Paralyzed Veterans of America

1875 Eye Street NW, Suite 1100,
Washington, DC 20006
(O) 202.872.1300
www.PVA.org

501(C)(3) Veterans Non-Profit

ANNUAL LEGISLATIVE PRESENTATION

ROBERT THOMAS

NATIONAL PRESIDENT PARALYZED VETERANS OF AMERICA

BEFORE A JOINT HEARING OF THE HOUSE AND SENATE COMMITTEES ON VETERANS' AFFAIRS

MARCH 4, 2025

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) 2025 policy priorities. For nearly 80 years, PVA has served as the lead voice on a number of 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 have developed 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 impact 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. In recent years, we have become increasingly 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, as well as the purported $6.6 billion shortfall at the Veterans Health Administration (VHA) for fiscal year (FY) 2025. Paralyzed veterans consistently choose VA-provided SCI/D care because it is the best care available for veterans with complex disabilities. That's why a growing number 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. We choose VA.

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 as a result 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. We have also developed long-standing partnerships with other veterans service organizations.

PVA, along with the co-authors of The Independent Budget—DAV (Disabled American Veterans) and the Veterans of Foreign Wars of the United States (VFW), continue to present comprehensive budget recommendations for the VA to influence debate on issues critical to the veterans we represent. We recently released our budget recommendations for the VA for FY 2026 and FY 2027 advance appropriations.[1]

VA's SCI/D SYSTEM OF CARE

In May 1970, a Life Magazine article relayed the deplorable conditions encountered by veterans at the Bronx VA Medical Center, specifically those with spinal cord injury. That article stirred the conscience of the nation and the public outcry that ensued served as the impetus for a complete transformation in the way the VA treated veterans with SCI/D. The deplorable conditions led PVA to begin conducting annual site visits at every VA SCI/D center. In the five decades that followed, the department rebuilt itself to become the leading provider of care for veterans with SCI/D and the benchmark for all other health systems in the world offering care to people with similar conditions.

Currently, 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. VA's SCI/D system of care is the crown jewel of the VA's health care system. It is unequaled in the care it provides for the tens of thousands of veterans with SCI/D. Protecting this system of care is PVA's number one priority. This system is the difference between life and death for our members. It's because of this system of care that veterans are able to live in their own homes, travel, work, volunteer, and otherwise contribute to society.

My statement addresses several specific priorities we hope 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 supports for veterans with catastrophic disabilities, and ensuring proper implementation of VA's electronic health record modernization. We continue to work on these and other areas of interest for paralyzed veterans and the broader veterans community. We have always appreciated the way these two committees have worked together in a nonpartisan way to address the needs of America's veterans. This will be more important than ever as Congress seeks to ensure that the needs of veterans and their families, caregivers and survivors are met. PVA looks forward to working with you on matters of mutual concern.

[1] Independent Budget Recommendations for Fiscal Years 2026 and 2027

PVA PRIORITY: PROTECT VA'S SPECIALIZED HEALTH CARE SERVICES

PVA firmly believes VA is the best health care provider for disabled veterans. More importantly, our members consistently choose VA's SCI/D system of care, because it provides a coordinated life-long continuum of services that has increased the lifespan of these veterans by decades. VA's specialized systems of care follow higher clinical standards than those required in the private sector. So, preserving and strengthening VA's specialized systems of care—such as SCI/D care, blind rehabilitation, amputee care, and polytrauma care—remains the highest priority for PVA.

Staffing Vacancies--When I appeared before these committees last year, 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. Blinded veterans and those with traumatic brain injuries also benefit from VA's specialized systems focusing on specific conditions or diseases that require advanced knowledge, technology, and treatment approaches. This distinction is vital for ensuring veterans receive appropriate and effective care for their distinct health challenges. Also, keep in mind that logistically, it can be quite difficult to assist a veteran with catastrophic disabilities in getting ready to leave the house, travel to the point of service for their care, and return home again. So, it is extremely important that the department maintains single points of care like its SCI/D centers and centers of excellence to allow veterans to receive comprehensive care at a single location.

