

.....**TABLE OF CONTENTS**

I. Introduction..... 2  
II. Critical Issues..... 2  
III. Background..... 4  
IV. Current Services..... 5  
    A. Blind Rehabilitation Centers..... 5  
    B. Visual Impairment Services Team (VIST)..... 5  
    C. Computer Access Training (CAT)..... 6  
    D. Blind Rehabilitation Outpatient Specialist (BROS)..... 6  
    E. Visual Impairment Services Outpatient Rehabilitation (VISOR)..... 8  
    F. Visual Impairment Center To Optimize Remaining Sight (VICTORS)..... 8  
V. Effects of VERA on Rehabilitation..... 9  
VI. Oversight..... 11  
VII. Department Of Veterans Affairs FY 2006 Budget Request..... 11  
VIII. Independent Budget..... 13  
IX. Prosthetic Service..... 14  
X. VA Research..... 15  
XI. Other Legislative Priorities..... 16  
XI. Conclusion..... 19

## ***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 2005. I wish to congratulate you, Mr. Chairman, and Senator Craig, on your new responsibilities as Chairmen of the House & Senate Committees on Veterans Affairs. I also wish to congratulate Mr. Evans on his appointment once again as Ranking member on the House Committee and Senator Akaka as the new Ranking member on the Senate Committee. These Committees are known for being the most bipartisan in Congress. We believe it is imperative for this trend to continue into the first session of the 109<sup>th</sup> Congress as we all work toward the same goal: Caring for America's veterans.

The Blinded Veterans Association is the only congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our nation's blinded veterans and their families. Later this month, BVA will celebrate its 60th anniversary 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. As a new generation of blinded veterans is returning home from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), our combined efforts will be extraordinarily important.

BVA and its members are strong ambassadors for VA's blind rehabilitation programs. Throughout our 60 years of service, BVA has closely monitored VA's capacity to deliver high-quality rehabilitative services in a timely manner. When problems or concerns are identified, BVA works diligently with VA and these Committees to resolve any service delivery deficiencies.

## ***II. Critical Issues***

We are happy to report that positive changes are happening within the field of VA Blind Rehabilitation.

Mr. Chairman, for the past two years BVA has presented grave concerns about the more than 2,500 blinded veterans awaiting entrance into one of 10 VA Blind Rehabilitation Centers (BRCs) across the country. BVA is pleased to announce that this number has been reduced to 1,549. While this number is still not acceptable, the reduction is a good sign. Thanks to the leadership of Senator Bob Graham, Ranking Minority Member of the Senate Veterans Affairs Committee, and Representative Rob Simmons, Chairman of the Subcommittee on Health of the House Veterans Affairs Committee, the Government Accountability Office (GAO) investigated the waiting list for blind rehabilitation. We are thankful to Senator Graham and Chairman Simmons for listening to our concerns and taking action. BVA looks forward to the continued reduction of this list through improvement of services and increased use of localized programs.

BVA is very grateful to the House Committee for holding a hearing to receive the report of GAO last summer. Former Chairman Smith promised a follow up hearing to evaluate VA's progress in implementing the recommendations of GAO. Mr. Chairman, we respectfully request that such a follow up hearing be conducted this year.

Due to the increasing age of our veteran population and the known prevalence of age-related visual impairment, the Visual Impairment Advisory Board (VIAB) has identified the need for a uniform national standard of care. It is important to note that GAO identified the same need. The VIAB is an interdisciplinary board that includes providers, the Blinded Veterans Association, research, and network representatives. There is a need to develop a continuum of care that augments the services already in place for legally blind veterans by taking into account the entire spectrum of visual impairment.

VIAB presented a proposal to the Health Systems Committee of the National Leadership Board (NLB), that would direct all Veterans Integrated Service Networks (VISNs) to implement a full continuum of care for visually impaired and blind veterans. The Committee received the proposal very positively and requested that a gap analysis be conducted. BVA supports the broad scope of this proposal. VIAB does not dictate to the VISNs how this continuum of care should be implemented. While BVA would point to successful models of unique and successful programs within VA across the country, VISNs may meet the continuum's needs in the best way for their particular geographic area. It is time for all blind veterans to receive the right service, at the right place, at the right time. We again are very pleased that significant progress has been achieved to this end. Blind Rehabilitation Service (BRS) has nearly completed the gap analysis to determine what vision rehabilitation resources are currently available and where the gaps exist. That analysis should be completed within the next couple of months. It will include cost estimates associated with providing services where resources currently do not exist. Additionally, the provision of a full continuum of vision rehabilitation services is now included in the network five-year strategic plans.

