



INSTITUTE FOR  
VETERANS HEALTH  
& SOCIAL POLICY

**CONGRESSIONAL POLICY BRIEF**

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# Closing the Cross-State Licensure Gap in Veteran Mental Health Care

*A Targeted Reform Within Existing Statutory Authority — and Why Congress Has Already Built the Record*

Prepared by

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**AT A GLANCE**

*One regulation. Two NDAA precedents. ~9.1 million enrolled veterans. The remedy is within the Secretary's existing authority.*

## EXECUTIVE SUMMARY

Federal law guarantees every enrolled veteran timely access to high-quality mental health care, and the VA MISSION Act of 2018 created the Veterans Community Care Program (VCCP) to ensure that access when VA direct-care capacity is insufficient. In practice, the dual-pathway system — VA care supplemented by VCCP referrals — fails to deliver continuous, clinically viable mental health treatment for veterans whose lives involve interstate mobility. The cause is structural and traceable to a single regulatory provision.

Under 38 C.F.R. § 17.417(b)(2)(iii), VA-employed clinicians may deliver tele-mental-health care across state lines under federal preemption; VCCP-contracted clinicians treating the same veteran for the same condition may not. When the veteran crosses a state line — for work, family, housing, military duty, or a VA-assigned specialty referral — the community-care therapist must terminate care. The system contains no bridge mechanism, no warm handoff, no escalation pathway. The veteran is returned to the back of the referral queue.

Congress has already enacted the precise remedy required to close this gap, twice, for analogous populations. Section 581 of the FY2024 NDAA extended cross-state licensure flexibility to DoD-contracted mental health counselors. Section 714 of the FY2025 NDAA extended licensure portability to TRICARE network mental health providers — the civilian network serving servicemembers, military retirees, and their families. Both passed with overwhelming bipartisan support. Both have been implemented without documented adverse outcomes. Veterans served through VCCP are now the only category of federally-sponsored mental health care recipients who remain excluded from this protection.

**THE BOTTOM LINE — The remedy requires no new spending. It does not change reimbursement rates. It does not displace state licensure compacts. It does not raise unresolved legal questions. And the Secretary of Veterans Affairs already holds authority to act — through notice-and-comment rulemaking, through legislative referral, or both.**

### What IVHSP Has Done

On May 13, 2026, the Institute for Veterans Health & Social Policy filed a Petition for Rulemaking with the Secretary of Veterans Affairs under 5 U.S.C. § 553(e), requesting initiation of notice-and-comment rulemaking to amend 38 C.F.R. § 17.417 within 180 days. The petition includes proposed regulatory text modeled directly on the framework Congress enacted at 10 U.S.C. § 1094(d)(4) for TRICARE network providers. The petition is accompanied by a working paper, *Crossing Lines*, providing the full structural, statutory, and clinical analysis.

### What Congress Can Do

- Amend 38 U.S.C. § 1730C to expressly include VCCP-contracted mental health providers as covered health care professionals — the most durable resolution and the one that avoids the limiting-principle questions facing pure regulatory action.
- Conduct oversight of the Department’s response to the IVHSP petition, particularly on whether any denial engages with the FY2024 and FY2025 NDAA enacted record and the Section 504 Rehabilitation Act framework.

- Direct GAO to study the relationship between cross-state mobility, VCCP referral failures, and veteran clinical outcomes — including suicide risk, administrative dropout, and anticipatory disengagement.
- Include continuity-of-care reforms in the next NDAA / VA authorization vehicle, mirroring the structure of FY2024 § 581 and FY2025 § 714.

## I. THE PROBLEM IN ONE PAGE

### *A National Entitlement on a Geographically Anchored Chassis*

VHA is the nation's largest integrated healthcare system and the primary mental health provider for U.S. veterans. As of 2026, approximately 9.1 million veterans are enrolled. The VA MISSION Act guarantees an appointment within 20 days for mental health care or eligibility for community-based care. Yet the delivery system anchored to state-bounded licensure regimes systematically underperforms for one structurally identifiable subset of enrolled veterans: those whose lives involve interstate mobility.

