THE BLINDED VETERANS ASSOCIATION
TESTIMONY

PRESENTED BY

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EXECUTIVE DIRECTOR

BEFORE THE
HOUSE VETERANS AFFAIRS COMMITTEE

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INTRODUCTION

Mr. Chairman and members of the House Veterans Affairs Committee, on behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to present BVA's legislative priorities for 2006. We believe it is imperative that members of this Committee work in a bipartisan manner during the second session of the 109th Congress. We all strive for the same goal, that of improving access to a high quality, fully integrated system of health care and benefits for America's blinded 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. Since the end of World War II, when a small group of blinded veterans formed BVA, our Association has grown to include blinded veterans from several wars and conflicts, and we will soon celebrate in March our 61st anniversary of continuous service to America's blinded veterans. It is vital that our issues and advice be included in this process so that we all can make a positive difference in the quality of life for the men and women who have sacrificed so much for our freedom.

BVA would like this Committee to know that the Walter Reed Army Medical Center staff alone has treated approximately 120 soldiers with either blindness or significant visual injuries. Twenty-seven of these soldiers have attended one of the ten VA Blind Centers, and others are in the process of being referred for admission. Seventy-eight service members, according to Veterans Benefits Administration (VBA) data, are service connected for total blindness in one eye from Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) injuries. When BVA representatives meet with these brave soldiers who have suffered catastrophic, life-altering injuries, the latter ask what services and benefits are going to be there to help them recover. It should be obvious to members of this Committee that a new generation of young blinded veterans is returning home from Afghanistan and Iraq, and that our combined efforts will be extraordinarily important. We must insure that we fully support them with the continuum of care and blind rehabilitative resources necessary during their transition from active duty to veteran status.

Mr. Chairman, we feel compelled to alert this Committee to what we believe to be a significant failure or flaw in the "Seamless Transition" for visually impaired or blinded service members. We learned that service members who have lost total vision in one eye are not always being referred to VA for low vision assessment or services. We believe many of these individuals most likely have some visual impairment in their remaining eye and should receive a comprehensive low vision assessment by VA to determine if they meet the definition of legal blindness. Such a determination would make a substantial difference in the benefits and services for which they would be eligible for through VA. Even if they do not meet the definition of legal blindness, they may very well be experiencing some functional loss with which VA rehabilitation services could be of assistance.

Throughout our 61 years of service, BVA has closely monitored VA's capacity to deliver high-quality rehabilitative services in a timely manner. Currently, approximately 41,700 blinded veterans are enrolled in VA. Demographic research projects that by the year 2010 there will be almost 55,000 veterans with blindness or significant low vision impairments enrolled. Census Bureau data, however, reveals that there are some 167,000 legally blind veterans in the United States. With an aging population this number will rise over the next decade.

CRITICAL ISSUES

Mr. Chairman, two years ago BVA presented grave concerns about waiting lists of more than 2,500 blinded veterans awaiting entrance into one of 10 VA Blind Rehabilitation Centers (BRCs) across the country. Thanks to the previous Chairman of the Subcommittee on Health of the House Veterans Affairs Committee at that time, the General Accountability Office (GAO) investigated the VA blind rehabilitation program at every level. GAO then testified before this Committee on July 22, 2004 regarding the status of VA services for the blind.

BVA was grateful to the House Committee for holding that hearing to receive the report of GAO, but we are here to report that while some progress has been made in reducing the waiting lists and times for admission, there are still 1,212 blinded veterans waiting an average of almost 19 weeks to enter one of these ten BRCs. Since then, the VA Visual Impairment Advisory Board (VIAB) has continued to evaluate VA’s progress in implementing the recommendations of GAO. At the request of the VHA National Leadership Board (NLB) Health Services Committee, VIAB commissioned a Gap Analysis to determine where VA currently has vision rehabilitation service and where there are gaps in service delivery. Additionally, cost estimates were requested to determine funding needed to close the gaps identified.

VIAB is an interdisciplinary board that includes health care providers, the Blinded Veterans Association, rehabilitation research, Prosthetics, and VA network representatives. Due to the increasing age of our veteran population and the known prevalence of age-related visual impairment, VIAB has identified the need for a uniform national standard of care. Along with the GAO report, VIAB also identified a need for increased outpatient blind rehab services. The Gap Analysis, mentioned above, revealed many areas of the country offer no outpatient vision rehabilitation services. There is a need to develop and implement a full continuum of vision rehabilitation care that augments the services already in place for legally blind veterans. The report envisioned the development of a full spectrum of visual impairment services.

To achieve such an objective, the GAO Testimony, the VIAB Report, and the VA Gap Analysis all strongly recommended the expansion of the Blind Rehabilitative Outpatient Service (BROS) program. As an example, Mr. Chairman, the BROS located nearest to us here, servicing both Baltimore and Washington, DC, has met with every newly blinded service member at Walter Reed Army Medical Center and the National Naval Medical Center in Bethesda, Maryland. This single BROS is from the Baltimore VA Medical Center, where approximately 512 blinded veterans are already enrolled and who need his services. The Washington DC VA Medical Center, with 541 blind veterans, has no BROS and has depended on the Baltimore

BROS. Only after almost three years of OIF/OEF causalities has a new part-time FTEE been established for both Walter Reed and for the Washington, DC VA Medical Center. It is time for all blinded veterans to receive the right service, at the right place, at the right time, without long delays because of tight budgets.

