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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



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I. Introduction

Mr. Chairman and members of these distinguished Committees, on behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to present BVA's legislative

priorities for 2003. We welcome to these Committees Senators Bunning, Ensign, Graham and Murkowski, and Representatives Beauprez, Bradley, Brown-Waite, Hooley, Michaud, Renzi, Ryan and Strickland. These Committees are known for being the most bi-partisan in Congress. We sincerely hope this trend continues in this 108th session as we all work toward the same goal: caring for America's veterans. BVA would like to acknowledge the passing of Senator Paul Wellstone. His passionate advocacy for our nation's veterans will be missed greatly.

The Blinded Veterans Association is the only congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. Later this month, BVA will celebrate its 58th year of continuous service to America's blinded veterans and their families. We are especially proud of the close working relationship and strong support we have enjoyed from these Committees through the years. Together we make a substantial difference in the quality of life for the men and women who have sacrificed so much for our freedom.

BVA and its members are strong ambassadors for VA's blind rehabilitation programs. Throughout our 58 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 and the programs and services designed by VA to address their special needs.

Mr. Chairman, I come to you this morning with some very deep concerns about the accessibility to rehabilitative services for blinded veterans. Over 2,500 blinded veterans await entrance into VA residential blind rehabilitation centers. We believe the Department of Veterans Affairs Blind Rehabilitation Service must undergo a fundamental change in its method of service delivery. BRS must work to increase outpatient initiatives and provision of localized services. VA must assure that these outpatient initiatives will be reimbursed at an adequate rate under VERA 10, so that Veteran Integrated Service Networks (VISNs) will support outpatient services. VA's world-renowned residential blind rehabilitation centers must be fully staffed in order to maintain their unparalleled reputation of quality rehabilitation services for blinded veterans.

Unfortunately, blind rehabilitation has fallen victim to all the same problems that the larger VA system is facing: long waiting lists for services, lack of adequate staffing, and a need for accountability and oversight.

Dr. Robert Roswell, VA Under Secretary for Health, recently reported that as the result of VA's transition from a hospital-based health care system to an ambulatory managed primary care system, the health care system is now out of balance. Unlike the larger health care system, VA BRS did not embrace the transition from hospital-based rehabilitative care to outpatient care, but has steadfastly maintained the inpatient approach to the provision of blind rehabilitation services.

As a consequence of failing to develop and implement outpatient models of blind rehabilitation, many of the residential or inpatient BRCs have lost capacity because essential

professional staff positions have been taken to support other outpatient priorities in their respective VISNs.

In our view, while Dr. Roswell struggles to achieve a more appropriate balance between tertiary and outpatient care, VA BRS must, for the first time, establish an appropriate balance between inpatient and outpatient service delivery by expanding its capacity to provide outpatient services at the local level. This is absolutely imperative if the unique and special needs of an aging veteran population with severe visual impairment and blindness are to be served.

II. Background

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

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

Mr. Chairman, there is absolutely no question that comprehensive residential BRCs provide the ideal environment to maximize a blinded veteran's opportunity to develop a healthy and wholesome attitude about his/her blindness and acquire the essential adaptive skills to overcome the handicap of blindness. This is especially true for newly blinded veterans.

III. Current Services

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

A. *Blind Rehabilitation Centers*

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

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

B. *Visual Impairment Services Team (VIST)*

The mission of each VIST program is to provide blinded veterans with the highest quality of adjustment to vision loss services and blind rehabilitation training available. To accomplish this mission, VIST will establish mechanisms to maximize identification of blinded veterans and offer review of benefits and services for which they are eligible. The VIST was created in order to coordinate the delivery of comprehensive medical and rehabilitative services for a blinded veteran. The "teams" were created in 1967. In 1978, VA established six full-time VIST Coordinator positions. Currently, the VA system employs 92 full-time Coordinators, which serve as the case managers for an estimated 35,000 blinded veterans. VA researchers estimate there may be over 100,000 blinded veterans nationwide.