### *Two Failure Modes*

**Relocation failure mode.** An established therapeutic relationship is severed when a veteran crosses a state line. The community-care therapist holds licensure in the original state; that license does not authorize practice while the veteran is in the new state. The relationship terminates without coordination or clinical handoff. The veteran returns to the referral queue, treated administratively as a new applicant. Months of clinical progress are lost.

**Continuous mobility failure mode.** For long-haul truckers, veterans cycling through shelter networks, seasonal workers, full-time RV travelers, and National Guard members with cross-state drill obligations, no fixed jurisdiction exists for the referral system to use as input. No therapeutic relationship can form. The system is, by design, structurally incapable of serving these veterans through community care.

### *Agency-Induced Mobility*

Sixteen of eighteen Veterans Integrated Service Networks span multiple states. Several VISNs cover eight or ten. VA routinely assigns specialty care across state lines as a function of network organization — the veteran does not choose this. A southern-Georgia-resident veteran enrolled at a Valdosta CBOC may be assigned in the ordinary course of clinical operations to receive specialty care in Gainesville, Florida. Their VCCP mental health therapist licensed in Georgia is legally barred from continuing care while the veteran is in Florida. The Department's own program design generates the cross-state mobility that the contractor exclusion then exploits to terminate continuity.

### *Who Is Affected*

- Approximately one-third of VHA enrollees — roughly 3 million veterans — live in rural or highly rural areas, often closer to out-of-state facilities than in-state ones.
- 32,882 veterans were identified as experiencing homelessness on a single night in the 2024 Point-in-Time count.
- Veterans are overrepresented in interstate transportation occupations — estimated at roughly 10% of the truck-driving workforce.
- Approximately 200,000 service members transition from active duty to civilian life each year, entering the highest-risk window for suicide during the geographic transition.
- In 2023, 6,398 veterans died by suicide; veterans with recent mental health diagnoses experienced suicide rates far exceeding the general population.

## II. CONGRESS HAS ALREADY ENACTED THE REMEDY — TWICE

The structural argument for closing the VCCP gap is not theoretical. It is documented in two consecutive NDAA's — both passed with overwhelming bipartisan support, both applying the precise mechanism this brief discusses, both applied to populations whose mobility profile, clinical needs, and federal-program-funded delivery architecture are materially identical to those of VCCP-served veterans.

PROVISION	POPULATION REACHED	MECHANISM	LEGISLATIVE VEHICLE
<b>Section 581, FY2024 NDAA (P.L. 118-31)</b>	DoD-contracted mental health counselors serving servicemembers and military families	Cross-state licensure flexibility for federally contracted civilian counselors regardless of provider/patient location	Bipartisan; enacted December 2023; implemented without documented adverse outcomes
<b>Section 714, FY2025 NDAA (P.L. 118-159)</b>	TRICARE network mental health providers serving the full population entitled under 10 U.S.C. § 1076 — active duty, retirees, dependents, survivors	Federal licensure portability for civilian network providers regardless of provider/patient location; codified at 10 U.S.C. § 1094(d)(4)	House 281–140; Senate 85–14 (conference report); enacted December 2024
<b>REQUESTED: Amendment to 38 C.F.R. § 17.417</b>	VCCP-contracted mental health providers serving enrolled veterans under 38 U.S.C. § 1703 / § 1703A	Federal licensure preemption mirroring TRICARE framework; same scope, same conditions, same protections	Within Secretary's existing authority via notice-and-comment rulemaking; legislative track also available via amendment to 38 U.S.C. § 1730C

*The structural analogy is precise — not approximate. Both VCCP and TRICARE involve a federal health entitlement, federal statutory contracting authority, a community provider network of independently licensed clinicians, and a beneficiary population whose mobility routinely places them in jurisdictions where their established providers lack licensure. When two federal departments reach opposite preemption interpretations of materially identical authority, the divergence establishes that neither interpretation is statutorily compelled. It is a policy choice — one Congress has now resolved, in successive years, in favor of preemption.*

### The Dual-Eligible Anomaly

A military retiree with twenty or more years of service routinely holds both VA enrollment for service-connected conditions and TRICARE for Life coverage for general health care. Under the current regulatory framework, that single individual may obtain cross-state tele-mental-health continuity from a TRICARE network provider while being denied identical continuity from a VCCP network provider. The federal government applies opposite preemption rules to the same person's mental health care depending solely on which federal program pays the bill on a given day. This outcome is not required by any statute. It is the product of one regulatory provision.