This early intervention is critical for both the soldier and family members in starting the process of learning about blind rehabilitation, which includes an introduction to early blind rehabilitation skills. The success of the process of adapting to traumatic blindness is dependent upon a seamless transition from Department of Defense Medical Treatment Facilities to VA Blind Centers. Despite some successes, BVA has found serious problems with three of the four VA Poly Trauma Centers of Excellence during the past year. There is no BROS on staff to facilitate the vital blind rehabilitation training that OIF soldiers should experience when they transfer to these centers. Only recently, after persistent questioning of the Veterans Health Administration (VHA), did they begin to advertise for a BROS FTEE. Worse, for some of the soldiers who attend a BRC and eventually return to their homes, the local VAMCs have no BROS to make home visits. These visits are crucial to the continuum of care for returning veterans. Such visits encourage the veterans to continue using the skills learned and to adapt to new changes in prosthetics and constantly evolving adaptive equipment.

More than a year ago VIAB presented a proposal to the Health System Committee of the National Leadership Board (NLB). The proposal directed all Veteran 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 has recently issued a report in November 2005 on the *Financial Projections for the Expansion of Low Vision Services in the VA's Continuum of Care* from the gap analysis. We are very pleased that as recently as Jan. 17,2006, the Health Services Committee unanimously endorsed the full recommendations of VIAB, including the Gap Analysis and cost estimates. The recommendation for the full continuum of vision rehabilitation services has now been referred to the Finance Committee of the NLB to attempt to identify funding to implement the proposal. BVA supports the broad scope of this proposal and, as outlined further in this document, we request your oversight assistance in insuring that action is taken on these recommendations. Mr. Chairman, BVA believes the only way these recommendations can be implemented is for additional funding to be included in the VA FY 2007 Appropriation directed for this initiative. We respectfully request additional funding be included in the "Views & Estimates" you will be submitting to the Committee on the Budget. VIAB does not dictate to the VISNs how this continuum of care should be implemented. BVA would point to successful VA models of unique programs across the country, such as the 60 percent increased utilization of contracting out Computer Assisted Training (CAT) for visually impaired veterans. Although these programs have contributed to the decrease in the veteran BRC waiting lists, there still needs to be further improvements. 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 recommended the establishment of new BRCs in VISN 16 and VISN 22. These centers have not yet opened. In 2005, another VAMC hosting a BRC was targeted for closure. A final decision regarding the VA medical center in Waco, Texas, is under review by an outside

contractor. In light of the Hurricane Katrina devastation to the Biloxi, Mississippi VA Medical Center, where one of the new BRCs was to be constructed as recommended by the CARES report, BVA would suggest that it would be more prudent and cost effective to expand the BRC currently located in Waco. This facility would then handle the projected increased vision rehab workload in VISN 16. Of course, it would be necessary to keep the Waco VAMC open, which would run contrary to the recommendation of the CARES report. Another recommendation set forth by the Commission states: "VA should develop new opportunities to provide blind rehabilitation in outpatient settings close to veterans' homes." GAO made a similarly strong recommendation in its testimony, indicating that when VA and GAO reviewed the waiting list of 1,500 veterans pending admission to BRCs, 21 percent of them could potentially be served if local BROS were available. We had hoped that this recommendation from the GAO testimony would be a significant first step towards closing the identified service delivery gaps leading to implementation of a full continuum of services for all visually impaired veterans. Mr. Chairman, BVA is convinced that the passage of "The Blinded Veterans Continuum of Care Act of 2005" (H.R. 3579) would increase VA's ability to staff BROS personnel in many facilities where none currently exist. We are extremely grateful to Mr. Michaud for introducing this vital legislation. Clearly, H.R. 3579 provides for a cost-effective model of service delivery. We would hope that the Committee act soon on this bill.

BVA strongly supports the concept of assured funding for veterans. Our support was strengthened after the admission last June that VA was insufficiently funded by more than $1.2 billion in FY 2005 and $1.9 billion in FY 2006 because of the current funding model process. This admission and revelation were not surprising to the VSO's. They did, however, appear surprising to those in Congress who have been content with the current discretionary process. The Independent Budget (IB) has, for many years made accurate funding projections for the amount really needed for VA health care. IB members had projected the shortfall long before last March. As always when such shortfalls occur, veterans waiting times grew, veterans appointment lists expanded, and the bureaucracy pointed fingers at who was to blame. The reality is that discretionary funding leaves more room for partisan politics than it does for health care for veterans. As a member of the Partnership for Veterans Health Care Budget Reform, our membership strongly believes that members of Congress must change the current modeling system that constantly leads to shortfalls. The Partnership supports moving VA health care from a discretionary to an assured funding method with a new model to prevent the shortages that occurred during the first session of this Congress. Assured funding would neither change the current eligibility requirements nor create a new entitlement benefit program. It would rather create a formula that would ensure necessary appropriations each year based on current enrollment, and the annual increased inflationary costs associated with the provision of excellent medical care.

