

THE LEGISLATIVE  
PRIORITIES OF  
THE BLINDED VETERANS ASSOCIATION

PRESENTED BY

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NATIONAL PRESIDENT

BEFORE THE  
HOUSE AND SENATE  
COMMITTEES ON VETERANS' AFFAIRS



MARCH 7, 2002

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## I. INTRODUCTION

Mr. Chairman and members of these distinguished committees, on behalf of the Blinded Veterans Association (BVA) I want to express our appreciation for this opportunity to present BVA's legislative priorities for 2002. Before I begin my formal remarks, I want to congratulate these committees for the critical veterans legislation you introduced and pushed through the first session of the 107th Congress. We appreciate the improvements to veterans health programs, the Montgomery GI Bill, and homeless veterans programs. I also want to welcome the new members to the House Committee: Mr. Miller, Dr. Boozman, Mr. Lynch, Mr. Hill, and Ms. Davis.

Later this month, BVA will celebrate its 57th year of continuous service to America's blinded veterans and their families. BVA is 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 57 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. This morning I will be reporting on the status of blinded veterans, as well as the programs and services designed by VA to address their special needs.

First, however, Mr. Chairman, I would like to take a minute to reflect on the tragic events of September eleventh. Clearly, America and its people are not the same. If I may, it appears a strong parallel exists between what our nation is experiencing and what we as blinded veterans have experienced. Actually, the experience is not limited to blinded veterans but to anyone who has experienced a significant loss. As the result of September eleventh, our way of life has been substantially changed. For weeks and months following that tragic event, Americans have lived in fear characterized by anxiety, depression, anger, and frustration. Americans have been forced to dramatically alter the way they live and have found it necessary to forgo many of the freedoms they have enjoyed for generations. America and its citizens have had to rally around each other providing assistance and support especially for those who suffered the loss of friends, family, and loved ones. We have been forced to adapt to a new way of life with greater emphasis on security and safety; many have eliminated their travel because of fears of terrorist attacks utilizing our air transportation system. America has also been forced to rebuild major portions of our infrastructure both in New York City and the Washington, DC. In order to recover, America is undergoing rehabilitation in an effort to try to restore what we lost a few months ago.

Mr. Chairman, these are the same reactions as mine and my fellow veterans who have lost sensory function. Fear, often overwhelming stress and anxiety, depression, and anger are typical responses to the loss of vision. Our degree of independence was dramatically diminished and was accompanied by the loss of the freedom to move around safely and independently. In order to overcome the limitations imposed by vision loss, it has been necessary for us to undergo comprehensive rehabilitation. As a result, we have learned new ways of coping with and

managing our lives in the absence of vision. Like America, we have learned new methods and techniques in order to adapt to new circumstances affecting our lives. We have struggled to adjust to a new way of living as America has been forced to do since September eleventh.

America has been able to make the adjustments necessitated because of the compassion, generosity, determination, and resolve of its citizens. Blinded veterans have been successful in achieving acceptance of and adjustment to vision loss thanks to the generosity of the American people. Their generosity has been channeled through these committees, Congress, and the specialized programs and services offered by the Department of Veteran's Affairs.

Mr. Chairman, it is truly unfortunate that it takes a tragedy to bring out the best in America, but we have been painfully reminded that there is a price for freedom, and once again, we have demonstrated that America can overcome the adversity in order to maintain it. Like our country, blinded veterans are not asking for handouts but rather a helping hand. Blinded veterans have largely been successful in adapting to adversity because of the support and assistance received from our families and the benefits and services provided by VA.

The process of recovery from any tragic or traumatic event is characterized by a period of grieving followed by rehabilitation and restoration. Normally, substantial changes are required as the result of such events before a new meaningful and productive life is to be achieved. Similar to the grief experienced and expressed by the American people following September eleventh, blinded veterans also must grieve over their loss of vision. Grieving is a very individualized process which lacks definite time limits, and only once completed is the individual ready to engage in the rehabilitative process. VA has pioneered and refined the rehabilitation process and provides America's blinded veterans with every opportunity to successfully acquire the essential skills necessary, and develop healthy attitudes about blindness, in order to enjoy a meaningful and productive life.

Reflecting on September eleventh, in addition to reminding us all of our vulnerability, it highlights the key role VA plays as contingency backup to the Department of Defense (DOD) in time of war or national emergency. If VA is to fulfill this vital role, it must receive adequate funding to assure the availability of high quality, timely medical care for casualties and the necessary staff to assist in recovery efforts. The role VA health care professionals played in the recovery effort following the terrorist attacks is extremely noteworthy. September 11<sup>th</sup> demands that VA be provided the essential resources to carry out its mission as DOD backup. This mission can no longer be ignored or discounted.

Last year, we outlined a number of concerns that affect the full continuum of care for blinded veterans. Regrettably, Mr. Chairman, little has changed during the past year. This lack of improvement magnifies our concerns for the future of these essential programs. Unfortunately, the changes that have occurred appear more cosmetic than substantive. Personnel and programmatic decisions continue to be driven by cost rather than customer service and quality of care. Much of the difficulties encountered by the Veterans Health Administration (VHA) in preserving and enhancing essential services can be directly attributed to an inadequate funding level. Programmatic decisions must absolutely be clinically driven as vacancies develop in critical Blind Rehabilitation Service (BRS) programs such as comprehensive

residential Blind Rehabilitation Centers (BRC) and full-time Visual Impairment Services Team (VIST) Coordinator positions. In the case of the VIST Coordinator positions, local managers and network directors continue to make every effort to restructure the position. They assign collateral duties rendering VIST responsibilities as part-time, they fill these positions with unqualified individuals, or they simply do not fill the positions at all. Nearly every time these decisions have been brought to the attention of VA Headquarters' officials, the local decisions are reversed.

This process is unnecessarily time consuming. In the interim, blinded veterans go without essential services. Additionally, headquarters intervention instills greater resistance in the field. Local managers and network directors complain they are being micro-managed and denied the opportunity to make decisions they believe are in the best interest of their facilities.

This example is typical of the over-arching issues that negatively affect VA BRS. Despite the national scope of these unique and specialized programs, local managers in possession of decentralized management authority are making devastating clinical decisions without consulting or gaining approval of subject matter experts. Furthermore, higher-level management charged with maintaining VA capacity to provide specialized services to disabled veterans are not approached regarding these decisions. The primary factor driving these decisions is cost and every aspect of the organizational structure is vulnerable to reduction or elimination in order to achieve cost savings. In other words, the end justifies the means. We find it hard to believe that one FTEE possessing essential professional knowledge, experience, and expertise will make or break a medical center. This is especially hard to comprehend when the FTEE is a VIST Coordinator who assures the delivery of comprehensive service to a unique population of severely disabled veterans. Furthermore, these positions are particularly vulnerable because they are a one-person service at a medical center serving a low incidence disability population.

Comparable to the failure to appropriately fill vacancies in critical VIST Coordinator positions in a timely manner as cited above, the comprehensive residential Blind Rehabilitation Centers (BRC's) are experiencing similar problems. They are also experiencing extreme difficulties in gaining approval to recruit for and fill vacancies in blind rehabilitation specialist positions. Consequently, several BRC's are not able to operate all of their authorized beds. Despite staffing shortages, these programs are being required to keep the beds filled whether or not sufficient teaching staff is available. This is purely a numbers game. The more blinded veterans they pump through the program the more they receive through the VERA allocation model.

While BVA does not argue decentralized management decision authority may best manage the delivery of managed primary care; we believe strongly that centralized management is required for the special-disabilities programs.

## **II. Outpatient Services**

While the problems outlined above have been ongoing, an even greater concern has

arisen for BVA. I am speaking of the failure of VA to adequately provide for the provision of essential blind rehabilitation services at the local level. 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 veteran's ages, more and more veterans are losing their vision, requiring rehabilitative services. Because of all the 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 as this often necessitates traveling hundreds of miles to the nearest 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.

The inability to attend a BRC for blind rehabilitation services should not result in the denial of needed services. It has become abundantly clear to BVA that VA must make a greater effort to contract with local or state agencies to provide these services. In many communities, highly trained professionals are available to provide essential services in our veteran's homes or communities. Many of these older blinded veterans have some residual vision that can be helped with good low vision evaluations and the provision of low vision aids. It is critical these veterans receive such evaluations and appropriate devices if they are to be able to remain in their homes to lead a reasonably independent life. Safety issues such as medication management can be effectively addressed with proper prescription of low vision aids.

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. Tradition also serves as an obstacle to this model of service delivery. With respect to the allocation model, if the local VAMC refers the veteran to the BRC, they will not have to pay for any services delivered or the prosthetics prescribed. Should they provide service locally, however, they then must pay through fee basis for the care, as well as for any prosthetic appliances prescribed. Tradition serves as an obstacle as when the VA BRC program was developed, high quality services were not available in most local communities. Over the years, many communities have established programs (though none are comparable to VA's) that can meet many of the special needs manifested by our older blinded veteran population.

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, they go without service. This, in part is due to a lack of support from local facility management as they are seeking to avoid those costs. Once again, the reimbursement allocation model serves as a significant disincentive. Blind center 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.

