Crossing Lines: Jurisdictional Barriers, Therapeutic Disruption, and the Case for Federal Preemption in Veteran Mental Health Care

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Author Disclosure

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this manuscript; (2) the author is a 100% service-disabled veteran enrolled in Department of Veterans Affairs health care, with documented direct experience as a beneficiary of the delivery system analyzed herein, including documented encounters with the failure mechanisms described, such as inability to access continuous community care due to interstate licensure constraints and an extended wait for VA direct care following exhaustion of Veterans Community Care Program (VCCP) options — experiences documented in the VA's own administrative record; and (3) the structural analysis presented in this manuscript is informed in part by that direct personal experience, as well as by the broader policy research conducted by IVHSP. The author's position is that the reforms advocated benefit enrolled veterans as a class and confer no financial or professional advantage on the author or on Purchinex, LLC; the procurement category in which Purchinex contracts with the Department is not affected by the reforms this manuscript proposes. These relationships are disclosed not as the basis for the arguments advanced — the analytical and policy case stands independently — but so that readers may assess them as part of the complete record. IVHSP is an independent policy research organization and received no external funding for this project. Correspondence: Matthew A. Williams, Institute for Veterans Health & Social Policy, 1001 East Railroad Street, Ochlocknee, GA 31773; research@ivhsp.org.

Crossing Lines: Jurisdictional Barriers, Therapeutic Disruption, and the Case for Federal Preemption in Veteran Mental Health Care

The Veterans Health Administration (VHA) is the nation's largest integrated healthcare system and the primary provider of mental health services for millions of veterans. As of 2026, approximately 9.1 million veterans are enrolled in VHA care, representing roughly half of the 18

million living veterans in the United States (U.S. Department of Veterans Affairs, 2024). Federal statute guarantees these veterans access to timely, high-quality mental health services, and the VA MISSION Act of 2018 (Pub. L. 115-182) established the Veterans Community Care Program (VCCP) as a permanent mechanism to ensure that access when VA facilities cannot meet designated standards. For mental health care, the statutory threshold is explicit: if a VA facility cannot provide an appointment within 20 days, the veteran becomes eligible for community-based care. This paper employs a policy analysis framework drawing on statutory and regulatory analysis, GAO and OIG oversight findings, peer-reviewed clinical literature, and direct observation of the described system interactions to identify structural failure modes within VA's community care delivery architecture and to propose targeted reforms grounded in existing statutory authority.

In practice, however, the dual-pathway system—direct VA care supplemented by VCCP referrals—fails to deliver continuous, clinically viable mental health treatment for a structurally predictable subset of veterans: those whose lives involve routine interstate mobility, housing instability, or geographically complex employment patterns. These veterans encounter a system designed around assumptions of residential stability, local capacity, and state-bounded licensure regimes that do not reflect the realities of modern veteran life. The result is a recurring pattern of access breakdowns, referral failures, and treatment interruptions that undermine clinical safety and erode trust in the federal system.

The structural incompatibility between a national entitlement and a geographically anchored delivery system is the central concern of this paper. It draws on federal policy, VA performance data, Government Accountability Office (GAO) oversight reports, peer-reviewed clinical literature, and composite vignettes derived from direct observation to analyze how

capacity shortfalls, interstate licensure constraints, and administrative delays converge to create what this paper terms the "dual-pathway failure loop"—a self-reinforcing cycle in which veterans attempt to access care through VA direct services, are redirected to VCCP when VA capacity is unavailable, encounter licensure or referral barriers in VCCP, and cycle back without ever successfully initiating or sustaining treatment, sometimes for months at a time. The loop is not incidental; it is the predictable output of a system whose operational architecture was designed for a stationary population. The structural mechanisms that produce this loop, and the two distinct failure modes through which it operates, are examined in detail in the following section; composite vignettes illustrating both modes in practice are presented there as well.

Mental health care is uniquely vulnerable to these disruptions. The therapeutic alliance—defined by agreement on goals, collaboration on tasks, and a sense of emotional trust—is one of the strongest predictors of treatment outcomes across modalities and populations (Flückiger et al., 2018; Wampold & Imel, 2015). When jurisdictional mismatches or referral delays force provider changes, veterans must repeatedly rebuild rapport, retell traumatic histories, and reestablish safety—a process that increases dropout risk and clinical vulnerability and that the analysis treats as a distinct category of system-induced harm. Evidence-based trauma-focused treatments including Cognitive Processing Therapy (CPT; Resick et al., 2017) and Prolonged Exposure (PE; Foa et al., 2019) require progressive engagement with distressing material within a stable therapeutic relationship; forced provider changes reset this process at measurable clinical cost.

The geographic architecture of the delivery system applies a facially uniform statutory entitlement unequally in practice. Congress enacted a uniform national benefit: every enrolled veteran holds the same statutory right to timely mental health care regardless of where they

reside. The delivery system provides functionally superior access to veterans who remain geographically stationary while imposing a disproportionate burden of administrative failure on veterans whose lives require mobility — a population that disproportionately includes working-class veterans, rural residents, transportation workers, and veterans experiencing homelessness. The government's obligation is to deliver the benefit it has already promised, uniformly, to the population entitled to receive it. When the delivery mechanism systematically advantages some beneficiaries over others based on residential stability — a characteristic the statute does not recognize as a basis for differential treatment — that obligation is not being met.

These failures carry significant consequences. In 2023, 6,398 veterans died by suicide, and veterans with recent mental health or substance use diagnoses experienced suicide rates far exceeding those of the general population (U.S. Department of Veterans Affairs, 2023). The specific contribution of mobility-related care disruption to this toll has not been empirically quantified in published literature; that causal relationship is advanced here as a hypothesis warranting systematic investigation rather than as an established finding. What is established is the structural sequence: a delivery system that cannot maintain therapeutic continuity across jurisdictional boundaries for a mobile population, and a population with elevated suicide risk concentrated in groups—transportation workers, veterans experiencing homelessness, recently separated service members—for whom geographic mobility is a defining feature of life.

A final dimension of this analysis warrants explicit framing. When systems fail to maintain continuity, the burden of managing that failure does not disappear—it shifts. In the absence of structural coordination, the veteran becomes the de facto care coordinator: tracking referrals across agencies, renegotiating authorizations, managing documentation handoffs, and re-initiating contact with new providers each time the system fails to sustain the prior

relationship. This coordination burden is not a designed feature; it is an artifact of a delivery system built without a designated coordination function. A viable federal response must therefore move on two tracks simultaneously: eliminating the fragmentation that generates navigation burden through structural reform and, pending those reforms, introducing a dedicated navigation infrastructure capable of performing the coordination function that the system currently offloads to veterans themselves.

The Structural Problem: A National Entitlement on a Geographically Anchored Chassis

Three purposes organize this manuscript: identifying and analyzing the structural mechanisms that produce mobility-related access failures within VA and VCCP pathways; demonstrating why these failures are not anomalies but the predictable outputs of design choices that can and should be changed; and advancing a targeted, fiscally responsible reform agenda grounded in existing statutory authority.

The Veterans Health Administration operates under a clear federal mandate: eligible veterans are entitled to timely, high-quality mental health care regardless of where they reside or travel within the United States. This entitlement is national in scope, uniform in its statutory guarantees, and grounded in federal authority. Yet the delivery system responsible for fulfilling that entitlement remains anchored to state boundaries, local capacity constraints, and administrative processes that assume residential stability. The structural mismatch between a national promise and a geographically bounded operational model generates predictable access failures for veterans whose lives do not conform to fixed-location assumptions.

A National Entitlement on a Local Infrastructure

The VA MISSION Act of 2018 codified a dual-pathway system: direct VA services supplemented by the Veterans Community Care Program when VA cannot meet access

standards. In practice, the system relies on a geographically distributed network of facilities and providers whose capacity, licensure, and availability vary widely across states and regions. VA enrollment is tied to specific facilities, scheduling is based on local clinic capacity, referrals are routed through regional Veterans Integrated Service Networks (VISNs), and community care providers are constrained by state licensure laws. These design features reflect mid-20th-century assumptions about residential stability that no longer align with the lived realities of a substantial portion of the enrolled veteran population.

A Veteran Population Defined by Mobility

Modern veteran life is characterized by significant mobility. Approximately one-third of VHA-enrolled veterans live in rural or highly rural areas, where travel to VA facilities often exceeds 60 miles one way (National Academies of Sciences, Engineering, and Medicine, 2023). The 2024 Point-in-Time count identified 32,882 veterans experiencing homelessness on a single night, with many more in transitional housing (U.S. Department of Housing and Urban Development & U.S. Department of Veterans Affairs, 2024). Veterans are overrepresented in transportation occupations; American Community Survey data indicate they constitute a substantial share of the truck-driving workforce—a figure frequently cited at approximately 10%, though this should be treated as an order-of-magnitude estimate rather than a precise data product, as the Bureau of Labor Statistics does not publish veteran status by occupation as a primary series (U.S. Bureau of Labor Statistics, n.d.; U.S. Census Bureau, n.d.). Other veterans relocate for caregiving, education, or seasonal employment; border-region veterans regularly cross state lines for services; and the Department of Defense estimates approximately 200,000 service members transition from active duty to civilian life annually (U.S. Department of Defense, 2023), making post-separation geographic transition the norm. The mental health

transition infrastructure designed to bridge this gap is itself fragile: a 2024 GAO review of DoD and VA transition mental health programs found that DoD's inTransition program — DoD's primary mechanism for facilitating mental health continuity for separating service members — failed to successfully connect with more than 70 percent of eligible transitioning service members identified in 2022, and that VA programs struggled to reach younger veterans and those in rural areas during the critical transition period (U.S. Government Accountability Office, 2024b). VA operational systems treat mobility as an exception requiring special coordination rather than a baseline condition requiring structural accommodation. This framing error is itself a policy failure.