It is a well-known fact that many of the reservists went on active duty with no private health care insurance. Upon returning home, they are looking to VA to give them the health care benefits they deserve for any conditions or injuries that may have resulted for two years following each deployment. The lack of predictability and accountability of the modeling used for the VA budget process allows only the status quo at best. The consequences can only be long waiting lists, decreased access, and risk of damage to the high quality of care that VA has built. If VISNs are receiving their budgets at the start of the second quarter through a fiscal year, and

are not sure when the year's funding will really be passed by Congress, why would they invest in any type of new initiative, never knowing when the money will catch up, or if any will be there during that budget year? Assured funding and implementation of a full continuum of care for blind and visually impaired veterans are inextricably linked.

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 for blindness or severe visual impairment. As the overall population of veterans ages, more and more of them 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. The primary obstacle is the fact that enrolling in the BRC often necessitates traveling hundreds of miles to the nearest facility. The Gap Analysis survey found that 47.4 percent of the older veterans on VIST rolls who would benefit from blind rehabilitation training actually declined to attend one of the ten blind centers. Their decision, in most cases, left them with no alternative services such as a local BROS. A common reason for a refusal to attend a BRC is a serious health problem or disability of a spouse. Consequently, the blinded veteran who has often been a long-term recipient of care himself/herself, becomes, out of urgency and necessity, the primary caregiver. In such instances it is impossible for the blinded veteran to spend several weeks in a residential blind rehabilitation program.

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, 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 VAMC has referred a veteran to the BRC, the local VAMC has not had to pay for any services delivered or the prosthetics prescribed. If the VAMC provided service locally, however, it had to internally fund the blind services, taking funds from other internal medical center programs. VA has approved a change in the Veterans Equitable Resource Allocation (VERA) model that now provides incentives for local VAMCs to provide care in the most appropriate setting. The new model, "VERA 10", now allocates increased levels of funding for vision rehabilitation service, thus removing the disincentives to the local facilities.

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 many social and physical challenges of blindness. This is especially true for newly blinded young 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 that include traumatic brain injury, amputations, and sensory loss. The training can also be advantageous to older veterans since intense repetitive training is often necessary to learn new skills. The BRC can bring the entire array of specialty care to bear on

these severely wounded service members, optimizing their rehabilitation outcomes and encouraging a successful reintegration with 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 and to provide comprehensive initial blind rehabilitation.

CURRENT SERVICES

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

A. Blind Rehabilitation Centers

VA currently operates ten comprehensive residential Blind Rehabilitation Centers 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 VAMCs 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 a community and family environment. To accomplish this mission, BRCs offer a comprehensive and individualized training program accompanied by 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.

More than 1,200 blinded veterans are waiting an average of more than 19 weeks to be admitted into one of these ten BRCs. The good news this year, however, is that the number has declined from the 1,500 in March 2004. Unfortunately, a majority of even the simplest services are not yet routinely made available at the local level. The recent Gap Analysis found that only 14 medical centers reported being able to provide advanced low vision care. Only 26 said they could provide intermediate low vision care. Some 78 facilities reported only basic or no outpatient services for blindness or low vision care! For the more than 30 percent of the blinded veterans who do attend a comprehensive BRC, there is usually no continuum of outpatient care when they return home. In order to preserve the integrity of these BRCs, more outpatient and local 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. To accomplish this mission, VIST will establish mechanisms to maximize the identification of blinded veterans and to offer a review of benefits and services for which they are eligible.

The VIST concept 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 93 full-time VIST Coordinators who usually work alone to take care of an average of 375 veterans. The VIST Coordinators serve as the case managers for the known 41,700 blinded veterans nationwide, a number that is estimated to increase to 54,000 within ten years. nded veterans within ten years.

VIST personnel associated with a given VIST Coordinator are in the unique position of providing comprehensive case management services for the returning blinded OEF and OIF service members for the remainder of their lives. They can assist not only the newly blinded veteran but also his/her family with timely and important information that facilitates psychosocial adjustment. The ideal of a seamless transition from DOD to VHA is best achieved through the dedication of VIST and BROS personnel.

A few of the VIST Coordinators have been very aggressive in identifying 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 of the Coordinators rely on the BRC because many have no local BROS orientation or mobility services. If the veteran is unable to attend a BRC program, he/she goes without service in those circumstances. We find also that many rural remote regions have no local private blind services of any kind, leaving the veteran with no options. Full implementation of the continuum of vision rehabilitation services should remedy this shortcoming. Given the increasing numbers of severely visually impaired and blinded veterans, BVA believes and has always maintained that any VA facility that has 150 or more blinded veterans on its rolls should have a full-time VIST Coordinator. BVA has found that the lack of VIST services is often due to the actions of local facility managers who seek to avoid the cost of even one FTEE position. In such cases management has insisted that part-time positions manage these duties along with other collateral duties.

C. Blind Rehabilitation Outpatient Specialist (BROS)

The other highly specialized outpatient program offered by BRS is the BROS program. This relatively new (at least for BRS) approach to the delivery of services is provided to blinded veterans who cannot attend a BRC program. Veterans who attended a BRC and who would otherwise lack continuum of care follow-up are also beneficiaries of the program. Such veterans in the latter case often require some additional training due to changes in adaptive equipment or technology advances. Ten years ago, 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 earmarking of $5 million for BRS in the FY 1995 VA appropriation, BRS was able to establish 14 new BROS positions in 14 different facilities throughout the system. Although this was a relatively small number of professionals, the creation of these initial BROS positions provided VA with an excellent opportunity to provide accessible, cost effective, quality outpatient blind rehabilitation services. The number of BROS has increased to 24 since the original appropriation.

