May 13, 2026

The Honorable Richard Blumenthal
Ranking Member
Committee on Veterans' Affairs
United States Senate
412 Russell Senate Office Building
Washington, DC 20510-6050

Re: Continuity of Care for Veterans Receiving Community-Based Mental Health Treatment; Targeted Statutory Amendment to 38 U.S.C. § 1730C and Companion Petition for Rulemaking

Dear Senator Blumenthal:

I write on behalf of the Institute for Veterans Health & Social Policy (IVHSP) to bring to your attention a continuity-of-care problem that affects a structurally identifiable subset of enrolled veterans receiving mental health treatment under the Veterans Community Care Program (VCCP), and to propose a targeted statutory amendment that addresses it without expanding the Department's reliance on community care or altering the conditions under which veterans become eligible for VCCP referral. The amendment functions only at the point at which a veteran has already been determined eligible for community care under existing law and a therapeutic relationship has already been established. It is a continuity fix for an enrolled population, not an eligibility expansion.

The problem. Once a veteran has been determined eligible for VCCP-funded mental health treatment and a therapeutic relationship has been established with a community provider, current regulation severs that relationship the moment the veteran crosses a State line. The community provider holds licensure in the State of treatment initiation; that license does not authorize practice while the veteran is in the new State. The relationship terminates without coordination or clinical handoff, and the veteran returns to the referral process to begin again. The disruption produces no clinical benefit and confers no fiscal saving. It is an artifact of a regulatory framework that treats community-based providers differently from Department-employed providers under a statute that does not require that distinction.

The asymmetry the amendment closes. Federal licensure preemption already exists for Department-employed clinicians under 38 U.S.C. § 1730C, as implemented by 38 C.F.R. § 17.417. A VA psychologist

may treat a veteran across State lines via telehealth; a VCCP-contracted clinician treating the same veteran for the same condition may not. A veteran enrolled in both VA care and TRICARE for Life — a substantial subpopulation of military retirees — may obtain cross-State tele-mental-health continuity from a TRICARE network provider but not from a VCCP network provider, because Congress enacted Section 714 of the FY 2025 NDAA establishing licensure portability for the TRICARE network while the VCCP network remains excluded. The amendment IVHSP requests would close the asymmetry by mirroring, for VCCP-contracted mental health providers serving enrolled veterans, the framework Congress has already enacted for the analogous TRICARE network.

What the amendment does not do. We recognize the legitimate concerns underlying recent proposals to ensure that VCCP operates as a supplement to, not a substitute for, VA direct care. The amendment we propose is consistent with that posture. It does not expand the population eligible for community care; it does not alter the conditions under which a veteran becomes eligible for community care under 38 U.S.C. § 1703; it does not authorize the Secretary to refer additional categories of veterans to VCCP; and it does not weaken the Department's ability to direct enrolled veterans toward direct care where direct care meets statutory access standards. The amendment operates only at the licensure-portability layer, and only for veterans the Department has already determined are entitled to community-based mental health care under existing law. It is, in that specific sense, a quality-of-care and continuity-of-care correction within the population the Department has already directed into the community-care pathway because it cannot meet the access standard internally.

Compact preservation. Interstate licensure compacts — the Psychology Interjurisdictional Compact (PSYPACT), the Counseling Compact, and the Social Work Licensure Compact — represent meaningful State-led progress on cross-jurisdictional behavioral health practice. The amendment we propose preserves the parallel and independent operation of these compacts. State licensure boards retain full authority over licensure issuance, disciplinary standards, scope-of-practice determinations, and continuing-education requirements. The federal preemption attaches only to the narrow question of whether a federally-contracted provider performing a federal program function for a federal beneficiary may continue treatment when the beneficiary is physically located across a State line. State authority over the underlying licensure relationship is unaffected. Section 714 of the FY 2025 NDAA established this preservation expressly, and the IVHSP framework adopts that structure verbatim.

Oversight and quality. The amendment is fully compatible with — and may strengthen — Department oversight of VCCP provider quality. The framework we propose conditions preemption on (a) a current State license, registration, or certification in at least one State; (b) practice under a contract or agreement entered into pursuant to 38 U.S.C. § 1703 or § 1703A; and (c) compliance with terms and conditions specified by the Secretary, which the Secretary may use to require continuing-education completion, suicide-prevention training, and other quality conditions consistent with the May 2025

GAO finding (GAO-25-106910) that only approximately two percent of community providers with behavioral health referrals had completed core Department clinical trainings. Far from weakening oversight, the amendment creates a federal hook for the Secretary to impose training and quality conditions on the entire preemption-eligible population, parallel to the framework Congress provided for TRICARE network providers.

Population most affected. The veterans for whom the continuity failure is most consequential share three characteristics: high mobility, elevated clinical risk, and reduced administrative capacity to navigate repeated referral failures. They include veterans in interstate transportation employment, veterans experiencing homelessness or housing instability, rural and border-region residents, caregivers traveling across State lines, recently separated service members in the highest-risk period for suicide, and dual-status National Guard members crossing State lines for drill obligations. These are populations the Department has identified as having elevated clinical vulnerability and limited alternatives to the federal pathway. A continuity fix at the licensure-portability layer benefits this population specifically and does not extend to populations for whom community care is not already available.

The request. We respectfully request that the Committee consider including a § 1730C amendment in any vehicle the Committee is moving in the current Congress that touches the VCCP statutory architecture. The technical amendment is narrow, fiscally neutral (federal preemption does not change reimbursement rates), and consistent with the Committee's stated priorities on community-care quality, oversight, and the integrity of the access standard. We are also prepared to support a standalone bill containing only this amendment, if the Committee determines that approach is preferable.

Relationship to the pending Petition. On May 13, 2026 — the date of this letter — IVHSP filed a Petition for Rulemaking with the Department of Veterans Affairs under 5 U.S.C. § 553(e), requesting that the Secretary amend 38 C.F.R. § 17.417 to extend the existing preemption framework to VCCP-contracted mental health providers under the Department's existing authority. We mention the petition for procedural transparency. The legislative path through statutory amendment of § 1730C is the more durable resolution; we offer the petition as evidence that IVHSP has approached the Department first and is engaging the policy question on multiple appropriate tracks. The Committee's consideration of the legislative amendment is independent of how the Department disposes of the petition.

We would welcome the opportunity to provide the Committee with the supporting analysis on which this request is based, including the IVHSP working paper Crossing Lines: Jurisdictional Barriers, Therapeutic Disruption, and the Case for Federal Preemption in Veteran Mental Health Care, released concurrently with this letter and available through the Social Science Research Network and at

www.ivhsp.org. We are prepared to assist Committee staff with drafting legislative text or technical analysis at the Committee's convenience.

Thank you for your attention to this matter, and for the Committee's continuing leadership on veterans' mental health care.

Respectfully submitted,

Matthew A. Williams, MPA
Founder & Chief Executive Officer
Institute for Veterans Health & Social Policy
100% Service-Disabled Veteran

Enclosures:

Petition for Rulemaking, 38 C.F.R. § 17.417, filed with the Department of Veterans Affairs (May 13, 2026)

IVHSP working paper, *Crossing Lines: Jurisdictional Barriers, Therapeutic Disruption, and the Case for Federal Preemption in Veteran Mental Health Care* (May 2026) available at https://ssrn.com/abstract=6744578.

Congressional Policy Brief, May 2026.

cc:

Members, Senate Committee on Veterans' Affairs
The Honorable Douglas A. Collins, Secretary of Veterans Affairs