While the failure loop cannot be directly quantified in published data—because VA's measurement architecture does not track the failure modes this paper identifies—the scale of the affected population can be approximated through available proxies. The 32,882 veterans identified in the 2024 PIT count as experiencing homelessness represent a population for whom address stability—the jurisdictional anchor the VCCP referral system requires—is structurally unavailable. The Department of Defense estimates that approximately 200,000 service members transition from active duty to civilian life annually, each entering the highest-risk period for suicide during a geographic transition that DoD's inTransition program fails to successfully connect with more than 70 percent of automatically enrolled separating service members (U.S. Government Accountability Office, 2024b). Veterans in transportation and logistics occupations—estimated at roughly 10 percent of the national truck-driving workforce based on American Community Survey data—face occupational mobility patterns structurally incompatible with the fixed-jurisdiction referral model. Rural veterans, approximately one-third of the enrolled population, often live closer to out-of-state facilities than in-state ones and face

border-region access failures invisible to a network adequacy framework built around enrolled facility catchment areas. These indicators do not measure the failure loop directly; they establish that the population for which the loop is structurally predictable is large, identifiable, and disproportionately concentrated among veterans with the highest clinical risk.

Geographic Anchoring as a Source of Systemic Failure

Geographic anchoring produces predictable failure modes: capacity mismatches trigger VCCP referrals while community providers in the same region are simultaneously at capacity; jurisdictional constraints block telehealth across state lines; administrative delays lag behind veterans' movements; and forced provider transitions reset clinical progress (National Academies of Sciences, Engineering, and Medicine, 2023). These failure modes interact within the dual-pathway failure loop: VA capacity shortfalls redirect veterans to VCCP; VCCP referrals stall or become jurisdictionally invalid when veterans move; veterans cycle back to VA or restart the VCCP process; the interval without care lengthens. The loop continues until the veteran abandons the process—administrative dropout—or experiences a crisis severe enough to trigger emergency intervention; both outcomes are available to both failure modes, as Figure 1 illustrates. Two distinct failure modes operate within this general architecture, each with different mechanisms and different implications for reform. Successful establishment of care does not permanently exit the loop. A veteran who establishes care following relocation remains subject to re-entry at the next geographic transition, making the loop recursive rather than episodic for veterans whose lives involve repeated mobility.

Two Failure Modes: Relocation and Continuous Mobility

The relocation failure mode describes the disruption of an established therapeutic relationship by a permanent or semi-permanent geographic transition. The veteran has an active

VCCP provider; that provider loses jurisdictional authority when the veteran moves; the relationship terminates without coordination or clinical handoff. Clinical progress is lost and intake restarts from the beginning. The system can, in principle, establish a new provider relationship in the new jurisdiction—however painful and clinically costly the disruption.

The continuous mobility failure mode is categorically distinct and more severe. It describes the condition of a veteran whose location is not transitioning between stable states but is continuously and unpredictably variable: the long-haul trucker running a multi-state circuit on a regular rotation; the veteran cycling through shelter networks across multiple states; the full-time RV traveler without a fixed domicile; the seasonal worker following employment across state lines; the consultant or contractor whose project work places them in different states on a rolling basis; the National Guard member whose drill obligations cross state lines; the caregiver providing intermittent support to a family member in another state. The VCCP referral architecture requires a fixed jurisdiction as an input: the TPA must match the veteran to a provider licensed in the veteran's current state, a process taking days to over a week. For continuously mobile veterans, the location used as the jurisdictional input at referral initiation may no longer apply by the time the referral is processed. There is no jurisdictional footing to establish, because stable residency is not a feature of the veteran's life during the relevant period. The loop's implicit exit condition is unavailable not temporarily but as a structural feature of the veteran's circumstances: the system requires a stable provider relationship in a fixed jurisdiction that the veteran cannot supply.

There is a further analytical consequence. The clinical analysis of non-fungibility and anticipatory non-disclosure is built on the premise that a therapeutic relationship exists and is disrupted. For continuously mobile veterans, that premise may not hold. The more fundamental

problem is that the system cannot establish a legally viable provider relationship in the first place—the therapeutic alliance never forms because the jurisdictional preconditions for initiating treatment are never met. This paper introduces anticipatory disengagement as a distinct and earlier-stage construct: the rational decision not to invest in a care-seeking process that prior experience or direct knowledge indicates cannot be completed. Anticipatory disengagement is prior to and distinct from anticipatory non-disclosure, which occurs within an established relationship.

Composite Vignettes: Both Failure Modes in Practice

The two vignettes below illustrate both failure modes through accounts derived from direct observation of the described system interactions, with all identifying details removed or generalized. The institutional facts—VCCP network coverage limitations, jurisdictional barriers to multistate practice, absence of administrative escalation pathways—are verifiable features of the delivery system.

Vignette 1 — Relocation failure mode. A veteran has been engaged in VCCP-funded trauma-focused therapy for four months. The therapeutic alliance is established, treatment is progressing, and the telehealth scheduling arrangement is workable for both parties. The veteran accepts a position with an employer in another state and relocates. There is no clinical reason to end the therapeutic relationship—the therapy is working, the trust is built, and telehealth makes geography logistically irrelevant. The only reason the relationship must end is that the veteran's therapist holds a license in the original state and not in the new one. There is no bridge authorization, no warm handoff protocol, no system-initiated transition support. The veteran is returned to the referral queue—not at the front (having already demonstrated eligibility and navigated a completed referral cycle) but at the back, treated administratively as a new applicant.

The wait for a new intake appointment extends to several months. The clinical progress of the prior four months does not transfer. The therapeutic work begins again from the beginning, not because anything clinical failed, but because a regulatory boundary that was never designed for this context was permitted to destroy a functioning clinical relationship.

Vignette 2 — Continuous mobility failure mode. A veteran with a complex multi-state travel pattern initiates a VCCP referral for mental health care. During scheduling, the veteran discloses an itinerary spanning several states over an extended period, including regular crossings of a state line separating the veteran's nearest clinical facilities from the veteran's nominal home location. The TPA scheduling coordinator attempts to identify a network provider holding licensure sufficient to cover the veteran's anticipated jurisdictions. The network cannot produce a provider licensed in the relevant state combination. The only resolution available to the scheduler is to return the veteran to VA direct care. The VCCP referral is closed before a single appointment is scheduled. The veteran is returned to the VA direct care queue, indistinguishable in administrative terms from a veteran initiating contact for the first time despite having already established eligibility and completed intake screening. The interval between that queue re-entry and a completed VA intake appointment may extend to weeks or months. No care is delivered in that interval. The system's record reflects a concluded referral process. The veteran's experience is an unbroken gap in access.

Three features of Vignette 2 warrant analytical attention. First, the network inadequacy surfaced at intake only because the veteran proactively disclosed a multi-state itinerary and knew to anticipate the jurisdictional implications—the system has no protocol for proactively assessing network adequacy against anticipated mobility at the point of referral. Veterans without prior experience of system failure would not know to raise this question; the inadequacy would remain

hidden until a mid-treatment jurisdictional failure, at which point a therapeutic relationship would have formed and would terminate without coordination. The clinical consequences of such uncoordinated terminations—what the therapeutic rupture literature terms unplanned endings (Safran & Muran, 2000; Swift & Greenberg, 2012)—are categorically more severe than those of a managed transition. This paper terms this the care network adequacy knowledge gap: the harm falls most severely on veterans encountering the system for the first time, who are least positioned to surface the gap before a clinical relationship has been established and lost. Second, the scheduler's only available resolution was referral back to VA—no bridge authorization, no escalation pathway, no partial-coverage option. The consult closed from the system's administrative perspective while representing a complete failure of access. Third, the veteran's knowledge of the jurisdictional barrier was itself a product of prior system failure: an earlier therapeutic relationship had ended abruptly when a provider was required to cease treatment upon learning of the veteran's relocation—the relocation failure mode in its most uncoordinated form. The care network adequacy knowledge gap is partially self-correcting through repeated system failure: veterans acquire the knowledge to protect themselves from one failure mode by having already been harmed by another. The system has externalized its own diagnostic function onto the population it is supposed to serve.

The Traveling Veteran Program: Helpful but Insufficient

The VA's Traveling Veteran Program facilitates temporary care coordination across VA facilities. Its limitations are structural: it assumes spare VA direct-care capacity exists, does not address interstate licensure barriers for community care, and cannot preserve continuity with VCCP providers when jurisdictional rules render those providers legally inaccessible. It

functions within one lane of the dual-pathway system and cannot remedy failures that originate in the other.

Uniform Entitlement, Unequal Application

Congress enacted a uniform national benefit. Every enrolled veteran holds the same statutory right to timely mental health care. The delivery system implements that entitlement unequally: veterans who remain geographically stable receive functionally superior access to the same benefit that mobile veterans receive in degraded form. This is accurately characterized as a statutory implementation failure with constitutional overtones. Congress enacted a uniform benefit; the administrative architecture fails to implement it uniformly; that is a statutory problem that raises questions about the government's obligation to deliver an enacted entitlement consistently across the population to which it applies. Whether residential stability constitutes an impermissible classification basis under the Fifth Amendment involves legal questions that exceed the scope of this analysis. What is not a legal question is this: in two consecutive NDAAs, Congress extended cross-state licensure flexibility for mental health providers to servicemembers and their families — the same population, under a different delivery pathway, facing the same geographic mobility problem. The government's obligation is clear in statutory terms: deliver what it has already promised, uniformly, to the full population entitled to receive it. Veterans assigned to the VCCP pathway through no choice of their own deserve the same protection Congress has already provided to beneficiaries served through other pathways in the same system.