The BROS is a highly qualified professional who, ideally, is dually certified; that is, he/she has a dual masters degree both in Orientation and Mobility (living skills and manual skills) and 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. Such training prepares these individuals to provide the full range of mobility, living, and adaptive manual skills that are essential in the veteran's home environment.

The delivery of such outpatient rehabilitative service is the most cost efficient method for those veterans who have rehabilitation needs but are unable to attend the residential program to receive care. Surveys in the Gap Analysis found that some medical centers were paying $90 per hour ($450 daily) for private blind training when it was available. Some centers had an average annual expenditure of more than $70,000 for contracted private blind services. Many low vision veterans are at risk of falls or making medication mistakes, resulting in costly hospital admissions, loss of independence, and an inability to live at home. In some cases, these individuals end up in nursing homes at an annual federal cost of more than $45,000 for each bed. Veterans must not be denied essential rehabilitative outpatient services simply to save a few dollars up front.

The rapidly growing older blinded veteran population, as mentioned previously, is clearly the therapeutic target for this type of service delivery. The highly skilled BROS professionals conduct comprehensive assessments of the newly identified blinded veteran's needs to determine if referral to a residential BRC is necessary. If residential training is the appropriate response, the BROS may also provide some initial training before admission, potentially reducing the length of stay in the BRC.

VA BRS has collected functional outcome data, through the outcomes project, regarding the success of this new program. Veterans' satisfaction ratings have been extremely high. The BROS program provides an excellent opportunity to test, refine, and validate the effectiveness of outpatient service delivery. It certainly assists in determining which veterans can receive maximum benefit from this rehabilitation model.

Mr. Chairman, the Veterans Benefits Administration (VBA) has worked extensively with members of this Committee and staff in explaining the importance of co-sponsoring and supporting this cost-effective legislation introduced by Congressman Michaud. We appreciate his introduction of "The Blinded Veterans Continuum of Care Act of 2005" (H.R. 3579), which would greatly expand the ability of VA to employ more BROS. Since it is more efficient to provide as much care as possible in an outpatient setting, we again refer to GAO testimony. Within the document is a statement that 21 percent of all veterans on waiting lists for admission to a BRC could receive care through local blind outpatient services. Under CARES, each admission to a BRC costs $28,900 per veteran. If even 240 veterans a year were instead provided local VIST/BROS services, the internal BRC inpatient cost saving would be an estimated $7,900,000 yearly. When also considering the alternative high costs for blinded veterans with no options other than costly long-term care and who cannot live independently, we wonder why this bill does not have far greater support. We strongly urge this session to approve and fund the additional BROS positions included in H.R. 3579.

In late December, S. 1182 was passed. It included the provision of 35 new BROS positions for VA Medical Centers over the next three years and of the funding to support these positions. We believe that the House should move H.R. 3579 forward as soon as possible.

D. Computer Access Training (CAT)

Because of the FY 1995 VA appropriation of special funds earmarked for VA BRS, monies were made available to establish Computer Access Training (CAT) programs at the five major blind rehabilitation centers. Over the intervening years, CAT programs have been established at the remaining five BRCs. However, the demand for admission to these programs has dramatically increased to the point that an eligible blinded veteran has been waiting a year or more to be admitted. There are approximately 396 blinded veterans presently waiting for more than 21 weeks to attend a blind center for both rehabilitative and CAT "dual" training. The problem is that many veterans live in rural and remote regions where local services are not available. They must attend a blind center or be left without training.

Having to admit a blinded veteran to an inpatient VA BRC for this specialized computer training, which includes housing the blinded veteran in a hospital bed, is unnecessarily expensive. The good news is that, despite all of the obstacles, local training has increased. On May 5, 2004, 674 veterans were waiting for admission to a BRC for CAT training. This list was reduced by local CAT contracted services for 520 of these veterans by August 1, 2004. This successful result is due in large part to the GAO study of VA BRS service delivery and its subsequent recommendations. It involves the referring of most blinded veterans to local resources, if they can be appropriately located, for CAT training. The reduction in the BRC waiting lists from more than 2,500 veterans in 2003 to 1,212 at present involves a more effective utilization of CAT resources. Some BRCs have been, correspondingly, returning beds previously dedicated to CAT training back to the basic adjustment program. Continuing to contract services in a similar manner, greater progress could be achieved in decreasing the long waiting times for younger veterans who require the full services of the blind centers.

