

501(C)(3) Veterans Non-Profit

ANNUAL LEGISLATIVE PRESENTATION

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Chairman Moran, Chairman Bost, Ranking Member Blumenthal, Ranking Member Takano, and members of the committees, I appreciate the opportunity to present Paralyzed Veterans of America's (PVA) 2026 policy priorities. For nearly 80 years, PVA has served as the lead voice on issues that affect severely disabled veterans. Throughout the years, we have championed critical changes within the Department of Veterans Affairs (VA) and educated legislators as they consider important policies that impact the lives of paralyzed veterans.

Today, I come before you with our views on the current state of veterans' programs and services, particularly those that affect our members—veterans with spinal cord injuries and disorders (SCI/D). Access to VA's specialized systems of care is the center of their universe because they rely on it perhaps more than any other group of veterans served by the VA. As I have testified several times in recent years, we are very concerned about the status of VA's SCI/D system of care due to ongoing staffing deficiencies and the lack of investment in infrastructure to support these services. Thousands of PVA members and their families, caregivers, survivors, and supporters have signed a petition opposing any efforts to dismantle the VA's SCI/D system of care and the life-saving services it provides. Our members want Congress to know that they choose VA for their care.

BACKGROUND—Our organization was founded in 1946 by a small group of returning World War II veterans, all of whom were treated at various military hospitals throughout the country because of their injuries. Realizing that neither the medical profession nor the government had ever confronted the needs of such a population, these veterans decided to become their own advocates and to do so through a national organization.

From the outset, PVA's founders recognized that other elements of society were neither willing nor prepared to address the full range of challenges facing paralyzed individuals, whether medical, social, or economic. They were determined to create an organization that would be governed by the members themselves and address their unique needs. Being told that their life expectancies could be measured

in weeks or months, these individuals set as their primary goal to bring about change that would maximize the quality of life and opportunity for all people with SCI/D.

Over the years, PVA has established programs to secure benefits for veterans; reviewed the medical care provided by the VA's SCI/D system of care to ensure our members receive timely, quality care; invested in research; promoted education; organized sports and recreation opportunities; and advocated for the freedoms of paralyzed veterans and all people with disabilities. Our mission is simple—to empower our brave men and women to regain what they fought for: their freedom and independence.

The Role of Community Care for Veterans with SCI/D

The overwhelming majority of veterans with SCI/D choose to receive their care at VA facilities. Unlike the VA, few facilities in the private sector have highly trained personnel on staff to properly care for SCI/D patients. A few private sector health care facilities do a good job of providing acute SCI/D recovery care, but only VA provides the full, lifelong continuum of services for veterans with SCI/D.

The VA exists to ensure that veterans can receive the care they need; so, the department alone bears the responsibility to treat, heal, and rehabilitate the men and women who served in our military and suffered injury or disease as a result. We have stated on multiple occasions that care delivered in the community is an essential component of VA's health care system; however, it is just a component. Congress must take the steps necessary to ensure that VA's direct care system is not weakened to the point where care in the community becomes the only choice for catastrophically disabled veterans.

My statement addresses many specific priorities PVA hopes you will pursue this year, but it is not inclusive of every area of concern for our members. Some interests not covered here include increasing access to VA dental care, improving employment services for veterans with catastrophic disabilities, VA's electronic health record modernization, and extending the eligibility age for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). We continue to work on these and other areas of interest for paralyzed veterans and the broader veterans community. We look forward to working with you on matters of mutual concern.

PVA PRIORITY: STRENGTHEN THE FOUNDATIONS OF VA'S SPECIALIZED HEALTH CARE SERVICES

VA's SCI/D system of care uses a hub and spoke model. The 25 SCI/D centers are the hubs and each center has highly trained and experienced providers, including doctors, nurses, social workers, therapists, psychologists, and other professionals who can address the unique problems that affect veterans with SCI/D. Protecting this system of care is PVA's number one priority, because access to the

care it provides is the difference between life and death for our members. I would personally like to thank these committees for your continued interest in protecting the SCI/D system of care.

Staffing Vacancies—When I appeared before these committees at the joint hearing last year and the Senate Veterans’ Affairs Committee (SVAC) in September, I spoke about the ways that insufficient funding, the lack of sufficient staffing, and infrastructure problems were undermining not just VA’s SCI/D system of care, but VA’s specialized services in general. Staffing has literally become a perennial concern as I and my four predecessors have cited it as a top concern every year since 2014. Frankly, we find it rather exasperating to have to bring it up year after year without resolution.

Using the levels prescribed in Veterans Health Administration (VHA) Directive 1176 as our guide, our calculations show a 36 percent staffing shortage on the acute care side and an 11 percent shortage on the long-term care side. These shortages mean the VA can only operate 565 out of its 980 available acute care beds. Another 96 beds are unavailable due to construction or other reasons. In similar fashion, VA can only operate 148 of its 167 available SCI/D long-term care beds. It’s important to note that in accordance with 1176, the department is required to maintain 181 operating long-term care beds at SCI/D centers. As evidence by the department’s responses to questions for the record stemming from SVAC’s September 17, 2025, hearing on VA’s SCI/D system of care, the previous Administration’s practice of eliminating unfilled positions continues. This is extremely concerning because it artificially presents the illusion that staffing levels are better than they really are. And I must call a “foul” on this, because at the same time VA is saying they are getting rid of positions that weren’t being filled, their hiring freezes and other policies prevented them from being filled. Vacancies coupled with steady losses in SCI/D trained staff have prevented untold veterans with SCI/D from receiving needed care. I urge you to continue to press VA for answers. This cannot be allowed to continue for another year.

Recently, VA announced plans to change the structure of the VHA. PVA has long raised concerns about how administrative bloat has hindered health care decision-making and made it difficult for VHA to hire the staff needed to deliver health care services more effectively. We believe reorganizing the department to eliminate, or at least significantly reduce, these unnecessary barriers is long overdue. We look forward to seeing how this reorganization will improve catastrophically disabled veterans’ care. While critical vacancies persist within the VA SCI/D system of care, the VA Secretary has reassured us that local VA leaders are authorized to fill these important positions. However, individual medical centers continue to drag their feet on getting this done. Increased accountability is needed to resolve these staffing challenges, and individual medical centers must make filling these positions a top priority.

Infrastructure—In reviewing VA’s infrastructure priorities, decision-makers must remember that VA’s SCI/D system of care provides a coordinated, life-long continuum of services for veterans with SCI/D that is unique, unmatched, and not replicated outside of the VA.

Summary of SCI/D Centers

VA’s SCI/D system of care is comprised of centers with an average age of 40 years old. Renovating older buildings (pre-1980s) often exposes, disturbs, and releases microscopic asbestos fibers from materials like insulation, flooring, and ceiling tiles. This creates severe health risks for veterans and health care staff. Key complications that directly affect SCI/D projects include high abatement costs, project delays, strict regulatory compliance, and the need for professional, specialized hazardous abatement handling companies to prevent contamination with other construction debris.

Fourteen of the 25 SCI/D centers continue to use four-bed patient rooms, accounting for 61 percent of the mandated available inpatient beds. Five of the six long-term care SCI/D facilities continue to use two-bed resident patient rooms, accounting for 40 percent of the mandated available long-term care beds. Four-bed patient acute care bedrooms and two-bed long-term care bedrooms do not meet VA requirements and represent an antiquated and outdated patient-care philosophy in modern health care environments due to infection control concerns.

