I

109TH CONGRESS
1ST SESSION

H. R. 2671

To provide for the expansion of Federal programs to prevent and manage vision loss, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 26, 2005

Mr. GENE GREEN of Texas (for himself, Ms. ROS-LEHTINEN, Mr. PRICE of North Carolina, and Mr. TIBERI) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To provide for the expansion of Federal programs to prevent and manage vision loss, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Vision Preservation Act of 2005''.

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) An estimated 80 million Americans have a potentially blinding eye disease. Three million Americans have low vision, 1.1 million Americans are legally blind, and 200,000 Americans are more severely visually impaired. Visual impairment is one of the 10 more frequent causes of disability in the United States.

(2) While it is believed that half of all blindness can be prevented, the number of Americans who are blind or visually impaired is expected to double by 2030.

(3) Vision is critical to conducting activities of daily living and affects developmental learning, communicating, working, health, and quality of life.

(4) Vision problems affect 1 in 20 preschoolers and, if untreated, can affect learning ability, personality, and adjustment in school.

(5) It is estimated that blindness and visual impairment cost the Federal Government more than $4 billion annually in benefits and lost taxable income.

(6) The four leading eye diseases affecting older Americans are age-related macular degeneration, cataract, diabetic retinopathy, and glaucoma.

(7) Age-related macular degeneration is the most common cause of low vision and legal blindness

in older Americans. More than 1.6 million Americans age 50 and older live with late stage age-related macular degeneration. It is recommended that individuals age 60 or older have their eyes examined at least once a year to detect age-related macular degeneration.

(8) The Federal Government spends more than $3.4 billion each year treating cataract through the Medicare program. Cataract affects nearly 20.5 million Americans age 40 and over. By age 80, more than half of all Americans have cataract.

(9) Diabetic retinopathy affects over 5.3 million Americans age 18 or older and can affect anyone with diabetes. The Centers for Disease Control and Prevention estimate that 10.3 million Americans have diagnosed diabetes, while an additional 5.4 million have undiagnosed diabetes. Because the number of Americans with diabetes is expected to grow significantly as the number of older Americans continues to increase, more people will be at risk for diabetic retinopathy.

(10) Glaucoma affects more than 2.2 million Americans age 40 and older. Glaucoma cannot be prevented, but most cases can be controlled and vision loss slowed or halted with treatment. Glaucoma

disproportionately affects minorities, affecting more than 10 percent of Black men and Hispanic women age 80 or older.

(11) Vision rehabilitation helps people with a serious vision loss learn to safely navigate within their home environs, avoid medication errors, cook and use kitchen implements safely, and avoid burns, falls, and other injuries. Vision rehabilitation promotes safety and independence for the vision-impaired elderly, and prevents injuries and further disabilities.

(12) Recognizing that the Nation requires a public health approach to visual impairment, the Department of Health and Human Services dedicated a portion of its Healthy People 2010 initiative to vision. The initiative set out as a goal the improvement of the Nation's visual health through prevention, early detection, treatment, and rehabilitation.

(13) Greater efforts must be made at the Federal, State, and local levels to increase awareness of vision problems, their impact, the importance of early diagnosis, treatment, and rehabilitation, and effective prevention strategies. It is the sense of the Congress that the Nation must have a full-scale pub-

lic health effort on vision problems that includes the following:

(A) Communication and education.

(B) Surveillance, epidemiology, and prevention research.

(C) Programs, policies, and systems change.

TITLE I—PUBLIC HEALTH PROVISIONS

SEC. 101. VISION LOSS PREVENTION.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 317S the following:

"SEC. 317T. PREVENTIVE HEALTH MEASURES WITH RESPECT TO VISION LOSS.

''(a) COMMUNICATION AND EDUCATION.—

''(1) IN GENERAL.—The Secretary, acting through the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the National Institutes of Health, shall expand and intensify programs to increase awareness of vision problems, including awareness of—

''(A) the impact of vision problems; and

''(B) the importance of early diagnosis, management, and effective prevention and rehabilitation strategies.

''(2) ACTIVITIES.—In carrying out this subsection, the Secretary may—

''(A) conduct public service announcements and education campaigns;

''(B) enter into partnerships with eye-health professional organizations and other vision-related organizations;

''(C) conduct community disease prevention campaigns; and

''(D) conduct testing, evaluation, and model training for vision screeners based on scientific studies.