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 in Lebanon, Pennsylvania, and treats patients in Network 4. This "service outside the box" delivery model is noteworthy. Patient satisfaction with

the program is nearly 100 percent, according to the VA Outcomes Project. Two current documents, *Gap Analysis: Vision Rehabilitation Services for Veterans Final Report* (Atlanta VA Rehabilitation R & D Center of Excellence for Veterans with Vision Loss), and *The Low Vision Services in the VA's Continuum of Care for Veterans with Visual Impairment* (VIAB Final Report), recommend that this delivery model should be considered for replication within each Network. The program uses hoptel beds to house veterans. The beds do not require 24-hour nursing coverage and are similar to staying in a hotel. Emergency care is available within the VAMC. The expenses associated with expanding this new cost-effective outpatient rehabilitation program from one facility to 11 facilities would be $5,474,733 for the initial year. Annual recurring costs to maintain these 11 programs, however, would be $4,700,883. This recurring cost works out to $427,353 per VISOR facility for all staffing, equipment, office supplies, and training. VISOR's annually projected caseload of 550 veterans (50 per VISOR facility) would cost an estimated at $8,545 per veteran, one-third of the $28,900 for a month at one of the BRCs.

The VISOR program is providing functional outcome data to the Outcomes Project and will make possible the comparison of functional outcomes derived from this approach with that of the more traditional residential BRC. Early functional outcome data indicates that the approach is very effective. Profiles gathered from early data suggest that visually impaired elderly veterans, 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. VA should be supported in its national leadership role in the field of blind rehabilitation services and must continue to explore additional alternatives in addressing the needs of blinded veterans.

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 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. The program is typically a very short (five-day) inpatient experience 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 from the facility to commute daily.

VICTORS has achieved the same outcomes and objectives as its inpatient counterpart. 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 program enables such individuals to maintain their employment and retain full independence in their lives. Unfortunately, Mr. Chairman, there are only three such programs currently within VHA. VIAB has recommended one VICTOR center in each Network where no VISOR program exists. This would result in 21 of these special programs. We submit that there is a critical need for these programs to assist veterans in their quest to remain in the workforce. In fact, the expansion of VICTORS could further assist

severely visually impaired (legally blind) or blinded veterans who have already attended a residential BRC, received low vision aids, and who now require only modifications. The effectiveness of new technology aids could be reviewed and researched. New prescriptions could be written when appropriate. Consequently, veterans would avoid the necessity of readmission to the much more expensive BRC for such reviews and evaluations.

EFFECTS OF VERA ON REHABILITATION

BRCs are admittedly resource intensive and costly. Currently, these programs are being viewed as potential revenue sources 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. A great deal of gaming occurred because of the high variance between the high and basic reimbursement rates.

If these services are necessary, they should be provided in either a hoptel environment or, even more appropriately, in the blinded veterans' home areas. More focused outpatient programs using hoptel beds are not reimbursed at the higher rate. The incentive is to admit blinded veterans to the inpatient bed at the BRC. When BRCs institute shorter programs, veterans are shortchanged. Programs such as VISOR and VICTORS admit a population with typically high residual vision (usually macular degeneration) and few, if any, co-morbidities. BVA recommends that these services should be funded and provided in the local area. Our concerns are especially relevant now that DOD Military Training Facilities are referring more young service personnel who have been blinded totally and who 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 should and must be anticipated for these very special veterans. Shortcuts for reimbursement advantages cannot be tolerated.

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 provides an apparent 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 because 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.

OVERSIGHT

Mr. Chairman, as previously mentioned, the last oversight hearing by the House Committee was held on July 22, 2004 to receive GAO's report on VA blind rehabilitation services. The comprehensive report examined the history and future issues surrounding such services to veterans. 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. They found that several BRCs were not complying with program office directions and policies. Regarding the current delivery models, we can point to the GAO and VIAB recommendations that there must be greater utilization of outpatient services in new BROS and VISOR programs, along with supporting changes occurring in the CAT program.

BVA believes that significant progress has been achieved following the release of the GAO reports, but we are concerned that resistance remains among some management employees. Starting with VHA, the National Leadership Board, and the Medical Center Director level, a clear goal should exist to provide high quality, cost-effective blind rehabilitation services in the continuum to which we have continually referred. We have pointed out in the past that a culture change must occur if BRS is to modernize in delivering cost-effective, appropriate outpatient blind rehabilitation services. Therefore, Mr. Chairman, we believe it is essential for this Committee to investigate issues presented today, and to hold a follow-up Health Subcommittee hearing in the near future to assess VA's progress in implementing the GAO recommendations.

DEPARTMENT OF VETERANS AFFAIRS FY 2007 BUDGET REQUEST

The Office of Management and Budget's FY 2005 and FY 2006 budget requests are prime examples of the urgent need for assured funding. The gaming must end, and old models that do not include the current thousands of returning OEF and OIF service members requiring care must be changed. BVA urges the members of these Committees to support a new model that would assure adequate funding. Further hearings could then be limited to the budgetary issues only.

As in years past, we are deeply concerned the FY 2006 budget request fell short by $1.9 billion, and we once again predict inadequacy in the FY 2007 budget requirements to adequately address the health care needs of an aging veteran population. We all heard Under Secretary for Health Dr. Perlin when he testified last summer that VHA needed a $1.9 billion increase for FY 2006, plus another $1 billion just to maintain current services once all the increased co-payments and other gimmicks were subtracted. As in past years, VA is being forced to rely more heavily on first and third-party collections to substitute for appropriation. These collections always fall short of their estimates.

To project a subsequent year's budget, the current discretionary appropriations process subjects veterans health care to numerous political agendas rather than to 1) a real model calculated on the number of veterans currently enrolled this year, 2) an index for inflation, and 3) an average cost for each veteran using VA health care.