The independent Capital Asset Realignment for Enhanced Services (CARES) Commission released recommendations to Secretary Principi in mid-February, 2004. While we still have concerns, we do feel that the Commission listened to BVA and the many blinded veterans across the country who provided testimony last year. Although the Commission recommended the establishment of new BRCs in VISN 16 and VISN 22, another VA medical center now hosting a BRC was targeted for closure. This facility is located in VISN 17, and the future of that BRC continues to be of great concern. Another recommendation put forth by the Commission states: "VA should develop new opportunities to provide blind rehabilitation in outpatient settings close to veterans' homes." GAO made a similar recommendation in its report. We hope that this recommendation by the independent CARES Commission will reinforce the need for timely implementation of a full continuum of services for all visually impaired veterans.

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

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

### **III. Background**

We are all painfully 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 of blindness or severe visual impairment. As the overall veteran population 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 is forced into becoming the caregiver.

It seems obvious to BVA that VA BRS needs to develop an aggressive strategic plan to address the needs of older veterans who are unable to attend the BRC program. Unfortunately, until this fiscal year, the current reimbursement model for resource allocation served as a definite disincentive for providing services locally. With respect to the allocation model, if the local VA medical center refers a veteran to the BRC, it does not have to pay for any services delivered or the prosthetics prescribed. Should the medical center provide service locally, however, it must pay for the care.

BVA is extremely pleased to report that, in response to the need for a more equitable allocation model for blind rehabilitation, the Secretary approved a substantial change in the Veterans Equitable Resource Allocation (VERA) model that now provides incentives for local VA medical centers to provide care in the most appropriate setting.

Mr. Chairman, there is absolutely no question that comprehensive residential BRCs provide the most 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 such as those now returning from Iraq and Afghanistan. The BRC becomes even more important for many of these blinded service members because they suffer from multiple traumas, including brain injury, amputations, and hearing loss. The BRC can bring the entire array of specialty care to bear on these severely wounded service members, optimizing their rehabilitation outcomes and successful reintegration into their families and communities. Frankly, Mr. Chairman, there is no better environment to facilitate the emotional adjustment to the severe trauma associated with loss of vision.

## **IV. 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 ten comprehensive residential BRCs across the country. The first blind center was established at the VA Hospital at Hines, Illinois, in 1948. Nine additional BRCs have been established and strategically placed within the VA system. The sites include VA Medical Centers in Palo Alto, California (1967); West Haven, Connecticut (1969); American Lake, Washington (1971); Waco, Texas (1974); Birmingham, Alabama (1982); San Juan, Puerto Rico (1990); Tucson, Arizona (1994); Augusta, Georgia (1996); and West Palm Beach, Florida (2000). The mission of each BRC is to address the expressed needs of blinded veterans so they may successfully reintegrate back into the community and family environment. To accomplish this mission, BRCs offer a comprehensive, individualized, adjustment-training program along with those services deemed necessary for a person to achieve a realistic level of independence. The environment is residential, but the centers are all located within VA facilities in order to provide medical services to blinded veterans while they participate in the rehabilitation process.

As stated last year, more than 2,500 blinded veterans await admission into one of these ten BRCs. The good news this year, however, is that this number has been reduced to 1,549. Many of these veterans may not even need to attend a residential BRC. Unfortunately, a majority of even the simplest services are not yet routinely made available at a local level. In order to preserve the integrity of the BRCs, outpatient and local services must be provided. BVA is optimistic that the new change in the VERA Allocation for blinded veterans will make these services possible when appropriate.