A few of the VA VIST Coordinators have been very aggressive and have identified local resources capable of delivering needed services to blinded veterans in their homes. Regrettably, only a few are managing such dynamic VIST programs; the majority relies on the VA BRC. If the veteran is unable to attend that program, he/she goes without service. Mr. Chairman, this is unacceptable. Given the increasing numbers of severely visually impaired and blinded veterans, BVA believes and has always maintained that any VA facility that has 100 or more blinded veterans on its rolls should have a full-time VIST Coordinator. Lack of service provision is due to local facility management seeking to avoid costs. Once again, the reimbursement allocation

model serves as a significant disincentive. BRC managers also contribute to this lack of service delivery because of the traditional belief that the only place a blinded veteran can receive high quality rehabilitative services is at the VA BRC. Consequently, they have insisted that BRS policy be extremely restrictive in this regard. This culture must change.

C. *Computer Access Training (CAT)*

As a result of the FY 1995 VA Appropriation with the special funds earmarked for VA BRS, monies were made available to establish Computer Access Training (CAT) programs at the five major 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.

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

D. *Blind Rehabilitation Outpatient Specialist (BROS)*

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

The BROS is a highly qualified professional who, ideally, is dually certified; that is, having a dual masters degree both in Orientation and Mobility as well as Rehabilitation Teaching. In the absence of such dually credentialed professionals, masters level blind rehabilitation specialists should be selected for these positions and receive extensive cross training at one of the BRCs. This 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, the BROS may also provide some initial training before admission, thus potentially reducing the length of stay in the BRC. VA BRS has collected functional outcome data, through the outcomes project, for this new program. Given that there are relatively few active BROS, sufficient data does not currently exist to unequivocally validate this treatment approach. However, current data trends do strongly suggest that this is a viable approach to service delivery deserving of expansion. Clearly, given the rapidly aging veteran population and the increased prevalence of blindness associated with aging, there certainly will be an increasing number of severely visually impaired and blinded veterans who will be at risk but who are unable or unwilling to attend a residential BRC.

The BROS program provides an excellent opportunity to test, refine, and validate the effectiveness of outpatient service delivery. It assists in determining which veterans can receive maximum benefit from this rehabilitation model. Even if providing services locally on an outpatient basis is the right thing to do, there are sufficient disincentives in VERA that discourage this approach. Currently, there are 20 BROS positions scattered around the system, and, based on their experience, many more such positions should be established. This is not likely, 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 that 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. BVA understands that VERA is continually being refined. It appears that the revised model (VERA 10), as announced, will not remove the disincentive. However, we are encouraged to hear that efforts are currently underway to further refine VERA 10 to more equitably reimburse all components of a full continuum of blind rehabilitation services.

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

E. Visual Impairment Services Outpatient Rehabilitation (VISOR)

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

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

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

This model combines the benefits of the residential model with those of outpatient service delivery. Unfortunately, however, the program is reimbursed at the basic rate rather than the complex care rate. Although it may be arguable whether this model requires the high or complex rate of reimbursement, it clearly requires more than the basic rate. Local and Network management will certainly resist establishing alternative models if they are not properly funded. This type of innovation should be encouraged rather than discouraged. Additionally, this new model of service delivery may prove to be an effective method for meeting the rehabilitative needs of an older visually impaired veteran population.

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

Another important model of service delivery that does not fall under VA 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 considered for this service. This typically is a very short (five-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 that there is a critical need for many more such programs. In fact, expansion of the rehabilitative programs could further assist severely visually impaired (legally blind) or blinded veterans who have already attended a residential BRC and received low vision aids. The effectiveness of those aids could be reviewed and new prescriptions written when appropriate. This would avoid the necessity of readmission to the much more expensive BRC for such reviews and evaluations.