### III. THE LEGAL FRAMEWORK

#### Three Tracks Activated by a Single Petition

Filing of the IVHSP petition under 5 U.S.C. § 553(e) activates three distinct tracks for closing the VCCP gap. They are not mutually exclusive.

##### *Track 1 — Regulatory*

The Secretary may amend 38 C.F.R. § 17.417 through notice-and-comment rulemaking under 5 U.S.C. § 553. The pathway runs through 38 U.S.C. § 1730C(b)(1)(B), which defines a covered health care professional as one who “is authorized by the Secretary to provide health care under this chapter.” VCCP contractors authorized under a § 1703 contract satisfy this language. The Department’s exclusion of contractors at § 17.417(b)(2)(iii) is a discretionary regulatory narrowing — adopted by the Department in 2018, preserved across two subsequent rulemakings, and never tested against the post-Loper Bright doctrinal posture or against the FY2024 and FY2025 NDAA enacted record.

##### *Track 2 — Legislative*

Congress may amend 38 U.S.C. § 1730C to add an express VCCP provider category. This is the most durable resolution. It avoids the systemic coherence constraint that the regulatory track creates — namely, the Department’s legitimate institutional concern that an expansive reading of (b)(1)(B) for VCCP mental health contractors might be invoked by other contractor categories (CHAMPVA, State Veterans Home contractors, grant recipients) seeking equivalent treatment. Statutory amendment forecloses that risk by drawing the line Congress chooses to draw, in language Congress controls.

##### *Track 3 — Judicial*

If the Department denies the IVHSP petition without engaging with the FY2024 and FY2025 NDAA record, the DoD/VA interpretive divergence, and the Section 504 Rehabilitation Act framework, the denial is reviewable as arbitrary and capricious under *Motor Vehicle Manufacturers Ass’n v. State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29 (1983). State Farm review does not require a court to resolve the underlying statutory construction question; it requires only that the agency engage with important aspects of the problem before it. The October 2025 final rule did not.

#### Doctrinal Posture After Loper Bright

In *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024), the Supreme Court held that courts must exercise independent judgment when interpreting statutes and may not defer to agency interpretations merely because a statute is ambiguous. The Department’s contractor exclusion was developed under the prior Chevron framework. A reviewing court applying *Loper Bright* would assess the consistency of the exclusion with § 1730C(b)(1)(B) using ordinary tools of statutory construction — including the canon against surplusage, which the Department itself invoked in the October 2025 rule preamble to defend a different construction of the same statute. Reconsideration through new rulemaking is the appropriate forum for the Department to address that doctrinal shift before a court is asked to do so.

#### Section 504 of the Rehabilitation Act

The contractor exclusion implicates 29 U.S.C. § 794, which prohibits exclusion from any federal program against any otherwise qualified individual with a disability. Service-connected disabled veterans receiving mental health care for service-connected conditions — PTSD, TBI sequelae, major depressive disorder, anxiety disorders — are presumptively qualified individuals with disabilities, a status the Department itself has determined through its rating processes. The Department has already determined, through its own employee preemption regulation, and Congress has determined twice through the NDAAAs, that cross-state licensure preemption is feasible, does not fundamentally alter the program, and does not impose undue burden. No prior § 17.417 rulemaking engaged with the Section 504 framework.

## IV. POLICY AND FISCAL RATIONALE

### Foreclosed Objections

The NDAA enacted record forecloses the three objections most commonly raised against extending preemption to VCCP providers.