New SCI/D Center Construction Projects

Construction of a new acute and long-term care SCI/D center at the Jennifer Moreno VA Medical Center in San Diego started in April 2021. Due to the diligent and collaborative efforts of the VA Medical Center, VA’s Office of Construction and Facilities Management, and the US Army Corps of Engineers, the state-of-the art project is scheduled to be open to veterans this summer. When completed, the new SCI/D center will triple the total amount of available SCI/D long-term care beds located west of the Mississippi River for the thousands of veterans with SCI/D that reside in this area of the country.

Phase one of a new SCI/D long-term care facility at the Dallas Campus of VA’s North Texas Health Care System started in November 2023. Despite unanticipated delays, the first phase of 30 new long-term care beds is now expected to be completed in September 2027; however, funding for the second phase (30 additional long-term care beds) has not been authorized. Furthermore, the number of long-term care beds for veterans with SCI/D is woefully inadequate for an aging veteran population with care needs not readily met in the community. We call on Congress to fund the additional 30 beds in Dallas this year.

Prioritize Minor and Non-Recurring Maintenance (NRM) Projects

PVA applauds VA’s return to the past practice of placing greater priority on funding more Minor and NRM projects within the VA’s Strategic Capital Investment Planning (SCIP) process. Greater investment

in areas like SCI/D care would strengthen VA's specialty care services and ensure their future availability.

Unfortunately, many SCI/D system projects are caught in the design and construction delays inherent in the VA SCIP project funding and delivery system. There are currently four super-major, three major and 17 minor SCI/D center projects either awaiting funding, in design, or pending approvals to proceed beyond their current status. The majority of SCI/D focused SCIP-submitted projects were initiated through our annual in-person site assessment recommendations by our PVA Medical Services and Architecture staff.

VA has spent a significant amount of money, resources, and support staff time on projects throughout the entire design process that were shovel-ready only to be abandoned by the VA. Year-after-year, VA requests, and Congress provides a fraction of the actual funding needed to sustain the physical infrastructure of VA's SCI/D system. As the cost of repairing or replacing these facilities rises, it's long-past time to examine the viability of other options, such as leasing the facilities needed to ensure the system's physical footprint remains sound.

Increase Staffing at the Facility Management Level

Even with a comprehensive strategy and adequate infrastructure funding, VA's internal capacity to manage a growing portfolio of construction projects is limited by the number and capability of its construction management staff. To manage a larger, more complex capital asset portfolio, VA must have sufficient personnel with appropriate expertise—both within VA Central Office and onsite throughout the VA system. Thus, PVA strongly supports legislation that would improve staffing to manage construction of VA assets and ensure that there are concrete plans to improve the planning, management, and budgeting of VA construction and capital asset programs.

Importance of Accessibility

Buildings that are not accessible are of little use to veterans with catastrophic disabilities. PVA strongly supports passage of the Veterans Accessibility Advisory Committee Act (H.R. 1147) to ensure that VA complies with federal disability laws and makes its programs accessible for people with disabilities. The bill would establish the Advisory Committee on Equal Access to evaluate and report on VA's compliance with federal disability laws. It would also issue recommendations for how VA can improve the physical accessibility of VA facilities, as well as the accessibility of technology, such as websites and apps.

Access to Inpatient Mental Health and Substance Use Disorder Treatment—In the last Congress, there was a significant increase in conversations around residential rehabilitation treatment programs (RRTP) but there was little discussion around the limited access to RRTP for veterans with SCI/D. When a veteran incurs an SCI/D, their identity and place in the world shifts dramatically, and it is common for veterans to experience a range of negative mental health outcomes as a byproduct of catastrophic

injury or illness. Significant medical comorbidities are also expected because of injury or trauma, which is especially true when discussing the lifecycle years beyond acute injury. These complexities make the holistic treatment of veterans with SCI/D critical for their independence and well-being. However, if a veteran needs assistance from a caregiver with an activity of daily living (ADL), they are unable to access RRTP, even within the VA.

Substance use disorders (SUD) are prevalent among SCI/D veterans, and while research is limited on the impacts of SUD for veterans living with SCI/D, data suggests that individuals living with SCI/D are disproportionately at-risk of SUD. Because of the risk factors associated with SCI/D veterans, it is critical that VA ensure these veterans can engage in residential SUD programs tailored to at-risk veterans.

The loss of identity associated with SCI/D, particularly for servicemembers separated due to injury or illness, can be a factor that leads to significant SUD among vulnerable veterans and increased risk of suicide. Among the SCI/D veteran population, there is an increased prevalence of suicidal ideation, suicide attempts, and suicide deaths. In U.S. studies, civilians with spinal cord injury (SCI) were reported to be three to five times more likely to die by suicide than individuals without an SCI. Newly separated veterans are already a high-risk cohort for suicide, compounding that with an SCI/D makes these veterans particularly at risk and all VA resources should be available to them.

We strongly believe VA should be a leader in access for disabled veterans, so we appreciate language in the Senate version of the Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025 (S. 275) requiring the department to establish a pilot program to address the lack of access to RRTP for veterans with SCI/D. This has been a longstanding problem for PVA members, and we thank Chairman Moran for attempting to ensure veterans with SCI/D are able to access this life-saving treatment.

Title 38 Protections for Community Care—PVA remains deeply concerned about the exclusion of protections for injuries that occur because of community care. Title 38 U.S.C. § 1151 protects veterans if medical malpractice occurs in a VA facility and some additional disability is incurred or health care problems arise by providing clinical appeal rights, no-cost accredited representation, and congressional oversight and public accountability. However, if medical malpractice occurs during community care, the veteran must pursue standard legal remedies and is not privy to VA's non-adversarial process. If these veterans prevail on a claim, they are limited to monetary damages instead of having access to the other ancillary benefits available under Title 38 intended to make them whole again. Congress must ensure that veterans who receive care in the community retain current protections unique to VA health care under 38 U.S.C. § 1151.

Research Funding—I would be remiss if I didn't talk about the importance of adequate funding for research. Recent discoveries have significantly advanced the understanding and treatment of veterans

with SCI/D. The development of advanced prosthetics and orthotics have aided their recovery, helped to restore function, and improved their quality of life. Advances in regenerative medicine show real promise to restore nerve and spinal cord function. The discovery of biomarkers that predict the body's response to treatment have aided the selection of the best medications for those with amyotrophic lateral sclerosis (ALS) and multiple sclerosis (MS). Other emerging treatments show real efficacy in slowing the progression of both diseases which could lead to a cure. Last year's decision by Congress to strip funding for SCI and MS from the Congressionally Directed Medical Research Program (CDMRP) undermined some of the progress that was being made with the treatment of and potential cures for SCI/D. Some of the money for CDMRP research for SCI and MS was restored this fiscal year (FY) with the passage of the Consolidated Appropriations Act, 2026 (P.L. 119-75) and I cannot thank you enough for making that happen. Still, if we are going to be serious about finding a cure for these conditions, we must see a more concerted effort to support research through funding, staffing, and other necessary supports.