### **III. EFFECTS OF VERA ON BLIND REHABILITATION**

Blind Rehabilitation Centers (BRC's) and programs admittedly are resource intensive and are costly. Currently these programs are being viewed as potential moneymakers under the Veterans Equitable Resource Allocation (VERA) model. As you know, VERA is the allocation model utilized for distributing funds to the networks. Under VERA, there are two reimbursement rates. The basic rate provides reimbursement for the provision of primary or basic care. The high reimbursement rate is intended to cover the higher costs of the more complex and specialized programs such as blind rehabilitation. 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 veterans home network. It appears 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

Given the current amount for complex care (\$42,000), it appears there are sufficient dollars being allocated for the specialized services required by blinded veterans. For example, if the cost of a single period of blind rehabilitation provided in a residential BRC is approximately \$25,000, which leaves in excess of \$10,000 in the veteran's home network. In our view, these dollars should be utilized for either ongoing care of that blinded veteran, or providing services to other veterans with the same disability. We do not believe this is the case however, and we believe those dollars are being utilized to fund other medical or network services.

BVA has become extremely concerned about the abuses of the VERA currently taking place at the expense of the blinded veterans receiving services. At least one BRC has begun a practice of establishing very short (1 to 2 weeks) programs 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. They only result in taking beds away from those veterans who indeed need the full benefit from the residential program. If these short programs are needed at all, and this is questionable, they are services that should be provided in the veteran's local area. The other option to accommodate such programs would be to admit these veterans to hospital beds and treat them as outpatients. This latter option would then not qualify for the complex care reimbursement rate.

Even more disturbing, is that this same BRC discharges veterans from the program in the last month of the fiscal year before the veteran completing his program. The veteran is told he or she can then be readmitted the next month, at the beginning of the new fiscal year. Obviously, the BRC manager believes this will qualify the veteran for the complex reimbursement rate for two consecutive years. This blatant manipulation of VERA is a gross disservice to these blinded veterans.

The other significant shortcoming of the VERA is failure under this model to adequately

reimburse for outpatient services or other alternative models of service delivery. For example, one VAMC has established an alternative model known as Visual Impairment Services Outpatient Rehabilitation (VISOR) program. This model combines the benefits of the residential model with those of outpatient service delivery. A blinded veteran is admitted for a ten-day program. S/he, however, is admitted to a hospital bed, which does not have 24-hour nursing or medical coverage. Substantial cost-savings are realized with this model. 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.

Another example of how the VERA fails to adequately respond to the resource needs of facilities and networks is the Blind Rehabilitation Outpatient Specialist (BROS) positions. I will provide detail on each of the service delivery components of BRS below, but for this discussion, the BROS are also funded at the basic rate. The BROS were established on a limited basis seven years ago in an effort to address the need for outpatient blind rehabilitation. The allocation model fails to recognize the travel involved in providing services in the veterans home, and the additional expense for prosthetics prescribed for those veterans. Again, an adjustment in the reimbursement model is essential if more cost effective alternative models of service delivery are to be encouraged and indeed established.

## **A. TRACKING FUNDS**

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 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, BRC's are continually required to share in facility FTEE reductions or freezes as the 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.

It is not our intent to suggest that VERA is flawed in terms of providing sufficient resources to the networks charged with providing specialized services. We are saying that there are not adequate tracking mechanisms in place to accurately assess whether the high

reimbursement rate is indeed appropriate to cover the real costs of these programs. As outlined, there is a determined effort on the part of facility and Network managers to force BRS to provide services that have been traditionally provided in the residential setting in an ambulatory or outpatient environment. This would, in their view, significantly reduce costs associated with the BRC component of BRS. Given the current VERA model, the only way field managers could afford alternative methods of delivering blind rehabilitation services would be to eliminate the residential program altogether, freeing those resources to fund the new delivery models. Of course, this option is unacceptable.

## **B. REIMBURSEMENT RATES**

Mr. Chairman, significant disincentives exist within the VERA model as currently constructed. BRS, through its BROS program, is making a substantial effort to provide blind rehabilitation services when appropriate on an outpatient basis and seek opportunities to contract for services in a veteran's local area. VERA however does not currently have an intermediate reimbursement rate that will compensate the local facility as this system objective is accomplished. For example, a BROS completes a comprehensive needs assessment for a blinded veteran. The BROS determines the veteran could have his needs met through the provision of local services. The local facility is required to pay for these services. In some cases, it may be appropriate to contract locally for such services. The basic reimbursement rate, however, is not likely to cover the costs of these contracted services. Therefore, it is in the interest of the local facility manager to refer this veteran to a BRC for training in order to receive the high reimbursement rate.

Clearly, it is much more cost effective for the system as a whole to provide services locally, when appropriate, rather than referring a veteran to a residential program some distance from his or her home. Unfortunately, local facility managers do not view this option as cost effective. Indeed, it is more costly than the resources 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, there is a growing segment of the blinded veteran population who, for whatever reason, cannot or will not attend a residential program and they still have needs that must be addressed. 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 19 BROS positions scattered around the system, and based on their experience many more such positions should be established. This is not likely, however, given the current reimbursement. Networks will have to provide the FTEE for these positions. It is important to note that the reason the current positions exist is they were funded by central office from funds earmarked in the VA FY 1995 Appropriation. We have conveyed this concern to VHA officials in the past and we have been advised that VERA is continually being refined and some major revisions are anticipated. It does not appear, however, that the model will be modified to remove this disincentive.

## **IV. IMPACT OF ELIGIBILITY REFORM**

Mr. Chairman, in our testimony over the past several years, BVA has described how VA has failed to maintain its capacity to provide specialized services to disabled veterans as mandated by the Eligibility Reform Act. Unfortunately, little has changed during the past year to improve this situation. We are more hopeful this year as the result of the legislation introduced by these committees and adopted last year. That bill, H.R. 3447, contained a provision extending VA's responsibility to report to Congress on whether it is maintaining its capacity to provide rehabilitative services to disabled veterans. Thanks to these committees, the language is much stronger and specific that that contained in the Eligibility Reform Act. .

### **A. FLAWED CAPACITY REPORT DATA**

BVA maintained throughout the VHA reorganization that the decentralized management decision approach would not be effective with respect to the specialized programs. The special-disabilities program identified in the Eligibility Reform Act are national in scope. They should not be subject to local interpretation or changes without the approval of the Under Secretary for Health. Failure to hold network and facility managers accountable for maintaining capacity by insuring sufficient, fully staffed operating beds are maintained has resulted in operating beds being taken out of service. Consequently, substantial waiting lists and times persist at all BRC's. A blinded veteran must wait more than one year for admission to Computer Access Training (CAT), and from 6 to 8 months for the basic blind rehabilitation program.

All the blame cannot be laid at the doorstep of network and facility managers, however. The failure of headquarters and BRS to establish national guidelines and standards for the provision of blind rehabilitation services leaves too much discretion to local and network managers. The lack of these standards allow the managers to count whatever they believe constitutes the elements to reflect maintenance of capacity. H.R. 3447 or PL 107-135 eliminates that discretion, and directs what data elements are necessary to capture and more accurately reflect capacity. We hope this statutory requirement will result in more accurate data collection.

Problems with data collection must be resolved, and by doing so will enable VA to accurately capture appropriate FTEE for the provision of comprehensive blind rehabilitation. Currently, numerous inappropriate FTEE are being charged to blind rehabilitation. It is imperative that essential FTEE directly involved in the provision of comprehensive services be identified and captured if an accurate picture of the status of blind rehabilitation is to be obtained. This imperative issue has not been made a priority in VA headquarters. The decentralized management authority has negatively affected other specialized services provided to blinded veterans. Specifically, the positions local or network managers have attempted to either eliminate or substantially alter are the Visual Impairment Services Team (VIST) Coordinators and the Blind Rehabilitation Outpatient Specialist (BROS) positions. In almost every instance, BVA and the VA Blind Rehabilitation Service (BRS) have found it necessary to involve the CNO to reverse such negative decisions. Once again, these local decisions are being driven not by veteran's needs but cost. Blinded veterans have experienced significant disruptions in service or in some case a total lack of service.

## **B. CPT CODES**

Closely related to the problems in data collection as outlined above and the identification of appropriate FTEE to be charged to BRS, is a basic concern about accurately capturing blind rehabilitation services. Nearly all the services currently provided to blinded veterans do not have CPT codes. These codes are necessary if VA is to be eligible for reimbursement under the Medicare model. Blind rehabilitation is not the only VA service without CPT codes. Given VA dependence on third-party reimbursement for revenue, it is imperative all services provided have appropriate codes satisfying insurance and Medicare requirements. BVA has learned that to receive a CPT code for a service rendered, it will be necessary for VA to apply to the American Medical Association (AMA); a process that we understand takes two years. BVA believes it is imperative that VA capture the workload associated with the services provided to blinded veterans. Without CPT codes, this workload may fall between the cracks or worse workload that is not deemed reimbursable will be more vulnerable to diminished management support.

This is an issue national in scope but is being ignored depending on the whims of either network or local managers. We understand not all networks or facilities have implemented the VHA computer software that will collect patient data. All networks and facilities must implement and utilize the same tools for data collection if there is any hope of rolling up credible national data and managers who fail to comply must be held accountable.

The problems of improperly coding or the complete failure to code uniformly across the system, highlights the difficulty VHA has in accurately reporting on capacity. National Standards and Guidelines must be established and implemented. Adequate education and training funds must also be allocated to assure that those responsible for coding know what they are doing. In addition to not being able to accurately reflect maintenance of capacity, the lack of national standards and guidelines for coding negatively affects VA's potential to accurately bill and realize maximum third party collections.