**Administrative novelty.** The remedy is not novel. Congress has designed, enacted, and implemented the same mechanism twice. The administrative architecture is established and functional.

**Legal uncertainty.** The constitutional authority to attach licensure conditions to federally-funded health care contracts has been exercised by Congress under the Spending Clause and the Commerce Clause and has not been judicially challenged with success. The Department has exercised this preemption for its own employed clinicians since 2018.

**Fiscal expansion.** Federal preemption does not change reimbursement rates. VCCP rates apply regardless of where the provider practices, exactly as TRICARE rates do. The cost of preemption is administrative; the cost of NOT extending it is borne by veterans in interrupted care, by the Department in crisis utilization, and by the federal fisc through downstream consequences of treatment discontinuity.

### Alignment with Stated Department Priorities

- Suicide prevention has been identified by the Secretary as a central priority of the current tenure.
- Expansion of the community care network is an articulated Department goal; the contractor exclusion is the regulatory provision most directly impeding continuity within that network.
- Advancement of the External Provider Scheduling system cannot resolve referral failures that resolve into legal non-viability rather than scheduling friction.
- Reallocation of administrative resources into the patient network is undermined when continuity failures generate new intake cycles, not new completed treatment episodes.

### The Cost-Benefit Direction

A bridge-care reimbursement episode — a short authorization to maintain continuity during a geographic transition — costs a fraction of a psychiatric inpatient admission triggered by continuity disruption. The current system effectively pays for the latter rather than the former. While IVHSP does not present a formal cost-benefit analysis in this brief — and acknowledges that systematic modeling remains an item for future research — the directional logic is clear: preventing avoidable crisis utilization is fiscally rational regardless of the precise multiplier applied.

## V. RECOMMENDATIONS TO CONGRESS

### Immediate Actions

- 1. Conduct oversight of the Department's response to the IVHSP petition.** Within the 180-day response window, request that the Secretary inform the relevant Veterans' Affairs Committees of the disposition of the petition and the reasoning behind it. If the Department denies, request that the denial address the FY2024 and FY2025 NDAA enacted record, the DoD/VA interpretive divergence, and the Section 504 framework. A denial that does not engage with these factors is a State Farm vulnerability the Committees should note.
- 2. Request a GAO study.** Direct GAO to investigate the relationship between cross-state mobility, VCCP referral failures, and clinical outcomes — including administrative dropout, anticipatory disengagement, and the agency-induced mobility pattern documented in multi-state VISNs. Existing GAO products (GAO-22-104668; GAO-23-105617; GAO-24-106410; GAO-24-106189; GAO-25-106910) supply the methodological foundation.
- 3. Include the § 1730C amendment in the Veterans' ACCESS Act conference text.** S. 275 (Moran) and H.R. 740 (Bost) — the Veterans' Assuring Critical Care Expansions to Support Servicemembers Act of 2025 — are the natural primary vehicles. Both bills already amend VCCP statutory architecture, codify access standards (§ 101), expressly address community-care telehealth (§ 105), and establish a community-care mental health pilot (Title II). The licensure preemption is the technical correction the bills' mental health provisions require to function for mobile veterans. Adding it during conference reconciliation — through managers' amendment, substitute, or staff merger — is germane to the bills' stated purpose and does not require new appropriations.
- 4. Support a standalone bill as a concurrent move.** A freestanding § 1730C amendment bill — modeled procedurally on H.R. 5357 (Flood, Bacon, Nunn) for college mental health providers — creates a referenceable bill number for floor amendments to other vehicles, an FY27 NDAA backstop, a citable artifact for the rulemaking petition record, and a discrete focal point for VSO endorsement. The standalone bill operates concurrently with the Veterans' ACCESS Act vehicle, not as a fallback.