''(3) EVALUATION.—In carrying out this subsection, the Secretary shall—

''(A) establish appropriate measurements for public awareness of vision problems;

''(B) establish appropriate measurements to determine the effectiveness of existing campaigns to increase awareness of vision problems;

''(C) establish quantitative benchmarks for determining the effectiveness of activities carried out under this subsection; and

''(D) not later than 12 months after the date of the enactment of this section, submit a report to the Congress on the results achieved through such activities.

''(b) SURVEILLANCE, EPIDEMIOLOGY, AND HEALTH SERVICES RESEARCH.—

''(1) IN GENERAL.—The Secretary shall expand and intensify activities to establish a solid scientific base of knowledge on the prevention and control of vision problems and related disabilities.

''(2) ACTIVITIES.—In carrying out this subsection, the Secretary may—

''(A) create a national ongoing surveillance system;

''(B) identify and test screening modalities;

''(C) evaluate the efficacy and cost-effectiveness of current and future interventions and community strategies;

''(D) update and improve knowledge about the true costs of vision problems and related disabilities; and

''(E) require the Surgeon General to assess the state of vision care and vision rehabilitation in the United States.

''(c) PROGRAMS, POLICIES, AND SYSTEMS.—

''(1) IN GENERAL.—The Secretary shall expand and intensify research within the Centers for Disease Control and Prevention on the prevention and management of vision loss.

''(2) ACTIVITIES.—In carrying out this subsection, the Secretary may—

''(A) build partnerships with voluntary health organizations, nonprofit vision rehabilitation agencies, Federal, State, and local public health agencies, eye health professional organizations, and organizations with an interest in vision issues;

''(B) work with health care systems to better address vision problems and associated disabilities; and

''(C) award grants for community outreach regarding vision loss to national vision organizations with broad community presence.''.

SEC. 102. EXPANSION OF VISION PROGRAMS UNDER THE MATERNAL AND CHILD HEALTH SERVICE BLOCK GRANT PROGRAM.

Section 501(a)(3) of the Social Security Act (42 U.S.C. 701(a)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (E);

(2) by striking the period at the end of subparagraph (F) and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(G) introduce core performance measures on eye health by incorporating vision screening standards into State programs under this title, based on scientific studies.".

SEC. 103. PREVENTION AND TREATMENT FOR UNDERSERVED, MINORITY, AND OTHER POPULATIONS.

(a) EXPANSION AND INTENSIFICATION OF VISION PROGRAMS.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall expand and intensify programs targeted to prevent vision loss, treat eye and vision conditions, and rehabilitate people of all ages who are blind or partially sighted in underserved and minority communities, including the following:

(1) Vision care services at community health centers receiving assistance under section 330 of the Public Health Service Act (42 U.S.C. 254b).

(2) Vision rehabilitation programs at vision rehabilitation agencies, eye clinics, and hospitals.

(b) VOLUNTARY GUIDELINES FOR VISION SCREENING.—The Secretary, in consultation with eye-health pro-

fessional organizations and other vision-related organizations, shall develop voluntary guidelines to ensure the quality of vision screening.

SEC. 104. NATIONAL INSTITUTES OF HEALTH.

(a) IN GENERAL.—The Director of the National Institutes of Health (in this section referred to as the ''Director'') shall expand, intensify, and coordinate programs for the conduct and support of research with respect to vision loss prevention and vision rehabilitation.

(b) COORDINATION.—The Director shall coordinate vision-related activities in consultation with Federal officials, voluntary health organizations, medical professional societies, and private entities as appropriate.

(c) RESEARCH.—In carrying out this section, the Director shall expand the following research activities:

(1) translational research within the National Eye Institute;

(2) diabetes and glaucoma related programs of the National Eye Institute;

(3) creation of an age-related macular degeneration public education program within the National Eye Institute to—

(A) increase awareness of age-related macular degeneration in selected high-risk target audiences in the United States;

(B) increase awareness of the importance of early detection of age-related macular degeneration in preventing vision loss;

(C) increase health care providers' awareness of the need for regular comprehensive dilated eye examinations for those at risk for age-related macular degeneration and other eye diseases, with the ultimate goal of early detection of eye disease and the linkage of patients to appropriate medical treatment and rehabilitation services; and

(D) encourage at-risk populations to take appropriate action based on their increased awareness.