### **B. Visual Impairment Services Team (VIST)**

The mission of each VIST program is to provide blinded veterans with the highest quality of available adjustment-to-vision-loss services and blind rehabilitation training. To accomplish this mission, VIST will establish mechanisms to identify the greatest number of blinded veterans and to review with them the benefits and services for which they are eligible. The VIST was created to coordinate the delivery of comprehensive medical and rehabilitative services to blinded veterans. The "teams" were created in 1967. In 1978, VA established six full-time VIST Coordinator positions. Currently, the VA system employs 93 full-time Coordinators who serve as case managers for an estimated 35,000 blinded veterans. VA researchers estimate that there may be more than 150,000 blinded veterans nationwide. VA BRS is in the unique position of providing comprehensive case management services for the returning service members for the remainder of their lives. They can assist not only the newly blinded veteran but also his/her family. Timely and important information facilitating adjustment is provided to both the veteran and his/her family. As a benchmark, the Veterans Health Administration (VHA) seeks to locate

all wounded service members transferred from DOD. Linking them to VA BRS comes closest to a truly seamless transition.

A few of the VA VIST Coordinators have been very aggressive in identifying local resources capable of delivering needed services to blinded veterans in their homes. Regrettably, such dynamic VIST programs are few and far between. The majority of the Coordinators rely on the VA BRC. If the veteran is unable to attend a BRC, he/she goes without service. Full implementation of the continuum of vision rehabilitation services should remedy this shortcoming. Mr. Chairman, in the absence of the full continuum, 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 new reimbursement allocation model should serve as a significant incentive. BRC managers also contribute to this lack of service delivery because of the traditional belief that the only place a blinded veteran can receive high quality rehabilitative services is at the VA BRC. Consequently, they have insisted that BRS policy be extremely restrictive in this regard. This culture must change.

### **C. Computer Access Training (CAT)**

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

Having to admit a blinded veteran into a VA BRC for this specialized computer training, which includes housing the blinded veteran in a hospital bed, is unnecessarily expensive. Local training would eliminate this expense, and, at the same time, be more responsive to the veteran's needs.

As a result of the GAO study of VA BRS service delivery, BRS is now referring all blinded veterans for CAT training to local resources, if available and appropriate for the individual veteran. The reduction in the BRC waiting lists from more than 2,500 to slightly more than 1,500 is due in large part to greater utilization of local resources. Some BRCs have been returning beds previously dedicated to CAT to the basic adjustment program, thus reducing waiting times for admission.

### **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 (for VA BRS) approach to the delivery of VA blind rehabilitation services is for blinded veterans who cannot or will not attend a residential blind rehabilitation program. A major shortcoming of VA BRS 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 Congressional action that earmarked \$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, eight 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, meaning the possession of a dual masters degree in both Orientation and Mobility as well as Rehabilitation Teaching. In the absence of such dually credentialed professionals, masters level blind rehabilitation specialists selected for these positions should receive extensive cross training at one of the BRCs. The training prepares such individuals to provide the full range of rehabilitation services in the veteran's home environment. The delivery of outpatient rehabilitative service may prove to be cost efficient for veterans who have rehabilitation needs but who are unable to attend the residential program. Many of these individuals may be at risk and must not be denied essential rehabilitative services. The rapidly growing older blinded veteran population, as mentioned previously, is clearly the therapeutic target for this type of service delivery. Additionally, the highly skilled professionals conduct comprehensive assessments of the newly identified blinded veteran's needs to determine if referral to a residential BRC is warranted. The BROS may also provide some initial training before admission to the BRC, thus potentially reducing the length of stay. 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 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 will certainly 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. Currently, there are 22 BROS positions scattered around the system, and, based on their experience, many more such positions should be established. It is hoped that the revised model (VERA 10), will provide incentives to networks to fund additional BROS positions.

Furthermore, it is noteworthy that the GAO study strongly recommended expanding the BROS program. Also, Mr. Chairman, the BROS located here servicing both Baltimore and Washington DC has met with every newly blinded service member at Walter Reed Army Medical Center as well as the National Naval Medical Center in Bethesda, Maryland. This intervention has proven highly successful in facilitating the seamless transition from the Department of Defense Military Treatment Facility to VA.

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

## ***E. Visual Impairment Services Outpatient Rehabilitation (VISOR)***

In 2000, VA Stars and Stripes Healthcare Network 4 initiated a revolutionary program to deliver services: Pre-admission home assessments 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 percent, as reported by the 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 medical center.

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

The aforementioned model combines the benefits of the residential model with those of outpatient service delivery. 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 an innovative program operated by VA Optometry Service. This is a special low-vision program designed to provide low-vision services to veterans, who, although 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. It consists of a short (five-day) inpatient program in which the veteran undergoes a comprehensive low-vision evaluation. Appropriate low-vision devices are then prescribed, accompanied by necessary training with the devices.