The FY 2006 Military Construction and Veterans Affairs Appropriations bill allows for $1.2 billion in "emergency funds" to make up for shortfalls if they occur. BVA questions why, if the defenders of the status quo discretionary funding system are so sure of budget needs each year, is "emergency funding" even required? Why would implementation of a new model of assured funding be less attractive?

Clearly, there will be insufficient funds to enable VA to implement the full continuum of vision rehabilitation care as recommended by GAO and VIAB if the traditional discretionary modeling process continues. The fact is that because of the problems that occurred with the FY 2006 budget process, some medical centers are already freezing levels of staffing and are not hiring replacements. Therefore, it is highly unlikely that medical centers will be able to consider hiring new employees qualified to provide vision rehab services. Local travel and educational funding are also being slashed as a result of the FY 2006 budget.

Given the current budget climate, VA medical facilities will almost certainly restrict or eliminate the use of funding to contract for local fee services, again negatively affecting provision of a continuum of vision rehabilitation services. BVA is gravely concerned that funding for essential prosthetic services and equipment will be severely curtailed with this budget modeling process. Medical centers will, out of necessity and within the culture of cost efficiency, continue to confine operations rather than create new programs. This will affect not only blinded veterans but all disabled veterans. The President's FY 2007 budget request will again prevent Category 8 veterans from being able to utilize VA, keeping thousands away from the VA health care system. The most interesting thing about this approach is that veterans with the least health care burden—those working and with their own health insurance who bring their own 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 preventive and acute care services. Those in the so-called "core group" benefit tremendously from the specialized services provided by VA, but they also need the full array of basic healthcare services. While members of Congress decry the budgetary shortages last summer, the House and Senate have repeatedly failed to provide a new model of assured 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 presidential administrations and the Congress.

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 country's highest priorities. Clearly, the President wants to care for the heroes returning from Afghanistan and Iraq, 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 who did not suffer

traumatic emotional or physical disabilities as a direct result of their service. No matter what their circumstance, many have served our Nation and now need help. National policy must recognize that care of our veterans is 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. They have 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 the states can make up for the loss of the VA payments. Paradoxically, if funding remains the only driving force behind care, then funding issues will drive the culture of VA long-term care. Creation of the innovative programs that utilize technology and human resources will be de-emphasized.

What is most alarming Mr. Chairman, is that the current budgetary situation, as I have described it in terms of the blinded veterans, uses so-called "efficiencies," which are "saving games" that profoundly affect veterans' ability to lead independent lives on a daily basis. The continuously negative budgets will influence the specialized programs for blinded veterans and will be reflected in other special disabilities programs that must fight for every single dollar. If VHA is not fiscally healthy, the specialized programs for the "core veterans" will not be healthy either.

VETERANS BENEFITS ADMINISTRATION

VBA is also facing major problems. After a few years in which the number of claims pending decreased, there has been a reversal. Some 400,000 are now in a logjam. BVA is painfully aware of the chronic backlogs for claims pending before VBA and the Board of Veterans Appeals, and the years of promises that the system is going to be fixed. Once again, this budget fails to provide the necessary resources to adequately assist VBA in its efforts to reduce these unconscionable backlogs. Veterans are literally waiting two or three 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 more appeals. Clearly, if claims were properly developed at the local VA Regional Office (VARO), the number of appeals would drop dramatically. Unfortunately, the VAROs are not doing a good job of assisting veterans in developing their claims.

It is disconcerting that some blame the veterans and the VSO service officers for filing too many claims. Recent articles have revealed that a large percentage of phone calls from veterans to VA requesting information on benefits are answered incorrectly more than 25 percent of the time. The government should not depend on the VSOs to do their job of instructing veterans properly on the benefits they have earned. More resources are sorely needed to improve staffing and provide new computer systems that integrate service members' medical records into both the VBA and VHA information technology processing system.

BVA members have been alarmed over many statements made over the past year that suggest or make accusations that veterans who are disabled are receiving too much compensation and therefore don't want to work. Public remarks "that it is very easy" in the current employment market to be employed imply that the disabled veteran must be lazy or uninterested in finding work! Recent multiple research studies have indicated that the labor force and employment trends for the disabled population have not been consistent with the trends of the nondisabled workforce population. The labor force rate of participation increased for the nondisabled population from 1970 to 2000 while it decreased for the disabled population.

The employment rate of the disabled did in fact decrease from 26 percent in 1996 to 19.5 percent in 2003. In addition, labor market earnings research during the past two decades has consistently found that the disabled earn less than non-disabled workers with many working at minimum wage jobs that offer few benefits. Literature reviews reveal that disabled persons suffer lost earnings capacity and that such loss of capacity is affected even further by such factors as age, education, and socioeconomic characteristics. The National Institute on Disability and Rehabilitation Research found that for people with no disability, the likelihood of having a job or business is 82.1 percent. For people with a mild disability, the employment rate is 76.9 percent. For those using a cane, crutches, or a walker, the rate is 27.5 percent while those relying on a wheelchair for mobility were able to find employment in 22 percent of the cases. For individuals with visual impairments (unable to read letters), the employment rate is only 30.8 percent. Instead of trying to develop plans to prevent disabled veterans from receiving compensation benefits, we recommend that the members of this Committee first look at what can be done to improve vocational, rehabilitative, and educational programs or benefits for those needing assistance in finding employment. The incorrect assumption is that simply because the United States has gone from an agricultural or industrial-centered economy to one highlighted by telecommunications, high technology, and automation, the employment field is now level for every disabled person. A recent 55-page report from the Office of Personnel Management also revealed that the number of veterans employed in the federal government in 1994 (558,347 or 28 percent of the federal workforce), decreased over the subsequent ten years (453,793 or 25.1 percent) in 2004. If the aforementioned assumptions and assertions statements were even remotely true, the employment rates for the disabled would not have decreased since 1994.

