



May 13, 2026

The Honorable Jerry Moran
Chairman
Committee on Veterans' Affairs
United States Senate
412 Russell Senate Office Building
Washington, DC 20510-6050

Re: Veterans' ACCESS Act (S. 275) — Recommended Technical Amendment to Ensure the Mental Health Provisions Function for Mobile Veterans; Companion Action to Petition for Rulemaking Filed with the Department of Veterans Affairs

Dear Chairman Moran:

I write on behalf of the Institute for Veterans Health & Social Policy (IVHSP) to bring to your attention a narrow technical question concerning S. 275, the Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025 — your committee's reported bill on Veterans Community Care Program (VCCP) reform. The question concerns whether the bill's mental health and telehealth provisions can deliver care to a structurally identifiable subset of enrolled veterans for whom the current regulatory framework forecloses continuity. The remedy is a single statutory amendment that mirrors language Congress has already enacted, twice, for analogous federally-sponsored populations.

S. 275 codifies VCCP access standards in statute, addresses telehealth options under VCCP expressly, and establishes a community-care mental health pilot. These are substantial reforms that respond to documented gaps in the current dual-pathway architecture. They will not function as intended, however, for the population most in need of them — veterans whose lives involve interstate mobility — unless the underlying licensure framework is corrected to allow community-care mental health providers to follow those veterans across State lines.

The structural barrier. Federal licensure preemption already exists for Department-employed clinicians under 38 U.S.C. § 1730C, as implemented by 38 C.F.R. § 17.417 and most recently amended by final rule effective November 3, 2025. A VA psychologist sitting in Topeka can lawfully treat a Kansas veteran traveling in Missouri, Oklahoma, or Nebraska through telehealth without holding a license in

those States. The same psychologist's VCCP-contracted counterpart cannot. The Department's own 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.

Why this matters for S. 275. The bill's mental health pilot will encounter the licensure barrier on Day 1 of operation. A veteran who initiates a community-care mental health relationship under the bill's authority — and who then crosses a State line for any reason, including for VA-assigned specialty care at a facility located across that line — will see the relationship terminated, 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 bill's telehealth provisions cannot resolve this; telehealth modality does not change the licensure jurisdiction in which the provider is permitted to practice. Without a corresponding amendment to § 1730C, the bill will produce community-care referrals that close administratively without delivering completed treatment episodes, particularly in the populations the pilot is most clearly designed to reach.

VISN 15 and the Kansas geography. The architecture is concrete in the State you represent. Veterans Integrated Service Network 15 — the VA Heartland Network — spans Kansas, Missouri, and portions of southern Illinois and southern Indiana. Specialty care assignments routinely place Kansas-resident veterans at facilities in Missouri or Illinois as a function of VISN clinical organization, not voluntary mobility. A Kansas veteran enrolled at a Kansas community-based outpatient clinic and assigned to specialty care at the Kansas City or Marion VA Medical Centers (which sit in Missouri and Illinois respectively) faces the contractor exclusion's effect not because of any decision the veteran made, but because the Department's own program design has placed the specialty care across a State line. A community-care mental health provider licensed in Kansas cannot lawfully continue treatment while that veteran is at the assigned specialty facility. The mental health treatment becomes a casualty of other necessary medical care over which the veteran has no control. This is the agency-induced mobility pattern the IVHSP working paper analyzes in detail.

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 — reaching the full population entitled under 10 U.S.C. § 1076, including military retirees and their dependents and survivors. 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 structural and clinical case for extending it is at least as strong as the case Congress has already accepted for the analogous DoD populations.

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. The amendment requires no new appropriations: federal preemption does not change reimbursement rates, just as TRICARE rates apply regardless of where the provider practices. Interstate licensure compacts — PSYPACT, the Counseling Compact, the Social Work Licensure Compact — would continue to operate as a parallel and independent system. The amendment preserves State licensure authority over disciplinary action and standards; it preempts only the cross-State licensure barrier as applied to providers performing federal program functions for federal beneficiaries under a § 1703 or § 1703A contract. The IVHSP Petition for Rulemaking enclosed with this letter contains finished proposed regulatory text that may be adapted for legislative use, and IVHSP is prepared to assist Committee staff with drafting.

The request. We respectfully request that the Committee consider including this amendment in S. 275 — whether through reconciliation with H.R. 740 in conference, through a managers’ amendment at floor consideration, or through a substitute amendment in the nature of a substitute. The amendment is germane to the bill’s stated purpose, internally consistent with its mental health and telehealth provisions, and necessary to ensure those provisions can deliver care to mobile veterans. We are also prepared to support introduction of a standalone bill containing only the § 1730C 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. The regulatory and legislative paths are independent; both are available; either is sufficient. The legislative path through S. 275 is the more durable resolution and avoids interpretive ambiguities that may complicate the regulatory path. Petitioner asks the Committee to consider the legislative amendment on its merits, regardless 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