It should be noted that one of the VICTORS programs has converted to a two-and-one half-day outpatient program and utilizes hoptel beds for veterans who live too far away to commute daily. This program has achieved the same outcomes and objectives as its inpatient counterpart.

Veterans most in need of these programs may be employed, but, because of failing vision, feel they cannot continue. The VICTORS program enables such individuals to maintain their employment and retain full control over their lives. The VICTORS also performs a crucial preventative function. Unfortunately, Mr. Chairman, there are only three such programs currently within VHA. We submit that there is a critical need for many more such programs. In fact, expansion of the rehabilitative programs could further assist severely visually impaired (legally blind) or blinded veterans who have already attended a residential BRC and received low vision aids. The effectiveness of those aids could be reviewed and new prescriptions written when appropriate. This would avoid the necessity of readmission to the much more expensive BRC for such reviews and evaluations.

## ***V. Effects of VERA on Rehabilitation***

BRCs are admittedly resource intensive and costly. Currently, these programs are being viewed as potential moneymakers under the Veterans Equitable Resource Allocation (VERA) model. As previously mentioned, BVA is pleased with the introduction of VERA 10 as recently modified. Instead of a blanket rate of \$42,000 for the higher reimbursement rate, BRCs 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 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. This has been done 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 BRCs institute shorter programs, veterans are shortchanged. Programs such as VICTORS and VISOR admit a very focused population--veterans with high residual vision (usually macular degeneration) and few, if any, co-morbidities. 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 blinded veterans needing full, comprehensive residential blind rehabilitation at a BRC in the name of the almighty dollar. Our concerns are especially relevant now that DOD Military Treatment Facilities are referring young totally blinded service personnel and who will clearly need the comprehensive residential BRC program. The rehabilitative needs of this new population cannot be serviced in so-called "short programs". There is no question that much longer stays must be anticipated for these very special veterans. Shortcuts for reimbursement advantages cannot be tolerated.

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. This means that 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 an individual veteran's home network. It appears that networks and/or facilities have discovered that if the length of stay in these programs is short enough, their cost is substantially reduced, therefore increasing a potential profit margin. This process then provides either the network or facilities with funds to operate other programs and services.

The inability to track funds allocated to the networks through VERA is another frustrating aspect of the funding issue. It is even more difficult, if not impossible, to track dollars allocated to the individual facility within the network. Dollars allocated to the host facilities are not fenced or earmarked for blind rehabilitation. Consequently, facility directors and BRC managers cannot determine how much funding they have received to operate these special programs. The decentralized resource allocation practice apparently provides a lump sum to each facility from which they have the discretion and responsibility to operate all of 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 such 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. 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. Oversight**

Mr. Chairman, as mentioned above, the last oversight hearing by the House Committee was held last July to receive GAO's report on VA Blind Rehabilitation Services. The report determined the accuracy of the waiting lists and times for admission to BRCs. It also examined the methodology involved in calculating wait times being maintained and looked at the delivery models currently utilized by VA BRS. Consistent with BVA's concerns, GAO found that there were serious inconsistencies from BRC to BRC as to how waiting lists were managed and waiting times calculated. GAO discovered that several BRCs were not complying with program office directions and policies. Regarding the current delivery models, GAO recommended greater utilization of outpatient services.

BVA was very encouraged that the lead VA witness, Dr. Michael Kusman, concurred with all of the GAO recommendations. BVA believes significant progress has been achieved following the release of the GAO reports but remains concerned that there is still substantial resistance from among BRS employees. We have pointed out in the past that a culture change must occur if BRS is to come of age in the 21st century with respect to its manner of providing blinds rehabilitation services.

Mr. Chairman, we therefore believe it to be essential for this Committee to hold a follow-up hearing to assess VA's progress in implementing the GAO recommendations.