Mr. Chairman, in connection with the issue of CPT codes raised above, I want to draw attention to HR 2484, The Medicare Vision Rehabilitation Coverage Act reintroduced in the first session of the 107th Congress. Under current Medicare law, vision rehabilitation services are not covered services. Additionally, services provided by blind rehabilitation specialists are not reimbursable under Medicare. Specifically, we are talking about those services provided by Orientation & Mobility Specialist or Rehabilitation Teachers. Both of these professions possess masters' degrees in their respective fields. Ironically, however, Medicare will reimburse Occupational or Physical Therapists for the provision of such services, though neither of these disciplines have the necessary education, knowledge, expertise, or professional training to deliver these services. If severely visually impaired and blind Americans are to be assured of receiving essential services from qualified professionals, it is imperative this legislation be approved. H.R.2484 would authorize vision rehabilitation services as covered services and designate blind rehabilitation specialists as authorized providers eligible for reimbursement for services provided. Clearly, this bill does not fall under the jurisdiction of these Committees but each of you may have the opportunity to vote in the future. We urge your support for the bill reintroduced by Mr. Capuano. If you have not already done so, please sign on as a cosponsor. This could be especially important to VA in its efforts to seek reimbursement for the provision of

health care and rehabilitative services. Nearly 2000 blinded veterans were provided comprehensive residential blind rehabilitation last year. Should VA ever receive the authority for reimbursement from Medicare, this represents a substantial source of revenue.

## **V. DEPARTMENT OF VETERANS AFFAIRS FY2003 BUDGET REQUEST**

Like many, BVA was pleased to hear that the Administration's FY 2003 Budget request for VA would include a historic increase for veteran's health care. Following the budget roll-out briefing and further analysis of the proposal, BVA is deeply concerned that the 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. Never the less, they will hardly allow the Veterans Health Administration (VHA) recover from this year's shortfall. As in past years, they also rely heavily on first and third party collections to substitute for appropriations. VA grossly underestimated the numbers of veterans that would enroll in their health care system and consequently has not had sufficient staffing available to provide timely care to enrollees. Long waiting lists exist nearly everywhere just for assignment to a Primary Care Team. Initial appointments for specialty clinics are similarly long and VA faces a shortage of physicians and nurses to meet the demand for care. The Special-Disabilities Programs have felt the financial crisis and service such as blind rehabilitation suffered as a result. Many BRC's are experiencing shortages in blind rehabilitation specialists and consequently are unable to operate all authorized beds. Therefore, waiting lists and times are dramatically increasing.

Another feature of this budget request that is objectionable is the provision that would establish a \$1500 deductible for Priority Seven veterans. Apparently, this measure was an attempt for the Administration to not stop enrolling new Priority Seven's as recommended by Secretary Principi. In fact, the measure seems designed to drive veterans from the system. It seems clear to BVA that it is time for a definitive public policy decision be reached regarding whether we are indeed going to provide health care for these so-called high income veterans. Creating a payment system that drives veterans away certainly is not providing veterans access to high quality health care.

Similarly, we are greatly concerned the request does not provide adequate spending levels to substantially reduce the existing benefits claims backlog. Despite the VBA's improvements in the numbers of claims being processed monthly, serious concerns continue regarding the accuracy of those claims decisions. More aggressive training is clearly required to develop the necessary proficiency and expertise within the ranks of claims adjudicators. Early-outs, buy-outs, and normal attrition have decimated the VBA, and technology will not fill in that gap. We certainly support the sincere efforts by Secretary Principi and the dedicated staff within VBA to reduce these backlogs, but question whether the requested spending level will support the necessary level of effort to accomplish their goals. We do not believe the number of new FTEE proposed in the President's budget will get the job done.

Mr. Chairman, it is evident that Secretary Principi has had an extremely positive impact on the Administration's budget request, but more needs to be provided. Substantial funding is being requested for Homeland Security and we strongly support these initiatives, but feel equally strongly that VA did not receive adequate recognition for the vital role they play in national security and in appropriate spending levels to assure VA's ability to respond to any national emergency. VA must also receive an increased spending level if it is to satisfy its mission as contingency backup to the Defense Department in the event the war on terrorism results in numerous casualties. We trust, as these committees develop their respective views and estimates to be forwarded to the budget committees, your recommendations reinforce the Administration's budget, reflecting the key role VA must play in Homeland Security and principal backup to DOD in time of war. It will also be necessary to reinforce the President's request if the Special-Disabilities Programs are to be able to operate at optimum levels.

## **VI. INDEPENDENT BUDGET**

BVA is very proud to endorse the Independent Budget (IB), prepared by four of the major VSO's: AMVETS, Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars (VFW). This is the sixteenth 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 2002 appropriations recommended for health care in our view is essential if VA hopes to keep pace with the increased costs for 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 for Medical and Prosthetic Research is also vital to VHA in order to fulfill their mission. The funds are critical for VHA's ability to attract and retain clinicians who are also seeking the opportunity to conduct research.

Much has been said about the unconscionable claims backlog within the Veterans Benefits Administration (VBA) and the need to resolve this chronic problem. In recognizing this problem, the IB has recommended an increase of some 840 FTEE to reduce the shameful backlog. VBA has demonstrated that information technology is not the sole solution underscoring the need for more employees. VBA has suffered the loss of many of its most experienced and knowledgeable adjudicators in recent years as the result of retirement, buy-outs, and early-outs.

The IB also outlines concerns regarding our National Cemetery System and the construction budget. We urge you to carefully review these recommendations as you prepare your views and estimates to be forwarded to the Committee on the budget. They are vital to America's veterans.

## **VII. BLIND REHABILITATION SERVICE (BRS)**

Mr. Chairman, outlined in this testimony are many problems BVA believes exist within VHA BRS, particularly as they relate to the provision of a full continuum of comprehensive services to blinded veterans. I have included in the following sections a more detailed description of the functions of each specialized component of the continuum of care that will be provided. We must emphasize that these various components represent a full and essential continuum, consistent with the objectives of the goals for VHA. Each component, as they are described, are essential if blinded veterans are to receive the services crucial to overcoming the handicap of blindness. In our view, the one glaring deficiency, and/or gap in this continuum is the limited availability of sufficient outpatient or local blind rehabilitation service. Despite the drive to reduce costs, the residential BRC component is essential. If I may draw an analogy between the provisions of health care generally and blind rehabilitation services, the BRC element represents the acute care portion of health care delivery and that acute care must always be available as many medical conditions can only be properly treated in an inpatient setting. Similarly, some blind rehabilitation services can most effectively be provided in a residential environment.

As you will see, VA BRS possesses all the essential elements to provide the right service at the right place and time. The BRC offers the acute care equivalent of health care while the BROS is the outpatient component currently being utilized. The VIST Coordinator serves as the case manager insuring the delivery of comprehensive services.

### **A. RESIDENTIAL BLIND REHABILITATION CENTERS**

Residential Blind Rehabilitation Centers are a most valuable component of VA BRS. Clearly there are those within VHA that seek to discount the value of residential blind rehabilitation centers. They desire to systematically dismantle this service delivery model in favor of a more cost-effective model. These individuals argue the same goals and functional outcomes achieved in the residential program can be duplicated in an outpatient environment. We insist there is absolutely no valid data to support this argument. In fact, Mr. Chairman, preliminary data obtained from the BRS Outcomes Project clearly contradicts this notion. It is absurd to suggest that comprehensive rehabilitative needs are the same for all veterans who meet the legal definition of blindness. Even more ridiculous is the assumption that all blinded veterans can be served on an outpatient basis. Without a doubt, there may indeed be a segment of the blinded veteran population that can receive optimal benefit from outpatient services. A clear profile of these veterans is currently not available to VA BRS. Through valid scientific outcomes research, the blinded veteran population can be segmented and profiled with respect to which treatment modality is the most appropriate to maximize rehabilitation. Until this

outcomes data is available, the residential program must be protected. Indeed we believe this was the intention of Congress as outlined in the provision of the Eligibility Reform Act, requiring VA to maintain its capacity to provide specialized service to disabled veterans.

It is important to note here that not all VA BRC's are currently operating all their authorized beds. For the most part, this is the result of reductions in Full-Time Employee Equivalent (FTEE) BRS positions. These are the professionals directly involved in the rehabilitation training. When vacancies develop in BRS positions, the BRC is not given authorization to recruit and fill these vacancies. Consequently, the BRC is not able to operate all authorized beds because of a lack of qualified instructors. The BRC's are being told they must share equally with all other services as the result of inadequate resources. This, despite the fact the resource allocation model provides a much more generous reimbursement rate than for basic service.

The reduction of operating beds is the direct result of the loss of more than 50 FTEE BRS positions. If additional reductions or freezes are imposed, it is very likely capacity will be further diminished. The high quality professional blind rehabilitation staff distinguishes VA as the world's premier provider of comprehensive blind rehabilitation services. Unfortunately, these are the positions management officials are targeting for reduction to achieve cost savings. Maintaining a high quality program resulting in favorable outcomes is directly related to the quality of the professionals providing care.

Unfortunately one BRC, the Western BRC located at VAMC Palo Alto CA., is experiencing severe problems in recruiting and filling the existing seven vacancies. This is due to the incredibly high cost of living in the Bay Area. Even with special rates designed to assist in overcoming the high cost of living, potential employees cannot afford to relocate to that area of the country. Unless something can be done to mitigate this problem, all VA healthcare in that region will be negatively impacted.

Despite the reduction of operating capacity and essential professionals, more blinded veterans received comprehensive blind rehabilitation last year than ever before. Moreover, the length of stay has been significantly reduced. As a result, length of wait is not as serious a concern as it has been in the past. These are truly remarkable achievements and have resulted in cost savings. At the same time, services have become more accessible to blinded veterans. For the most part, this has been achieved largely through the initiative of the BRS staff and the changing needs of the blinded veteran population being served. It is not the result of artificially imposed limits. Unfortunately, this does not appear to be enough. Pressure is increasing to reduce these lengths of stay even more. As an example, one BRC Chief recently reported he was instructed that he was to increase the number of discharges this year by 10% over last year. The only way to achieve this performance goal is to cut corners in the program or establish artificial limits on the length of stay regardless of the veterans needs. We believe this is for the intended objective of increasing a perceived profit margin. It certainly appears the challenge for these facility and network managers is to maintain just enough of the residential bed capacity to insure receiving the high reimbursement rate as provided under VERA.