TITLE II—MEDICARE PROVISIONS

SEC. 201. IMPROVEMENT OF OUTPATIENT VISION SERVICES UNDER PART B.

(a) COVERAGE UNDER PART B.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (Y), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (Z), by adding ''and'' after the semicolon at the end; and

(3) by adding at the end the following new subparagraph:

''(AA) vision rehabilitation services (as defined in subsection (bbb)(1));''.

(b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Vision Rehabilitation Services: Vision Rehabilitation Professional

''(bbb)(1)(A) The term 'vision rehabilitation services' means rehabilitative services (as determined by the Secretary in regulations) furnished—

''(i) to an individual diagnosed with a vision impairment (as defined in paragraph (6));

''(ii) pursuant to a plan of care established by a qualified physician (as defined in subparagraph (C)) or by a qualified occupational therapist that is periodically reviewed by a qualified physician;

''(iii) in an appropriate setting (including the home of the individual receiving such services if specified in the plan of care); and

''(iv) by any of the following individuals:

''(I) A qualified physician.

''(II) An occupational therapist.

''(III) A vision rehabilitation professional (as defined in paragraph (2)) while under the general supervision (as defined in subparagraph (D)) of a qualified physician.

''(B) In the case of vision rehabilitation services furnished by a vision rehabilitation professional, the plan of care may only be established and reviewed by a qualified physician.

''(C) The term 'qualified physician' means—

''(i) a physician (as defined in subsection (r)(1)) who is an ophthalmologist; or

''(ii) a physician (as defined in subsection (r)(4) (relating to a doctor of optometry)).

''(D) The term 'general supervision' means, with respect to a vision rehabilitation professional, overall direction and control of that professional by the qualified physician who established the plan of care for the individual, but the presence of the qualified physician is not required during the furnishing of vision rehabilitation services by that professional to the individual.

''(2) The term 'vision rehabilitation professional' means any of the following individuals:

''(A) An orientation and mobility specialist (as defined in paragraph (3)).

''(B) A rehabilitation teacher (as defined in paragraph (4)).

''(C) A low vision therapist (as defined in paragraph (5)).

''(3) The term 'orientation and mobility specialist' means an individual who—

''(A) if a State requires licensure or certification of orientation and mobility specialists, is licensed or certified by that State as an orientation and mobility specialist;

''(B)(i) holds a baccalaureate or higher degree from an accredited college or university in the United States (or an equivalent foreign degree) with a concentration in orientation and mobility; and

''(ii) has successfully completed 350 hours of clinical practicum under the supervision of an orientation and mobility specialist and has furnished not less than 9 months of supervised full-time orientation and mobility services;

''(C) has successfully completed the national examination in orientation and mobility administered by the Academy for Certification of Vision Rehabilitation and Education Professionals; and

''(D) meets such other criteria as the Secretary establishes.

''(4) The term 'rehabilitation teacher' means an individual who—

''(A) if a State requires licensure or certification of rehabilitation teachers, is licensed or certified by the State as a rehabilitation teacher;

''(B)(i) holds a baccalaureate or higher degree from an accredited college or university in the United States (or an equivalent foreign degree) with a concentration in rehabilitation teaching, or holds such a degree in a health field; and

''(ii) has successfully completed 350 hours of clinical practicum under the supervision of a rehabilitation teacher and has furnished not less than 9 months of supervised full-time rehabilitation teaching services;

''(C) has successfully completed the national examination in rehabilitation teaching administered by the Academy for Certification of Vision Rehabilitation and Education Professionals; and

''(D) meets such other criteria as the Secretary establishes.

''(5) The term 'low vision therapist' means an individual who—

''(A) if a State requires licensure or certification of low vision therapists, is licensed or certified by the State as a low vision therapist;

''(B)(i) holds a baccalaureate or higher degree from an accredited college or university in the United States (or an equivalent foreign degree) with a concentration in low vision therapy, or holds such a degree in a health field; and

''(ii) has successfully completed 350 hours of clinical practicum under the supervision of a physician, and has furnished not less than 9 months of supervised full-time low vision therapy services;

''(C) has successfully completed the national examination in low vision therapy administered by the Academy for Certification of Vision Rehabilitation and Education Professionals; and

''(D) meets such other criteria as the Secretary establishes.