## **VII. Department Of Veterans Affairs FY 2006 Budget Request**

The President's FY 2006 Budget Request is a prime example of the urgent need for mandatory funding. The gaming must end. BVA urges the members of these Committees to support mandatory funding. As in years past, we are deeply concerned that the FY 06 Budget Request falls far short of projected requirements to adequately address the health care needs of an aging veteran population let alone a new generation of veterans returning from OEF and OIF, many of which have serious multiple traumas and permanent catastrophic disabilities. When budget gimmicks, enrollment fees, and increased co-pays for prescriptions are backed out of the request, the remaining numbers are totally inadequate. The real increase in appropriated dollars is approximately \$100 million, less than a one percent increase over the FY 05 appropriated level. Several years ago, before these Committees, Dr. Robert Roswell, then Undersecretary for Health, testified that VA needed an increase of 12-14 percent annually just to maintain current services. The President's request does not come close to approaching the medical care inflationary rates. As in past years, VA is being forced to rely more heavily on first- and third-party collections to substitute for appropriations. It is clear that the Administration expects some veterans to pay for the care of other veterans. Additionally, some veterans are being classified as more worthy than other veterans. BVA strongly opposes implementation of the \$250 annual enrollment fee and the more than doubling of the co-payments for prescription drugs. BVA is convinced that the progress and momentum achieved over the past year, as outlined above, will be lost should this budget be adopted. Clearly, there will be insufficient funds to enable VA to implement the full continuum of vision rehabilitation care as recommended by GAO and VIAB. Because the proposed budget would result in the reduction of 3,700 FTEE, it is highly unlikely

that medical centers will be able to consider hiring new employees qualified to provide vision rehab services. We are already hearing about freezes on hiring around the country in anticipation of the shortfall in the FY 05 appropriation, and that there are even fewer resources in FY 06.

Furthermore, VA medical facilities will certainly restrict or eliminate use of funding to contract for local services, again negatively affecting provisions for a continuum of vision rehabilitation services. BVA is also gravely concerned that funding for essential prosthetic services and equipment will be severely curtailed with this budget proposal. Medical centers will certainly begin to deny prescriptions for necessary devices, not only for blinded veterans but for all disabled veterans.

The President's FY 06 Budget Request will effectively drive more than 200,000 veterans from the VA health care system. What is interesting about this approach is that the veterans with the least health care burden, those who can be treated at least expense and who bring the most medical care dollars into the system, are the ones who will be denied access. Focusing solely on the so-called "core veterans" will certainly compromise VHA's ability to provide the full scope of preventative and acute care services. Those of us in the so-called "core group" benefit tremendously from the specialized services provided by VA, and we also need the full array of basic health care services. While Members of Congress decry the Administration's reliance on third-party collections, they have repeatedly failed to provide adequate appropriations to sufficiently fund the VA health care system. Responsibility for the constant under funding of VA health care through the discretionary process rests with both past and present Administrations and Congress. Mandatory funding appears to be the best approach to achieve this goal. The recent delays in FY 2004 and 2005 funding make the argument for mandatory funding even more compelling. Having been forced to operate at the prior year's funding level for the first few months of each of the past two fiscal years has been devastating for VA.

Mr. Chairman, service in the Armed Forces of the United States must count for something more than a few laudatory speeches each year. Care for America's veterans must be one of our countries highest priorities. Clearly, the President wants to care for those heroes returning from Iraq and Afghanistan, but it must not be accomplished at the expense of those who have served in previous wars and conflicts. Similarly, we cannot forget about those who served honorably but did not have to be deployed into harm's way or did not suffer traumatic emotional or physical disabilities as a direct result of their service. National policy must recognize care for our veterans are an integral component of national defense.

BVA is also deeply disturbed by the proposed change in eligibility criteria for long-term care. The change would result in the elimination of substantial numbers of nursing home beds within VA and, even more importantly, substantially reduce the per diem payments currently made by VA to state veterans' homes. The state veterans homes have been extraordinarily successful, having been important partners in VA's ability to provide long-term care. This change may very well cause veterans currently in state veterans homes to be discharged. It is highly unlikely that states can make up for the loss of the VA payments.

In our view, the meager increase for veterans health care proposed by the Administration will result in the return of incredibly long waiting lists for appointments and long waiting times for admission for care. Veterans will be denied timely access to high quality care.

Blinded veterans represent a relatively small number of users in the VA system but they are a population that is extremely dependent on the system. If VHA is not fiscally healthy, the specialized programs for the "core veterans" will not be healthy.