BVA is becoming increasingly concerned over what appears to be an alarming trend. It seems that some of the BRC managers, in an effort to please facility and/or network managers, are beginning to support shortcuts in the individual training programs to achieve further reductions in length of stay. We will be closely monitoring this phenomenon in an effort to validate this practice.

The unconscionable backlogs we have complained about in the past appear to be becoming more manageable, except for computer access training. Much of this improvement can be attributed to changes in the blinded veteran population being served in the BRC's. The effectiveness of the professionals formulating individualized rehabilitation plans responsive to changing needs is also a major factor. They also reflect advancements made in technology available, and adapted for blind people to enhance independent living. The residential blind rehabilitation program has evolved during the past fifty-three years in response to changing needs. VA BRS retains the same pioneering spirit that produced the premier service model in the world. It is clear they must not rest on their laurels. They are continually challenged to respond to changing needs with innovative high quality services. If this quality of service is to continue, the subject matter experts must be the architects of new delivery models not managers concerned only with the bottom line.

In an effort to reduce the length of wait for admission to the CAT program, BRC Chiefs have converted beds historically dedicated to the basic adjustment to blindness program to beds dedicated to CAT. As a result, while the waiting time for admission to CAT is declining, the waiting time for the regular program is once again on the increase. We absolutely oppose this trend. Priority must be given to the regular program emphasizing overcoming the handicap of blindness, rather than reducing access to the basic program. BVA feels strongly that local contracts could be used to provide the computer training. This would reduce the workload on the BRC CAT program, once again freeing beds for the basic program.

It seems perfectly clear that when facility or network fiscal managers are tasked with achieving cost savings, they only look at the bottom line figure in the aggregate and by individual programs. When any program stands out as being expensive, such as blind rehabilitation, it is targeted for cost savings. The only objective is to reduce the cost of the particular program without any knowledge or understanding of how the program operates, what its objectives are, what outcomes expect to be achieved, and what professional resources are necessary to provide those services. Typical of the pressures being placed on BRC managers are demands that the number of veterans admitted and discharged be increased over the previous year. Second, another blind rehabilitation center has been told that it must reduce the average length of the program by eight days. The justification for the requirement is to reduce cost regardless of whether the rehabilitative needs of the veterans are being met. How long a blinded veteran needs to be in a blind center is a clinical decision that must be made by competent blind rehabilitation professionals, not by budgeters or unqualified administrative officials. The length of stay is also directly determined by the individual veteran's capacity to learn new skills and gain confidence in his or her ability to integrate these skills into his or her daily activities. As we all know, everyone does not learn at the same rate. Historically, the VA Blind Rehabilitation Program has provided blinded veterans with sufficient time and repetition during training to allow the veteran not only to acquire but also master a given skill. As I am sure you can

imagine, being introduced to an adaptive technique or skill is not the same as mastering its application sufficiently to gain a reasonable level of confidence in one's ability to utilize that skill on a daily basis.

The other major contributing factor to length of stay is how quickly a veteran is able to make the emotional or psychological adjustment to sight loss. Acquisition of skills is of no value if the veteran has not achieved a healthy level of adjustment. A blinded veteran who remains chronically depressed about his or her blindness or cannot accept him/herself as a blind person, will certainly not utilize learned skills. These individuals tend to return home and resume a very withdrawn and dependent lifestyle. The adjustment aspect of the residential blind rehabilitation program in many ways is the most critical factor. Unfortunately, it is also the most intangible in terms of measurement. The first chief of the Hines BRC has frequently noted that before a blinded veteran can successfully acquire the necessary adaptive skills to overcome the handicap of blindness, he/she must first get their head screwed on straight. In other words, they must develop healthy and wholesome attitudes about blindness. From a cost benefit standpoint, artificially reducing the length of stay in the program will only result in veterans not making the necessary adjustment to sight loss or acquiring the essential adaptive skills to assist in overcoming the handicap of blindness.

It has been proven that blinded veterans having the opportunity of living with other blinded veterans on a daily basis while undergoing intensive rehabilitation can optimize their adjustment to vision loss. The opportunity for one blinded veteran to share the problems associated with adjusting to sight loss with other blind veterans has been proven most therapeutic in terms of instilling healthy and wholesome attitudes about blindness. The intensity of the residential program clearly facilitates adjustment along with skill acquisition. It is important to note here that two of the BRC's are testing veterans in the program on degrees of depression present upon admission and again upon discharge. Preliminary data suggest remarkable improvements as a direct result of the BRC program. I emphasize this data is only preliminary, but we expect that further data collection will validate these early findings.

At the risk of sounding overly dramatic, Mr. Chairman, I would like to share the thoughts of a recognized expert in the field of blind rehabilitation. Father Thomas Carroll, formerly the Director of the Catholic Guild for All the Blind in Boston, and consultant to VA during its early years of blind rehabilitation. Father Carroll wrote a landmark book about blindness entitled "Blindness: What It Is, What It Does and How To Live With It." This book continues to serve today as a "bible" for professionals in the field. In his book, Father Carroll states that the person who loses their vision must first grieve for the loss of the sighted self. The grieving process varies greatly from person to person. The residential BRC facilitates this process.

Setting is the other ingredient that is so crucial. In a therapeutic environment, such as a BRC, there is a certain level of expectation. Many well-intentioned loved ones in a home setting are likely to be overly protective of the veteran. Family and friends expect little or nothing from their blinded veteran and in fact believe that blind people are unable to function independently. The attitude in a BRC is just the opposite. The professional staff expects blinded veterans to learn to be independent and to care for themselves. They believe strongly in the process and the potential of each person who is blind. Veterans in the BRC program are expected to take care of

their own laundry, keep their rooms clean, including changing linens, and to take care of their clothing, including color identification. This atmosphere does not exist at home but is essential if adaptive skills are to be learned and integrated into activities of daily living. Successful completion of a comprehensive residential program enables a blinded veteran to regain control of his environment and indeed to take charge of his/her life. One network director has been quoted as saying VA blind rehabilitation is antiquated. We believe he is referring to the residential or inpatient model. He seems to be insisting that blind rehabilitation services should be provided on an outpatient basis consistent with the transition to outpatient based managed primary care. This attitude clearly does not adequately consider and appreciate the importance of healthy adjustment issues involved in the rehabilitation process. It only assumes all the same outcomes can be achieved more cheaply on an outpatient basis. Again, we have no data to support this attitude or opinion.

BVA does not argue that a concerted team effort must be undertaken to achieve desired VHA goals and objectives; it must truly be a team effort. This means all team members must have equal opportunity to share input in the decision-making processes affecting any VA service. Management cannot ignore or exclude program officials or subject matter experts when programs are subject to review cost savings. Program managers, including blind rehabilitation officials, must be challenged to engage in an honest, concerted effort to identify cost savings without compromising quality care. We cannot emphasize this enough. The quality of the blind rehabilitation should never be sacrificed in the name of cost savings. The blinded veterans rehabilitation training program should be driven by his/her particular needs and ability to participate in the program.

Dr. Kizer had repeatedly stressed that his vision of the VA health care system is one that is driven by outcome measures. Decisions on clinical programs should be based on outcome measures that validate the effectiveness and quality of that program. BVA subscribes to this approach for validating program effectiveness. VA BRS has completed the testing, refinement, and validation of functional outcome measurement instruments for the residential Blind Rehabilitation Program and has begun data collection. Thus far, data collection has validated what BVA has maintained for years; namely, the BRC program is highly effective and significantly out-performs outpatient models of service delivery as well as similar non-VA programs. Veteran satisfaction also has consistently revealed a 98 percent level of satisfaction. The database from which this data was extracted contains over 5000 blinded veterans discharged from the BRC's. The outcomes data is potentially very powerful. The VA Rehabilitation Research and Development Center at VAMC Decatur, Georgia is coordinating the collection of this data and has worked in collaboration with the private sector in the development and refinement of appropriate instruments for data collection.

We are confident that as more veterans are entered into the database, it will further validate the value of the residential blind rehabilitation program in terms of desired outcomes and cost-effectiveness. Preliminary data suggests that veterans with multiple medical problems are more capable of independently managing those problems following Blind Rehabilitation Training. This reduces their dependency on VA for acute medical care. BVA has argued for years that blinded veterans who had access to blind rehabilitation would be less likely to require hospitalization or nursing home care solely because of their blindness. Older veterans are

particularly more susceptible to falling and incurring serious injuries that are expensive to treat. Providing proper rehabilitation training would significantly diminish that likelihood.

BRS managers should be challenged to identify or develop programmatic changes that might result in cost savings without compromising quality. I submit, Mr. Chairman, that BRC managers have undertaken this challenge. The statistics verify that they have achieved significant changes resulting in substantial cost savings without compromising rehabilitation. We are fearful however, that increasing pressures from upper management to reduce cost will ultimately lead to BRS program officials compromising the tradition of excellence achieved over the past 53 years. Blinded veterans attending the residential BRC programs are evaluated and an individualized rehabilitation treatment plan is especially designed to address their needs. In our view, this approach, patient focused, and needs driven, is exactly the core values espoused by VHA. We submit for many blinded veterans the residential BRC is indeed the right place to deliver these comprehensive services. There is no mandated length of stay applicable to all blinded veterans. The length of stay is driven solely by need and the rate of progress necessary for the individual to develop healthy attitudes about self and blindness as well as acquire essential adaptive skills.