IV. Effects of VERA on Rehabilitation

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

BVA is extremely concerned about the abuses of the VERA currently taking place at the expense of the blinded veterans receiving services. At least two BRCs have established a very short one to two week program, while another BRC implemented a three-day program for vocational interests in order to increase the number of admissions, thus increasing the number of veterans who qualify for the high reimbursement rate. These so-called short programs certainly do not translate into comprehensive residential blind rehabilitation, nor should they qualify as complex care. Indeed, they do not require admission to a BRC at all. If these services are necessary, they should be provided either in a hoptel environment or, even more appropriately, in the veterans' home area. More focused outpatient programs (using hoptel beds) are not reimbursed at the higher rate. The incentive is to admit to the inpatient bed. When Blind Rehabilitation Centers institute shorter programs, veterans are shortchanged. Programs such as VICTORS and VISOR admit a very focused population--veterans with high residual vision (usually macular degeneration) and few, if any, co-morbidities. If these short programs within blind rehabilitation centers are needed at all, and this is questionable, they are services that should be provided in the veteran's local area. Valuable time should not be taken from those

blinded veterans needing full comprehensive residential blind rehabilitation at a BRC in the name of the almighty dollar.

A blinded veteran must spend at least one day in a BRC bed to qualify for the high reimbursement rate paid for complex care. Under the current methodology, the reimbursement rate goes to the veteran's host Network on a pro-rated basis. That is, if the BRC providing the blind rehabilitation is located in another Network, the cost of that care is allocated to that Network and the remainder of the high reimbursement rate remains within the 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.

V. 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 that the specialized programs for which the Network and facilities are receiving the high reimbursement rate are indeed being utilized for those purposes. Theoretically, VERA provides Networks with sufficient funds to operate the special disabilities programs. Unfortunately, BRCs are continually required to share in facility FTEE reductions or freezes as a result of funding shortfalls. Field managers strenuously resist demanding this degree of accountability. They complain that this will infringe upon their flexibility as managers to establish priorities and carry out their assigned missions. This is an example of what Dr. Roswell referred to as the system being out of balance. Priority has been given to establishing greater capacity for outpatient services and new Community Based Outpatient Clinics (CBOCs) at the expense of tertiary care capacity.

Clearly, it is much more cost effective for the system as a whole to provide services locally, when appropriate, rather than referring a veteran to a residential program some distance from his/her home. Unfortunately, local facility managers do not view this option as cost effective. Indeed, it is more costly than the 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, that there is a growing segment of the blinded veteran population who, for whatever reason, cannot or will not attend a residential program while they still have needs that must be addressed.

VI. 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.

A. *Flawed Capacity Report Data*

BVA maintained throughout VHA's 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. Network and facility managers must be held accountable for maintaining capacity. Failure to maintain capacity has resulted in operating beds being taken out of service. Consequently, substantial waiting lists and times persist at all BRCs. A blinded veteran may wait up to one year for admission to a blind rehabilitation program.

All of 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. 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 of VA Headquarters. The decentralized management authority has negatively affected other specialized services provided to blinded veterans. Specifically, the positions that local or Network managers have attempted to either eliminate or substantially alter are those of the Visual Impairment Services Team (VIST) Coordinators and the Blind Rehabilitation Outpatient Specialist (BROS) positions. In almost every instance, BVA and VA Blind Rehabilitation Service (BRS) have found it necessary to involve the Deputy Under Secretary for Health for Management and Operations to reverse such negative decisions. Once again, these local decisions are being driven not by veterans' needs but by cost. Blinded veterans have experienced significant disruptions in service or, in some cases, a total lack of service. Again, we believe this is another reflection of a significant lack of resources to fully operate the VA health care system.

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. Almost none of the services currently provided to blinded veterans 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 that 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 that 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. 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. The success of a VA Plus Choice program is directly dependent on achieving these critical changes.