PVA PRIORITY: MAXIMIZE VA LONG-TERM SERVICES AND SUPPORTS FOR VETERANS WITH SCI/D

Insufficient Long-Term Care Beds and Services for Veterans with SCI/D—Our nation's lack of adequate long-term care options is an enormous problem for people with catastrophic disabilities who, because of medical advancements, are now living longer. As of last month, only 148 VA SCI/D long-term care beds were available, which is a reduction of another five beds since last year. This number fluctuates depending on several variables like staffing, women residents, isolation precautions, and deaths. When averaged across the country, that equates to about three beds available per state. Many aging veterans with SCI/D need VA long-term care services, but because of the department's extremely limited capacity, veterans sometimes remain in the acute setting for months or years at a significant cost because other placements are simply not available. Others must reside in nursing care facilities outside of VA that are not designed, equipped, or staffed to properly serve veterans with SCI/D. As a result, veterans staying in community nursing facilities often develop severe medical issues requiring chronic re-admittance back into an acute VA SCI/D center.

In addition to ensuring access to VA SCI/D long-term care beds, we support expanding access to assisted living options. Currently, the VA can refer veterans to assisted living facilities, but it cannot directly pay for that care. Last year's passage of an amended version of the Expanding Veterans' Options for Long Term Care Act, which was included in P.L. 118-210, created a three-year pilot program in two Veterans Integrated Service Networks (VISNs). Each of the VISNs must have at least one program site in a rural or highly rural area and one in a State Veteran Home to test the benefit of having VA pay for this care. Veterans eligible for the pilot would include those already receiving nursing home-level care paid for by the VA and those who are eligible to receive assisted living services or nursing home care. We believe improving access to assisted living facilities would help veterans and reduce costs for long-term care,

allowing more veterans to receive needed assistance. We urge the committees to conduct oversight regarding the pilot's status to ensure Congress's intent is fully addressed.

Improve Availability of VA's Home and Community-Based Services (HCBS)—We remain very appreciative of Congress's passage of the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act (P.L. 118-210). This bill made critically needed improvements to VA HCBS, such as lifting the department's cap on the amount they can pay for home care, increasing access to the Veteran Directed Care (VDC) program, and improving support to caregivers of veterans. From improving access to mental health and long-term care for the veterans who need it, to supporting those who care for them, as well as their survivors, this bipartisan and bicameral measure will have a tremendous impact on the entire veteran community.

One of the most important provisions in that bill raised the cap on how much the VA can pay for the cost of home care from 65 percent of the cost of nursing home care to 100 percent, and even more if it's in the veteran's best interest. This was extremely helpful for families with service-connected veterans on ventilators who were bearing a significant part of the cost of care—financially, physically, and emotionally—for their loved one. VA officially announced the change early last month, and they estimate that up to 200 veterans will benefit from the higher expenditure cap in FY 2026.

Another section of the bill requires the VA to administer its VDC program, the Homemaker and Home Health Aide program (H/HHA), the Home-Based Primary Care program, and the Purchased Skilled Home Care program at all medical centers within two years of the date of enactment of this legislation. Our members are particularly interested in VDC because it allows them to prioritize their own care needs and select their own care providers from their local communities.

VDC is particularly effective in rural areas that have limited or no access to home health agency care, since veterans enrolled in the VDC program can hire and supervise their own workers in their communities. Additionally, VDC enables the VA to better meet the needs of veterans that are at high-risk for hospitalizations and nursing home admission. Veterans that require more care than what is traditionally offered through H/HHA care are often offered the option to self-direct their care through the VDC program. In addition, VDC serves veterans of all ages, including younger veterans with serious illnesses and injuries like SCI/D.

According to the VA, VDC programs have been established at all major VA facilities, but the feedback we have received from the field suggests some of them exist in name only or serve few veterans. We continue to receive reports of members being told their facility does not offer the program. This may simply be the result of a readily correctable training deficiency with the facility's Geriatrics and Extended Care (GEC) coordinators. Other sites say they would love to offer the program to more veterans but lack the funding to do so. The department continues to have a difficult time finding

agencies willing to participate in the program, especially in the southwestern part of Minnesota. Unfortunately, this is a pretty common problem as many VA facilities do not have the appropriate Aging and Disability Network Agencies within their catchment areas to support veterans as they plan for and direct their long-term services and supports. VA is currently examining ways to execute Veteran Care Agreements (VCA) with alternative VDC providers. We encourage Congress to support those efforts and make sure VA has adequate funding for the proper expansion of this important program.

To date, we've had little insight into how the H/HHA, Home-Based Primary Care, and Purchased Skilled Home Care program expansions are going. Last year's moves to reduce the federal workforce and proposed reorganization have created confusion about the status of these programs and if they will be appropriately staffed. We would appreciate an update from VA about the changes directed by the Elizabeth Dole Act for these critical programs.

Address Direct Care Workforce Shortages—I consider myself to be extremely lucky to have my wife as my primary caregiver. For more than 30 years, LaShon has been at my side to offer me the care I need and her prolonged presence has been a source of great comfort to me. Some PVA members do not have family members close by, or their physical needs are so great that they must secure direct care workers to support them in home and community settings.

Direct care workers provide a wide range of supportive services to veterans with SCI/D including habilitation, health needs, personal care and hygiene, transportation, recreation, housekeeping, and other home management-related supports, so veterans can live and work in their communities and live productive lives. Finding the right candidate who understands the unique nature of the job and possesses the right combination of hard and soft skills can prove to be a formidable challenge.

The shortage of caregivers or home care workers doesn't just affect disabled veterans. Across the country, there is a tremendous shortage of direct care workers, and a national effort is needed to expand and strengthen this workforce. Increasing the amount veterans can pay for essential caregivers is a necessary component of attracting and retaining a diverse set of people to provide HCBS but raising pay alone is not sufficient to solve the crisis we face. VA should develop a pilot program that retains the former caregivers of veterans to care for other veterans. These individuals are familiar with the unique needs of veterans and the many nuances of the VA health care system, making them a provider of choice for other disabled veterans. Utilizing multiple strategies, such as raising public awareness about the need and value of caregiving jobs, providing prospective workers quality training, and developing caregiving as a sound career choice are a few of the other changes that could help turn this problem around.

Caregiver Support for Hospitalized Veterans—Prior to April 2023, veterans with high-level quadriplegia and other disabilities were required to pay out of pocket for their caregivers or caregivers

donated their time, as veterans could not receive caregiving assistance through VA programs while in an inpatient status. PVA raised this issue to the attention of VHA's GEC National Program office. In 2023, GEC issued guidance to the field stating if a veteran is assigned Case Mix "V" or who has a score of "K" they may continue to receive VDC services during inpatient hospitalization, if it is clinically indicated and in support of the veteran's care needs. The Case Mix Tool is specifically designed to assist clinicians in determining the appropriate budget to best support veterans' home care needs.

While we greatly appreciated this change, it benefits a very limited number of veterans. Plus, it excludes many deserving veterans with catastrophic disabilities who rely on caregivers but are not assigned into Case Mix "V" or have a score of "K." Section 124 of P.L 118-210 would address this problem, and we urge you to compel VA to implement this change immediately.

