Congress to enact legislation to fund categorical programs for the professional preparation of education and rehabilitation personnel serving people who are severely visually impaired and blind. There is a shortage of trained professionals in the field of blindness.

XIII. Conclusion

Once again, Mr. Chairman, thanks to you and these Committees for this opportunity to present BVA’s Legislative Priorities for 2004. BVA is extremely proud of our 59 years of continuous service to blinded veterans and all the accomplishments we have enjoyed. Our relationships with VA and Congress, in particular these Committees, have been most productive

and rewarding. Our priorities, as previously stated, are the product of the resolutions adopted at our 58th National Convention held last August in Myrtle Beach, South Carolina.

While our membership and indeed all blinded veterans are most appreciative of the programs and services provided by VA, we recognize that change is necessary and believe this may be an opportunity, with strong and dynamic leadership, for significant improvements. It is BVA's hope that more blinded veterans than ever before can avail themselves of these services. There is no question that VA's services for the blind are the finest in the world. Our ongoing efforts are to ensure that they remain the finest. Clearly, we will need the assistance of these Committees in this worthwhile effort. We know we can count on you. Again, Mr. Chairman, thank you for this opportunity. I will gladly answer any questions you or other members of these Committees may have.