For each skill area within the comprehensive program, lesson plans are designed to build upon success. The veteran progresses to more complicated or advanced skill acquisition only after s/he has demonstrated command of the skill being taught. Systematically building upon individual success accounts in great part for the overall success of the BRC program. The pace at which a veteran moves from the basic to more complex varies from veteran to veteran- some may require more repetition than others. This is also driven by the individual needs and goals of each veteran- some may require a greater degree of complexity because of the potential lifestyle the veteran hopes to resume when reintegrated into his family and community. As the blinded veteran progresses in the program and gains proficiency with new adaptive skills, one can observe a corresponding marked increase in self-confidence and esteem. Contrary to what some VHA officials would have you believe, the BRC program is not a cookie cutter approach to service delivery. It is not one size fits all.

Data collection from the VA BROS program is not as far along because there are so few in the system. The trend does however suggest veterans do receive significant benefit from these programs and like the VA residential programs; they have out performed the non-VA programs.

## **B. VISUAL IMPAIRMENT SERVICES TEAM (VIST) PROGRAM**

The fundamental vehicle of service delivery to blinded veterans in the VA system is the Visual Impairment Services Team (VIST) program. VIST is an interdisciplinary team approach to the delivery of comprehensive services developed by VA more than 30 years ago. The program was the result of a pilot project sponsored by BVA, the American Foundation for the Blind (AFB) and VA. The failure of blinded veterans to utilize the benefits and services to which they were entitled precipitated this aggressive outreach effort. The isolating effects of blindness accompanied by the depression and feelings of overwhelming grief induced these veterans to remain in their homes. It is important to note the establishment of a VIST did not

require new resources; only the organization of existing professional disciplines already present at the medical centers that could deliver essential services to blinded veterans.

As a direct result of this outreach effort, newly blinded veterans learned that programs and services were available to assist them in working through the trauma of vision loss. Exposure to a full range of benefits and services, including rehabilitation, instills hope for resuming a meaningful and productive life.

The primary reason for the success of this vital program is the VIST coordinator. The Coordinator is the key member of the interdisciplinary team responsible for coordinating the delivery of comprehensive services. When the program was first established, the coordinator was a part-time position usually filled by the social worker assigned to the team. Shortly after its inception, it became evident that this position required a full-time coordinator to manage the expanding workload. It took nearly ten years before VA recognized this need and provided six full-time centralized VIST coordinator positions. Through subsequent years, that number has increased to 93. This would not have been possible without the intervention of these Committees from time to time, to encourage VA to provide more positions that are full-time. We have always maintained that any station that had at least 100 eligible blinded veterans on their rolls could support a full-time VIST Coordinator. Mr. Chairman, this program has been extremely successful in identifying blinded veterans not previously known to VA and coordinating the delivery of comprehensive services to these needy and deserving veterans.

As the program has evolved, a significant body of knowledge about blindness has been developed and shared among these professional providers. They have become the subject matter experts at VA facilities regarding blindness and appropriate services to assist in coping with the problems associated with vision loss.

Through the years, VIST Coordinators organizationally have been very vulnerable because they are essentially one-person services. In the new organizational structure, that vulnerability has become even more pronounced. There is no consistency throughout the system with respect to their organizational alignment. Consequently, they have become targets for cost savings reductions. As I reported last year, several stations had arbitrarily decided these positions were not full-time and VIST responsibilities had been assigned as collateral duties to existing social work staff. As VIST coordinator vacancies developed at these stations, management could not resist the opportunity to eliminate one FTEE and withdraw support for this vital program. Only one station attempted to submit statistical documentation to support the decision. However, the numbers sighted were irrelevant and unrelated to the purpose of the basic program. The other stations made no effort and in fact had no data, such as outcome measures or patient satisfaction surveys, to justify the elimination of the full-time position. All stations insisted they would provide all necessary services and blinded veterans would not experience any reduction in the level or quality of service. This has simply not proven to be the case. Fortunately as I indicated above, these situations were reversed, at least on paper. If these reversals are cosmetic as we suspect, the appropriate level of quality service will not be restored.

Unfortunately, these examples are becoming the rule rather than the exception. Nearly every time a full-time coordinator position becomes vacant, local management attempts either to

eliminate the position altogether or assign the duties to other medical personnel as collateral duties. This behavior only reinforces our contention that centralized management is required if the integrity of this vital program is to be preserved. In summary, Mr. Chairman, the VIST coordinator is the case manager through which the blinded veteran gains access to the full continuum of VA health and rehabilitative care. They are involved in the day-to-day lives of blinded veterans, serving as the catalysts for delivering the right service in the right place at the right time. In the past, the BRC has been the focal point for the delivery of services to blinded veterans. This is no longer the case. VIST should be the focal point for lifetime service delivery. Therefore, VIST should be protected, strengthened and expanded rather than diluted.

VHA repeatedly indicates that before any decisions which impact special-disabilities programs are made in the field, field managers are to consult with program officials at VA headquarters. This is not occurring. In fact, the field is extremely hesitant to talk with program officials in headquarters. On the rare occasions they have made contact, it is only to inform officials of their decisions regardless of that professional's knowledge or experience. It seems apparent that field managers have been given mixed messages. On the one hand, they are told they have decentralized decision-making authority and are free to manage their networks or facilities as they see fit given the available resources. On the other hand, they are being told in some areas such as special-disability programs, they do not have authority to independently make decisions that affect those programs. The increasing pressures on these programs may be symptomatic of the continual erosion of resources for health care. Regardless, it is increasingly more evident that greater centralized management control of the special-disabilities programs is definitely warranted.

These decisions are also difficult to understand in light of the emphasis VHA has placed on VA moving towards case management. VIST coordinators are exactly that, case managers. The VIST program has employed this methodology for 30 years with great success and we applaud VHA for moving in this direction for all veterans. It seems entirely consistent that these coordinator positions should be maintained and increased where appropriate.

The transition to managed primary care does not preclude the need for the VIST program as some in the field are attempting to maintain. The primary care team does not possess the knowledge, expertise, or frankly, the time to become experts in the field of blindness. Without a doubt, the primary care team can address the blinded veterans' medical needs. Issues more directly related to blindness should be referred back to the VIST coordinator to insure appropriate VA and non-VA resources are mobilized on behalf of the blinded veteran and his or her family. Yes, the family is directly impacted by the veterans' vision loss and if not properly educated regarding the ramifications of sight loss can often sabotage the rehabilitation or adjustment process. This can and does occur despite the best of intentions on the part of family members. Family training is another area in which VA BRS has made pioneering advancements. It is essential the family have realistic expectations for the blinded veteran upon completion of rehabilitation. Primary care teams cannot be expected to possess all the knowledge associated with vision loss, rehabilitation, family adjustment, community resources, and the full range of VA services available to blinded veterans and their families. Additionally, VIST coordinators review the blinded veteran's VA disability ratings annually to insure they are properly rated either for disability compensation or pension purposes. As you all know, the VA disability-

rating schedule is complex. Coordinators are extremely familiar with those sections of the code pertaining to blindness. Even more important in this regard, they have become familiar with those areas of the code that allow for Special Monthly Compensation (SMC) and increases that may be associated with combinations of disabilities. Knowledge of the latest prosthetic devices, sensory-aids, and appliances for the blind enhance the coordinator's ability to assist blinded veterans. Again, primary care teams do not possess this knowledge or expertise. Can there be any question that to facilitate the delivery of comprehensive services to this special group of veterans it is imperative highly qualified and skilled professional must be dedicated on a full-time basis to achieve the desired outcomes?

Mr. Chairman, if the VIST program did not embrace the concepts currently being implemented in VHA and did not have a proven record of accomplishment, we could understand the attempts to either curtail or eliminate this program. Again, we are painfully aware of the necessity to identify cost savings. Once again, we reiterate the VIST program is not the place to cut. This program provides a blinded veteran with access to essential services such as preventive primary care that can be scheduled by the medical center thus controlling workload. The absence of such workload management will certainly result in blinded veterans appearing in the emergency room with acute episodes that are much more costly to treat. Additionally, the availability of the full continuum of service available throughout the VIST clearly enhances the blinded veteran's opportunity to maximize his or her level of independent functioning. History demonstrates that a blinded veteran's ability to receive quality health care, essential information about his or her blindness, access to comprehensive blind rehabilitation, the latest in prosthetic devices for the blind, comprehensive review of VA disability rating, and community resources enables him/her to lead a more meaningful and productive life.

Achieving cost efficiencies in the delivery of healthcare service is directly contingent upon providing the right care in the right place at the right time. Who better to direct the blinded veteran to the most appropriate service to address his/her needs than the VIST coordinator?

Another tool the VIST coordinator utilizes to assist blinded veterans in their adjustment to sight loss is the support group. These are gatherings consist of other blinded veterans struggling with the same kind of adjustment issues, negative feelings, and problems within their families and communities. Special knowledge and expertise is required to conduct such a focused therapeutic group. There is an attitude that exists at certain facilities that blinded veterans are no different than any other veteran seeking care and do not require specialized services or care managers. This attitude is completely unacceptable and is not compatible with highly proclaimed customer satisfaction.