''(6) The term 'vision impairment' means vision loss that constitutes a significant limitation of visual capability resulting from disease, trauma, or a congenital or degenerative condition that cannot be corrected by conventional means, including refractive correction, medication, or surgery, and that is manifested by 1 or more of the following:

''(A) Best corrected visual acuity of less than 20/60, or significant central field defect.

''(B) Significant peripheral field defect including homonymous or heteronymous bilateral visual field defect or generalized contraction or constriction of field.

''(C) Reduced peak contrast sensitivity in conjunction with a condition described in subparagraph (A) or (B).

''(D) Such other diagnoses, indications, or other manifestations as the Secretary may determine to be appropriate.''.

(c) PAYMENT UNDER PART B.—

(1) PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(AA),'' after ''(2)(W),''.

(2) CARVE OUT FROM HOSPITAL OUTPATIENT DEPARTMENT PROSPECTIVE PAYMENT SYSTEM.—Section 1833(t)(1)(B)(iv) of such Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting ''vision rehabilitation services (as defined in section 1861(bbb)(1)) or'' after ''does not include''.

(3) CLARIFICATION OF BILLING REQUIREMENTS.—The first sentence of section 1842(b)(6) of such Act (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking ''and'' before ''(G)''; and

(B) by inserting before the period the following: '', and (H) in the case of vision rehabilitation services (as defined in section 1861(bbb)(1)) furnished by a vision rehabilitation professional (as defined in section 1861(bbb)(2)) while under the general supervision (as defined in section 1861(bbb)(1)(D)) of a qualified physician (as defined in section 1861(bbb)(1)(C)), payment shall be made to (i) the qualified physician or (ii) the facility (such as a rehabilitation agency, a clinic, or other facility) through which such services are furnished under the plan of care if there is a contractual arrangement between the vision rehabilitation professional and the facility under which the facility submits the bill for such services''.

(d) PLAN OF CARE.—Section 1835(a)(2) of the Social Security Act (42 U.S.C. 1395n(a)(2)) is amended—

(1) in subparagraph (E), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting ''; and''; and

(3) by inserting after subparagraph (F) the following new subparagraph:

''(G) in the case of vision rehabilitation services, (i) such services are or were required because the individual needed vision rehabilitation services, (ii) an individualized, written plan for furnishing such services has been established (I) by a qualified physician (as defined in section 1861(bbb)(1)(C)), (II) by a qualified occupational therapist, or (III) in the case of such services furnished by a vision rehabilitation professional, by a qualified physician, (iii) the plan is periodically reviewed by the qualified physician, and (iv) such services are or were furnished while the individual is or was under the care of the qualified physician.''.

(e) RELATIONSHIP TO REHABILITATION ACT OF 1973.—The provision of vision rehabilitation services under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) shall not be taken into account for any purpose under the Rehabilitation Act of 1973 (29 U.S.C. 701 et seq.).

(f) EFFECTIVE DATE.—

(1) INTERIM, FINAL REGULATIONS.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall cause to have published in in the Federal Register a rule to carry out the provisions of this section. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment.

(2) CONSULTATION.—The Secretary shall consult with the National Vision Rehabilitation Association, the Association for Education and Rehabilitation of the Blind and Visually Impaired, the Academy for Certification of Vision Rehabilitation and Education Professionals, the American Academy of Ophthalmology, the American Occupational Therapy Association, the American Optometric Association, and such other qualified professional and consumer organizations as the Secretary determines appropriate in promulgating regulations to carry out this Act.

SEC. 202. STUDY ON OBSTACLES FOR UNDERSERVED POPULATIONS FOR VISION SERVICES UNDER THE MEDICARE PROGRAM.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study on barriers faced by medically underserved populations (such as racial or ethnic minorities) to vision services that are covered under the medicare program under title XVIII of the Social Security Act, including vision rehabilitation and other vision-related services. In conducting the study, the Secretary shall consider economic barriers posed by cost-sharing requirements, such as copayments and deductibles and the awareness of medicare beneficiaries of vision services benefits currently covered and those benefit for which coverage is not provided under the program.

(b) REPORT.—Not later than one year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a). The report may include such recommendations for administrative action or legislation as the Secretary determines to be appropriate.

SEC. 203. COMPREHENSIVE EYE EXAMINATIONS.

The Secretary of Health and Human Services shall enter into an agreement with the Institute of Medicine of the National Academy of Sciences to conduct a study on

the cost benefit of providing a universal dilated eye exam under the medicare program.

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