At a hearing last June, I warned the House Veterans' Affairs Committee that VA's SCI/D system of care was not sufficiently funded to properly care for all of the SCI/D veterans on the department's registry. Staffing levels for the SCI/D system of care are detailed in VHA Directive 1176. PVA strongly believes in each of the requirements outlined in this directive because they are based on the level of care needed to maintain the health and wellbeing of veterans with SCI/D. Unfortunately, VA leaders have ignored these requirements, viewing them as more of a guide rather than a directive based on the best care standards.

For months, our staff in the field have told us that critically needed positions at SCI/D centers were going unfilled. As a result, essential positions across VHA have been "lost" due to an inability to recruit for them. In some cases, they were even being "abolished." Specifically, many vacant positions in social work, nursing, and several therapy disciplines have been eliminated. Additionally, when medical staff leave, their vacated positions are often not being backfilled, causing strain on the system and ultimately denying veterans access to earned health care services.

Caring for veterans with SCI/D requires sharp assessment, time- and labor-intensive physical skills, and genuine empathy. Nurses who work in SCI/D must possess unique attributes and specialized education. All Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Nursing Assistants (CNA), and Nurse Practitioners working with the SCI/D population are required to have increased education and knowledge focused on health promotion and prevention of complications related to SCI/D. This includes the prevention and treatment of pressure injuries, aspiration pneumonia, urinary tract infections, bowel impactions, sepsis, and limb contractures.

During their annual visits to each of the 25 SCI/D centers, PVA's medical services team identifies critical vacancies at each facility and then provides that information to VA's leadership. Totaling in the hundreds, VA agrees with roughly 80 percent of our recommendations but only a fraction of them are filled. Too often at VA we see "staffing on a wire," an unstable practice of maintaining just enough staff to handle beds, but not enough to adapt to changing life events like staff illnesses and injuries. VA should staff each SCI/D center to the levels prescribed in VHA Directive 1176.

Depending on the function level of an acute SCI/D patient, a nurse may spend an hour or more each time they enter a veteran's room doing physical transfers, repositioning, wound care, feeding assistance, bowel and bladder care, and other tasks. Nurses in other areas of work may be in and out of a patient's room in a matter of minutes. Despite the increased care that veterans with SCI/D require, not all SCI/D nursing staff (including LPNs and CNAs) receive specialty pay, which often elevates turnover rates.

Despite VA's past hiring successes and the flexibility gained by workforce provisions in the RAISE Act (P.L. 117-103) and the PACT Act (P.L. 117-168), nothing in the SCI/D system of care shows ongoing improvement in staffing levels. Staffing shortfalls continue to have a direct, adverse impact on the SCI/D system and the veterans it serves. It is alarming how fragile it is now.

Currently, the acute care facility at one of the 25 SCI/D centers can only use half its beds, because staffing vacancies exceed 50 percent. The leadership there recently denied (again) the center's request to hire an RN and an LPN to backfill a pair of resignations. As a result, overtime is increasing and we expect additional resignations due to burnout and/or the closure of additional SCI/D beds there.
The SCI/D system of care has been short hundreds of nurses for the past few years with total staffing vacancies hovering around 35 percent. Also, if forced to rely solely on its staff without the copious use of overtime, one of the department's six SCI/D long-term care centers could not staff nearly 40 percent of its beds. The department has been concealing its vacancy problems through the use of overtime which, if taken away, may reveal much more serious staffing issues. Without proper staffing, veterans may be forced to accept care in the community, even when it is not the quality or type of care they would receive at a VA facility, and most importantly, when it is not their choice to do so.

The PACT Act and the RAISE Act gave the VA new pay and bonus authority to recruit in-demand health care workers but we know that more needs to be done. Giving VA additional tools, including additional financial resources so it can better compete for the highly qualified medical personnel it needs to care for catastrophically disabled veterans, is a must.

Recent efforts to reshape the federal workforce through a hiring freeze and the deferred resignation program, as well as the dismissal of nearly 2,500 probationary VA employees, has alarmed some of our members because they have seen and experienced first-hand, the adverse impacts of an understaffed program. The instability has also undoubtably made it more difficult for VA staff to remain focused on their veterans when they are worried about providing for themselves and their families. While additional guidance for the hiring freeze and deferred resignation program did exempt certain VA positions from these initiatives, there remain significant concerns as to how these cuts will impact the VA workforce and in turn, the ability for this workforce to provide timely, quality care and benefits to veterans.