### **C. BLIND REHABILITATION OUTPATIENT SPECIALIST (BROS) PROGRAM**

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 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 for veterans having completed the residential program. VA BRS did not possess the work force to carry out effective follow-up to assess how effectively the veteran had transferred the newly learned skills to his home environment. Thanks to Congress earmarking \$5,000,000 for BRS in the FY 1995 VA Appropriation, BRS was able to establish 14 new BROS positions in 14 different facilities around the system. Following that time, four or more positions have been established. Although this is a comparatively small number of professionals, it provides VA with an excellent opportunity to evaluate the effectiveness of the rehabilitation approach and with what segment of the overall blinded veteran population is it most effective.

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, master's level blind rehabilitation specialists selected for these positions undergo extensive cross training at one of the BRC's. This 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 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, clearly is 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 indicated. If this proves to be the case, they may also provide some initial training before admission, thus potentially reducing the length of stay in the BRC. VA BRS is currently in the process of collecting functional outcome data, through the outcomes project mentioned above, for this new program. Once sufficient data has been collected, decisions regarding the effectiveness of this method of service delivery can be more appropriately evaluated. Given there are relatively few active BROS, sufficient data does not currently exist to unequivocally validate this treatment approach. 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 unable or willing to attend a residential BRC. Field managers, however, seem determined to accomplish all blind rehab services using this model, in effect fully dismantling the residential programs.

Mr. Chairman, the outcome measures gradually being implemented and continually refined by VA BRS will eventually provide a wealth of extremely valuable data about VA Blind Rehabilitation Services. There is hope this data will not only validate the efficiency of these services but also provide VA with a profile to determine just what method of rehabilitation intervention is most effective with each type of blinded veteran. Here again VA BRS is engaged in a pioneering effort. This type of data or data collection is unavailable anywhere in the field of blind services. Having a relatively complete profile outlining the rehabilitative needs of blinded veterans and what training model would be most beneficial in addressing those needs would be an extremely valuable tool for VIST coordinators as they assess the needs of a given blinded veteran. Such a profile should facilitate making the most appropriate referral. Provided the outcome data validates the outpatient delivery model, this could result in substantial cost savings.

We caution however, outcome measures must be fully implemented with sufficient data collection and analysis before programmatic decisions are made.

While we understand the urgency many network and facility directors feel to complete the transformation of the VA health care system and achieve substantial cost savings, we firmly believe these decisions must be based on solid data. In the case of the special disability programs, those decisions must await sufficient data collection.

Currently VA provides only three options in terms of rehabilitative service delivery, residential blind rehabilitation, BROS, and VISOR. The BROS is not much more than four years old and is still under development. Furthermore, 19 positions clearly do not provide equality of access to this model of service delivery. Additionally, the vast majority of blinded veterans do not have access to the service delivery option.

I am pleased to report however, that VA has initiated a new approach combining the features of a residential program with those of outpatient service delivery. The VAMC Lebanon, Pennsylvania established the Visual Impairment Service Outpatient Rehabilitation (VISOR) program. This approach employs the use of hospital beds for veterans to stay in for ten days while attending a regular blind rehabilitation training program. The beds do not enjoy 24-hour nursing coverage and essentially are similar to staying in a hotel. 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 this approach is very effective. Hopefully, additional data will give an accurate profile of which blinded veterans benefit most from this 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. They must continue to explore additional alternatives to addressing the needs of blinded veterans. Hasty decisions to move to new untested or unproven models must be strongly resisted.

#### **D. COMPUTER ACCESS TRAINING (CAT)**

Until the explosion in computer technology and the more recent advancements in adaptive access technology, blind people were at a distinct disadvantage obtaining essential information previously available only in print. As our society began to enter the information super highway, people with severe visual impairments or blindness were effectively left by the wayside. Adaptive access technology is now beginning to catch up with the information technology enabling people who are blind to access the same information sighted people have had access to from the onset of the electronic revolution.

Even more important is the increasingly popular opportunity to participate in e-commerce. Access to the internet enables blind people to conduct much of the business of daily living such as banking, shopping, and paying bills. Possessing this capability alleviates the need for transportation, which is a chronic problem for people who are blind. For a number of years, BVA advocated that VA provide computer evaluation and training for blinded veterans to enable

them to have similar access to information as their sighted counterparts. As you well know, employment today almost demands the ability to utilize computers for most entry-level positions and certainly is required for upward mobility. When BVA began advocating for this important evaluation and training, qualified instructors equipped to teach adaptive access technology were not available in the local community. Consequently, from our perspective it was imperative that VA BRS provide such services to enable blinded veterans to enjoy greater opportunities to obtain meaningful employment and to access essential information.

As the result of the FY 1995 appropriation with the special funds earmarked for VA BRS, monies were made available to establish Computer Access Training section (CAT) programs at the five major blind rehabilitation centers. 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. Ironically, as the waiting time for admission to the basic adjustment to blindness programs has declined, the waiting time for computer training has increased. During the intervening years, the private sector has begun to catch up in terms of having qualified providers who can teach adaptive access technology to the blind. BVA has been working with VA BRS encouraging the referral of eligible blinded veterans, when appropriate, to local resources for this vital training. We believe this approach will dramatically reduce the length of wait for veterans and substantially reduce the cost for VA.

Having to admit a blinded veteran into a VA BRC for this specialized training and housing the blinded veteran in a hospital bed is quite expensive. Local training would eliminate this expense and at the same time, it would be more responsive to meeting the veteran's needs. Unfortunately, this is an excellent example of VERA providing a disincentive for local managers. If they provide local training and recommended equipment, they are responsible for paying for those services. Referral to a VA BRC enables them to avoid those expenditures. Furthermore, VERA encourages referral to the BRC because this way the veteran qualifies for the high or complex reimbursement rate. Providing services locally is only reimbursed at the basic rate. This saves their facilities 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, this expansion of CAT beds is at the expense of basic adjustment to blindness beds. VERA also provides an incentive for increased CAT beds. The CAT program tends to be shorter than the basic program and therefore can move more veterans through the program and realize greater revenue or reimbursement at the complex care or high rate.

As outlined previously, quality must be assured if VA is to pursue contracting for this specialized training. To satisfy this objective, VA BRS can and should develop training protocols incorporating VA standards and necessary outcome measures that must be achieved to meet the obligations of the contract. We expect some resistance to this service delivery approach from the VA BRC programs because of turf issues and potential loss of sufficient workload to support the existence of the CAT programs. We believe there will continue to be sufficient workload for the CAT programs at the VA BRC because not all blinded veterans will have this specialized training available in their local communities. Therefore, they will continue to depend on the VA for these services. Let me be clear Mr. Chairman, we certainly are not recommending wholesale contracting authority, but we do feel this is one instance within the blind rehabilitation

array of services that could potentially realize cost savings without seriously compromising access to quality service.

## **E. VICTORS**

Another important model of service delivery that does not fall under Blind Rehabilitation Service 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 eligible for service. This typically is a very short (5-day) inpatient program wherein 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 there is a critical need for many more such programs.

## **VIII. BENEFICIARY TRAVEL**

Despite all the potential benefits to be realized from participating in blind rehabilitation, many veterans are not highly motivated to leave home after losing their vision, particularly the elderly. There are several reasons for this reluctance. For one, veterans are anxious about leaving their home and families for a period of six to eight weeks because they remain unconvinced that the proposed rehabilitation would be beneficial. Most of us had little or no experience with blindness or blind people before loss of our own vision and consequently, we were influenced by the negative stereotypes of blindness. Further, we had little confidence that rehabilitation would have any benefit. Depression, characterized by feelings of being overwhelmed and without hope, does not generate a high degree of motivation to reach out for help. Motivating such veterans to receive the rehabilitation that will prove beneficial to overcoming that depression is the primary task of the VIST coordinator.

The physical and emotional limitations inherent in sight loss are formidable deterrents for veterans seeking blind rehabilitation. Those limitations are severely exacerbated by the veteran's inability to travel to the appropriate BRC. Some blinded veterans are not eligible for Beneficiary Travel and therefore are expected to pay for their own travel to the BRC. In most of these cases, air travel is required because of the long distances involved and the price of airline tickets are cost prohibitive for these veterans. When motivation is marginal to begin with, the additional financial burden of transportation often proves to be the proverbial straw causing the veteran to decline rehabilitation.

When the beneficiary travel law was changed in part to reduce the VA cost for this program, we believe the law and subsequent regulations were intended to address beneficiary travel applicable to veterans traveling to their local VA facilities for care. The special disability

programs are only available at a few facilities around the system and require longer and more expensive travel. We strongly believe that if a veteran enrolled in VA health care must be referred to another VA facility other than the primary station to receive the care they need, VA should then be required to pay for those travel expenses. Although these veterans are normally outpatients when referred for blind rehabilitation, we believe for beneficiary travel purposes they should be treated as inter-facility transfers. This form of transfer is not bound by the general beneficiary travel regulations and relieves the veteran of the burden of paying for his or her own travel.

We understand VHA has completed a review of the beneficiary program to determine whether the amounts paid for travel should be increased, which they should be. However, VHA believed increases would negatively affect the medical care account and, given constrained funds, it was determined not to provide such increases. BVA hoped, because of this program review, that VHA would offer a legislative initiative to amend Title 38 to provide a waiver of beneficiary travel for those veterans accepted for care in special disabilities programs. Mr. Chairman, we encourage these Committees to consider favorably an amendment to Title 38 governing beneficiary travel, and an exception for beneficiary travel associated with participation in one of the special-disabilities programs. Exceptions should only be granted to veterans who have been accepted for care at the receiving facility. In the case of blind rehabilitation, there is a very formal and detailed application procedure for admission to a BRC. An application must be completed at the veteran's home facility and then forwarded to the appropriate BRC. Clearly, therefore, these are veterans who are patients enrolled at one facility that is unable to provide the necessary care and who have been accepted by a distant VA facility capable of providing the needed services. The cost to expand the travel eligibility to these veterans would certainly be minimal for VA. If the responsibility continues to fall on the veteran, it will surely serve as a deterrent to blind rehabilitation or any other specialized program that requires veterans to travel great distances at their own expense.