The Veterans Benefits Administration (VBA) budget proposal is no better than that for health care. We are all painfully aware of the chronic backlogs for claims pending before VBA and the Board Of Veterans Appeals. Once again, this budget fails to provide the necessary resources to adequately assist VBA in its efforts to reduce the unconscionable backlogs. Veterans are waiting literally years for claims to be adjudicated or appeals to be resolved. Shortages of qualified adjudication officials and rating specialists have resulted in inaccurate decisions leading to appeals. Clearly, if claims were properly developed at the local VA regional office, the number of appeals would drop dramatically. Unfortunately, the regional offices are not doing a good job of assisting veterans with their claims. If not for the VSOs and their service officers, the record would be even more dismal. The government should not depend on the VSOs to do its job. More resources are sorely needed.

### ***VIII. Independent Budget***

BVA is very proud to once again 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.

In our view, the IB's proposed health care increase over FY 2005 appropriations (\$3.5 billion) keeps pace with the increased costs in salaries, benefits, goods, and essential services. Additionally, the recommended funding level will also enable VA to more adequately fund Congressionally mandated initiatives. We also firmly believe that this funding level is necessary if the Special Disabilities Programs are to be protected and remain viable. More specifically, if VA is to implement the GAO recommendations for a full continuum of vision rehabilitation services as outlined above, the President's FY 06 Budget Request will not provide sufficient resources to achieve this goal. The recommended reduction in VA medical and prosthetic research, vital to VHA's mission, is extremely disturbing. These funds are critical to VHA's ability to attract and retain clinicians who are also seeking the opportunity to conduct research. The President's proposed reduction will result in the elimination of 270 FTEE researchers. This is unconscionable at a time when prosthetic research and development of state-of-the-art prosthetics are in greater demand than ever. Our returning service members should have access to the very best, and VA should be on the cutting edge of developing the very best artificial limbs and other essential sensory aids and appliances. How can we consider reducing medical and prosthetic research at a time when we still have undiagnosed illness from Operation Desert Storm, with prospects of additional undiagnosed illnesses from our current conflicts? The loss of clinician researchers will also compromise VA's ability to provide timely, high-quality medical care.

This is the 19<sup>th</sup> consecutive year in which BVA has endorsed the IB. Along with other endorsers, BVA participated in the preparatory sessions and provided input to the formulation of this extremely important document. We trust that 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.

## ***IX. Prosthetic Service***

BVA is very pleased with the outcome of the Prosthetic Clinical Management Program (PCMP) process as it impacts visually impaired and blinded veterans. The stated focus of the PCMP is on the quality of prescriptions rather than on the dollars expended for the prescriptions. When the PCMP process was initially established through the use of national contracts as a mechanism to attempt to standardize prescription of prosthetic equipment, VSOs and consumers were not included as members of the PCMP Work Groups designated to develop specifications for each item. They were also not part of the Clinical Practice Recommendations (CPRs) for issuance of equipment.

The driving activity behind the PCMP is the establishment of work groups composed of clinicians to review the prescription practices associated with an individual prosthetic device. As a result of efforts by BVA, DAV, and PVA, consumers were allowed to be members of the work groups. BVA's representatives took an extremely active role in the work groups related to aids and appliances for the blind. The work groups have been tasked with developing specifications for the devices and recommendations for issuance. The intent of the specification development is to facilitate the establishment of national contracts if the majority of the devices are procured from one vendor. Thanks to the hard work and oversight of the BVA representatives, blinded and visually impaired veterans received fair CPRs.

BVA has some reservations regarding the potential for standardization. We question the premise that one size fits all when it comes to prosthetics. 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 part of a national contract, even if they are more expensive, without fear of reprisal from local or network management.

BVA has two major concerns with the prosthetics program: First, the Acting Under Secretary For Health is proposing to appoint the Chief Consultant for Prosthetics & Sensory Aids Service (PSAS) Strategic Healthcare Group (SHG) as the Chief Officer for Logistics. What is troubling about this appointment is that the proposal includes realigning PSAS under the Logistics Office. The Chief Officer for Clinical Logistics would then have a Deputy for PSAS and a Deputy for Clinical Logistics. This scenario, in our view, has the potential to reduce the focus on prosthetics at an extremely critical time. Centralized funding of prosthetics has eliminated most of the problems that previously existed with the timely service delivery of

prosthetics services. We are afraid that merging the two services could result in the diversion of prosthetics funds to other logistics priorities. Additionally, PSAS has had a strong interface with Patient Care Service and all the clinical services associated with delivering care to disabled veterans. The clinical interface should not be placed in jeopardy or diminished in any way.