Interstate Licensure Constraints and Jurisdictional Mismatch

Interstate licensure constraints are the primary regulatory mechanism through which mobility produces care disruption. The Veterans Community Care Program operates through

community providers who remain bound by state licensure laws: a federal entitlement delivered through a network of clinicians whose legal authority to practice is determined not by federal statute but by the laws of 50 states, the District of Columbia, and U.S. territories (Center for Connected Health Policy, n.d.; U.S. Department of Health and Human Services, n.d.). For veterans whose lives involve routine interstate mobility, this mismatch between the national scope of the entitlement and the state-bounded scope of provider authority is the single most consequential structural barrier to continuity of care.

VCCP Vendor Mechanics and the Jurisdictional Gap

The Veterans Community Care Program operates through third-party administrators (TPAs) — currently Optum Serve and TriWest Healthcare Alliance — who manage provider networks, process referrals, credential providers, and report network adequacy to VA. This intermediary structure introduces processing latency that is consequential for mobile veterans: a consult initiated by a VA facility must be transmitted to the TPA, routed to a network provider, and confirmed before scheduling can begin, commonly adding days to over a week before provider availability or licensure is even assessed. For veterans whose location is changing during this interval, the referral may become jurisdictionally invalid before it is acted upon. Network adequacy standards — which assess provider availability within geographic radii — are designed around residential stability and do not account for veterans with variable or multistate locations. When a referred provider lacks licensure in the veteran's current state, the TPA must restart the processing cycle, extending the gap in care. Community care referrals are managed through the HealthShare Referral Manager (HSRM), transmitted to providers listed in the VA Provider Profile Management System (PPMS). Neither system performs an automated cross-check of provider licensure state against veteran location state at the point of referral

transmission — a gap that renders licensure mismatches invisible until they surface operationally, often after a referral has already been transmitted and acted upon. As of 2026, approximately 164 of 170 VA medical facilities operate on VistA/CPRS; Oracle Health has been deployed at six facilities with broader rollout planned for 2026. The process descriptions in this paper apply to the CPRS environment in which the overwhelming majority of VCCP referrals originate and will continue to originate for the foreseeable future.

Accountability is structurally diffused. When a consult fails because a provider lacks out-of-state licensure, it may be classified as a provider-level issue by the TPA, a network adequacy issue by VA oversight, or a veteran-related complication by the referring facility. No single entity holds continuous accountability for a veteran's care across referral boundaries — the architecture distributes responsibility in ways that allow each actor to attribute failure to another. Under 38 U.S.C. § 1730C, VA-employed clinicians may deliver telehealth services across state lines regardless of the veteran's location — federal preemption enacted in 2018 and implemented by final rule published October 2, 2025 (90 Fed. Reg. 47595) (38 C.F.R. § 17.417). Given the rule's recent effective date, the absence of documented adverse events should be treated as a preliminary indication rather than a confirmed safety record. This preemption does not extend to VCCP providers, who must hold an active license in the state where the veteran is physically located. A veteran who crosses a state line becomes legally inaccessible to their established VCCP provider even if the provider is clinically appropriate, available, and willing to continue treatment. The result is a two-tiered system: VA-employed clinicians can follow veterans across state lines; VCCP clinicians cannot — a distinction that falls most heavily on veterans who rely on VCCP precisely because VA direct care is unavailable.

Agency-Induced Mobility: Cross-State Scenarios Within VISN Architecture

The cross-State licensure constraint the contractor exclusion preserves operates not only against voluntary veteran mobility but against a category of cross-State mobility that the Department itself generates through its own administrative architecture. The Department's Veterans Integrated Service Network structure organizes the delivery of veteran health care into eighteen regional networks, the substantial majority of which span multiple States. Several VISNs encompass as many as ten States within a single network. Specialty care services are concentrated at specific facilities within each VISN, and Department clinical assignment practices routinely refer enrolled veterans to those facilities for treatment that is not available at the veteran's enrollment site. The referral is a function of VISN clinical organization, not of veteran residence-State boundaries. The VISN architecture is a feature of Department program design; it is not a feature of veteran life circumstance.

The structural scope of this phenomenon is significant. With sixteen of eighteen VISNs spanning multiple States, and several VISNs covering eight or ten States (U.S. Department of Veterans Affairs, n.d.-d), the number of plausible directed scenarios in which a veteran's State of residence differs from the State of a Department-assigned treatment facility runs into the hundreds. Each such scenario represents a category of veterans for whom Department specialty care assignment may produce cross-State mobility without any voluntary decision on the veteran's part. Representative multi-State VISNs include VISN 16 (South Central), spanning Alabama, Arkansas, Florida, Louisiana, Mississippi, Missouri, Oklahoma, and Texas; VISN 19 (Rocky Mountain), spanning Colorado, Montana, Utah, Wyoming, and portions of Idaho, Kansas, Nebraska, Nevada, and Texas; and VISN 23 (Midwest), spanning Iowa, Minnesota, Nebraska, North Dakota, and South Dakota, with portions of Illinois, Kansas, Missouri, Wisconsin, and Wyoming.

VISN 8, the VA Sunshine Healthcare Network, illustrates the pattern with particular clarity. The network encompasses Florida, southern Georgia, Puerto Rico, and the U.S. Virgin Islands (U.S. Department of Veterans Affairs, n.d.-e). The North Florida/South Georgia Veterans Health System operates Community-Based Outpatient Clinics in southern Georgia — including Valdosta, St. Marys, and Waycross — alongside full medical centers in northern Florida, including the Malcom Randall VA Medical Center in Gainesville. A southern-Georgia-resident veteran enrolled at one of the Georgia CBOCs may be assigned in the ordinary course of clinical operations to receive specialty care at Gainesville. The veteran does not choose this assignment; it is a function of VISN clinical architecture established prior to the veteran's enrollment and independent of State boundaries. The assignment occurs before any mobility decision is made, and the mobility it produces is a product of Department program design rather than veteran choice. This pattern is replicable across multi-State VISNs nationwide — in VISN 7, southern Georgia and South Carolina veterans are routinely referred to the Charleston or Augusta VAMCs; in VISN 9, northern Mississippi veterans may be referred to the Memphis VAMC; in VISN 20, veterans in northwestern Montana receive services from the Spokane VAMC — and it is structural to a delivery system whose VISN architecture does not account for the cross-State licensure constraint the contractor exclusion preserves.

The implication for veterans receiving VCCP-funded mental health care is direct. A Georgia-resident veteran assigned to a VCCP telehealth mental health provider licensed in Georgia, who is then required to travel to the Gainesville VAMC for specialty medical care assigned within the VISN's normal operations, encounters the contractor exclusion's effect not because of any voluntary mobility decision but because the Department's own administrative architecture has placed the specialty care in a different State. The provider's Georgia licensure

does not authorize practice while the veteran is in Florida. The mental health treatment becomes a casualty of other necessary medical care over which the veteran has no control. The Department's own program design creates the conditions that the contractor exclusion then exploits to terminate continuity of care. This is not incidental to the regulatory analysis; it is the fact pattern that gives the disability accommodation analysis examined in the following section its most concentrated doctrinal force.

The Interstate Licensure Compact Landscape

Interstate licensure compacts — PSYPACT for psychologists, the Counseling Compact for licensed professional counselors, the Social Work Licensure Compact — permit cross-jurisdictional practice within member states and represent meaningful progress. They are insufficient as a complete solution for four reasons: compact membership is not universal across all states; compacts do not cover all mental health disciplines; VCCP network providers participate voluntarily and unevenly, with compact status often untracked in TPA credentialing databases; and compacts offer no remedy in non-member states. The TRICARE-mirror framework proposed in Recommendation 1 addresses all four limitations without imposing conditions beyond those Congress enacted for TRICARE: federal preemption extends to all VCCP-contracted mental health providers operating under the federal contract, with compacts continuing to operate as a parallel and independent system. Near-term, VA should require VCCP network contractors to verify and document compact participation for all mental health providers and prioritize compact-eligible providers in referral matching, consistent with the parallel operation of the compact system alongside the extended preemption.

Interstate licensure compacts and the federal regulatory pathway operate independently of one another. Regulatory amendment of 38 C.F.R. § 17.417 does not require compact

infrastructure and does not depend on compact membership in any state. Compacts continue to govern cross-jurisdictional practice independently of whether § 17.417 is amended. The rulemaking request proposed in this paper expressly preserves the independent operation of interstate licensure compacts alongside the extended regulatory preemption, consistent with the framework Congress adopted in Section 714 of the FY2025 NDAA, which preserved state compact authority alongside the federal portability provision it enacted for TRICARE network providers.

Legal Authority for Extension of Preemption

Three tracks exist for achieving federal licensure preemption for VCCP mental health providers, and all three are activated simultaneously by the filing of a petition for rulemaking under 5 U.S.C. § 553(e). The first track is regulatory: the Department amends 38 C.F.R. § 17.417 through notice-and-comment rulemaking. The second track is legislative: Congress amends 38 U.S.C. § 1730C to add an express VCCP provider category. The third track is judicial: a petition denial that fails to engage with the NDAA enacted record, the DoD/VA interpretive divergence, and the Section 504 framework is reviewable as arbitrary and capricious under Motor Vehicle Manufacturers Ass'n v. State Farm Mutual Automobile Insurance Co., 463 U.S. 29 (1983), without requiring resolution of the underlying statutory construction question. These tracks are not mutually exclusive and not strictly sequential. The Secretary's response to the petition — rulemaking, congressional referral, or denial — determines which track becomes primary. The most powerful predicate for any of the three tracks is not found in constitutional doctrine — it is found in Congress's own enacted conduct, which has twice extended the identical mechanism to adjacent military-connected populations.