For example, the exemptions list does not include information technology specialists, health care administration officials, financial management positions, and other occupations critical to the continued operations of VA facilities. It also has minimal exclusions for the Veterans Benefits Administration (VBA) and the National Cemetery Administration. These types of workforce cuts must be undertaken with careful precision to ensure the continuity of operations for veterans.

More recently, an Executive Order directed federal agency heads to prepare for reductions-in-force, giving them 30 days to submit reorganization plans as part of a further attempt to downsize the federal government. This suggests that even greater personnel cuts across all federal agencies could be coming soon. The VHA is supposed to operate one of the nation's largest integrated health care delivery systems for a good reason—to ensure veterans timely access to care for their service-connected disabilities. VA's community care networks are designed to supplement its direct care system, not replace it. Any plan to cut VHA clinical staff that harms VA's ability to provide direct care for catastrophically disabled veterans would be a violation of the nation's obligation to take care of those who volunteered to serve this country in uniform. We would also have grave concerns about large-scale cuts to VBA as well, because most veteran's association with the VA, and in particular, access to VA health care and benefits often begins with the claims process.

Additionally, the recent Supplemental Guidance from the National Institutes of Health (NIH), capping indirect costs for research grantees at 15 percent, has the potential to threaten the current infrastructure that enables all biomedical research, including SCI/D research, done at NIH and all other institutions that rely on federal research funds. Without appropriate funding to cover indirect costs, institutions may be unable to sustain their research, as these indirect costs are often used to cover vital aspects of research projects, such as specialized equipment, long-term database maintenance, and other crucial administrative and facility costs. These delays could lead to fewer trials, less cutting-edge discoveries, and diminished potential to attract the top talent, all of which will affect the health, function, and quality of life for those living with SCI/D.

Infrastructure—VA's SCI/D system of care is comprised of 25 acute care centers and six long-term care centers ranging in age from four to 70 years with an average age of nearly 40 years old. Many of the older SCI/D centers have only had minor cosmetic interior finish renovations. Consequently, we saw traumatic and disruptive incidents at several SCI/D centers last year. For example, a piping system failure at one facility flooded half of the SCI/D center. This caused the immediate evacuation of the acute and long-term care units and ultimate relocation of veterans with SCI/D into the unaffected patient care units and an adjacent community living center. Fortunately, the medical center was able to repair the plumbing system, restore the impacted areas, and move patients back into the SCI/D center in about a month. Meanwhile, a faulty HVAC design at another facility allowed condensation from the cooling system to form and drip onto patients while they were in bed. The problem, which PVA identified a few years ago, was finally corrected when a construction project at the facility was completed late last year.

Fourteen of the 25 acute care SCI/D centers continue to use four-bed patient rooms, accounting for 61 percent of the mandated available in-patient beds. These four-bed patient rooms do not meet VA requirements and represent an antiquated and outdated patient-care philosophy in modern health care environments due to infection control concerns.

This high percentage of four-bed patient rooms limits available bed capacity whenever patients need to be isolated. 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. Currently, only one of VA's six specialized SCI/D long-term care facilities lies west of the Mississippi River. Even after a construction project at the San Diego VA Medical Center is completed, only 32 long-term care beds are available for the thousands of veterans with SCI/D that reside in this area of the country. Construction of the new SCI/D acute and long-term care 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, US Army Corps of Engineers, the design team, and the construction team, the state-of-the art project is expected to be open to veterans by this summer. Unanticipated delays prolonged construction of the new SCI/D long-term care center at the Dallas Campus of VA's North Texas Health Care System, so it is now expected to be completed in the fall of 2027.

The SCI/D system of care is not immune to the design and construction delays inherent in the VA project funding and delivery system. There are currently two super-major, 10 major and 16 minor SCI/D center projects either awaiting funding, in design, or pending approvals to proceed beyond their current status. VA has spent a significant amount of money and resources on these projects, most of which have languished within the department's Strategic Capital Investment Planning process. Also, replacement SCI/D center projects designed for the Bronx, New York, (acute and long-term care) and the Brockton, Massachusetts, (long-term care) VA medical centers intended to modernize and expand capacity were shovel-ready but abandoned by the VA.