The sudden rush to judgment that many veterans with PTSD must be faking or committing fraud was evidenced during the past year when demands were made that 75,000-plus claims be reviewed. The demand came about as a result of a small sample of errors found in reviewing a limited number of files. Following a more thorough review, many of the errors were discovered to be misplaced documentation and not widespread deception or fraud. BVA members also believe that disability benefits should cover loss of earnings and include compensation for quality of life. Because of the injuries they have sustained, veterans who have suffered catastrophically and have lost mobility, an ability to perform routine daily tasks, and opportunities for social interaction should receive benefits that include compensation for the change in their quality of life.

INDEPENDENT BUDGET

BVA is very proud to again endorse the Independent Budget, prepared by four of the major VSOs: AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars. This is the 21st consecutive year that BVA has endorsed the IB. Along with many other endorsers, we participated in the preparatory sessions and provided input to the formulation of this extremely important document. We trust that this Committee will read the document carefully. 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 that these suggestions are very sound and that they should receive serious consideration as the budget process moves forward.

The FY 2007 budget must keep pace with the increased medical costs in salaries, benefits, goods, and services utilized. The recently passed FY 2006 appropriations included $3.3 billion for operating and maintaining VA medical facilities, $464 million less than the 2005 level. While the medical and prosthetics research budget for FY 2006 did include $412 million, a $10 million increase over 2005, BVA is concerned that the FY 2007 budget will not keep pace with the urgent needs for expansion in this area. Additionally, the recommended funding level must also enable VA to more adequately fund congressionally mandated initiatives. It is vital to VHA's mission to have the research funding necessary for continued medical advances. These funds are critical to VHA's ability to attract and retain clinicians who are seeking the opportunity to conduct research in prosthetics.

PROSTHETIC SERVICE

As reported last year, BVA is very pleased with the outcome of the Prosthetic Clinical Management Program (PCMP) as it affects visually impaired and blinded veterans. The stated focus of the PCMP is the quality of prescriptions rather than only the dollars expended for the prescriptions.

The driving activity behind 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. Were it not for the fact that BVA had an opportunity to actively participate in the work groups related to aids and appliances for the blind, visually impaired and blinded veterans would not have faired very well. The work groups have been tasked with developing specifications for the device in question 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 that works on the premise that one size fits all. Severely disabled veterans need to be treated as individuals with unique needs who might not always benefit from a 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.

The effort to standardize the purchasing practices of VHA with respect to prosthetic services has been successful in large part to centralized funding for prosthetics. The combination of centralized funding and improved prescription practices has clearly enhanced disabled veterans access to high quality state-of-the-art Prosthetic Sensory Aids and Appliances.

BVA is concerned, however, over the recent organizational realignment of Prosthetic & Sensory Aid service (PSAS) from Patient Care Services (PCS) to a new Office of PSAS & Clinical Logistics. The former Chief Consultant for PSAS is the new Chief Officer of the Office of PSAS & Clinical Logistics. We are especially concerned that PSAS will not receive the same level of attention that resulted in the improvements noted above. Unfortunately, this realignment has occurred at a time when PSAS has lost its two most senior and experienced managers to retirement.

Mr. Chairman, we do wish to commend PSAS for their outstanding efforts overall to insure a seamless transition for service members transitioning from DOD to VA.

VA MEDICAL AND PROSTHETICS RESEARCH

BVA supports the Friends of VA Medical Care and Health Research (FOVA) request for $460 million for FY 2007 for investments in veteran-centered research projects at VA. Such projects in the past have led to an explosion of knowledge that has advanced the understanding of many diseases and unlocked strategies for prevention, treatment, and cures. Additional funding is needed to take advantage of the burgeoning opportunities to improve quality of life for our veterans and the Nation as a whole. VA must concurrently address the needs of its longstanding patient base as well as the evolving challenges being presented by our newest veterans. With these funds, it is expected that VA would pursue the following in fiscal year 2007: prosthetics, PTSD, depression, neuromuscular diseases, and other specialized research. This funding level would also allow for an increase in funding for Rehabilitation Research & Development so desperately needed during this period of war. It would also allow the continuation of several RR&D initiatives in the area of retinal implants and/or prostheses.

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. These are funds that could be used to provide medical care to veterans. We believe that this policy is grossly unfair to sick and disabled veterans in need of medical care and to a health care system already forced to operate with constrained funding. NIH has refused every effort by VA to seek payment for these indirect costs. We therefore believe that legislative action is required.