The Regulatory Pathway: Amending 38 C.F.R. § 17.417. Section 1730C of title 38, United States Code, enacted as section 151 of the MISSION Act of 2018, authorizes a "covered health care professional" to practice across state lines via telemedicine notwithstanding state licensure restrictions. Section 1730C(b)(1) as currently in force — following a structural reorganization by Pub. L. 116-283, § 9101 (Jan. 1, 2021) that added specific provisions for postgraduate employees and health professions trainees — defines a covered health care professional as one who: (A) is an employee of the Department appointed under section 7306, 7401, 7405, 7406, or 7408 of this title or under title 5; (B) is authorized by the Secretary to provide health care under this chapter; (C) is required to adhere to all standards for quality relating to the provision of health care in accordance with applicable policies of the Department; and (D) holds an active, current, full, and unrestricted license, registration, or certification in a State. The phrase "contractor of the Department," which appeared in the original 2018 enacted text of § 1730C, was not carried forward in the 2021 restructuring. The 2021 amendment's evident purpose was to add new categories for trainees and postgraduate employees, not to narrow contractor coverage — there is no committee report language indicating any intent to foreclose the Secretary's authority to reach contractors through the authorization-based framework of (b)(1)(B). Nonetheless, the absence of the explicit "contractor" enumeration means the textual argument for contractor inclusion must now be routed through the current statutory text rather than through the 2018 formulation. The Department's implementing regulation at 38 C.F.R. § 17.417, originally promulgated by final rule published May 11, 2018 (83 Fed. Reg. 21897, effective June 11, 2018) and most recently revised by final rule published October 2, 2025 (90 Fed. Reg. 47595, effective November 3, 2025), narrowed the statutory definition by excluding VA-contracted health care professionals from coverage. The exclusion operates

through two regulatory mechanisms. First, the preemption paragraph at § 17.417(c) limits preemption to providers "practicing telehealth within the scope of their VA employment" — a phrase that VCCP contractors, who practice under commercial contracts rather than federal employment, cannot satisfy. Second, the definition of "health care professional" at § 17.417(a)(2) requires appointment to a VHA occupation listed in or authorized under 38 U.S.C. § 7401(1) or (3) — a requirement VCCP contractors cannot satisfy because they are not appointed to VA occupations but contracted under 38 U.S.C. §§ 1703 and 1703A. The operational consequence is confirmed in VHA Directive 1915 (Veterans Health Administration, n.d.), which states explicitly that VA-contracted telehealth professionals "do not have the same legal protections as VA-employed" professionals and that "additional requirements must be met" before authorizing contracted providers to deliver cross-facility care. Public commenters during the 2022 notice-and-comment period (which produced the 2025 final rule) specifically requested contractor inclusion; the Department declined, treating the request as outside the scope of the rulemaking. Earlier rulemakings in 2017 and 2020 addressed similar comments in similar terms. The exclusion is therefore not an oversight or an ambiguity — it is a deliberately maintained regulatory construction.

The Department's rationale for excluding contractors rests on three load-bearing premises. All three are contestable under the current statutory text, though with varying degrees of textual force, and none survives the full weight of the structural and constitutional analysis that follows. The first premise is that preemption under § 1730C operates through the employment relationship: the Supremacy Clause protects the federal government's conduct of its own employment relationship from state interference, and because contractors are not federal employees, the preemption rationale has nothing to attach to. The second premise is that the

regulation's own preemption paragraph — which limits preemption to providers "practicing telehealth within the scope of their VA employment" — confirms that contractors are excluded. The third premise is that contractors' authority to practice derives from their state licenses rather than from federal authorization, so state licensure requirements cannot be preempted on their behalf.

Each premise is contestable under the current statutory text, though with varying degrees of textual force. The surplusage argument operates most naturally through § 1730C(b)(1)(B), which provides that a covered health care professional is one who "is authorized by the Secretary to provide health care under this chapter." VCCP contractors authorized under a § 1703 contract are authorized by the Secretary to provide health care under title 38. VA's conjunctive reading — that (A) through (D) must all be satisfied, and that (A)'s appointment requirement limits coverage to VA employees regardless of what (B) says — renders § 1730C(b)(1)(B) surplusage in a specific sense: any employee appointed under (A) is by definition authorized by the Secretary, so (B) would do no independent work if VA's conjunctive reading is correct. The canon against surplusage — which the Department itself invoked in the October 2025 preamble to defend its reading of a different provision of the same statute, 90 Fed. Reg. 47595, 47597 (citing Montclair v. Ramsdell, 107 U.S. 147, 152 (1883); TRW Inc. v. Andrews, 534 U.S. 19, 31 (2001)) — cuts against an interpretation that renders one of the four conjunctive elements a redundancy. This argument is strong but is more inferential than a direct textual compulsion: the natural grammar of § 1730C(b)(1) is conjunctive, and a reviewing court or the Department could read (B) as adding an independent authorization requirement rather than as creating an alternative qualifying pathway. The argument is best presented as one strong leg of a multi-leg case rather than as the dispositive textual point.

The second premise is circular. VA wrote the "scope of VA employment" limitation into the preemption paragraph of its own regulation at § 17.417(c), and then cited that regulatory limitation as the justification for excluding contractors from the regulatory coverage the statute requires. The regulation is subordinate to the statute; its terms cannot determine the scope of the statutory authority that governs the regulation's own validity. The underlying statutory question — whether § 1730C requires or permits contractor inclusion — was never answered in the rulemaking record. It was foreclosed by the regulatory construction before it could be addressed. Three successive rulemaking cycles accepted the employment-scope limitation as settled without resolving the statutory question that limitation was designed to answer. A new rulemaking that takes that question seriously — beginning with the text of § 1730C(b)(1)(B) — and taking seriously the question of whether the Secretary's authorization of VCCP contractors under § 1703 constitutes authorization "to provide health care under this chapter" within the meaning of (b)(1)(B) — would confront the statutory question the prior rulemakings foreclosed without addressing.

The third premise — that contractors' authority to practice derives from their state licenses rather than from federal authorization, leaving preemption nothing to attach to — is refuted by two independent arguments. First, the VCCP contract under 38 U.S.C. § 1703 is not a purely commercial transaction. It is the Secretary exercising a specific federal statutory authority to arrange for the care of veterans. The Secretary's authorization of a specific individual to provide health care to enrolled veterans under that contract is an exercise of federal statutory power — precisely the kind of federal governmental act that Supremacy Clause preemption exists to protect from state interference. VA's rationale treats the VCCP contract as a private arrangement that happens to involve VA. The statute treats it as the exercise of a federal

entitlement delivery authority. Second, Section 714 of the FY2025 NDAA extended cross-state licensure portability to TRICARE network mental health providers — who are also contractors, not Department of Defense employees. They hold state licenses; they are not federally employed; they deliver care under a network contract with the Defense Health Agency (a component of the Department of Defense — operating under the secondary title "Department of War" pursuant to Executive Order 14347, 90 Fed. Reg. 43893 (Sept. 5, 2025), pending statutory rename; cited throughout as "DoD"). Congress extended preemption to them anyway, using an authorization-based framework: the Secretary of Defense's authorization of the individual to provide care to covered beneficiaries. If VA's employment-based preemption theory were correct, the NDAA extension would itself be legally infirm. Congress clearly did not accept the employment-based theory when it enacted Section 714. Congress's enacted conduct is a more authoritative statement of what the preemption mechanism can reach than VA's regulatory interpretation of a statute Congress itself authored.

The cumulative effect of these three failures is that the scope-of-federal-employment rationale, which has persisted across three rulemaking cycles without serious examination, does not survive textual and structural scrutiny. The Secretary possesses the authority to amend 38 C.F.R. § 17.417 through notice-and-comment rulemaking under 5 U.S.C. § 553 to include VCCP-contracted mental health providers as covered health care professionals — providers whose exclusion from the preemption framework is a regulatory choice consistent with the authorization-based framework Congress preserved in § 1730C(b)(1)(B) and explicitly enacted for the analogous TRICARE population in Section 714 of the FY2025 NDAA, and that can therefore be revised by regulatory action — if the Secretary determines that the regulatory path is preferable to the legislative alternative. The amended regulation should require of covered

community care mental health professionals: (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, including continued application of the Controlled Substances Act and its implementing regulations, cooperation with state licensing authorities on disciplinary matters, and the independent operation of interstate licensure compacts alongside the regulatory preemption. VHA Directive 1915 and any subordinate operational guidance would require corresponding revision. The Department faces a systemic coherence constraint that a sympathetic Secretary must weigh honestly: extending preemption to VCCP contractors through a § 1730C(b)(1)(B) regulatory interpretation requires the Department to draw and defend a principled limiting principle distinguishing VCCP mental health contractors from other categories of Secretary-authorized providers — CHAMPVA providers, State Veterans Home contractors, grant recipients — who might argue for equivalent treatment under the same authorization-based pathway. That limiting principle is available and defensible, but defending it imposes institutional costs that the legislative path avoids entirely. A Secretary who concludes that the regulatory path creates more systemic risk than the policy benefit warrants has a legitimate institutional basis for referring the matter to Congress rather than acting by regulation — and should say so explicitly in the petition denial, creating the public record that accelerates legislative action.