In reviewing VA's infrastructure, decision-makers must remember that VA's SCI/D system of care is unique and not replicated outside of VA. The VA SCI/D system of care provides a coordinated, life-long continuum of services for SCI/D veterans that is often unmatched anywhere in the community. PVA believes that VA should return to the past practice of placing greater emphasis on funding facilities that support the types of services, like SCI/D care, which the department uniquely provides. Greater investment in areas like SCI/D care would greatly strengthen VA's specialty care services and ensure their future availability.

Even with a comprehensive strategy and adequate infrastructure funding, VA's internal capacity to manage a growing portfolio of construction projects is constrained 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's 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.

Finally, PVA strongly supports passage of the Veterans Accessibility Advisory Committee Act of 2025 (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—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 acquires 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. An estimated 14 percent of SCI/D individuals report significant alcohol-related problems and more than 19 percent report heavy drinking. For veterans with SCI/D, nine percent were diagnosed with alcohol-related SUD and an additional eight percent related to illegal drug use.

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 SCI were reported to be three to five times more likely to die by suicide than non-SCI individuals. 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. The VA must begin to tackle ways in which all enrolled veterans can use RRTP programs. We call on the department to develop plans and pilot a program to test models for providing this care to veterans with SCI/D.

Title 38 Protections for Community Care—PVA remains deeply concerned about the exclusion of protections for injuries that occur as a result of community care. Title 38 U.S.C. § 1151 protects veterans in the event that 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 enjoying 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.

PVA PRIORITY: INCREASE ACCESS TO VA'S 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. There are very few long-term care facilities that are capable of appropriately serving veterans with SCI/D. All totaled, the department is required to maintain 198 authorized (181 operating) long-term care beds at SCI/D centers.

As of last month, only 153 beds were actually available. This number fluctuates depending on several variables like staffing, women residents, isolation precautions, and deaths. When averaged across the country, that equates to about 3.4 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 facilities, 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 (VISN). Each of the VISNs must have at least one program site in a rural-urban 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. At the conclusion of the pilot program, participating veterans will be given the option to continue receiving assisted living services at their assigned site, paid for by the VA. We believe this would help veterans and the VA alike by giving greater access to assisted living and reducing costs for long-term care, allowing more veterans to receive needed assistance. We won't fully know how this change will help veterans until its implemented; so, we urge these committees to leverage its oversight authority to ensure the test pilot is launched in a timely manner.

Improve Availability of VA's Home and Community-Based Services (HCBS)—We are very appreciative of Congress's passage last year 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.

Raising 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, will be extremely helpful for families with service-connected veterans on ventilators who currently are bearing a significant part of the cost of care—financially, physically, and emotionally—for their loved one. Since it's the one provision of the Dole Act that would bring immediate relief to some of our nation's most critically ill and injured veterans, its roll out bears close watching because VA has suggested it may take a while for it to be implemented. Unfortunately, veterans with ALS and other catastrophic disabilities do not have time to wait any longer for this relief for them and their families.

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. It gives veterans greater control of their health care choices, and enhances their quality of life by ensuring they receive the necessary support to live comfortably and safely in their own homes.

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 were established at all major VA facilities last year, but the feedback we have received from the field suggests many of them exist in name only. Some locations lack dedicated staff to manage the program, and insufficient funding often constrains the number of veterans who can participate in it at many others. In Minnesota, there are only 10 veterans using VDC, and out of those 10, only six are SCI/D veterans. We know many more are likely eligible for the program because VISN 23 has 1,485 veterans on its SCI/D registry. We understand VA wants to expand VDC and enroll more veterans but the department is having a difficult time in 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 proper funding for the expansion of this important program.

Additionally, last year, many SCI/D veterans inexplicably saw their H/HHA hours greatly reduced. Using VISN 23 again as an example, many veterans saw their hours cut in half from 25 to 30 per week to as low as 14 despite there being no change in their physical condition. Some veterans had their hours eliminated altogether. The majority of these veterans who were reduced or discontinued do not qualify for aid and attendance or the family caregiver program. Being able to enroll in VDC would offset the reduced or discontinued hours of H/HHA services. We understand lack of funding drove this change;

thus, VA must request, and Congress must provide, sufficient funding to ensure veterans receive proper assistance and care.