VII. Oversight

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

VIII. Department Of Veterans Affairs FY2004 Budget Request

The President's FY 2004 Budget Request is a prime example of the urgent need for mandatory funding. The gaming must end. BVA urges the members of these Committees to support mandatory funding. Like many, BVA was pleased to hear that the Administration's FY 2004 Budget request for VA would include an historic increase for veterans' 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. Nevertheless, they will hardly allow the Veterans Health Administration (VHA) to recover from this year's shortfall. As in past years, VA is being forced to rely more heavily on first and third party collections to substitute for appropriations. While members decry the Administration's reliance on Third Party Collections, Congress has failed to provide adequate appropriations to sufficiently fund the VA health care system. Responsibility for the constant underfunding of VA health care through the discretionary process rests with both past and present Administrations and Congress. Public policy must clearly define for whom VA is to provide care and, once that policy has been established, Congress and the Administration must provide the necessary resources to care for those veterans. Mandatory funding appears to be the best approach to achieve this goal. The recent delay in FY 2003 funding makes an argument for mandatory funding even stronger. Operating at the FY 02 level for the first five months of the new fiscal year was devastating for VA.

VA grossly underestimated the numbers of veterans that would enroll in its 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 services such as blind rehabilitation suffered as a result. Many BRCs are experiencing shortages in blind rehabilitation specialists and are therefore unable to operate all authorized beds. Therefore, waiting lists and times will continue to increase.

IX. Independent Budget

BVA is very proud to endorse the Independent Budget (IB), prepared by four of the major VSOs: AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars. This is the 17th 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 2003 appropriations recommended for health care is, in our view, essential if VA hopes to keep pace with the increased costs in salaries, benefits, goods, and services utilized by VA. Additionally, the recommended funding level will also enable VA to more adequately fund the Congressionally mandated initiatives adopted last year. We also firmly believe this funding level is necessary if the special disabilities programs are to be protected. The recommended increase in VA medical and prosthetic research is also vital to VHA's mission. The funds are critical to VHA's ability to attract and retain clinicians who are also seeking the opportunity to conduct research.

X. Prosthetic Service

BVA is carefully observing the relatively new initiative underway within VA's Prosthetic Service. The stated focus of the Prosthetic Clinical Management Program (PCMP) is the quality of prescriptions rather than solely on the dollars expended for the prescriptions. Panels of experts in each Network have been 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 such a focus will contribute dramatically to improved quality of care. BVA is particularly interested in the approach. We are hopeful that it will result in the establishment of national prescription recommendations and issuance criteria that have been sorely absent within BRS. Now, with the ability to accurately monitor prescriptions at each facility through the National Prosthetic Patient Database, 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 work groups have been tasked with developing specifications for the device and recommendations for issuance. The intent of the specification development is to facilitate the establishment of national contracts for a device if the majority of the devices are procured from one vendor. BVA has some reservations regarding the potential for standardization on the belief that one size fits all. Severely disabled veterans need to be treated as individuals with unique needs who might not always benefit from the more standard device. The opportunity must exist for clinicians to prescribe items not on national contract, even if they are more expensive, without fear of reprisal from local or Network management.

BVA is extremely pleased and encouraged by the decision to reinstate the Prosthetic Representative National Training program. Prosthetic Service, like many other services within VHA, is facing a significant loss of experienced Prosthetic Representatives. For the past several years, VA did not have a program to adequately train professionals to assume these vital positions as they became vacant.

XI. CARES Phase II

BVA was very skeptical when the plans for CARES Phase II were initially rolled out last June. Originally, there was no plan to address the future needs of the special disability populations. Thanks to the hard work of the VSO community, efforts are being made to include the needs of our veteran special disability populations. VA Rehabilitation Strategic Health Care Group recommends the following steps be taken to meet the future needs of our nation's blinded veterans: restore residential blind rehabilitation centers to their Congressionally mandated capacity levels (FTEE and beds), initiate a VISOR program in every NETWORK which does not host a blind center, add a BROS in every site which employs a full-time VIST Coordinator, and establish low vision clinics in all tertiary facilities. Fortunately, because of the clinical interface between the Rehabilitation Research and Development Center at Decatur, GA, and Blind Rehabilitation Service, both epidemiological and functional outcome data is readily available so that Network planners can develop planning initiatives to address gaps in service delivery for blinded veterans.