The surplusage argument is strengthened by the Department's own conduct in the October 2, 2025 final rule. In the preamble to that rule, the Department applied the canon against surplusage to defend its preferred construction of 38 U.S.C. § 1730C(d), reasoning that an alternative reading would "effectively render 38 U.S.C. § 1730C(d) surplusage with regard to

prescribing via telemedicine, an interpretation that is not generally favored." 90 Fed. Reg. 47595, 47597 (Oct. 2, 2025) (citing Montclair v. Ramsdell, 107 U.S. 147, 152 (1883); Duncan v. Walker, 533 U.S. 167, 174 (2001)). The canon the Department invoked to defend its reading of subsection (d) operates with equal force against its conjunctive reading of subsection (b)(1). The Department cannot consistently maintain that the surplusage canon controls when it favors the agency's construction of one provision of § 1730C while disregarding the same canon when it disfavors the agency's reading of another provision of the same statute — specifically, a reading of (b)(1) that renders element (B) of that subsection an empty requirement.

The doctrinal posture under which a reviewing court would evaluate the contractor exclusion has materially shifted since the regulation was originally promulgated. In Loper Bright Enterprises v. Raimondo, 603 U.S. 369 (2024), the Supreme Court held that the Administrative Procedure Act "requires courts to exercise their independent judgment in deciding whether an agency has acted within its statutory authority," and that "courts may not defer to an agency interpretation of the law simply because a statute is ambiguous." A reviewing court considering the consistency of the contractor exclusion with § 1730C now applies traditional tools of statutory construction — including the canon against surplusage — without the deferential thumb on the scale that Chevron previously provided. The Department's prior rulemaking proceedings, including those that produced the October 2025 final rule, were developed under the prior deference framework and were not formulated to withstand the independent-judgment review Loper Bright now requires. Reconsideration of the contractor exclusion through notice-and-comment rulemaking is the appropriate forum in which to address that doctrinal shift before a reviewing court is asked to do so.

Independent of the construction question, the preservation of the contractor exclusion in the October 2025 final rule is exposed to reasoned-decisionmaking review under Motor Vehicle Manufacturers Ass'n v. State Farm Mutual Automobile Insurance Co., 463 U.S. 29 (1983). An agency rule is arbitrary and capricious if the agency "entirely failed to consider an important aspect of the problem." Id. at 43. The October 2025 final rule was promulgated after Congress had enacted both Section 581 of the FY2024 NDAA (December 2023) and Section 714 of the FY2025 NDAA (December 2024), each extending Federal licensure preemption to mental health providers serving analogous Federally-sponsored populations. The rule's preamble does not engage with these intervening Congressional enactments or with their implications for the contractor exclusion as applied to a structurally identical population of veterans served through VCCP. Under State Farm, an agency confronting changed legal and policy circumstances bearing directly on the question before it is required to engage with those circumstances in its reasoning. The 2025 final rule did not.

The line of constitutional authority addressing State licensure of Federally-engaged personnel performing Federal duties supports, rather than complicates, the Department's authority to extend preemption to VCCP mental health providers. In Johnson v. Maryland, 254 U.S. 51 (1920), the Supreme Court held that a State lacked power to require a Federal postal employee to obtain a State license before performing Federal duties, reasoning that such a requirement "lays hold of [Federal personnel] in their specific attempt to obey orders, and requires qualifications in addition to those that the [Federal] government has pronounced sufficient." Id. at 57. The Court extended that principle to Federal contractors in Leslie Miller, Inc. v. Arkansas, 352 U.S. 187 (1956), holding that a State licensing requirement is invalid as applied to a contractor performing a Federal contract because it interferes with Federal program

functions and conflicts with Federal program standards. Id. at 189–90. Lower Federal courts have applied Leslie Miller to invalidate State licensure requirements against Federal contractors. See, e.g., Gartrell Construction, Inc. v. Aubry, 940 F.2d 437, 437–39 (9th Cir. 1991). This doctrinal line establishes that State licensure regimes that "lay hold of" Federal personnel in the specific performance of Federal duties — whether Federally employed or Federally contracted — yield to the Federal interest in uninterrupted execution of Federal program functions. The existing § 17.417 preemption already implements this principle for VA-employed clinicians; the regulatory amendment this paper proposes would extend it to the contracted VCCP mental health providers performing the same Federal program function for the same Federally-entitled beneficiary population.

A structurally complete analysis of the contractor exclusion requires acknowledging a pattern of consequences that any decision to preserve the exclusion should address explicitly. Section 714 of the FY2025 NDAA extended cross-state licensure portability to TRICARE network mental health providers. Many veterans enrolled in VHA care are concurrently TRICARE-eligible: military retirees with twenty or more years of service routinely hold both VA enrollment for service-connected conditions and TRICARE for Life coverage for general health care. Under the current regulatory framework, such a veteran may obtain cross-state tele-mental-health continuity from a TRICARE network provider while being denied equivalent continuity from a VCCP network provider — a disparity that falls on a single individual depending solely on which federal benefit pathway is used to access care on a given day. The budget consequence of this disparity is directionally consistent with VHA's financial interest: mental health care delivered through TRICARE is borne by the Defense Health Agency budget, not by VHA's community care budget. This paper does not assert that the contractor exclusion

was designed to produce this routing effect, and no published regulatory record document asserts or implies such a purpose. The stated rationale across all three rulemaking cycles is the scope-of-federal-employment argument analyzed above. What this paper asserts is structural rather than intentional: the exclusion, whatever its origin, produces a pattern of outcomes that a cost-allocation-motivated actor would find convenient, and any administrative decision to preserve the exclusion after this analysis has been placed on the public record should account explicitly for this pattern. The burden of that routing falls most heavily on exclusively VHA-enrolled veterans — those without the twenty-year service threshold required for TRICARE eligibility — who are disproportionately non-career, working-class, and lower-income veterans with no alternative federal coverage pathway. The contractor exclusion therefore concentrates its access burden on the population least positioned to absorb it, while the dual-eligible population — those with alternative coverage — retains an imperfect workaround through TRICARE portability. A preservation of the exclusion that relies, whether explicitly or silently, on this routing pattern as justification would be both analytically untenable and administratively indefensible in light of the Department's stated priorities of veteran access, suicide prevention, and community care expansion.

The NDAA enacted record forecloses the three objections most commonly raised against extending preemption to VCCP providers. In December 2024, Congress enacted Section 714 of the Servicemember Quality of Life Improvement and National Defense Authorization Act for Fiscal Year 2025 (P.L. 118-159), establishing licensure portability for TRICARE network mental health providers — allowing those providers to deliver tele-mental health care without regard to the location of the provider or the patient. This provision was drafted by the bipartisan House Armed Services Committee Quality of Life Panel, carried into law as part of the FY2025 NDAA

conference report, which passed the House 281–140 and the Senate 85–14; those vote margins, while reflecting passage of the conference report as a whole, evidence the bipartisan recognition that cross-State licensure barriers produce continuity-of-care failures the Federal government may, and should, address through preemption. One year earlier, Section 581 of the FY2024 NDAA (P.L. 118-31) extended cross-state licensure flexibility to DoD-contracted mental health professionals counseling servicemembers and military families regardless of provider or patient location. Congress has therefore enacted the remedy both pathways propose — in two consecutive NDAAs, for two classes of providers serving populations substantially overlapping with VHA enrollees, with overwhelming bipartisan support. This enacted record forecloses three objections: the remedy is not administratively novel; it raises no unresolved legal questions; and it does not expand fiscal obligations, since preemption does not change reimbursement rates and Congress has accepted this structure for TRICARE.

The Interpretive Divergence Between DoD and VA. The most direct evidence that VA's employment-based interpretation is a policy choice rather than a statutory compulsion is that the Department of Defense reached the opposite conclusion when confronted with materially identical statutory architecture. The TRICARE network is the DoD equivalent of the VCCP: a federal health entitlement delivery system that contracts with privately licensed community providers under federal statutory authority to serve a geographically mobile beneficiary population when DoD-operated facilities cannot meet access standards. The structural analogy is not approximate — it is precise. Both systems involve a federal health entitlement; a federal statutory contracting authority (38 U.S.C. § 1703 for VCCP; 10 U.S.C. § 1079 and § 1086 for TRICARE); a community care network of independently licensed private providers; and a beneficiary population whose mobility routinely places them in jurisdictions where their

established providers lack licensure. When Congress extended cross-state licensure portability to TRICARE network mental health providers in Section 714 of the FY2025 NDAA, it did so through an authorization-based framework: the Secretary of Defense's authorization of the provider to deliver care to covered beneficiaries sufficed, regardless of whether the provider was employed by DoD. DoD did not assert — and Congress did not require — that the preemption mechanism be grounded in a federal employment relationship. The authorization framework was sufficient. VA, confronting the same basic architecture through the VCCP and § 1703, asserted the employment-based limitation and excluded contractors accordingly. The two departments have therefore arrived at operationally opposite interpretations of what is functionally the same statutory structure: federal entitlement plus federal contracting authority plus community provider network plus mobile beneficiary population. VA's interpretation holds that the preemption mechanism requires federal employment. DoD's enacted practice — reflected in both FY2024 and FY2025 NDAA provisions — holds that federal authorization by the Secretary suffices. This divergence is itself probative: when two departments with parallel statutory structures reach opposite interpretations of materially identical authority, the divergence establishes that neither interpretation is compelled by the statutory structure. It is, instead, a policy choice. VA has never identified a legally meaningful distinction between the TRICARE network architecture and the VCCP architecture that would justify opposite preemption treatment. The only operationally relevant differences are the administering department and the appropriations account — neither of which is a cognizable basis for differential treatment under the Supremacy Clause. A veteran enrolled in both VA and TRICARE for Life — a military retiree whose service-connected conditions are managed through VA and whose general health care is covered by TRICARE — is simultaneously subject to both interpretations. That veteran's

TRICARE-funded mental health provider can follow them across state lines; their VCCP-funded mental health provider cannot. The federal government, through two of its departments, 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. That outcome is not required by any statute. It is the product of VA's employment-based regulatory construction, standing alone, against the weight of DoD's authorization-based enacted practice.