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. Anne, an Army veteran and PVA member is a good example. In October 1999, while deploying on a training exercise to Fairbanks, Alaska, she sustained an SCI as a result of a military vehicle accident. Since that time, she has been a quadriplegic. Her spouse, Harry, has been her primary caregiver, but Anne's physical needs are so great they also rely on direct care workers to help provide the care she needs. Finding the right candidate who understands the unique nature of the job and possesses the right combination of hard and soft skills to help her proved to be a formidable challenge.

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 to help her proved to be a formidable challenge. She was forced to interview over 100 applicants because most weren't experienced with specialized care or physically strong enough to care for her.

The shortage of caregivers or home care workers doesn't just affect disabled veterans. Across the country, there is an increasing shortage of direct care workers, and a national effort is needed to expand and strengthen this workforce. The lack of home care providers is adversely impacting the care and quality-of-life of veterans with SCI/D. Veterans with disabilities have the right to quality care in their homes.

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. 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.
On a national level, Congress could consider establishing a College Service Corps that provides incentive bonus awards to college students who agree to serve as a direct care worker for a specific timeframe. Meanwhile, the 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.

For years, PVA voiced concerns about veterans with catastrophic disabilities having to rely on their caregiver during hospitalization, and if they are enrolled in the VDC Program, when the veteran is hospitalized, the VDC payment is discontinued until the veteran is discharged from hospital care. Neither community hospitals nor VA medical centers are adequately staffed or trained to perform the tasks veterans with SCI/D need.

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 Geriatric and Extended Care (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." Many SCI/D veterans are still unable to receive payment for their caregivers when they are hospitalized. Section 123 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. As of February 1, 2025, the VA reported having 18,194 applications in process, but the department is no longer reporting the number of approved applications. Instead, they are reporting the percentage of approvals reported by VISN. Without being able to track the number of applications approved in comparison to the number of pending applications, it is difficult to keep track of their progress.

Recently, VHA published its long-awaited rulemaking to make changes to the current caregiver regulation. After years of conversation with the VA about the program, we are appreciative of some of 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 have serious concerns about the regulations as proposed and 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.

We are also concerned about VA's failure to propose regulations governing the appeal process for determinations made under the PCAFC. The lack of a defined appeal process in the current caregiver program has led to inconsistencies in eligibility. Rather than addressing the appeal 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 comment on it. In PVA's response to the proposed changes, we urged VA to reconsider its decision and either publish an appeal process proposal as a supplemental proposed rule or in an interim final rule, which would allow for public comment.

Codify VA's Bowel and Bladder Program—SCI/D can significantly impact a person's quality of life, and neurogenic bladder and bowel dysfunction are crucial aspects of their care. These conditions affect many veterans with SCI/D and can lead to complications, re-hospitalizations, and mortality. Therefore, managing neurogenic bladder and bowel requires specialized attention, as it can be costly, is unrelenting over time, often necessitates substantial caregiver support, 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 on a daily basis 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 actually 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 allow Congress to finally resolve the tax burden and delayed payments for family members who perform bowel and bladder care. And because our members are the principal users of the program, we hope that Congress and the VA will provide PVA ample opportunity to "shape" the program's language.

PVA PRIORITY: IMPROVE VETERANS' FINANCIAL SECURITY

Special Monthly Compensation (SMC) Aid and Attendance Rates—An important lifeline for seriously disabled veterans is being whittled away due to indifference. SMC represents payments for "quality of

life" issues, such as the loss of an eye or limb, the inability to naturally control bowel and bladder function, the inability to procreate, or the need to rely on others for ADLs like bathing or eating. To be clear, given the extreme nature of the disabilities incurred by most veterans in receipt of SMC, PVA does not believe that a veteran can be totally compensated for the impact on quality of life, however, SMC does at least attempt to offset some of that loss. Many severely disabled veterans have lost the means to function independently and need intensive care on a daily basis. Because of the many specialty services needed for their care at home, their expenses rapidly outpace the amount of their SMC.