Further complicating this entire issue is the fact that these same veterans, determined not to be eligible for beneficiary travel, are also required to pay the social security co-pay for their episode of care. The vast majorities of blinded veterans who fall into this category have income that barely exceeds the NSC pension threshold and certainly are not in a position to pay the co-pay, let alone the expenses associated with travel. BVA respectfully requests these Committees to consider further amending Title 38 in addition to the beneficiary travel law, exempting from means testing veterans in need of the services provided by special disabilities programs. Mr. Chairman, there are not many wealthy blind people, particularly veterans. Furthermore, necessary services are not readily available in the local community. The specialized nature of these services and the VA's international reputation for being the premier provider should not be denied to blinded veterans.

## **IX. PROSTHETIC SERVICES**

Crucial to the rehabilitation of blinded veterans is the proper prescription of sensory aids and appliances. As outlined above, it is the blind rehabilitation specialist that prescribes the appropriate adaptive equipment to assist in overcoming the handicap of blindness. Fundamental

to the process is the timely and accurate procurement of these devices. The professional service that manages this activity is Prosthetics and Sensory Aids Service (PSAS).

More than 10 years ago, the Senate Committee on Veterans' Affairs conducted an oversight hearing on prosthetic services because of numerous reports of severely disabled veterans not receiving essential prosthetic devices in a timely manner. Indeed, many of these veterans had to wait months for prosthetic limbs and other appliances critical to independent functioning. That hearing exposed the fact that dollars allocated to the local facilities for prosthetics were being utilized for other medical center functions rather than for essential prosthetic services. Many of the major VSO's testified at that hearing, reporting on the failure of VA to provide these services and the ensuing consequences that affected the quality of life for our nation's severely disabled veterans. We also testified in support of centralized funding for prosthetics services to insure sufficient dollars for these services, and to ensure that appropriated funds for prosthetics were appropriately utilized to purchase prosthetic equipment rather than to support other medical center functions. Further, we believed the method of funding these vital services would lend itself to closer monitoring of these appropriated dollars.

As a direct result of the hearing and its findings, VA did in fact implement centralized funding for prosthetic services. A dramatic reduction in the number of complaints surrounding delayed orders and difficulties in receiving prosthetic devices was experienced almost immediately. Despite this significant improvement in service delivery, VA management, particularly at the local level, had attempted to have the prosthetic funds decentralized once again and nearly every year thereafter. Obviously, the motivation is to have the opportunity to utilize those funds for purposes other than for providing prosthetic services. Clearly, this is just another symptom of the magnitude of the under-funding of veterans' health care. Despite the vigorous opposition by the major VSO's and the Federal Advisory Committee on Prosthetics and Special Disabilities Programs, Dr. Kizer decentralized prosthetics funding to the networks.

Mr. Chairman, BVA was encouraged by the action taken by Dr. Kizer to strengthen the PSAS program and eliminate the problems identified two several years ago. He began by returning Mr. Fred Downs to the Chief Consultant for the PSAS Strategic Health Group (SHG) position. Dr. Kizer also provided two additional FTEE for the VA headquarters staff. This has enabled PSAS to monitor more aggressively prosthetic activities in the field. Further, an aggressive Prosthetic Program Reengineering Project (PPRP) was implemented. This has resulted in significant improvements and provided electronic methods for tracking prosthetic expenditures, insuring appropriate uses of these dollars. A direct outcome of the PPRP project has been the development of the National Prosthetic Patient Database (NPPD). This is an extremely powerful tool to assist PSAS managers. They can virtually monitor prosthetic activities, which provides invaluable data regarding not only who ordered an item, for which it was intended, when the order was placed, and whether the order was properly coded.

As mentioned above, BVA has strongly supported centralized funding for PSAS. We were very pleased by Dr. Garthwaite's decision to resist pressures from the field and re-centralize Prosthetic funding, as the dollars being spent resulted in an increase in delayed orders. Additionally, BVA is also encouraged by the decision to establish lead prosthetic representatives for each network. These positions are referred to as VISN Prosthetic Representatives (VPR).

These individuals are responsible for developing an integrated network prosthetic plan that would include the budget, PSAS activities at each facility within the network, and educational and training needs for staff. Initially, the selection of these positions has been slower than anticipated, however, and this seems directly related to efforts on the part of several networks to assign VPR duties collaterally to an existing Prosthetic Representative. Clearly, this new position must be full-time and filled by an individual with a strong background in prosthetics as well as management. As in other positions we have described above, there has been a tendency to try to fill these new positions with individuals who do not meet these basic criteria.

Generally, we are pleased with the progress to date with this new concept for managing the prosthetic program, and we feel it holds great promise for the future. For this management concept to be effective however, it is essential that the VPR be authorized to manage the prosthetic budget for the network and make appropriate staff level and salary decisions. Some of the VPR's have been given that authority and in fact, a directive from Dr. Garthwaite authorized the prosthetic budgets to be co-managed by the VPR and the VFO. The necessary tools are in place to allow PSAS SHG to accurately monitor prosthetic activities and advise the USH of any problems or deficiencies that may develop.

BVA continues to be frustrated by the abject defiance of some network directors regarding the responsibilities, authority, and scope of operation for these VPR positions. Such directors have chosen to ignore directives from the USH regarding these issues and there is no evidence they are being held accountable for their actions.

Mr. Chairman, we also question the level of support for the prosthetics program demonstrated by most network directors. Since the adoption of the Eligibility Reform Act, the prosthetic workload has increased by 87 percent with only a 13 percent increase in FTEE to manage this increased workload. First quarter delayed order reports for PSAS show more than 11,000 delayed orders. The reason given for more than 8,000 of those orders is excessive workload and inadequate staffing. Although facility and network directors no longer have the financial burden of paying for prosthetics with the return to centralized funding, they absolutely must support the service with appropriate staffing levels. Further complicating the staffing situation is the refusal on the part of many high-level managers to properly grade the prosthetic purchasing agent positions. Consequently, PSAS is experiencing an unusual rate of turnover. Employees are working numerous unreported overtime hours, both paid and unpaid, in an effort to keep up. They are becoming quickly burned out and look for other employment opportunities with higher pay and more reasonable workloads.

Despite the positive improvements, such as centralized funding and the establishment of VPR positions, one of the most significant problems confronting prosthetics is the lack of qualified professionals to assume the duties of the prosthetic representative. The prosthetic training program that operated very successfully for many years has been discontinued and this action has eliminated an excellent source of highly trained and qualified personnel prepared to move into these valuable positions. Failure to restore the training program and accompanying funding will certainly result in increasingly unqualified individuals being selected to fill prosthetic representative positions. The quality of service to disabled veterans assuredly will suffer as a direct consequence.

Mr. Chairman, I discussed in some detail the BRS Outcome Project, which is developing a functional outcome database from which management decisions conceivably can be made. We believe the next step in this process is to enable the database to talk or interface directly with the NPPD. Both are powerful tools for monitoring their respective activities. Think how much more effective and efficient each service might be if blind rehab professionals could analyze functional outcomes not only in terms of the rehabilitation model employed, but the impact of prosthetic aids and appliances prescribed on the rehabilitation outcomes.

With this in mind, BVA is very pleased by the new initiative underway within prosthetics service. Specifically, it has launched the Prosthetic Clinical Management Program whose focus is on the quality of prescriptions rather than solely on the dollars expended. Panels of experts in each network will be established to review prescriptions and their impact on the overall well-being and improvement in the quality of life of veterans. We are convinced this is where the focus should be and believe this will contribute dramatically to improved quality of care. We are particularly interested in this approach because the chapter in the new PSAS Handbook related to the provision of aids for the blind is unacceptably restrictive. Specifically, it denies qualified local providers from prescribing or providing certain aids for the blind without the approval of a BRC Chief. Now, with the ability to accurately monitor prescriptions at each facility through the NPPD, inappropriate prescription and issuance practices can be exposed and properly dealt with.

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. The workgroups have been tasked with developing specifications for the device and guideline for issuance. The intent of the specification development is to facilitate establishing national contracts for the device if the majority of devices are procured from one vendor.

Unfortunately, VSO's were not permitted to participate in these initial workgroups. We were gratified however, that after several such groups had begun their work, VSO's were invited to participate. BVA was so represented on a work group developing specification and guidelines for the issuance of CCTV's. This very useful low vision aid enables many severely visually impaired veterans to manage visual tasks, including reading as they have in the past. We are outraged however, that BVA's recommendations and suggestions have been totally ignored, and extremely unacceptably restrictive guidelines have been recommended by this workgroup. Hopefully, at the next level of review, we will be successful in changing these antiquated and restrictive recommendations.

## **X. WOMEN'S PROGRAMS**

BVA commends the VA on its progress in establishing gender specific services for our nation's female veterans. Although there is much work to accomplish, dramatic progress has been made to provide essential services to women who have served America as faithfully as their male counterparts. BVA believes that female veterans have greater access to VA medical care facilities, and that there is a great opportunity for women who are experiencing vision loss to access the valuable services available to help overcome this devastating disability. In the past, when a female veteran applied for service, she was usually contracted and did not have the

opportunity to be referred to the VIST coordinator. Hopefully that trend will be substantially reduced and the women's coordinator can work closely with the VIST coordinators to insure that eligible female veterans can and do receive these vital services.