Assistance for Family Caregivers—Executing the Program of Comprehensive Assistance for Family Caregivers (PCAFC) continues to be challenging for the VA. VHA recently published a portion of its long-awaited rulemaking to make changes to the PCAFC. PVA is appreciative of the extension granted to legacy caregivers, but we are eagerly awaiting the second half of the proposed rule. PVA is eager for VA to adopt the positive changes that have been proposed, to include removing the requirement that a veteran require assistance with an ADL "each time" it is performed, the inclusion of veterans receiving Individual Unemployability, the removal of the requirement to need "hands-on" assistance, and the reduction in frequency of reassessments. However, we believe more must be done to meet the needs of the veteran and caregiving community. Specifically, the VA must provide clear, concise definitions and standards and eliminate overly strict eligibility criteria that does not reflect either the language of the statute or the day-to-day realities of caregiving. Furthermore, we understand that the change in administration requires additional time for the regulatory review process, but we are one year past the closing of the comment period on the proposed rule, and VA has yet to issue a final regulation. Caring for a severely disabled veteran can make every day unpredictable, and our caregivers deserve a supportive and consistent program.

An area not addressed in the pending rule is the appeals process for PCAFC. The lack of a defined appeals process in the current caregiver program has led to inconsistencies in eligibility. Rather than addressing the process in their proposed regulations, the department has chosen to address it through policy. This denies veterans, their caregivers, and other stakeholders an opportunity to provide comments on it. In PVA's response to the proposed changes, we urged VA to reconsider its decision and either publish an appeals process proposal as a supplemental proposed rule or in an interim final rule, which would allow for public comment.

VA has introduced another element of uncertainty to the current appeals process with the announced VHA restructuring that will lead to major changes to the VISNs. When a caregiver appeals their decision, it is reviewed by the Centralized Eligibility and Appeals Teams (CEATs), which sit at the VISN level. PVA

has many concerns about where the CEATs will end up, staffing levels, and their ability to provide comprehensive, accurate, and timely responses.

Although Congress has made many improvements to PCAFC since it was established in 2010, the program does not fully consider that many caregivers are forced to reduce their work hours, take unpaid leave, or leave the workforce entirely to provide care. They sacrifice wages, retirement savings, and financial stability to care for those they love. The time away from their jobs creates gaps in their resumes and many lose the employment certifications they previously held. When their loved one either passes away or returns to independent functioning, caregivers need to return to the workplace and must address these issues. Also, those who were relying on CHAMPVA for their health care lose this coverage within 90 days of leaving PCAFC through the death or discharge of the veteran. Users of other insurance programs have 180 days to transition their health insurance benefits. The Veteran Caregiver Reeducation, Reemployment, and Retirement Act (H.R. 2148/S. 879) seeks to strengthen the PCAFC by addressing these, and other common problems that many caregivers face. We strongly support this bill and urge Congress to pass it quickly.

Codify VA's Bowel and Bladder Program—SCI/D can significantly impact a person's quality of life, and support for neurogenic bladder and bowel dysfunction is a crucial aspect of their care. These conditions affect many veterans with SCI/D and can lead to severe complications. Therefore, managing neurogenic bladder and bowel requires specialized attention and is essential for maintaining veterans' health and well-being. VA's Bowel and Bladder program is administered by VHA's SCI/D National Program office. Veterans with SCI/D who qualify for bowel and bladder care may receive that care through a home health agency, a family member, or an individually employed caregiver. The clinic of jurisdiction, or VA medical facility, authorizes bowel and bladder care under the Office for Integrated Veteran Care (IVC), to enrolled veterans with SCI/D who are dependent upon others for bowel and bladder care while residing in the community. As soon as designated caregivers successfully complete training from the VA, all necessary forms are forwarded to IVC for approval. Additionally, the caregiver must obtain a National Provider Identifier, complete a VCA, track the amount of time needed to perform the veteran's bowel and bladder care daily, and submit it along with a VA Form 10-314, Request for Payment of Bowel and Bladder Services, to be reimbursed.

The current program is fraught with challenges for caregivers and is unevenly applied across the VA system. Timely reimbursement and the tax treatment of payments are the chief complaints of PVA members who must rely on bowel and bladder care to meet their needs. For example, unlike virtually all other VA payments, including those provided through the PCAFC, Bowel and Bladder program reimbursements are taxable. Even family caregivers are considered federal contractors for providing this care and must pay self-employment tax.

Another compelling reason to make the Bowel and Bladder program a statutory requirement is that the current program fails to offer veterans due process. There is no formal notification to the veteran, caregiver, or the provider that a VCA agreement is coming up on its three-year renewal and that it must be re-signed. Hence, due to the lack of notification, veterans and caregivers continue to file monthly claims, but payments stop and they don't know why. Getting the program reinstated is a tremendous challenge, and due to lack of payment, the veteran may lose the caregiver. The whole process starts all over again, with the veteran having to find, train, and formally designate a caregiver which can take weeks or months to complete, putting the veteran with SCI/D at risk of not receiving timely bowel and bladder care. In similar fashion, neither the veteran nor the caregiver is notified if they file a monthly claim that has errors or missing information. They just simply don't get paid, and it is up to the veteran or caregiver to reach out to the IVC to find out why.

The Bowel and Bladder program is a life-sustaining program providing support to veterans with SCI/D. Codifying the program would fix many of these problems and I thank Chairman Moran for the recent introduction of his bill, the Disabled Veterans Dignity Act (S. 3647) to do just that.

PVA PRIORITY: FORTIFY THE FINANCIAL SECURITY OF VETERANS WITH SCI/D, THEIR FAMILIES, AND SURVIVORS

Veterans with SCI/D generally require a range of services and benefits, including health care, specially adapted housing, adaptive equipment for their vehicles, insurance, and compensation that are tailored to their needs. Those with service-related medical conditions are entitled to compensation benefits under the law. The Veterans Benefits Administration (VBA) administers these tax-free compensation benefits through their Compensation Service, which determines the appropriate percentage rating, whether the veteran is entitled to dependency pay, and the date the veteran was entitled to start receiving this compensation. The percentage assigned to a veteran is designed to offset a veteran's loss of earning capacity that is caused or exacerbated by these conditions.

Many veterans, especially those with catastrophic disabilities, like SCI/D, rely on these payments for a substantial portion of their income. For these reasons, we are deeply concerned whenever we see attacks on the system that threaten to undermine this critical safety net for our members. Proposals like VA's recently published interim final rule regarding disability claim ratings decisions is a perfect example. We are relying on you to protect the entire VA system which is intended to support those who serve the nation in uniform. Every one of them deserves the comprehensive health care and benefits that VA is supposed to provide. Any actions that could be viewed as reneging on the nation's promise to them sends the wrong message to the future young men and women we need to maintain the viability of the all-volunteer force.

Special Monthly Compensation (SMC) Aid and Attendance (A&A) Rates— In extreme cases, where the profoundness of the condition goes beyond just earning potential, the VA uses Special Monthly Compensation (SMC) to cover costs that arise from the impact on the veteran’s quality of life. SMC is arguably the most important ancillary benefit for veterans with severe, service-connected disabilities. The benefit is unique in that it is dependent on non-economic factors such as the profoundness of the disability, personal inconvenience, and social inadaptability. For example, a veteran who lost the use of their lower extremities in service to their country is compensated not just for the loss in their future earnings potential, but also all future hardships and costs associated with the disability. VA considers entitlement to SMC based on the medical evidence when adjudicating a claim for service connection or an increase in an evaluation. VA considers it an “inferred issue.” To be clear, given the extreme nature of the disabilities incurred by most veterans in receipt of SMC, we do not believe that the impact on quality of life can be totally compensated for; however, SMC does at least offset some of its loss.