Due to the unique needs of the seriously disabled, the VA provides an additional SMC benefit called Aid and Attendance (A&A). However, securing the services of a direct care provider is very expensive and the A&A benefits provided to eligible veterans do not come close to covering this cost. Many of PVA's most severely disabled members who pay for full-time attendant care incur costs that far exceed the amount they receive as SMC beneficiaries at the R-2 compensation level (the highest rate available).

Ultimately, they are forced to sacrifice their standard of living in order to meet the rising cost of the specialized services of a trained caregiver; expensive maintenance and certain repairs on adapted vehicles, such as accelerated wear and tear on brakes and batteries that are not covered by prosthetics; special dietary items and supplements; additional costs associated with needed "premium seating" during air travel to decrease the chance of injury in boarding and deplaning; and higher-than-normal home heating/air conditioning costs in order to accommodate a typical paralyzed veteran's inability to self-regulate body temperature. In addition, many of our members choose to live close to VA medical centers, which are almost exclusively in large cities, where the cost of living is higher and those who rely on disability compensation must learn to stretch an already strained budget.

Likewise, SMC fails to account for the cost of home delivery fees from inaccessible businesses, building a wheelchair ramp, acquiring and maintaining service animals, buying a more expensive car in order to accommodate a larger power wheelchair, purchasing food for special diets, or paying more for housing in order to find a place that is accessible and convenient. Oftentimes, veterans are forced to dedicate more and more of their monthly compensation to supplement the shortfalls in the A&A benefit. It slowly erodes their overall quality of life and can lead to serious health issues.

Both SMC and A&A are subject to annual cost-of-living increases but the formula used to establish the increase often understates the actual rate of increase in goods and services required by the seriously disabled veteran. Also, the baseline rates have not been examined by Congress in years. We urge the Committees to review and subsequently increase the rates of SMC and A&A soon to ensure these benefits meet the needs of veterans and their families.

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.

The Servicemembers and Veterans Empowerment and Support (SAVES) Act has been introduced in several sessions of Congress in both the House and the Senate. The SAVES Act would improve claims processing within VBA and access to health care within the VHA. However, despite several VA Office of Inspector General reports highlighting the failures of VBA and VHA to improve claims delivery and ensure a warm hand off from VBA to VHA, Congress has conducted little oversight of MST claims or subsequent health care delivery.

The annual MST reports compiled by VA over the past several years show an alarming trend, thousands of veterans each year are filing MST claims, and the number is only increasing. MST impacts men and women and research shows sexual trauma can have lasting mental and physical health impacts that could be detrimental to a veteran's ability to live a full life. It is the responsibility of VA, and Congress, to ensure that veterans who experienced MST are given the benefits and services they deserve because of their military service.

PVA eagerly awaits the reintroduction of the SAVES Act, and we encourage all committee members to support this legislation.

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 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 allowing all military retirees to retain their full military retired pay and VA disability compensation without any offsets.

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 2025, this compensation starts at $1,653.07 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 created 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 and we urge Congress to pass the Caring for Survivors Act of 2025 (H.R. 680), which would increase the rate of compensation for DIC payments to achieve parity with similar compensation federal employees' survivors receive.

Additionally, if a veteran was rated totally disabled for a continuous period of at least eight years immediately preceding death, their surviving spouse can receive an additional amount (currently $351.02) 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 one who, once diagnosed, has 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 legislation to provide the DIC kicker to eligible survivors of veterans who died of service-connected ALS.

Home Modification Grants—Despite proposals to increase the VA's Home Improvements and Structural Alterations (HISA) grant program, Congress has yet to raise the limited rate of funding currently available to veterans for home modifications. HISA grants assist in improvements and changes to eligible disabled veterans' homes. 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 and supports.

Since 2010, the HISA grant amounts have languished in the face of increased costs associated with construction materials, labor, and crushing inflation. For ease of delivery, the HISA grant program should be modified to be a single rate for all veterans. Currently, the benefit is limited to $6,800 for service-connected veterans and $2,000 for veterans who are not service connected but are enrolled in the VA health care system.

PVA urges Congress to support legislation that raises HISA grant rates and indexes the grants to ensure the benefit is aligned with the costs of needed improvements.