### Statutory Amendment to 38 U.S.C. § 1730C — Approaches Available

Three approaches are available to enact the statutory amendment, in descending order of conference-window viability:

- Veterans' ACCESS Act (S. 275 / H.R. 740) conference reconciliation. Active vehicle, both bills reported by their respective committees, both addressed to the same VCCP architecture the amendment corrects. This is the recommended primary path.
- Standalone bill — a Veterans Mental Health Continuity Act containing only the § 1730C amendment. Concurrent with, not contingent on, the primary vehicle. Useful for FY27 NDAA carriage if the primary vehicle stalls or moves on a timeline that does not accommodate the amendment.
- FY27 NDAA carriage — the backstop. Section 714 of the FY25 NDAA originated in HASC; the analogous House Veterans' Affairs entry point is the Subcommittee on Health. FY27 markup is forthcoming.

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The amendment language mirrors the structure Congress already enacted at 10 U.S.C. § 1094(d)(4) for TRICARE network mental health providers. IVHSP maintains legislative-counsel-formatted statutory text and is prepared to assist Committee staff with drafting at any of the three vehicle stages.

### **Continuity and Measurement Reforms**

Beyond preemption, the working paper identifies operational and measurement reforms that warrant Congressional attention:

- Bridge-care reimbursement under 38 U.S.C. § 1703(d) for short-term continuation of established treatment relationships across geographic transitions.
- Network adequacy redesign requiring TPAs to demonstrate sufficient telehealth-capable, preemption-eligible provider capacity for high-need, low-supply regions and for cross-state mobility patterns generated by VISN architecture.
- Consult accountability requiring that consults be classified as resolved only when a first clinically viable appointment has been completed, with administrative closures tracked as a distinct outcome category.
- Revised access metrics capturing time-to-first-completed-session, forced provider-change rates, administrative dropout rates, and network adequacy failure at intake — outcomes invisible under the current 20-day standard.
- A National Mobility and Continuity Data Infrastructure built on the VA Corporate Data Warehouse, capable of correlating interstate movement with referral viability, continuity disruption, and clinical outcomes.

## VI. POSITION SUMMARY

*A national entitlement requires a national delivery system. Congress has twice extended the federal cross-state preemption mechanism to mental health providers serving military-connected populations. Veterans served through the VCCP pathway are now the only category still excluded. The remedy lies within the Secretary's existing authority. The fiscal cost is administrative. The legal questions have been answered by Congress's own enacted conduct. The only remaining question is whether the federal government will deliver, uniformly, the benefit it has already promised.*

### Key Statutory and Regulatory References

- 38 U.S.C. § 1730C — telemedicine licensure preemption (current text reflects P.L. 116-283, § 9101)
- 38 U.S.C. § 1703 / § 1703A — Veterans Community Care Program contracting authority
- 38 C.F.R. § 17.417 — VA implementing regulation (most recent amendment: 90 Fed. Reg. 47595, Oct. 2, 2025)
- Section 581, FY2024 NDAA — DoD-contracted mental health counselor portability (P.L. 118-31)
- Section 714, FY2025 NDAA — TRICARE network mental health provider portability (P.L. 118-159; codified at 10 U.S.C. § 1094(d)(4))
- 5 U.S.C. § 553(e) — petition-for-rulemaking authority
- 29 U.S.C. § 794 — Section 504 of the Rehabilitation Act
- *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024); *Motor Vehicle Manufacturers Ass'n v. State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29 (1983); *Massachusetts v. EPA*, 549 U.S. 497 (2007)

### Companion Materials

**Working paper** — *Crossing Lines: Jurisdictional Barriers, Therapeutic Disruption, and the Case for Federal Preemption in Veteran Mental Health Care* (Williams, IVHSP, May 2026). Available at <https://ivhsp.org/crossing-lines> and through SSRN at <https://ssrn.com/abstract=6744578>.

**Petition for Rulemaking** — *In the Matter of the Authority of Department of Veterans Affairs Health Care Professionals to Practice Health Care via Telehealth*, 38 C.F.R. § 17.417 (filed by IVHSP under 5 U.S.C. § 553(e) on May 13, 2026).

## **For Further Information**

The Institute for Veterans Health & Social Policy welcomes inquiries from Members and staff at any stage of consideration.

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