



May 13, 2026

The Honorable Mark Takano
Ranking Member
Committee on Veterans' Affairs
U.S. House of Representatives
B234 Longworth House Office Building
Washington, DC 20515

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

Dear Ranking Member Takano:

I write on behalf of the Institute for Veterans Health & Social Policy (IVHSP) to bring to your attention an oversight and accountability question concerning the Veterans Community Care Program (VCCP), and to propose a targeted statutory amendment that addresses one specific structural failure within the program's mental health pathway. The amendment is consonant with the oversight concerns you have publicly raised about VCCP performance and the proportion of veteran care delivered through community providers; it is not a privatization or expansion measure, and it does not authorize the Department to refer additional categories of veterans to community care. It is, in technical terms, a continuity-of-care correction operating within a population the Department has already directed into the community-care pathway because it could not meet the access standard internally.

The accountability concern at issue. The Committee has consistently raised, in oversight hearings and in dialogue with the Department, the question of whether community-care spending is producing measurable clinical benefit proportional to its scale. The mental health portion of that spending is structurally compromised by a regulatory provision that ensures a substantial share of community-care mental health referrals will fail to deliver completed treatment. Under 38 C.F.R. § 17.417, VCCP-contracted mental health providers are excluded from the federal licensure preemption framework that Department-employed clinicians enjoy. When a veteran in active community-care mental health treatment crosses a State line, the community provider is legally barred from continuing care. The treatment relationship terminates without coordination, the consult closes administratively, and the veteran returns to the referral queue. Department spending occurred; clinical engagement is partial;

therapeutic continuity is lost. This is exactly the inefficient expenditure pattern oversight is designed to surface.

Why this is an accountability frame, not an expansion frame. The amendment we propose 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; 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. Its effect is to ensure that the dollars the Department has already spent on these referrals produce completed treatment episodes rather than administrative closures. By making cross-State continuity actually work for the population for whom community care has already been opened, the amendment reduces administrative dropout, repeat referral cycles, and crisis-pathway escalations that currently come out of community-care spending without producing clinical benefit.

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. 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. This is, in effect, a federal program in which two adjacent components apply opposite rules to the same person’s mental health care.

Oversight findings already on the record. Independent oversight findings establish the structural pattern. The Department’s Office of Inspector General reported in April 2024 that the Department’s Office of Integrated Veteran Care did not hold Third-Party Administrators accountable for implementing network adequacy contract requirements. The Government Accountability Office reported in May 2025 (GAO-25-106910) that only approximately two percent of community providers with behavioral health referrals had completed core Department clinical trainings, and the Department was not monitoring completion. GAO further reported in July 2024 (GAO-24-106189) that the Department of Defense’s inTransition program failed to successfully connect with more than seventy percent of eligible separating service members during the highest-risk period for suicide. These findings are independent of one another, but together they describe a community-care behavioral-health architecture in which veterans the Department directs to community care frequently encounter compounding structural barriers — of which the cross-State licensure barrier addressed by this amendment is one.

Quality and oversight strengthening. 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. 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. The amendment is fully compatible with — and may strengthen — the kinds of accountability mechanisms the Committee has been pressing the Department to implement.

Compact preservation. Interstate licensure compacts — PSYPACT, the Counseling Compact, the Social Work Licensure Compact — represent meaningful State-led progress on cross-jurisdictional behavioral health practice. The amendment preserves their parallel and independent operation. 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. Section 714 of the FY 2025 NDAA established this preservation expressly, and the IVHSP framework adopts that structure verbatim.

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 — including H.R. 740, currently in conference posture with S. 275. 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 introduction of a standalone bill containing only this amendment.

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, House Committee on Veterans' Affairs

The Honorable Mariannette Miller-Meeks, Chair, Subcommittee on Health

The Honorable Douglas A. Collins, Secretary of Veterans Affairs