PVA PRIORITY: ENHANCE ACCESS TO HEALTH CARE SERVICES FOR VETERANS WITH SCI/D

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. Transportation is the largest barrier to health care access for over five million veterans living in rural and urban areas and especially the catastrophically disabled. It is important to understand this because according to the VA, missed appointments cost the department over $4 billion per year and most are due to lack of transportation. That number may be higher since it probably didn't account for veterans who are not eligible for travel reimbursement. From an economic standpoint, missed appointments set off a cascade of higher costs in the VA health care system, through the ripple effect created by patients with a higher risk of negative health outcomes to clinicians and medical assistants in rescheduling.

Several PVA members have received the additional automobile allowance as part of the Veterans AUTO and Education Improvement Act (P.L. 117-333). Congress has provided them the means to not only purchase a new vehicle but also preserve their independence. We urge Congress to consider providing a similar auto allowance to veterans with non-service-connected catastrophic disabilities. Like those with service-connected disabilities, these veterans served honorably. They are eligible for VA health care and having access to an adapted vehicle helps them get to and from their appointments at the VA, particularly if they live in a rural area.

The Veterans AUTO and Education Improvement Act also changed the definition of "medical services" to include certain vehicle modifications (e.g., van lifts) offered through VA's Automobile Adaptive Equipment program. 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 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. This change inadvertently limits the scope of an existing benefit and these changes better reflect the congressional intent of the original provision. PVA strongly supports H.R. 1364, the Automotive Support Services to Improve Safe Transportation Act of 2025, which addresses this oversight to ensure that seriously disabled veterans are getting the equipment and modifications needed to travel safely.

In addition, even if they have access to an adaptive vehicle, some PVA members do not qualify for beneficiary travel when traveling to and from a VA medical facility for an appointment. A case worker shared with us that she has been working with an 85-year-old veteran paraplegic whose transportation issues have had a significant negative impact on his physical and mental health over the past few years. He is just over the income limit for VA funded travel and therefore has to try and find his own transportation to the VA for SCI/D care. County agencies are extremely limited in the help they can provide due to staffing issues, and his wife's ability to transport him is even more limited due to age and her own health-related issues. The veteran missed a multitude of medical appointments, including

those for pain management and outpatient physical/occupational therapy. His physical and mental health was rapidly deteriorating, to the point he was verbalizing symptoms of high anxiety, lack of sleep, depression, and passive suicidal ideation. The VA referred him to mental health support groups and individual psychotherapy, however, the underlying problem of not having consistent transportation to the VA remained. His lack of transportation clearly had a "snowball effect" on his health that unless addressed would only worsen.

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.

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. Last month, GSA increased its mileage reimbursement rates to $0.70 per mile. PVA urges Congress to pass the Driver Reimbursement Increase for Veteran Equity Act (H.R. 1288) to ensure the beneficiary travel reimbursement rate is at least equal to GSA's.

VA's Beneficiary Travel Self-Service System (BTSSS) needs continued attention. For many years, veterans could check in for appointments and file claims for travel pay using VA's self-service kiosks. The kiosks let veterans file for reimbursement of travel expenses to VA appointments and were highly popular among the veteran community. However, in 2020, VA decommissioned the kiosks as it rolled out an online- and application-based program, the BTSSS. Shortly after BTSSS' introduction, many veterans had trouble with the online interface and app. VA staff members also had trouble with the system, forcing them to develop workarounds or use the old system to approve claims. According to the VA OIG, veterans used BTSSS for just 49 percent of all claims through mid-2022. The OIG also found that while BTSSS was meant to solve claims without human intervention at least 90 percent of the time, barely 17 percent of claims were automatically decided from February 2021 through July 2022.

While VA continues working to resolve fundamental flaws in BTSSS, every VA health care facility should have at least one fully functioning kiosk. Also, as VA modernizes and upgrades platforms and engagement methods, it is critical to remember that many veterans do not have equal access to computers, broadband, and even smart phones. The traditional ways of accessing VA benefits are still necessary for our rural, low-income, disabled, and aging veterans. To ignore them and their needs, is not an option.

VA provides some 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 of the medical center. We also hear complaints about medical centers that are not capable of meeting their veterans' transportation needs due to insufficient transportation vendors.