Some of the most seriously disabled veterans who, because of their disability, can no longer take care of themselves without aid, may be eligible for A&A. There are three rates for A&A within special monthly compensation. If the veteran has a single 100 percent schedular-evaluated disability and requires the aid of another person to perform the personal functions required in everyday living, the veteran would be considered for A&A under 38 U.S.C. § 1114 (r). If the veteran is entitled to the maximum rate under either 38 U.S.C. § 1114 (o) or (p), and needs regular A&A, the veteran would be considered for A&A under 38 U.S.C. § 1114 (r)(1) or SMC R1. If the veteran meets the requirements for R1, and then clearly establishes the need for supervised, daily, skilled health care on a continuing basis, the veteran would be considered for a higher A&A benefit under 38 U.S.C. § 1114 (r)(2) or SMC R2. These veterans live with the most severely disabling conditions and might be bedridden due to a traumatic SCI or a disease such as ALS. Currently, the SMC rates of R1, and R2 are \$9,826.88 and \$11,271.67, respectively. Meanwhile, SMC T is provided to veterans with severe medical residuals related to a service-connected traumatic brain injury (TBI). These veterans often need additional care, and SMC T is provided at the SMC R2 rate.

Even with additional financial support, many of our most severely disabled veterans are struggling. They often spend more on daily home-based care and other disability-related needs than they receive in SMC benefits, which generates a tremendous financial strain on them. Eventually, some are forced to opt for care in an institutional setting, which is even more costly to the taxpayer. This problem is due in part to SMC’s baseline rates, which haven’t been adjusted in decades, so they are inadequate to offset the burden placed on veterans by their disabilities.

Most veterans receiving SMC are spending it directly on their care. Some veterans are fortunate to have family members who can provide for many of their care needs. It may cost \$30-\$35 an hour for a veteran to hire someone to attend to such needs. If the veteran needed skilled care nursing, the cost would be much higher. Even veterans who have family members to help provide daily care, or receive

home-based supports from the VHA, often need to hire additional assistance. Bringing someone in for just six hours a day could cost \$180 per day or \$5,400 a month. That's about half of the SMC a veteran with R2 receives.

The higher direct and indirect costs of living with a disability are well documented. A 2020 study determined a household containing an adult with a disability that limits their ability to work requires, on average, 28 percent more income (or an additional \$17,690 a year) to obtain the same standard of living as a similar household without a member with a disability. Many PVA members have examples of additional costs for daily living due to their disability that many of us take for granted. They run the gamut from the mundane to life threatening. For example, owning an accessible vehicle is costly despite the funding offered through the VA's auto grant program. A PVA member in West Virginia lives in a rural area, and air travel is challenging and potentially even dangerous for him. So, he relies extensively on his adapted vehicle. It's easy to think that an eligible veteran receives their auto grant and then the issue is resolved, but that isn't the case. The auto grant amount is currently \$27,074.99, which might sound like a lot, until you realize an adapted vehicle can cost anywhere between \$50,000 for a sedan to upwards of \$90,000 for a van. Adapted vehicles are also usually larger and heavier which causes them to consume more fuel and require additional maintenance. To maintain an adapted vehicle means to acquire unique costs that the average vehicle owner does not encounter. Our member in West Virginia says the increase in his SMC over the past few years was erased by a single purchase of new tires for his vehicle because of increased costs.

Damage to the spinal cord or nerves often makes veterans more susceptible to temperature. For those with MS, inflammation in the nervous system causes damage to the myelin sheath, a fatty coating around nerve fibers that helps them send electrical signals. This damage and myelin loss (demyelination) impairs the nerves' ability to send electrical signals and makes it harder for them to regulate their body temperature. Roughly three-fourths of all veterans with MS find their symptoms get worse in response to heat, so they rely heavily on air conditioning to help manage their condition. In similar fashion, many veterans with high level SCI (above T-6) experience difficulties because their heat dissipating and heat conserving mechanisms are interrupted. This can trigger Dysautonomia, a nervous system disorder that disrupts body processes, and in the severest cases, Autonomic Dysreflexia, a dangerous situation that requires immediate medical attention.

While SMC receives a modest annual cost-of-living adjustment, it does not account for actual increases in the types of services our members require. For example, retail electricity prices have increased faster than the rate of inflation since 2022, and the U.S. Energy Information Administration expects this trend to continue for at least another year. Some veterans who are kept alive by a ventilator have reported electricity bills of more than \$1,000! Another veteran has had modifications made to their very rural home to include electrical door openers, electrical sinks, adapted lights, etc. However, due to the unreliable power grid in the area, VA also installed generators to ensure the veteran is not put in a life-

threatening situation. These generators need maintenance and fuel, which are costly and not covered by the VA.

In 2007, after studying veterans' benefits for two and a half years, the Veterans' Disability Benefits Commission, which was established by P.L. 108-136, the National Defense Authorization Act of 2004, released its long-awaited report that addressed the benefits and services available to veterans, servicemembers, and their families. In their concluding recommendations, they stated succinctly that, "Congress should review the profound impact of disabilities on a veteran's quality of life and consider increasing SMC payments and determine if additional ancillary benefits are warranted."

Being disabled is costly, both financially and otherwise. Thus, we are pleased to support the Sharri Briley and Eric Edmundson Veterans Benefits Expansion Act (H.R. 6047), which would increase the amount of R1, R2, and T, SMC rates by \$10,000 annually. For paralyzed veterans who are in receipt of the highest levels of SMC, time is a luxury they do not have. Many have gone years without an increase in compensation while their disabilities and their bodies have only worsened with age. While Congress debates how to give adequate increases, the disabled veteran waits to see if they can afford the rising electricity bill that powers their ventilator, or the rising gas prices that fuel their adapted vehicle that gets them to their hospital visits. The wait has already been too long, and we thank the supporters of this bill for seeking to address this issue now.

Military Sexual Trauma (MST)—During the 118th Congress, very little attention was paid to the important area of MST. An alarming number of servicemembers and veterans report unwanted sexual harassment, attention, and other behaviors that our men and women in uniform should not have to tolerate. Despite legislation being enacted that was intended to improve the claims process for survivors of MST, veterans are still encountering barriers and excessive backlogs when it comes to MST claims.

A May 2025 Congressionally Mandated Report (CMR) analyzed FY 2024 VBA data related to MST claims. In FY 2024, the VBA received MST claims for more than 36,000 unique veterans. Of that total, 69 percent were from women veterans and 30 percent were from male veterans. From those numbers, 33 percent of female MST claims were denied, and a staggering 42.5 percent of male MST claims were denied. The CMR highlights that the most common denial reasons were: 1) no diagnosis – or no diagnosis of record for the claimed condition resulting from MST; 2) not incurred in or caused by service, meaning there was no corroborating evidence, including markers; and 3) not aggravated by service, which means a disability diagnosed prior to service did not increase in severity due to events incurred during service. A key factor to consider within this data is that more than 10 percent of MST claims denied were due to a veteran's failure to report to a medical examination.