## **XI. 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. The final GAO report on this issue released last year, further documenting VA's failure to maintain capacity, should be the focus of the hearing. This would be particularly timely given the passage of H.R.3447. Such a hearing should explore VHA's plan to implement the new requirements with respect to reporting on capacity. How these specialized services are being integrated into the new managed primary model of health care delivery must be thoroughly examined. Additionally, the VERA model must be reviewed in terms of its applicability to the special programs.

The major question concerns the appropriateness of a capitated model of resource allocation for these programs. Furthermore, we have maintained that the issue of centralized management and funding should be explored in greater debate as we believe other questions need answers such as the role of the program officials at VA headquarters. If the special disability programs are national in scope, who is responsible for developing and disseminating the national guidelines and performance standards for these programs? In the same context, do the special program managers at VA headquarters have any real authority or responsibility for the conduct of the programs in the field? Ongoing oversight hearings could shed light on these important issues and assist in protecting these programs as intended by the Eligibility Reform Act.

## **XII. OTHER VETERANS' ISSUES**

### **A. HOMELESS VETERANS**

As you know, the homeless veteran population is a major concern of the VSO's. BVA believes no man or woman who would willingly risk his or her life for this great nation should be homeless. We commend the members of these Committees for introducing and moving through the first session of the 107th Congress the progressive homeless veterans legislation. There are several initiatives within the areas of employment, health care, housing, prevention, and technical assistance that must be funded at their authorized appropriation level, at the very least, as most of these programs are desperately under-funded. Ending the cycle of homelessness, not simply producing "band-aid" fixes, should be the aim of these Committees and Congress as a whole.

Following are just a few of the many programs that we believe need the support of these Committees:

◆ **Appropriations at an authorized level for the Homeless Veterans Reintegration Program**

The capstone of employment efforts for homeless veterans has been the *Homeless Veterans Reintegration Program (HVRP)* of the Department of Labor (DOL).

◆ **Access to mainstream DOL programs for homeless veterans**

Mainstream programs are not reaching the homeless veteran population. Homeless veterans have many barriers and complex life circumstances which make them difficult to serve. The current DOL-targeted program for veterans (2700 federally funded staff positions, DVOP/LVER) should be but is not effective for homeless veterans, except in a handful of locations across the nation.

◆ **Improvement of Service Members' Transition Programs and Services**

BVA is concerned about the number of recently discharged service members that do not have adequate life skills to reintegrate into civilian life and thus prevent them from becoming at risk for homelessness. BVA supports 1) a proactive assessment of all separating service members to determine those at risk, and 2) training in life skills for such service members prior to and for a period after release.

### **XIII. LEGISLATIVE PRIORITIES**

BVA believes these issues are vital to the survival of the 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 continuation of full funding for the core appropriation for VA health care. Authorizing VA to retain third-party collection should be viewed as a supplement to, and not a substitute for, core appropriations. Veterans' insurance companies should not be required to pay for veterans' health care, as this is clearly a moral responsibility of the federal government.
  
- B. 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, 2002. 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, though 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 SC disability compensation or DIC

benefits. The income of spouses of deceased veterans should have no bearing on the DIC benefit.

- C.** BVA strongly supports legislation that would allow concurrent receipt of military retirement pay based on longevity and SC Disability Compensation. We urge your support for the concepts embraced in the Military Retirement Restoration Act of 2001: H.R. 303 introduced by Mr. Bilirakis, and the companion bill, S.170, introduced by Senator Reed. We commend both of these men but especially Mr. Bilirakis for his persistence on this important issue. We appreciate inclusion of concurrent receipt in the FY 2002 Defense Authorization Act (DOA) and trust Congress will provide the necessary funding in FY 2003 appropriations whether requested by the Administration or not.
- D.** Medicare subvention is an issue critical to the future funding of VA health care programs. Considerable discussion of this issue has occurred during the years with strong resistance coming particularly from the House Ways and Means Committee on Health, 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 second session of the 107th Congress. Authorizing VA to bill Medicare for services provided to certain veterans seems to be a win-win situation. VA benefits from additional revenue to supplement core appropriations and the Medicare trust fund benefits because VA will be reimbursed at a discounted rate. There is no question VA should be given the opportunity to demonstrate its ability not only to collect these funds but also afford the trust fund with real savings.
- E.** BVA supports passage of the Medicare Vision Rehabilitation Coverage Act, affording all blind Americans access to highly qualified rehabilitation specialists. This bill was introduced in late 1999 as HR 2870 and has been reintroduced again as H.R.2484. Failure to insure this access is blatant discrimination against people who are blind. The federal government (Medicare) should provide leadership in this regard and private insurance companies will hopefully follow suit. From the blinded veterans perspective, adoption of this Act would provide an additional source of needed revenue for VA once Medicare subvention is approved.
- F.** Any settlement by the federal government with the tobacco industry, allowing government health care providers to recover the cost of health care services to individuals suffering health related problems associated with the use of tobacco, must include the VA. In our view, any funds received through such a settlement should first be used to restore adequate core appropriations for VA health care before any new initiatives are entertained. Additionally, settlement funds should be used to offset the government's cost-paying compensation to veterans determined to have disabilities related to tobacco addiction acquired in the military.

**G.** As the federal government seeks to strengthen homeland security, VA receives 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.

**H.** Again, BVA requests these committees support of S. 984: The Veterans Road To Health Care Act 2001. Introduced by Senator Enzi last summer, this bill amends Title 38 and authorizes VA to pay travel costs associated with veterans attending a VA special-disabilities program as well as the amount reimbursed per mile for SC veterans' medical appointments. We also recommend amending the Means Test Law exempting catastrophically disabled veterans from SSA co-pay responsibility when receiving service from a special disabilities program.

**I.** Several years ago, the Social Security benefits were modified to allow seniors between the ages of 65 and 69 to retain more of their earned income before losing any of their social security benefits. After five years, this group would be able to earn up to \$30,000 per year before they experience any reduction in their social security retirement benefits. Moreover, they would only lose one dollar for every three dollars by which they exceed the earned income limitation.

- a. Subsequently, SSA has been reformed to remove all earned income limitations for this group. Seniors now have no limitations on income without the loss of Medicare benefits. Before the change in the law, blind Social Security Disability Insurance (SSDI) beneficiaries had their income earning limitations, known as Substantial Gainful Activity (SGA) levels, directly linked to that of seniors. The new law severed that linkage. Worse was that when a blind SSDI beneficiary exceeded the SGA level by as little as one dollar, they lost the total benefit.

We believe the same elimination of earned income limitations should be provided to blind SSDI beneficiaries. BVA strongly urges support for such a measure. Mr. Ehrlich has introduced H.R.498: The Blind Empowerment Act of 2001 and Senator McCain has introduced S. 682: The Blind Persons Earning Equity Act of 2001.

**J.** Under current law, the SSA is required to evaluate claims for disability benefits using a definition of legal blindness found in statute. This definition requires specific diminution in one's visual field, which is determined primarily, if not exclusively, by using a procedure called manual perimetry, or the Goldmann perimeter. For a number of years now optometrists have been moving toward another standard for visual field testing, automated perimetry, and especially the Humphrey automated perimeter. These two technologies do not always give comparable results.

The Social Security Administration has engaged researchers, and held meetings with advocacy groups and medical professionals, to address the impact of this changing technology on the Administration's ability to accurately evaluate the disabilities of claimants seeking benefits under the statutory blindness definition. Many have suggested that the key to resolving this issue is a change in the definition of statutory blindness, which would reflect changes in technology. Others have suggested changes that are more sweeping. It is noteworthy that many government programs rely on the definition of blindness used by the SSA in establishing their own eligibility criteria. Therefore, substantial changes in this definition could affect programs and services for the blind nationwide. A much narrower definition, for example, may result in denial of disability benefits to individuals who should qualify because of severe vision loss. A broader definition could extend the criteria established in the listings to many individuals who might not be considered statutorily blind under the current definition, thereby diluting already scarce resources to persons currently defined as blind.

- K.** 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.

BVA strongly urges all members of these committees to become original cosponsors of H.Con Res introduced last year by Mr. Evans. The resolution expresses the sense of Congress that every state requires all applicants for driver's licenses to demonstrate knowledge and awareness of white cane laws. White canes and guide dogs are widely recognized symbols of their users blindness. Far too many incidents occur each year where people who are blind or their canes are run over by motor vehicles. We believe this is a non-controversial resolution deserving of your support. The safety of blind people is at risk and we trust you will not allow this resolution languish. There are no costs involved and as you know it is non-binding.

- L.** BVA also seeks your support for accessible voting for all disabled Americans. As both chambers of Congress consider election reform legislation, we strongly encourage each of you to insist that any such legislation contain a provision mandating that every polling place in the U.S have at least one voting machine fully accessible for the visually impaired and blind. Blind and visually impaired citizens should have the right to independently cast his/her vote in secret. Technology currently exists to achieve this goal. Many of our members lost their vision in an effort to protect this freedom. Additionally, every polling place should be fully accessible for all Americans with physical disabilities.

#### **XIV. CONCLUSION**

Once again, Mr. Chairman, thank you and these Committees for this opportunity to present BVA's Legislative Priorities for 2002. BVA is extremely proud of our 57 years of continuous service to blinded veterans and all the accomplishments we have enjoyed. Our relationships with the 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 56th National Convention held last August in Las Vegas, Nevada.

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 those services. There is no question that VA's services for the blind are the finest in the world. Our ongoing efforts are to ensure 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.