Sometimes, the problem is with the VA-contracted transportation company (CTC) itself. Recently, one of our members had to reschedule his VA appointment because the CTC at his facility called him an hour prior to the appointment to let him know they had no one to pick him up. The veteran was supposed to go for a therapy session and it wasn't the first time no service was available. The CTC for his facility is headquartered more than two hours away which doesn't help. They have to drive two hours to pick up the veteran, take him to his appointment which is 45 minutes from his home, wait for his session to end, drive him home, and then drive the two hours back to their company headquarters. The CTC is always 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. Thus, we encourage passage of legislation that would help more veterans in rural areas get transportation to VA health facilities and access the care they've earned.

Health Care and Benefits for Women Veterans—More attention and oversight are needed to ensure that women veterans can access comprehensive, gender specific care, services, and benefits. The VA should be providing the highest standards of care when it comes to quality, privacy, safety, dignity, and accessibility. While the VA has a robust SCI/D system of care to serve veterans with SCI/D, there needs to be greater collaboration between SCI/D centers and gender-specific care for our women veterans.

Ensuring that women PVA members have timely access to quality care will only help VA to be better positioned to deliver care for all veterans, particularly those with complex injuries and illnesses. Women veterans are the fastest growing veteran cohort using VA benefits and services, accounting for nearly 30 percent of all new VA enrollees. It is our obligation to ensure that women veterans encounter barrier-free access to health care and benefits equal to their male counterparts. Our women members often report that it is difficult to access gender-specific care within the SCI/D system because it requires a high level of cooperation and coordination with the women's health clinics. With limited staff inside women's clinics, there is often difficulty in coordinating this care. It is left up to each facility to proactively establish integrated care for patients within the SCI/D system, and unfortunately, this has not been a priority for many locations. One PVA leader shared that OB/GYN services have only been available at her VA for four years. The only way to access them is through a consult from her primary care provider at the SCI/D center and the women's health clinic, which is sometimes difficult to arrange.

Many women veterans receive their primary care through a women's health clinic which eliminates this extra step in accessing their care.
Women PVA members have shared that accessibility for them goes beyond the women's clinic. Recently, a member needed an MRI but the changing rooms in radiology were not accessible for wheelchair users, leaving her feeling vulnerable and exposed. Despite the efforts made by VA to provide gender-specific care for women veterans, we still hear stories of our members experiencing a number of different barriers at VA facilities. Accessibility goes beyond parking spaces and automatic doors.

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.

Assisted Reproductive Technologies (ART)—Recognizing the need for ART options, Congress granted temporary authorization in 2016 for the VA to provide in vitro fertilization (IVF) to veterans with a service-connected condition that prevents the conception of a pregnancy. This temporary authorization has been reapproved multiple times, but Congress has always stopped short of permanently authorizing it and expanding the types of ART provided to veterans. While PVA is grateful for these provisions, it is time to permanently fund these treatments and include infertility as part of the regular medical benefits package offered by the VA. To improve access to services and ensure that all veterans can receive treatment if they receive an infertility diagnosis, Congress should pass the Veterans Infertility Treatment Act (H.R. 220), which would allow appropriate infertility treatments to be authorized as part of the medical benefits package.

Recent policy changes have been made within the VA and the Department of Defense to increase access to IVF services, and we are hopeful they will remain in place. There should be fewer barriers to servicemembers and veterans who are struggling to grow their families and for veterans who have infertility due to their military service. They should be afforded the opportunity to access this benefit without the additional stress of adhering to the narrow understanding of direct service-connection.

In closing, the working environment across the country, within VHA and VBA, is quickly becoming untenable. How can we expect doctors, nurses, claims raters, vocational rehabilitation counselors, and other staff to be focused on their mission to care for veterans while the specter of losing their jobs hangs over their heads? The simple answer is, they can't, and unless something is immediately done to restore a stable environment at VA, veterans will be harmed. Taking care of PVA members is hard enough without these distractions. As the body charged with VA oversight, I urge you to intervene before something like that happens.

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 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.

Fiscal Year 2022

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $ 437,745.

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 2024 during the organization's 78th Annual Convention, and began serving his second one-year term as President and Chairman of the Board on July 1, 2024. 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.