INSTITUTE FOR
VETERANS HEALTH
& SOCIAL POLICY

May 13, 2026

The Honorable John Cornyn
United States Senate
517 Hart Senate Office Building
Washington, DC 20510

Re: Veterans Mental Health and Addiction Therapy Quality of Care Act (S. 702) — Recommended Companion Amendment to 38 U.S.C. § 1730C; Companion Action to Petition for Rulemaking Filed with the Department of Veterans Affairs

Dear Senator Cornyn:

I write on behalf of the Institute for Veterans Health & Social Policy (IVHSP) to bring to your attention a structural barrier within the Veterans Community Care Program (VCCP) mental health pathway that bears directly on the comparative-quality questions S. 702 — your committee-reported Veterans Mental Health and Addiction Therapy Quality of Care Act — directs the Department to study. The barrier is regulatory in form, narrow in scope, and amenable to remedy through a single statutory amendment that mirrors language Congress has already enacted, twice, for analogous federally-sponsored populations. We approach you as a potential secondary champion of this remedy, particularly if the primary vehicles (S. 275 / H.R. 740) move on a timeline that does not accommodate the amendment.

Why the amendment matters for the S. 702 analytic frame. S. 702 directs the Department to study and report on comparative quality between VA direct mental health care and non-VA (community-care) mental health care. Any such study will encounter, as a confounding variable, the structural fact that a substantial proportion of community-care mental health referrals fail to deliver completed treatment because of the cross-State licensure barrier preserved in 38 C.F.R. § 17.417. A community-care mental health provider, when the veteran crosses a State line, must terminate treatment — not for clinical or behavioral reasons, but because the provider's State license does not authorize practice while the veteran is in a different State. The treatment relationship terminates, the consult closes administratively, and the veteran returns to the referral process. Comparing the clinical outcomes of community-care treatment against direct VA treatment without controlling for this systemic continuity failure produces an artificially deflated picture of community-care quality. The amendment we propose corrects the underlying barrier; the resulting comparison is more analytically valid.

The structural barrier. Federal licensure preemption already exists for Department-employed clinicians under 38 U.S.C. § 1730C. A VA psychologist sitting in San Antonio can lawfully treat a Texas veteran traveling in Oklahoma, New Mexico, or Louisiana through telehealth without holding a license in those States. The same psychologist's VCCP-contracted counterpart cannot. The Department's implementing regulation excludes

contractors from the preemption framework Congress provided, producing a two-tiered system in which a veteran's access to cross-State continuity depends on whether the provider treating them is on the VA payroll or under a VCCP contract — a distinction the veteran does not choose and cannot control.

Texas geography. The architecture is concrete in the State you represent. Veterans Integrated Service Network 17 — the VA Heart of Texas Health Care Network — encompasses all of Texas. But VISN 16 (South Central) extends into Texas from Louisiana, Mississippi, and Arkansas, and the multi-State patterns the IVHSP working paper analyzes apply to Texas with particular force: long-haul trucking, oilfield mobility along the Texas-Louisiana corridor, multi-State seasonal and contract-work patterns, and substantial cross-border mobility between Texas and the Gulf Coast States. Veterans in interstate transportation employment — a population in which veterans are documented as overrepresented — are particularly affected.

Congress has enacted the remedy — twice. Section 581 of the FY 2024 NDAA (P.L. 118-31) extended cross-State licensure flexibility to Department of Defense-contracted mental health counselors. Section 714 of the FY 2025 NDAA (P.L. 118-159) added 10 U.S.C. § 1094(d)(4), extending licensure portability to mental health providers practicing through the civilian network of TRICARE. Both provisions passed with overwhelming bipartisan support. Both have been implemented without documented adverse outcomes. Veterans served through VCCP — many concurrently TRICARE-eligible — remain the only category of military-connected mental health care recipients excluded from the protection.

The technical amendment. Statutory language amending 38 U.S.C. § 1730C to expressly include VCCP-contracted mental health professionals within the definition of "covered health care professional," mirroring the structure Congress employed in Section 714 of the FY 2025 NDAA, would resolve the textual question that currently divides the two pathways. Federal preemption does not change reimbursement rates. Interstate licensure compacts continue to operate as a parallel and independent system. The amendment preserves State licensure authority over disciplinary action and standards.

The request. We respectfully request that you consider championing this amendment in any vehicle the Senate is moving in the current Congress that touches the VCCP statutory architecture — including S. 702 itself, which we recognize is narrower in scope but whose subject matter would be analytically improved by simultaneous correction of the licensure barrier. We are also prepared to support introduction of a standalone bill containing only this amendment, with you as a potential original cosponsor. We approach you as a secondary champion specifically because the IVHSP framework is consonant with the substantive concerns S. 702 addresses, and because the amendment fits within the Texas geography and the broader veteran-access policy framework on which you have led.

Relationship to other tracks. 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. IVHSP has also written this same date to Chairman Moran, Ranking Member Blumenthal, and the leadership of the House Veterans' Affairs Committee. The legislative and regulatory paths are independent; both are available. We

approach you in the legislative track as a potential additional champion alongside Chairman Moran, particularly if the primary committee vehicles encounter timing constraints that do not accommodate the amendment.

We would welcome the opportunity to discuss this amendment with your office or with Committee staff, and to provide the supporting analysis on which the 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 with drafting legislative text or technical analysis at your 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:

The Honorable Jerry Moran, Chairman, Senate Committee on Veterans' Affairs

The Honorable Douglas A. Collins, Secretary of Veterans Affairs