For years, veterans service organizations have demanded that Congress and VA take measures to improve the claims process, including Compensation and Pension (C&P) examinations for MST claims. If a veteran is filing an MST claim and they are required to attend a medical examination, there is no shortage of reasons why a veteran may miss it. Veterans are often given only one opportunity to reschedule their appointment, and if something prohibits them from attending, the examiner sends the claim back to VBA, which drags out the process for many veterans. This becomes especially relevant for many women veterans who may have family obligations that impede their ability to attend an appointment. For this reason, PVA supports the Review Every Veteran's Claim Act (H.R. 2137/S. 1657), which would authorize that a veteran's claim could not be denied due to missing a medical appointment.

It is critically important for VBA to adjudicate MST claims correctly. PVA assisted a veteran with an appeal of an MST claim that was recently approved. This veteran filed the initial claim in 2005, and after more than 20 years of fighting, it was approved, and the entire appeal resulted in a retroactive payment of more than \$700,000. The years of anguish this veteran experienced are tragic, and no amount of compensation can fully redress that harm. To improve the claims process for MST survivors, PVA supports the Servicemembers and Veterans Empowerment and Support (SAVES) Act (H.R. 2576/S. 1245), which creates a working group focused on improving language around MST communication and authorizes reports to identify gaps in services, and annual training, as well as other aspects in the decision-making process, to improve the quality of the MST claims process for veterans. We urge Congress to pass these pieces of legislation to ensure MST survivors do not have to wait in limbo because of antiquated processes.

Concurrent Receipt—The issue of concurrent receipt falls under the purview of the Armed Services Committees but it is closely linked with the VA committees' efforts. A pair of changes approved by Congress in the mid-2000's allowed military retirees with over 20 years of service and VA disability ratings of 50 percent or greater to receive their military retired pay and VA disability compensation payments without offset. A lone exception to the 20-year requirement was granted for servicemembers retired under the Temporary Early Retirement Authorities Congress granted to the Department of Defense (DOD) in the National Defense Authorization Acts for FY 2012 and FY 2017 (P.L. 112-81 and P.L. 114-328). Despite these reforms, thousands of military retirees continue to have their military retirement offset by VA disability payments today. Congress should pass legislation like the Disabled Veterans Tax Termination Act (H.R. 333) and the Retired Pay Restoration Act (H.R. 303) allowing all military retirees to retain their full military retired pay and VA disability compensation without any offsets. In addition, Congress should make every effort to allow combat disabled veterans to keep those same benefits that were earned in war. PVA urges Congress to pass the Major Richard Star Act (H.R. 2102/S. 1032), which would allow medically discharged veterans whose injuries were incurred in combat to receive their full disability retirement pay from the DOD and their VA disability compensation.

Benefits for Surviving Spouses—Our oldest veterans are passing away, and in the case of many of our members, their surviving spouses were their primary caregivers for 40 years or more. For many of these spouses, being a caregiver was their primary occupation. So, when their loved one passes away, the monthly compensation that may have been upwards of \$10,000 a month stops, and the spouse receives roughly a fifth of that per month in Dependency and Indemnity Compensation (DIC), creating a tremendous hardship on those left behind. Adjusting to this precipitous drop of revenue into the household can be too difficult for some surviving spouses who may be forced to sell their homes and move in with friends or family members.

Losing a spouse is never easy but knowing that financial help will be available following the death of a loved one can ease this burden. DIC is intended to protect against survivor impoverishment after the death of a service-disabled veteran. In 2026, this compensation starts at \$1,699.36 per month and increases if the surviving spouse has other eligible dependents. DIC benefits last the entire life of the surviving spouse except in the case of remarriage before a certain age. For surviving children, DIC benefits last until the age of 18. If the child is still in school, these benefits might go until age 23.

The rate of compensation paid to survivors of servicemembers who die in the line of duty or veterans who die from service-related injuries or diseases was established in 1993 and has been minimally adjusted since then. In contrast, monthly benefits for survivors of federal civil service retirees are calculated as a percentage of the civil service retiree's Federal Employees Retirement System or Civil Service Retirement System benefits, up to 55 percent. This difference presents an inequity for survivors of our nation's heroes compared to survivors of federal employees. DIC payments were intended to provide surviving spouses with the means to maintain some semblance of economic stability after the loss of their loved one.

PVA strongly believes the rate of compensation for DIC should be indexed to 55 percent of a 100 percent disabled veteran's compensation. We urge Congress to pass the Caring for Survivors Act (H.R. 2055/S. 611), which would increase the rate of compensation for DIC payments to achieve parity with similar compensation federal employees' survivors receive. Also, a provision in H.R. 6407 would increase the baseline amount of DIC by 1.5 percent over a period of two years. PVA strongly supports this increase, but it only represents an initial downpayment on what is truly owed to veterans' survivors, and we are committed to continuing to work to bring DIC in parity with other federal survivor benefits.

Additionally, if a veteran was rated totally disabled for a continuous period of at least eight years immediately preceding death, their eligible survivor can receive an additional \$360.85 per month in DIC. This monetary installment is commonly referred to as the DIC "kicker." Unfortunately, surviving spouses of veterans who die from ALS rarely receive this additional payment. ALS is an aggressive disease that quickly leaves veterans incapacitated and reliant on family members and caregivers. Many

spouses stop working to provide care for their loved ones who, once diagnosed, have an average lifespan of between three to five years, making it very difficult for survivors to qualify for the kicker.

The VA already recognizes ALS as a presumptive service-connected disease, and due to its progressive nature, automatically rates any diagnosed veteran at 100 percent once service connected. The current policy fails to recognize the significant sacrifices these veterans and their families have made for this country. We urge Congress to pass the Justice for ALS Veterans Act (H.R. 1685/S. 749), which would provide the DIC kicker to eligible survivors of veterans who died of service-connected ALS.

Home Modification Grants—Despite PVA’s persistent advocacy to increase the amount available to veterans through the Home Improvements and Structural Alterations (HISA) grant program, Congress still has not passed legislation that would raise the grant amount. HISA grants are available for modifications such as improving entry and exit to a veteran’s home through the installation of a wheelchair ramp, improving electrical systems due to home medical equipment, and installing handrails in a bathroom to increase safety.

Recently, PVA had the honor of testifying at an SVAC hearing on adaptive sports and ancillary benefits that facilitate a veteran’s independence which allows them to engage with adaptive recreation opportunities. In our testimony, we shared the importance of VA adaptation programs like the HISA grant, and our support of the Autonomy for Disabled Veterans Act (H.R. 2245/S. 1644). This legislation would authorize an increase to the HISA grant program. Rates for this important grant program haven’t increased since 2010 despite the rising costs of construction. H.R. 2245 seeks to raise the HISA grant to \$10,000 for service-connected veterans and \$5,000 for non-service-connected veterans while tying the amount to the Consumer Price Index (CPI). S. 1644 increases the HISA grant to \$10,000 for veterans with disabilities who apply after the bill becomes law, helping to cover the true cost of home improvements like accessible bathrooms. It also increases the grant amount from \$2,000 to \$6,800 for veterans with non-service-connected disabilities who applied before the bill is enacted but are subsequently service connected, ensuring they also get better support. Finally, it requires VA to adjust the grants annually using a construction index, so the grant amount stays relevant as the cost of home modification prices change.