Disability Accommodation Under Section 504 of the Rehabilitation Act

The regulatory exclusion under review also implicates the Department's affirmative obligations under section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, which prohibits exclusion from, denial of benefits of, or discrimination under any program or activity conducted by any Executive agency against any otherwise qualified individual with a disability. The Department's programs — direct medical care under chapter 17 of title 38 and community care under the Veterans Community Care Program — are programs conducted by an Executive agency within the meaning of the statute. The section 504 framework requires Federal agencies to make reasonable modifications to enable qualified individuals with disabilities to participate in covered programs on terms equivalent to those available to others; reasonableness is evaluated against feasibility, fundamental alteration of the program, and undue burden.

A substantial portion of the population affected by the contractor exclusion consists of qualified individuals with disabilities within the meaning of section 504. Service-connected disabled veterans receiving Department mental health care for service-connected conditions — including post-traumatic stress disorder, traumatic brain injury sequelae, major depressive disorder, and anxiety disorders — are presumptively qualified individuals with disabilities. The

Department itself, through its disability rating and adjudication processes, has already determined the disability status of these individuals.

The accommodation framework has particular force here because the Federal government has already determined, through multiple independent mechanisms, that cross-State licensure preemption for mental health providers serving federally-sponsored populations is feasible, does not fundamentally alter the programs in which it operates, and does not impose undue burden. The Department's own regulation at 38 C.F.R. § 17.417 implements this determination for Department-employed clinicians. Congress's enactments at Section 581 of the FY2024 NDAA and Section 714 of the FY2025 NDAA implement the same determination for DoD-contracted counselors and TRICARE network mental health providers, respectively. The accommodation has been evaluated against operational and policy considerations and adopted across multiple Federal programs serving military-connected populations. The contractor exclusion at 38 C.F.R. § 17.417(b)(2)(iii) preserves the only category of Federally-sponsored mental health care delivery in which this accommodation has not been extended. Veterans referred to community care under VCCP — a population disproportionately consisting of qualified disabled persons receiving care for service-connected mental health conditions — face the structural barrier the accommodation is designed to address, while equivalently situated populations receive it through other Federal programs.

The agency-induced mobility analysis examined in the preceding subsection sharpens the section 504 argument. The accommodation framework carries heightened force when the agency's own program design creates the conditions requiring the accommodation. The Department's VISN architecture generates cross-State care scenarios as a structural feature of program design: specialty care assignments routinely place the treatment facility in a different

State from the veteran's State of residence, producing cross-State mobility through agency administrative decision rather than veteran choice. The contractor exclusion then severs VCCP-funded mental health continuity for the veteran whose cross-State mobility the Department's own clinical assignment generated. An agency cannot consistently maintain that it has discharged its section 504 obligations when its own administrative decisions are the source of the mobility triggering the disability accommodation question. This paper advances section 504 not as a primary legal claim but as a substantive obligation the Department must evaluate as part of any comprehensive assessment of the contractor exclusion — an obligation that prior rulemaking proceedings did not address.

The Statutory Pathway: Amendment of 38 U.S.C. § 1730C. The statutory amendment pathway provides a more durable resolution by eliminating the need to rely on regulatory interpretation of the authorization-versus-employment question. Under the Commerce Clause (U.S. Const. art. I, § 8, cl. 3) and the Spending Clause (U.S. Const. art. I, § 8, cl. 1), Congress may regulate the provision of healthcare services across state lines and attach conditions to federal funding that require VCCP network contractors to ensure cross-jurisdictional telehealth delivery. The statutory hook is 38 U.S.C. § 1730C, which already authorizes VA-employed clinicians to practice across state lines; extending this preemption expressly to VCCP-contracted providers would eliminate the authorization-versus-employment ambiguity on which the current exclusion rests. Regulatory action under 38 U.S.C. §§ 1703 and 1703A provides VA authority to establish network adequacy standards requiring multistate licensure coverage as a condition of VCCP participation independently of § 1730C. A parallel pattern of legislative momentum is visible in the 119th Congress: H.R. 5357, the College Students Continuation of Mental Health Care Act of 2025, introduced September 15, 2025 by Representative Mike Flood with original

cosponsors Representatives Don Bacon and Zachary Nunn, would extend functionally identical licensing reciprocity to college mental health providers serving students across state lines — demonstrating that the continuity-of-care principle is not veteran-specific. The HHS Office of the Assistant Secretary for Planning and Evaluation reached the same conclusion through independent analysis: its 2024 issue brief found that interstate licensure barriers are the primary structural obstacle to telehealth behavioral health access and explicitly recommended federal action to overcome them (U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2024). The executive branch, the legislative branch, and independent oversight bodies have all identified the same problem and pointed toward the same remedy. A Secretary who concludes, after receiving the petition and considering the systemic coherence constraint, that the legislative path is preferable to the regulatory path has a specific and constructive option: a formal denial of the petition that explicitly acknowledges the structural harm, states that the statutory architecture constrains the regulatory remedy, and transmits to Congress a formal request for the targeted legislative amendment described in this paper. Such a denial would not be a defeat for the policy objective — it would be a more powerful predicate for legislative action than an advocacy organization's proposal alone. The Department transmitted analogous legislative requests to Congress preceding the Veterans Access, Choice, and Accountability Act of 2014, which established the Veterans Choice Program, establishing that this mechanism is an established feature of the VA-Congress legislative relationship rather than an extraordinary act. A secretarial referral converts a petition denial into a policy commitment on the public record — one that a subsequent Secretary would face as a political and institutional obstacle to reversing.

Timeliness, Clinical Risk, and the Consequences of Delay

In mental health care, timeliness is a core determinant of clinical safety. The period between help-seeking and treatment initiation is a high-risk interval, particularly for individuals experiencing acute symptoms, suicidal ideation, or destabilizing life events. The VA MISSION Act's 20-day standard reflects an acknowledgment of this urgency. For mobile veterans, the failure loop routinely pushes access far beyond this threshold through compounding delays: VA capacity shortfalls commonly extend initial appointment waits beyond the statutory standard; VCCP referral processing adds one to two weeks before any provider contact occurs; licensure mismatches restart the processing cycle entirely; and even when a provider is identified, scheduling backlogs may push the first intake appointment weeks or months further. Veterans with recent mental health or substance use diagnoses face suicide rates significantly higher than the general population (U.S. Department of Veterans Affairs, 2023), and the period of active help-seeking is a known risk interval. Whether the specific delays produced by the failure loop causally increase suicide risk among mobile veterans has not been established in the published literature; that relationship is hypothesized here based on the documented structural conditions and the elevated risk profile of the affected populations.

Administrative dropout represents the terminal expression of cumulative delay: disengagement that becomes permanent. Veterans who must restart the referral process following a licensure-based failure do not re-enter at the front of the queue—they join the back, treated administratively as new applicants despite having already established eligibility and navigated a prior referral cycle. The cumulative wait across a failed VCCP referral and a subsequent VA direct-care queue can extend to months during which the veteran receives no care and the system records no unresolved failure. Current VA data classification records this disengagement as no-

show, declined care, or lost to follow-up (Swift & Greenberg, 2012)—categories that attribute the outcome to the veteran rather than to the structural sequence that produced it.

Measurement Failures

VA's access measurement framework optimizes for administrative timeliness (the interval between a veteran's request and a scheduled appointment) rather than for whether veterans actually receive continuous, effective care. This produces goal displacement: facilities and TPA contractors optimize for scheduling speed and consult closure, because those are the metrics on which they are evaluated. A consult closed because a provider lacked out-of-state licensure generates the same administrative record as a consult closed because the veteran completed a successful intake. Consults closed at the network adequacy stage — before any appointment is scheduled, because the network cannot identify a provider licensed in the veteran's anticipated jurisdictions — are recorded identically to completed referrals. The OIG has documented that community care consults may be administratively closed after a single attempt to retrieve medical documentation from the community provider, even though VA policy requires two additional retrieval attempts after closure — meaning a closed consult reflects an administrative step, not a completed episode of care (U.S. Department of Veterans Affairs Office of Inspector General, 2025a; Veterans Health Administration, 2024). A 2025 GAO report on behavioral health community care referrals found that 33 percent of referrals were missing records for initial visits and that only 2 percent of community providers with a behavioral health referral had completed one or more of eight core VA trainings on veteran-specific clinical topics, including suicide prevention — with VA providing no monitoring of either metric (U.S. Government Accountability Office, 2025). A 2026 OIG preliminary advisory found that nearly one million of 2.1 million specialty care call attempts from August 2024 through July 2025 lacked critical call

data at 13 of 15 reviewed facilities, including at least 109,000 calls to mental health clinics — making it impossible to evaluate whether veterans successfully accessed care (U.S. Department of Veterans Affairs Office of Inspector General, 2026). GAO reports in 2022 and 2023 documented inconsistent wait-time tracking, unreliable community care timeliness data, and incomplete referral outcome documentation (U.S. Government Accountability Office, 2022, 2023). These findings confirm that the gap between measured performance and delivered care is a documented and recurring feature of the current data environment. The March 2025 House Veterans' Affairs Subcommittee on Technology Modernization hearing on interoperability between VA and community providers captured the same dynamic from the data architecture side: VA's Chief Medical Informatics Officer testified that while VA is connected to approximately 90 percent of U.S. hospitals through Health Information Exchanges, far fewer physicians' offices exchange data with VA, and that gaps in data standardization mean that even when records are exchanged they may not be usable — producing precisely the "new patient" dynamic at every provider transition that the continuity framework identifies as clinically harmful (U.S. House of Representatives, Committee on Veterans' Affairs, 2025b).