XII. Other Legislative Priorities

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

- A.** BVA strongly encourages passage of legislation instituting mandatory funding of VA health care.
- B.** Authorizing VA to retain third-party collection should be viewed as a supplement to, and not as a substitute, for federal funding. Veterans and their insurance companies should not be required to pay for veterans' health care, as this is clearly a moral responsibility of the federal government.
- C.** BVA strongly supports the provision of a full Cost of Living Adjustment (COLA) for veterans receiving disability compensation and surviving spouses and dependent children receiving Dependency and Indemnity Compensation (DIC). Further, we support this COLA being made effective December 1, 2003. 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 service-connected disability compensation or DIC benefits. The income of spouses of deceased veterans should have no bearing on the DIC benefit.
- D.** BVA strongly supports legislation that would allow concurrent receipt of military retirement pay based on longevity and service-connected disability compensation. We urge your support for the concepts embraced in the Military Retirement Restoration Act of 2003: H.R. 303, introduced by Congressman Bilirakis. We commend Mr. Bilirakis for his persistence on this important issue.
- E.** Medicare subvention is an issue critical to the future funding of VA health care programs. Considerable discussion of this issue has occurred over the years, with strong resistance coming particularly from the House Ways and Means Committee, regarding a pilot Medicare subvention demonstration project for VA. We trust legislative language can be crafted this year to move this legislation rapidly through the 108th Congress. Authorizing VA to bill Medicare for services provided to certain veterans seems to be a win-win situation. VA benefits from additional revenue to supplement core appropriations while the Medicare trust fund benefits because VA will be reimbursed at a discounted rate.
- F.** BVA supports passage of the Medicare Vision Rehabilitation Services Act, affording all blind Americans access to highly qualified rehabilitation specialists. Failure to insure this access is blatant discrimination against people who are blind. Priority 8 veterans, who are dealing with the challenges of low vision (and are not legally blind) will no longer be able to receive high quality services from VA facilities. The federal

government (Medicare) should provide leadership in this regard and private insurance companies will hopefully follow suit. Adoption of this Act would provide an additional source of needed revenue for VA, if Medicare subvention were approved.

- G.** As the federal government seeks to strengthen homeland security, VA should receive an appropriate share of resources dedicated for this purpose. VA must be recognized as an essential component of homeland security and the role it can play, particularly in terms of responding with medical resources in times of national emergencies.
- H.** 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 blind SSDI beneficiaries exceeded the SGA level by as little as one dollar, they lost the total benefit. BVA urges members of these Committees to support legislation that would restore the linkage.
- I.** 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.
- J.** BVA urges members of these Committees to support House Concurrent Resolution (H. Con. Res.) 56, introduced by Ranking Member Evans. H. Con. Res. 56 expresses: “that it is the sense of the Congress that each State should require any candidate for a driver’s license candidates to demonstrate, as a condition of obtaining a driver’s license, an ability to associate the use of the white cane and guide dog with visually impaired individuals and to exercise great caution when driving in proximity of a potentially visually impaired individual.” We are grateful to Congressman Evans for introducing this important resolution.
- K.** As mentioned previously, aging is the single best predictor for blindness or severe visual impairment. Veterans are not the only ones who are growing old and losing their sight. BVA encourages Congress to enact legislation to fund categorical programs for the professional preparation of education and rehabilitation personnel serving people who are severely visually impaired and blind. There is a shortage of trained professionals in the field of blindness.

XIII. Conclusion

Once again, Mr. Chairman, thanks to you and to these Committees for this opportunity to present BVA's Legislative Priorities for 2003. BVA is extremely proud of our 58 years of continuous service to blinded veterans and all the accomplishments we have enjoyed. Our relationships with VA and Congress, in particular these Committees, have been most productive and rewarding. Our priorities, as previously stated, are the product of the resolutions adopted at our 57th National Convention held last August in San Antonio, TX.

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