Since our testimony in early February, we have received several personal accounts from our members that highlight some of the recent shortcomings in the administration of another crucial housing modification program, the Specially Adaptive Housing (SAH) program. We understand that current staffing rates in the SAH program are at alarmingly low levels. Without appropriately trained staff, the SAH program is struggling to aid our most vulnerable veterans.

Currently, some veterans, including those with ALS, are being sent a checklist that needs to be submitted to the SAH program for approval. It covers 28 different lines of various pictures, dimensions,

and other information for an SAH agent to understand the amount of work that needs to be done to make a home accessible and safe for a disabled veteran. One veteran was attempting to fill out the checklist and fell in the process of collecting the required measurements. These veterans are not trained contractors, they have no experience doing this type of assessment, and frankly this veteran is quite lucky that they did not injure themselves. Adding insult to injury, once they finished collecting the information for their SAH agent, they were informed it would have to be done again since the photos and measurements were not considered to be accurate.

In catchment areas lacking an SAH agent, PVA service officers have been volunteering to assist with pictures, measurements, and collecting the necessary information required of veterans to begin the process of adapting their homes. This work was previously done by SAH agents who are trained to walk a veteran through their homes and discuss possible adaptations.

This spits in the face of the promise this country made to disabled veterans in 1946 when the SAH program was established. SAH agents sat with veterans and their families, their caregivers, and explained this program, as well as other VA programs that exist to help them improve their independence and quality of life. Now, veterans are on their own to work through the most complicated and difficult process of SAH approval. VA benefits are not transactional yet the lack of trained SAH agents, and the VA's expectation that our nation's most severely disabled veterans could accomplish this check list on their own, is ridiculous. It is our understanding that the checklist was established during the COVID pandemic when remote work was prioritized for the safety of VA staff. That is no longer a concern, and VA should prioritize staffing the SAH program to ensure smooth delivery of this critical benefit.

SAH agents are only supposed to handle a caseload of 25 veterans per agent. The current staffing ratio, however, is more than double that, and the situation is made worse with VA's decision to eliminate travel funds for SAH agents to physically visit the homes of these veterans. Congress should press the department to increase staffing rates to effectively oversee the SAH program and to restore travel funds so agents can perform necessary pre-design documentation on site and conduct physical inspections during all phases of construction. Catastrophically disabled veterans should not be burdened with performing functions under the purview of the VA.

PVA PRIORITY: INCREASE SCI/D VETERANS' ACCESS TO HEALTH CARE SERVICES

Transportation Programs and Supports—Just like every American, access to safe and reliable transportation is essential to the mobility, health, and independence of catastrophically disabled veterans. Thus, addressing transportation concerns is a top priority for PVA.

First, the Veterans AUTO and Education Improvement Act of 2022 (P.L. 117-333), which Congress passed in late 2022, allowed eligible veterans to receive a second automobile allowance and changed the definition of “medical services” to include certain vehicle modifications. Specifically, it amended the definition of “medical services” under 38 U.S.C. § 1701(6) to include the provision of medically necessary van lifts, raised doors, raised roofs, air conditioning, and wheelchair tiedowns for passenger use. The change was intended to codify VA’s existing practice of furnishing certain items, like van lifts and wheelchair tiedowns, to all catastrophically disabled veterans. However, where the VHA has used these items as examples, the statute defines them as the only types of modifications that are permissible. Like the VA, we agree that a technical amendment to 38 U.S.C. § 1701(6) is needed to give the department greater flexibility in making the necessary modifications to veterans’ vehicles to ensure they can safely enter or exit the vehicle and transport needed equipment, including power wheelchairs. PVA strongly supports the Automotive Support Services to Improve Safe Transportation Act of 2025 (H.R. 1354/S. 1726), which addresses this oversight to ensure that seriously disabled veterans are getting the equipment and modifications needed to travel safely.

Next, PVA is deeply concerned about the effect of VA guidance issued on January 16, 2026, that ends facility prepayment of round-trip common-carrier airfare for veterans traveling to VA SCI/D facilities. The new policy requires veterans to arrange and pay for travel up front and seek reimbursement after their appointment, effectively preventing many from attending necessary, scheduled specialty care appointments. This change creates a barrier to medically necessary services, disproportionately affecting veterans with disabilities and limited resources. Already it has caused veterans who could not afford out-of-pocket airfare to cancel essential appointments, interrupting the continuity of their care. The change will also likely result in higher costs for taxpayers because prepayment and planned bookings allow VA to obtain lower negotiated fares.

The new guidance is based on VA’s view that the statute does not provide affirmative authority for VA to obligate funds in advance for common-carrier transportation and concerns about implicating the Anti-Deficiency Act. To their credit, VA is actively seeking a solution to the problem, and we ask that you assist them with that. If it’s determined that a legislative solution is needed, we ask that you introduce and pass legislation quickly that authorizes VA to prepay common-carrier transportation for eligible veterans. Such authority will restore the department’s ability to book cost-effective travel on behalf of veterans who cannot pay up front, protect veterans from undue financial burden, and ensure uninterrupted access to critical SCI/D care.

VA provides some ground transportation services directly to veterans through its Veterans Transportation Service. Veterans must live within a VA medical center’s catchment area to receive transportation to and from medical appointments. Unfortunately, it is not available at all VA facilities and cannot help veterans who live beyond a certain distance from the medical center. We also hear

complaints about medical centers that cannot meet their veterans' transportation needs due to insufficient transportation vendors.

Sometimes, the problem is with the VA-contracted transportation company (CTC). Some CTCs always seem to be short-staffed and sometimes the drivers are needed in the local area, so there have been times when the drivers do not want to drive such long distances. According to publicly available contracting documents, it does not appear that VA has a metric to hold CTCs accountable for late cancellations and failing to have proper staffing to service all eligible veterans. PVA would like to see VA take steps to ensure their contracts meet the requirements of all veterans in the catchment area.

Additionally, we often hear about problems in getting wheelchairs to veterans when they must travel by stretcher. The wheelchair might be at the veteran's home because the veteran traveled by ambulance to the medical facility or at the medical facility, but the veteran must be transported home on a stretcher. Wheelchairs are not optional equipment; they are our members' primary and essential means of mobility. This problem is not isolated to a single facility or region. It is occurring throughout the SCI/D system, including spoke sites. For individuals who depend on a wheelchair for mobility, being separated from it is equivalent to depriving them of the very ability to move, function, and safely navigate their environment. Despite repeatedly documenting this issue over a period of several years in our SCI/D site visit reports, we have seen no meaningful effort to correct the problem. This persistent failure places veterans at risk and must be addressed systemwide.

Finally, for those eligible for beneficiary travel, the rate of reimbursement is too low. Fifteen years ago, Congress passed P.L. 111-163, which set the mileage reimbursement rate at a minimum of \$0.41 per mile which at the time was comparable to rates federal employees were reimbursed for work-related travel. This law also gave the Secretary the authority to increase rates going forward to be consistent with the mileage rate for federal employees for the use of their private vehicles on official business, as established by the Administrator of the General Services Administration (GSA). Since that time, VA's travel mileage reimbursement rate has remained stagnant, even while gas prices and other costs like auto insurance and vehicle maintenance costs have increased significantly. GSA's current mileage reimbursement rate is \$0.72.5 per mile. PVA urges Congress to pass the Driver Reimbursement Increase for Veteran Equity Act (H.R. 1288/S. 599) to ensure the beneficiary travel reimbursement rate is at least equal to GSA's.