What the measurement framework does not capture at all is more consequential than what it captures poorly. Continuity of care — the central determinant of therapeutic effectiveness in mental health treatment — has no corresponding metric in VA's performance reporting infrastructure. Forced provider-change rates, cumulative appointment-gap durations, and intake-restart frequencies are not tracked. Mobility is not a recorded variable. Administrative dropout is misclassified as no-show or declined care (Swift & Greenberg, 2012), attributing disengagement to the veteran rather than to the structural sequence that produced it. Anticipatory disengagement — the decision not to initiate a referral process that prior experience indicates cannot be

completed — leaves no administrative trace at all. Network adequacy failure at the point of referral initiation, and the care network adequacy knowledge gap that makes that failure invisible to first-time system users, are entirely absent from the measurement framework. The dual-pathway failure loop operates within a system that reports compliance precisely because the metrics were not designed to detect the failure modes the loop produces. This is not a missing-dashboard problem. Some of these phenomena — forced provider-change rates, consult closure reasons, licensure mismatch frequency — are observable in principle and could be captured with targeted data infrastructure investment. Others — anticipatory disengagement, the care network adequacy knowledge gap, the clinical consequences of a relationship that never formed — are epistemically invisible under any measurement regime that records only what the administrative system touches. Conflating the two obscures both the remedies and their limits: the first category calls for data system reform; the second calls for structural reform of the conditions that prevent the system from making contact with the veteran in the first place.

Economic Costs of Discontinuous Care

Discontinuous mental health care generates downstream costs that the current system externalizes and obscures. When veterans cannot access continuous outpatient care, they are more likely to present through emergency departments, crisis lines, and inpatient psychiatric units—settings that are significantly more expensive per episode and clinically less effective at producing sustained therapeutic engagement. VA data confirm higher rates of emergency and inpatient utilization among veterans with unstable mental health conditions (U.S. Department of Veterans Affairs, 2023). Studies of chronic homelessness costs, including Culhane et al. (2002) and subsequent urban homelessness literature, estimate public system costs of $30,000 to $50,000 per person per year—a figure that is directly relevant given the feedback loop between

mental health discontinuity and housing instability documented throughout this paper. Each forced provider change also generates redundant administrative costs within the VA and VCCP systems: new intake assessments, repeated diagnostic evaluations, and duplicated documentation cycles that add expense without adding clinical value. In January 2025, the House Committee on Veterans' Affairs convened its first full committee oversight hearing on community care of the 119th Congress. Chairman Bost framed the issue directly: "community care is VA care. It is not a substitute, but an essential extension of VA's mission to serve veterans where and when they need it without delay" (U.S. House of Representatives, Committee on Veterans' Affairs, 2025a). Ranking Member Takano noted that VA was on track to spend more than $42 billion on community care in FY2025 — representing more than 40 percent of all veterans' care — while oversight of that spending remained critically inadequate (U.S. House of Representatives, Committee on Veterans' Affairs, 2025a). The cost-benefit case presented here is an order-of-magnitude illustration, not a systematic analysis; the point is directional. The cost of the structural reforms proposed in the following section is measurably lower than the cost of perpetuating the current system's failure modes.

Policy Recommendations: A Mobility-Aligned Reform Agenda

The failures documented in this paper are the predictable outputs of a national entitlement delivered through a geographically anchored system designed for a stationary population. The nine recommendations that follow are organized in three tiers, but they are not co-equal. Regulatory amendment of 38 C.F.R. § 17.417 is the primary near-term reform, achievable through administrative action without new legislation; statutory amendment of 38 U.S.C. § 1730C provides the durable long-term resolution. All other reforms are either complements to the preemption pathway or stopgaps pending its achievement. Tier 2 reforms — operational

changes to network standards, consult accountability, and case management — can be initiated through administrative action immediately and reduce failure frequency while the Tier 1 regulatory and statutory reforms are pursued. Tier 3 reforms — measurement, data infrastructure, and governance — ensure that failures remain visible, attributable, and correctable over time. No combination of Tier 2 or Tier 3 reforms can substitute for Tier 1; the jurisdictional barrier that produces both failure modes requires the regulatory and, ultimately, statutory remedy that Tier 1 proposes.

Tier 1: Structural Corrections (Continuity Enablers)

Recommendation 1: Extend Federal Preemption to VCCP Mental Health Providers

Extending federal licensure preemption to VCCP mental health providers is the primary reform this paper proposes, achievable through three tracks that the petition process activates simultaneously: regulatory amendment of 38 C.F.R. § 17.417; statutory amendment of 38 U.S.C. § 1730C; and judicial review of a petition denial that fails to engage with the NDAA enacted record and the Section 504 framework. The regulatory track is immediately available but requires the Department to navigate a systemic coherence constraint that gives a sympathetic Secretary legitimate institutional reasons to prefer the legislative track. The legislative track is the most durable resolution and avoids the limiting-principle problems that the regulatory track creates. The judicial track operates independently of the statutory construction question and is available whenever the Department's denial fails the State Farm reasoned-decisionmaking standard. Every other recommendation in this paper is either a complement to one or more tracks or a stopgap pending their achievement. The core principle is clinical rather than administrative: when a therapeutic relationship is effective, the alliance is established, and the logistics of

telehealth delivery are workable, there is no clinical justification for ending it. The only justification under the current system is jurisdictional.

The framework this paper proposes mirrors precisely what Congress enacted for TRICARE network providers in Section 714 of the FY2025 NDAA: licensure portability without regard to the location of the provider or the patient, conditioned on the provider holding a valid license in at least one state and operating under the relevant federal contract. No 90-day trigger. No compact participation requirement. No tiered structure. Congress designed a clean, durable framework for TRICARE and it operates without documented adverse outcomes. The VCCP fix should be identical. Adding conditions beyond what Congress imposed on TRICARE would implicitly concede that the VCCP case is weaker than the TRICARE case. It is not. The statutory architecture is the same, the population mobility problem is the same, and the fix should be the same. IVHSP has filed a Petition for Rulemaking under 5 U.S.C. § 553(e) with the Department of Veterans Affairs requesting initiation of notice-and-comment rulemaking to amend 38 C.F.R. § 17.417 accordingly; that petition includes proposed regulatory text modeled on the framework Congress enacted in Section 714 of the FY2025 NDAA. Under the amended 38 C.F.R. § 17.417, covered community care mental health professionals would be required to demonstrate: (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, including continued application of the Controlled Substances Act and its implementing regulations, cooperation with state licensing authorities on disciplinary matters, and the independent operation of interstate licensure compacts alongside the regulatory preemption. Interstate licensure compacts continue to operate as a parallel and independent system; a provider who holds compact privileges satisfies this

framework and continues to operate under compact governance in compact member states. A provider who does not hold compact privileges operates under federal preemption directly. The compact system neither limits nor conditions the preemption; the preemption neither displaces nor supersedes the compact system. They are parallel instruments addressing the same underlying access problem through different mechanisms.

Five objections to this framework warrant direct engagement. First, critics may argue that cross-jurisdictional preemption creates consumer protection risks by allowing providers licensed in lower-standard states to practice in higher-standard jurisdictions. This objection applies with equal force to the existing preemption for VA-employed clinicians, which has operated since the October 2025 final rule without documented adverse outcomes, and to the TRICARE network portability Congress enacted in the FY2025 NDAA. The framework conditions preemption on holding a valid license in at least one state and meeting VA credentialing requirements — a federal floor consistent with the TRICARE framework. Second, fiscal objections misread the cost structure: preemption does not expand VA's reimbursement obligations; VCCP rates apply regardless of where the provider practices, and Congress accepted this structure for TRICARE. Third, broadband equity concerns are real but are addressed at the network standards level in Recommendation 3, which requires TPA networks to maintain in-person or hybrid provider capacity in regions where broadband access is insufficient; preemption enables national network allocation without mandating telehealth as the exclusive delivery modality. Fourth, malpractice jurisdiction questions — which state's standard of care governs when a provider licensed in one state treats a veteran located in another — are resolved under VA's existing implementing framework for § 1730C preemption, which establishes the provider's home-state licensure as the governing standard; the same framework extends to VCCP providers under amended

preemption. Fifth, enforcement compliance is addressed through the PPMS credentialing architecture, which already records provider licensure state. Attestation at credentialing renewal, combined with TPA audit requirements under § 1703(h) and the consult accountability reforms in Recommendation 4, creates a layered verification structure without requiring new enforcement authority.

