ARTICLE

When a Spouse Isn’t Enough

Why some of the most severely disabled veterans reach a ceiling at the M-Half rate, and the professional-care line that holds them there.

There is a moment that repeats across these VA decisions. A veteran cannot bathe, dress, cook, or manage medication without help. A spouse does all of it, often around the clock. And the Board still concludes that the veteran has reached his ceiling, at a rate called M-Half, and can go no higher. To a family living the reality, that can feel impossible to square. The explanation is a single distinction buried in the rules, and it is worth understanding plainly.

The top of the ladder, in plain terms

Special monthly compensation, or SMC, pays extra when a veteran’s losses go beyond what a normal percentage rating captures. Near the top of the ladder sit the highest rates, labeled with the letters (o), (r), and (t). The two (r) rates do different jobs: (r)(1) adds an allowance for regular aid and attendance, while (r)(2) pays more when the veteran needs a higher level of care. M-Half sits below those top rates. Reaching the very top is not just a matter of being severely disabled. It requires meeting specific criteria, and one of them trips up case after case.

Aid and attendance versus a higher level of care

The rules draw a line between two kinds of help. The first is “aid and attendance,” meaning help with the ordinary tasks of daily life: dressing, bathing, eating, staying safe at home. A spouse or family member can provide this, and it supports the (l) rate that anchors many of these claims. The second is “a higher level of care,” which means something more medical. The regulation defines it as personal health-care services provided every day in the home by someone who is licensed to provide them, or by an unlicensed person working under the regular supervision of a licensed professional (Donnelly, A25072861, Aug. 28, 2025, quoting 38 C.F.R. section 3.352(b); Martz Ames, A25037222, Apr. 23, 2025).

That single word, licensed, is the hinge. Devoted family care, no matter how constant, generally does not satisfy the higher-level-of-care standard on its own, because a spouse is usually not a licensed health-care professional and is not being supervised by one.

The “but for the spouse” trap

The pattern shows up most clearly in two decisions. In the first, a veteran’s wife prepared his meals, managed his medication, and helped him keep his balance. Private examiners said he would likely need nursing-home placement or a home health aide if she were unavailable, but the Board found that opinion inconsistent with other records showing substantial independence (Knope, A26039775, Apr. 28, 2026). In the second, a veteran with traumatic brain injury needed, in his wife’s words, 24-hour monitoring for his safety; she showered him, cooked every meal for fear he would start a fire, drove him everywhere, and administered all his medications. The Board found that her help met the standard for regular aid and attendance but not the

higher-level-care standard, and it found that the remaining evidence did not show he would require institutional care without her assistance (Donnelly, A25072861, Aug. 28, 2025).

The logic still has a hard edge. Extensive family care can establish regular aid and attendance and still fall short of the higher-level-care standard. In Donnelly and Knope, the Board asked whether institutional care would be required without the spouse's assistance. That creates a practical catch-22: the care keeping a veteran at home can also make it harder to prove that institutional care would otherwise be required. The higher standard still requires daily personal health-care services from a licensed professional, or from someone working under regular professional supervision.

A narrower path for brain injuries

There is one route that softens this for a specific group. For veterans whose need for care comes from the residuals of a traumatic brain injury, a separate rate known as (t) was written to remove the usual requirement of first reaching the very top of the ladder. It still, however, asks whether the veteran would need hospitalization or institutional care without the aid he receives. In the brain-injury case above, the Board considered this (t) route and still said no, because the care being given was not the licensed kind and the veteran was not found to need institutional placement (Donnelly, A25072861, Aug. 28, 2025). The path exists, but it runs through the same gate.

The other ceiling: "loss of use"

Families sometimes ask why severe difficulty using a limb does not open a higher rate. The answer is that "loss of use" has a demanding legal meaning. It is treated as existing only when what remains of a hand or foot would be no better than an amputation stump fitted with a prosthesis. Real and serious limitation is often not enough. In one case the Board pointed to the veteran's own statements that he could still grip objects, still climb stairs, and at times still played golf without a cane, and concluded that he retained too much function to meet the standard (Knope, A26039775, Apr. 28, 2026). Another decision spent pages on the same demanding line (Reiss, 25009598, Jul. 24, 2025).

What this means for veterans and families

None of this is legal advice, and every case turns on its own facts. But the decisions point to a few practical realities. The higher-level-care allowance under (r)(2), and the TBI route under (t), require professional or professionally supervised care, so documentation that a licensed clinician is involved in the veteran's home care, or a physician's statement about the level of care actually needed, can matter a great deal. In fact, one decision was sent back specifically so a physician could give an opinion on whether the veteran needed a higher level of care (Martz Ames, A25037222, Apr. 23, 2025). For veterans whose needs stem from a brain injury, the (t) route is worth raising by name. And because SMC is meant to be granted whenever a veteran becomes eligible, without a separate application, it is always fair to ask the Board to consider every rate the record could support. A veteran or family navigating this is far better served working with an accredited representative than going it alone.

The cases behind this piece

Decision	Date	What it shows
Knope, A26039775	Apr. 28, 2026	Spousal care and loss-of-use both fall short of the higher standards.
Donnelly, A25072861	Aug. 28, 2025	Round-the-clock family care is not "licensed" care; (t) route considered and denied.
Martz Ames, A25037222	Apr. 23, 2025	Case remanded for a physician's opinion on higher-level-of-care need.
Reiss, 25009598	Jul. 24, 2025	Extended treatment of the demanding "loss of use" standard.

A note on method and confidence

This piece draws on Board decisions collected because they involve the M-Half rate. It describes the reasoning judges applied, not how commonly veterans succeed or fail, and it is general information rather than legal advice. These are non-precedential, fact-specific decisions, so similar situations can come out differently. The care distinction and the loss-of-use standard are quoted as the decisions and the underlying regulation (38 C.F.R. sections 3.350 and 3.352) state them.