Second, PSAS, like many services in VHA, is facing a significant shortage of qualified individuals to fill vacancies resulting from retirements now and in the very near future. Critical to the PSAS succession planning is the Prosthetics Representative Training Program. If VHA does not receive sufficient funding, this essential training program will not be funded. Failure to have qualified personnel in these vital positions will result in disabled veterans not receiving prosthetics services in a timely manner. We will return to “back to the future” with all of the problems that previously resulted in centralized funding for prosthetics. Delays in orders will become, once again, the rule rather than the exception.

## **X. VA Research**

BVA feels strongly that legislation should be initiated that would require the National Institutes of Health (NIH) to pay VA for the indirect cost of NIH-funded research grants. Currently, NIH pays for the indirect cost to almost everyone receiving NIH grants except for VA. Consequently, VA must utilize medical care dollars to cover the indirect costs. To put this into perspective, the President’s FY 06 proposed funding for Research is \$393 million for the direct cost of research, representing a reduction of \$9 million (2.2 percent) from last year. An additional \$393 million is required for indirect costs and support that will come from appropriated dollars for VA health care. These funds are not available to provide medical care to veterans. We believe this is grossly unfair to sick and disabled veterans in need of medical care. We also feel it is unfair to a health care system that is already forced to operate with constrained funding. NIH has refused every effort by VA to collect payment for the indirect cost of research. Under such circumstances, we believe that legislative action is necessary.

Further exacerbating the inadequate funding for research is the fact that Rehabilitation Research & Development (RR&D) Service, one of the four components of the Office of Research & Development, has had its budget reduced in favor of other research priorities. We again believe this to be unconscionable at a time when severely disabled service members are returning from war zones and need the very finest in prosthetic equipment, training, and rehabilitative care. If anything, RR&D funding levels should be increased to address the emerging needs of this new generation of heroes. The VA Secretary’s Advisory Committee on Prosthetics and Special Disabilities Programs strongly advised that RR&D Services, previously aligned organizationally under Patient Care Services, not be aligned under the Office Of Research and Development. The Committee anticipated what has now begun to occur, that RR&D funds are being siphoned off for other research priorities. Unfortunately, Dr. Kizer ignored the Committee’s advice.

If the President’s proposed funding level is enacted, RR&D’s capacity to engage in essential research will be squeezed even further. This is unacceptable.

## ***XI. Other Legislative Priorities***

BVA believes that the following 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, H.R. 515, The Assured Funding for Veteran's Health Care Act of 2005, instituting mandatory funding of VA health care.
- B.** Authorizing VA to retain third-party collection should be viewed as a supplement to, and not a substitute for, federal funding. Veterans and their insurance companies should not be required to pay for veterans health care, which is clearly a moral obligation and 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, 2005. 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 despite the continuous rise in medical costs. 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 encourages Congress to adopt legislation that would provide full concurrent receipt for all military retirees who have suffered service-connected disabilities (H.R. 303).
- E.** Medicare subvention, including a VA pilot demonstration project, 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. We trust that legislative language can be crafted this year to move this legislation rapidly through the 109<sup>th</sup> Congress. Authorizing VA to bill Medicare for covered 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 as VA is reimbursed at a discounted rate.
- F.** As the Federal Government seeks to strengthen homeland security, VA should receive an appropriate share of resources dedicated to this purpose. VA is an essential component of

homeland security, particularly in terms of responding with medical resources in times of national emergencies. Funding must be allocated to assist VA in fulfilling its vital role.