In 2017, Congress amended the beneficiary travel rule to authorize travel for any veteran with a vision impairment, a veteran with a SCI/D, or a veteran with double or multiple amputations. To be eligible for beneficiary travel under this change, the travel must be in connection with care provided through a special disabilities' rehabilitation program of the department (including programs provided by SCI/D centers, blind rehabilitation centers, and prosthetics rehabilitation centers) and if such care is provided on an in-patient basis; or during a period VA provides the veteran with temporary lodging to make such

care more accessible to the veteran. Unfortunately, the language of that amendment excluded catastrophically disabled veterans from beneficiary travel when traveling to a special disabilities' rehabilitation program for outpatient services. Veterans, service officers, and VA staff consistently cite the lack of travel reimbursement as a major impediment for veterans to get the care they need. The exclusion of travel reimbursement for outpatient care may well have been a cost saving move, but it results in higher health care costs for the VA and poorer health outcomes for veterans due to delayed treatment or diagnosis.

Health Care and Benefits for Women Veterans—Women veterans are the fastest growing cohort of enrolled veterans at the VA, and they make up more than 17 percent of the active duty ranks and almost 22 percent of the guard and reserves. The VA has made commendable progress in ensuring that women veterans can access gender specific care across the country; however, there is still plenty of work to do to ensure equal access to care and benefits.

PVA's women members have consistently encountered accessibility barriers when utilizing VA health care. It is critical that the VA recognize that while catastrophically ill and injured women veterans may be a small population in the greater veteran community, their needs are still real. Guaranteeing that exam tables are accessible, ensuring access to mammography exams and other preventative screenings, and building the trust required to maintain dignity for our women veterans is our duty.

To help our women members feel confident in their role within our organization and in their communities, PVA has made the commitment to invest in them. PVA hosts an annual Women Veterans Empowerment Retreat (WVER) that allows them to build community with other women from across the country, to learn skills in advocacy at the national and local levels, and other important skills that will set them up for success. Additionally, we host ongoing webinar series for them with various topics throughout the year including a session on MS and ALS awareness, adaptive sports and the National Veterans Wheelchair Games, and accessible home design. Our women members often express to us that they struggle with recognition of their veteran status, not just in their communities, but at times even at VA. It is critical that the VA recognize the contributions of women veterans and ensure their safety while they access their earned health care and benefits. For the women members of PVA, this also means that the VA needs to be accessible for veterans with catastrophic injuries and illnesses. Expecting VA to provide accessible, gender specific care to our women veterans should not be up for debate, women have selflessly served this country for centuries. They are owed the same access to health care and benefits as their male counterparts.

We continue to support increased access for women veterans to mammography screening. The Mammography Access for Veterans Act (H.R. 7411/S. 3395) would permanently authorize the telescreening mammography pilot program that was authorized with the passage of Making Advances in Mammography and Medical Options (MAMMO) for Veterans Act (P.L. 117-135). Only half of the

states in the country have in-house mammography access at VA facilities and this bill would fill critical care gaps for veterans.

Assisted Reproductive Technologies (ART)—For many veterans, especially for PVA members, their service-connected disabilities may impact their ability to grow their families. For the last decade, the VA has offered in vitro fertilization (IVF) services for eligible veterans, however, eligibility for IVF is very narrow, barring many veterans from accessing this critical benefit. Access to IVF is the only medical service barred to veterans who are rated 100 percent, total and permanently disabled. PVA is disappointed that we have made little progress on improving the access to IVF for disabled veterans.

In 2024, the VA updated its regulations to allow the coverage of costs of donated genetic material for eligible veterans, which PVA applauded. However, that protection is not covered in statute. PVA is concerned that this expansion could subsequently be retracted.

Several bills would address this concern, as well as improve access to IVF for disabled veterans. The Veterans Infertility Treatment Act (H.R. 220) would allow appropriate infertility treatments to be authorized as part of the medical benefits package. Another piece of legislation is the Veteran Families Health Services Act (H.R. 4855/S. 2534), which would codify a veteran's ability to purchase donated genetic materials, increase the financial support for the adoption of a child, and include access to IVF within the medical benefits package for enrolled veterans. It is our hope that Congress passes legislation like this to protect access to IVF for veterans with SCI/D who are struggling to build their families.

Chairman Moran, Chairman Bost, Ranking Member Blumenthal, Ranking Member Takano, and members of the committees, I would like to thank you once again for the opportunity to present the issues that directly impact PVA's membership. We look forward to continuing our work with you to ensure that veterans get timely access to high quality health care and all the benefits that they have earned and deserve. I would be happy to answer any questions.

Information Required by Rule XI 2(g) of the House of Representatives

Pursuant to Rule XI 2(g) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2026

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events—
Grant to support rehabilitation sports activities — \$368,500.

Fiscal Year 2025

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant
to support rehabilitation sports activities — \$502,000.

Fiscal Year 2023

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant
to support rehabilitation sports activities — \$479,000.

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.

ROBERT L. THOMAS JR.
PVA NATIONAL PRESIDENT & CHAIRMAN OF THE BOARD



“PVA has changed my life by introducing me to things that I believed to be over when I became injured, such as the National Veterans Wheelchair Games, and showing me that you can still live a fulfilling life although you have sustained a catastrophic injury.”

Robert Thomas grew up in Cleveland, Ohio and played football and basketball. He enlisted in the U.S. Army shortly after graduating high school in 1987. Thomas served as a power generation equipment specialist at Fort Sill, Oklahoma; Camp Humphreys, South Korea; and Fort Bragg, NC. While on active duty, in 1991, Thomas had a diving accident that severed his fifth and sixth vertebrae. He was introduced to PVA through the Cleveland VA Medical Center. PVA helped him navigate his new life by working to obtain his earned benefits through the VA, and reintegrating him back into society

through social outings with the recreational therapist.

Thomas joined PVA in 1993 as a member of the Buckeye Chapter of PVA in Ohio, and a little while later, began volunteering with the chapter. He took some time off to earn his associate degree in Information Technology, and returned to the Buckeye Chapter of PVA board in 2010. He served as the chapter’s vice president from 2012-2015, and as the chapter’s representative on the national Field Advisory Committee and the Resolution Committee.

Thomas was reelected in May 2025 during the organization’s 78th Annual Convention, and began serving his third one-year term as President and Chairman of the Board on July 1, 2025. He initially joined PVA leadership at the national level in 2015 as the parliamentarian, and was elected to serve on the Executive Committee in 2017.

Thomas continues to serve PVA because he wants to help lead the organization well into the future. “My inspiration to serve stems from PVA’s past and present leadership,” Thomas says. “Being a member for 30 years and seeing how unselfishly each leader, member, employee, and volunteer gives of themselves makes me want to continue to serve an organization that does so much for veterans and the disabled community.”

In addition to serving as the President and Chairman of the Board for PVA, Thomas currently serves as the chair of PVA’s Education Foundation. He was also appointed to the VA’s Family Caregiver and Survivors Advisory Committee. Thomas and his wife, LaShon, live in Macedonia, Ohio. Thomas enjoys reading, watching sports, and playing adaptive sports like power soccer, bowling, air guns, and scuba diving.