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 H.R.515, The Assured Funding for Veteran's Health Care Act of 2005, which will institute mandatory funding for 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 obligation and a responsibility of the federal government.

C. BVA, along with the veterans and military organizations, supports legislation stopping the offset between the Survivor Benefit Plan (SBP) and Dependency and Indemnity Compensation (DIC). SBP is purchased by the retiree and is intended to provide a portion of retired pay to the survivor. DIC is a special indemnity compensation paid to the survivor when a member's service causes his or her premature death. In such cases, the VA indemnity compensation should be added to the SBP the retiree paid for, not substituted for it. It is also noteworthy as a matter of equity that surviving spouses of federal civilian retirees who are disabled veterans, and who die of military service-connected causes, can receive DIC without losing any of their purchased federal civilian SBP benefits.

D. BVA requests that this Committee hold a hearing on "The Disabled Veterans Equity Act" (H.R. 2963), which currently has 68 bipartisan co-sponsors. In 2002, Congress passed and the President signed P.L. 107-330. The law included a provision (Section 103) to correct a similar deficiency in the "Paired Organ" law. Currently, a veteran, who is service connected for loss of vision in one eye due to injury or illness incurred on active duty is denied additional disability compensation if they become legally blind in the remaining eye. Because the Paired Organ section on vision did not address the legally accepted definition of blindness, (visual acuity 20/200, or loss of field of vision to 20 degrees), some veterans are denied an increase in compensation if they become legally blinded in both eyes. This change in the law would only affect a small percentage of the 13,109 veterans who are service connected for loss of vision in one eye. We would argue that for the veteran with blindness in one eye who subsequently loses vision in his/her remaining eye, full paired organ benefits should not be denied. Research reveals that less than five percent of the current service-connected veterans for loss of vision in one eye would eventually lose vision in the remaining eye.

E. BVA strongly encourages Congress to adopt legislation that would provide full concurrent receipt for all military retirees who have suffered service-connected disabilities The VSOs responsible for development of the Independent Budget have urged Congress to correct this serious inequity. Congress should enact legislation that repeals

the inequitable requirement that veterans' military retired pay based on longevity be offset by an amount equal to their VA disability compensation.

F. 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 DIC. Further, we support this COLA being made effective December 1, 2006.

G. BVA encourages the U.S. Senate to adopt legislation introduced by Senator Specter. "The FAIR Act" (S. 852) establishes 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 and causes many disabled veterans to wait many years before ever receiving any compensation for suffering caused by asbestos exposure.

H. 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 that legislative language can be crafted this year to move this legislation through the 109th 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. The Medicare trust fund benefits at the same time since VA will be reimbursed at a discounted rate.

I. As evidenced by the vital emergency role that the VA played during the past hurricane season, VA should have the funding necessary to respond in the event of either a natural or terrorist attack. In addition, as the federal government seeks to strengthen homeland security, VA should receive an appropriate share of resources dedicated to this purpose. The importance of the VA's capacity to respond with medical and human resources in times of national emergency cannot be underestimated.

J. BVA urges members of the Congress to support passage of House Concurrent Resolution (H. Con. Res. 235), introduced by Ranking Member Evans and adopted by the House of Representatives last year (H. Con. Res. 56). The resolution failed last year because there was no follow-up on the Senate side. H. Con. Res. 235 states "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 again and urge members to co-sponsor this as method of improving pedestrian safety. We are pleased that companion Senate Resolution 71 was recently introduced in the Senate Transportation Committee.

K. As mentioned previously, aging is the single best predictor of blindness or severe visual impairment. Veterans are not the only ones who are growing old and losing their sight.

BVA encourages Congress to enact legislation to fund categorical programs for the professional preparation of education and rehabilitation personnel serving people who are severely visually impaired and blind. There is a shortage of trained professionals in the field of blindness. The shortage may very well be further aggravated as a result of the President's FY 2007 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.

L. 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 and authorize a plebiscite to provide the opportunity for Puerto Ricans to make an informed decision regarding the island's future.

M. Once again this year, BVA urges this Committee 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 are accepted to one of the VA special disabilities programs and who are not currently eligible for travel benefits. These veterans are already required to pay the Social Security Administration co-payment as well as a daily per diem rate during the rehabilitation experience. Adding the burden of paying their own travel, usually air transportation, serves as a strong disincentive for these veterans to take advantage of the world class service offered by VA.

N. BVA absolutely opposes any legislative initiative that would change the current "Line of Duty" standard for determining "Service Connection" to "Performance of Duty."

CONCLUSION

Once again, Mr. Chairman, thank you for this opportunity to present BVA's legislative priorities for 2006. BVA is extremely proud of our 61 years of continuous service to blinded veterans and all of the accomplishments we have enjoyed. The future strength of our Nation depends on the willingness of young men and women to serve in our military, and that depends in part on the willingness of our government to meet its obligation to them as veterans.

When BVA representatives meet the young service members from OEF and OIF at Military Treatment Facilities, one of the first questions asked is the following: "Is VA going to be able to provide me with the long-term rehabilitation that I will need to adjust to my blindness?" We would like to ask that question of the members in this room. Again, Mr. Chairman, thank you for this opportunity. I will gladly answer any questions you or other members of this Committee may have.