- G.** BVA encourages the U.S. Senate to adopt legislation, to be introduced by Senator Specter, establishing a national trust fund that would provide equitable compensation to Americans suffering from illnesses caused by exposure to Asbestos. The national trust fund would replace the current tort system that is clearly broken.
- H.** BVA encourages Congress to carefully scrutinize any proposed changes in the statutory definition of legal blindness. Such scrutiny will ensure that the Social Security Administration 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 in either central or peripheral vision, with best correction in the better eye.
- I.** BVA urges members of the U.S. Senate to support passage of House Concurrent Resolution (H. Con. Res.) 56, introduced by Ranking Member Evans and adopted by the U. S. House of Representative last year. 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.
- J.** Aging is the single best predictor of blindness or severe visual impairment. Veterans are not the only ones who are growing old and losing their sight. BVA encourages Congress to enact legislation to fund categorical programs for the professional preparation of education and rehabilitation personnel serving people who are severely visually impaired and blind. There is a shortage of trained professionals in the field of blindness. The shortage may very well be further aggravated as a consequence of the President’s FY 06 Budget Request. Contained within the request is a Department of Education, Rehabilitation Services Administration (RSA) initiative that would cut back on funding support for Personnel Preparations programs.
- K.** BVA strongly supports adoption of the Baker Amendment to H.R. 3550. This Transportation Act would establish a Demonstration Project in the Greater Metropolitan Washington, DC area. The proposal is known as the “Remote Infrared Audible Signage (RIAS) Model Accessibility Project”. If adopted, the Baker Amendment would establish the District of Columbia as the first city to have an intra-modal demonstration project of Remote Infrared Audible Signage throughout all public transportation modalities in its region. The amendment would cover buses, Metrorail stations, trains, etc. RIAS is tested technology that provides audible information in spoken words from a transmitter installed on such means of transportation. Blind and visually impaired individuals would carry a receiver that would provide the audible information. BVA supports all VA medical center

Formatted: Bullets and Numbering

efforts to install RIAS in their facilities, affording blinded veterans greater independence when visiting them.

- L.** Sighted people traveling in an unfamiliar area utilize signage, maps, and landmarks to move through an environment. People who are severely visually impaired or cognitively disabled are unable to access the normal signage. The RIAS model project would provide this kind of information, enhancing safe and independent travel for those who are visually impaired. Additionally, approval of this important demonstration project would provide the opportunity to evaluate the effectiveness of this technology and provide important access information and potential access solutions.
- M.** The Blinded Veterans Association has many members in Puerto Rico who served honorably in the U.S. Armed Services. BVA therefore encourages Congress to adopt legislation that would define the political status options available to the U.S. Citizens of Puerto Rico. The legislation would also authorize a Plebiscite vote to provide the opportunity for Puerto Ricans to make an informed decision regarding the future of the island.
- N.** BVA urges these Committees to introduce legislation that would amend the Beneficiary Travel Regulation in Title 38. We believe that the law needs to be changed to allow VA to pay travel for catastrophically disabled veterans who have been accepted to one of the VA Special Disabilities Programs and who are currently not eligible for travel benefits. These veterans are already required to pay the SSA co-payment as well as a daily per diem rate during the rehabilitation episode. Adding the burden of having to pay their own travel, usually air transportation, creates a strong disincentive for these veterans to take advantage of the world-class service offered by VA.
- O.** BVA is one of 29 VSOs presently addressing a long-term gap in the collection of veterans-related stamps produced by the United States Postal Service. The coalition has proposed a commemorative stamp sheet that would honor the significant contributions of organizations such as BVA and their members. The stamp sheet would be dedicated to a theme of widespread national appeal, "Still Serving America", and would consist of a block of 29 stamps. Each stamp in the block would represent a different group of Americans that are still serving the nation and its military veterans. The case for the stamp sheet is based on the long history of voluntary service provided by veterans to one another, the present concern for veterans returning from Iraq and Afghanistan, and the financial success enjoyed by military-related stamps in the past. The 29 organizations directed a written proposal package to the Citizens Advisory Committee of the USPS in mid-December. Supporting the effort with a letter of endorsement attached to the package was Former Secretary Principi. BVA and the other 28 organizations would greatly appreciate whatever inquiries or demonstrations of support for the stamp sheet are feasible from Members of Congress. Such communications can be directed to the Postal Service Citizens' Stamp Advisory Committee and the Postmaster General.

## ***XII. Conclusion***

Formatted: Bullets and Numbering

Once again, Mr. Chairman, thanks to you and to these Committees for this opportunity to present BVA's Legislative Priorities for 2005. BVA is extremely proud of our 60 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 59th National Convention held last August in Reno, 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 the opportunity for significant improvements is now. We believe that the strong support from these Committees has assisted in the progress made over the last year. 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 that you or other members of these Committees may have.