Recommendation 2: Implement a Mobility-Aware Bridge-Care Reimbursement Mechanism

Even with preemption in place, transitions inherent in mobile life will create intervals during which established providers are temporarily unavailable or veterans are between referrals. A bridge-care reimbursement mechanism addresses this residual gap by authorizing short-term continuation of care with an existing provider, temporary telehealth sessions during geographic transitions, and reimbursement for out-of-network care when no in-network alternative meets the statutory access timeframe. The statutory hook is 38 U.S.C. § 1703(d). Eligibility would require: (1) an existing VCCP or VA treatment relationship disrupted by geographic transition; (2) documentation that the disruption resulted from the veteran's interstate movement; and (3) clinician certification that continuation is medically necessary. Bridge-care eligibility is limited to defined transition periods — no more than 90 days — after which standard VCCP processes resume. This mechanism is cost-rational: a bridge-care episode costs a fraction of a psychiatric inpatient admission triggered by continuity disruption.

Tier 2: Operational Reforms (Continuity Stabilizers)

Recommendation 3: Redesign VCCP Network Standards for National Coverage

Federal preemption changes the legal framework; network adequacy standards determine whether the provider supply exists to make preemption meaningful in practice. The current standards assess provider availability within geographic radii from veterans' enrolled VA

facilities — a design premised on local delivery that produces systematic inadequacy for mobile veterans and for rural veterans who lack local provider supply regardless of their mobility.

Preemption enables a structural transformation in how network adequacy is conceived. When any VCCP provider licensed in any state can legally serve any veteran anywhere via telehealth, the relevant unit of analysis is no longer the local or regional provider pool — it is the national network. Urban therapy markets, where licensed mental health providers are concentrated, currently hold supply that cannot reach veterans in high-need, low-supply rural regions because jurisdictional boundaries prevent it. Preemption removes that barrier. A provider in Phoenix can serve a veteran in rural North Dakota. A provider in Atlanta can serve a veteran in rural Appalachia. The geographic inequality in provider access, which currently mirrors and amplifies the geographic inequality in clinical need — including the higher prevalence of seasonal affective disorder and subsyndromal seasonal depression in high-latitude, low-density regions (Rosen et al., 1990) — begins to flatten as supply can be allocated across demand nationally rather than locally.

Mobility-aligned network adequacy standards should require VCCP network contractors to demonstrate: (1) sufficient telehealth-capable, preemption-eligible provider capacity to serve veterans in high-need, low-supply regions; (2) a minimum proportion of network providers holding compact privileges or capable of operating under federal preemption across multiple jurisdictions; (3) proactive network adequacy assessment for veterans flagged as continuously mobile at the point of referral initiation, verifying that the network can identify a provider capable of serving the veteran's anticipated jurisdictions before the referral is transmitted; and (4) network response protocols for veterans who travel outside their enrolled VISN region. A 2024 OIG audit found that VA's Office of Integrated Veteran Care did not hold TPAs accountable for

implementing network adequacy contract requirements and did not conduct analyses of facilities' network adequacy needs to help TPAs build adequate provider networks (U.S. Department of Veterans Affairs Office of Inspector General, 2024; U.S. Government Accountability Office, 2024). A 2025 GAO report found that only 2 percent of community providers with behavioral health referrals had completed one or more of eight core VA clinical trainings — and that VA was not monitoring completion — raising substantive questions about the clinical preparedness of VCCP network providers for the veteran population they serve (U.S. Government Accountability Office, 2025). Implementing authority is VA, through contract modifications with VCCP TPAs under 38 U.S.C. § 1703(h).

Network adequacy assessments must also account for cross-State mobility generated by Department specialty care assignment practices within multi-State VISNs. The Department's clinical architecture routinely refers veterans across State lines for specialty care — an administrative decision over which the veteran exercises no control. Where that assignment generates cross-State mobility, network adequacy must include sufficient telehealth-capable, preemption-eligible mental health provider capacity in the receiving States to maintain continuity of mental health treatment for the population thereby mobilized. A VCCP network that satisfies geographic proximity standards within a veteran's enrollment State while failing to include licensed providers in the States where the Department's own specialty care assignments will place that veteran is inadequate for the enrolled population the VISN architecture actually serves. TPA contract requirements should reflect this dimension of mobility explicitly, with network adequacy reporting disaggregated by VISN to identify gaps in receiving-State provider coverage relative to documented cross-State referral patterns.

Recommendation 4: Strengthen Consult Accountability and Referral Viability Requirements

The current system allows VCCP consults to be closed as complete when administrative steps have been taken, regardless of whether the veteran has successfully initiated treatment. Strengthened consult accountability would require that a consult be classified as successfully resolved only when the veteran has completed a first clinically viable appointment — not merely when a provider has been matched or an appointment scheduled. Consults closed for administrative reasons — licensure mismatch, veteran travel, provider unavailability, expired referrals — would be classified separately as administratively closed and excluded from access performance metrics.

Two additional requirements address the continuous mobility failure mode specifically. First, VA should require VCCP network contractors to conduct a proactive network adequacy assessment for any veteran flagged as high-mobility at the point of referral initiation, verifying that the network can identify a provider licensed in the veteran's anticipated jurisdictions before the referral is transmitted. This assessment should be documented and its outcome recorded regardless of whether a match is found. Second, referrals exhausted at the network adequacy stage—in which the VCCP network cannot produce a viable provider before any appointment is scheduled—must be classified as a distinct outcome category, separate from referrals that fail mid-process, and must be excluded from access performance metrics. Currently, both outcomes generate the same administrative record. Distinguishing them is essential to making the continuous mobility failure mode visible in system data. The statutory hook is 38 U.S.C. § 1703(f), which requires VA to monitor the quality of community care. Implementing authority is VA, through directive and TPA contract modification.

Recommendation 5: Expand the Traveling Veteran Program to Include VCCP Coordination

The Traveling Veteran Program facilitates care coordination across VA facilities but does not address VCCP licensure constraints. An expanded program would create a unified continuity framework across both pathways, including: coordination of VCCP referrals across jurisdictions; continuity protocols prioritizing maintenance of established therapeutic relationships when technically feasible; mobility-aware case management for high-risk veterans; and a dedicated mobility coordinator role within each VISN responsible for managing cross-jurisdictional continuity cases and liaising with TPAs on referral viability. Implementing authority is VA through administrative directive; no new legislation is required.

Recommendation 6: Prioritize High-Risk Populations for Targeted Continuity Interventions

Certain subpopulations face disproportionately high continuity risk and warrant targeted intervention even before system-wide reforms are fully implemented. These populations—veterans in transportation and logistics occupations, veterans experiencing homelessness or housing instability, rural and border-region veterans, and veterans recently discharged from psychiatric inpatient facilities—share elevated mobility, elevated clinical risk, and reduced administrative capacity to navigate repeated referral failures. Targeted interventions include: proactive case management outreach at the time of referral initiation; telehealth continuity plans developed at intake identifying providers licensed in the veteran's most frequent interstate locations; expedited referral processing for veterans flagged as high-mobility; and priority access to bridge-care reimbursement during geographic transitions.

Across Tier 2, the operational logic points toward a function the current system has not formally designated: care navigation. The failures documented in this paper—stalled referrals, expired consults, licensure mismatches, intake restarts, and administrative dropout—share a common feature: they occur in the space between institutional actors, where no single entity

holds continuous responsibility for ensuring the veteran reaches and sustains care. Formalizing care navigation as a defined system function—whether through VA-administered programs, contracted partners, Veteran Service Organizations, or third-party navigation entities operating in coordination with VA and VCCP—is both feasible within existing constraints and deployable without new legislation.

Tier 3: Accountability and Measurement (Continuity Enforcement)

Recommendation 7: Redefine Access Metrics to Capture Continuity and Clinical Outcomes

The current 20-day access standard measures administrative timeliness and is structurally incapable of detecting the continuity failures that constitute the primary access problem for mobile veterans. A revised measurement framework would include: (1) a time-from-request-to-first-completed-session metric capturing actual care initiation rather than scheduling; (2) continuity metrics—forced provider-change rates and appointment-gap durations for veterans in active mental health treatment; (3) referral viability metrics, including licensure mismatch rates and the proportion of consults closed for administrative rather than clinical reasons; (4) treatment engagement rates measuring the proportion of referred veterans completing a minimum number of sessions; (5) provider-reassignment frequency at the VISN and market level; (6) administrative dropout rates as a distinct trackable outcome; (7) network adequacy failure at intake as a distinct outcome category, tracking referrals exhausted before a first appointment because the network could not identify a provider licensed in the veteran's anticipated jurisdictions; and (8) anticipatory disengagement as an estimated outcome, tracked through screening instruments administered at points of VA contact and through analysis of enrollment lapses among veterans with documented continuous mobility patterns. Implementing authority rests with VA's Office of Community Care and Office of Mental Health and Suicide Prevention.

Recommendation 8: Establish a National Mobility and Continuity Data Infrastructure

A national mobility and continuity data infrastructure would: (1) track interstate movement patterns among VHA enrollees using enrollment update data, address changes, and claims location data; (2) monitor referral failures attributable to licensure mismatch, enabling real-time identification of veterans at risk of care gap; (3) generate continuity disruption reports at the VISN and national level, linking provider-change events to enrollment data and clinical outcomes; (4) track administrative dropout as a distinct outcome category correlated with mobility, licensure mismatch, and crisis utilization; and (5) correlate these variables to enable evidence-based targeting of high-risk populations for preventive intervention. Implementing authority is VA, building on existing infrastructure—the Corporate Data Warehouse and existing enrollment databases—rather than creating parallel systems.

Recommendation 9: Create a National Mental Health Continuity Task Force

A National Mental Health Continuity Task Force would provide the governance infrastructure needed to coordinate across VA program offices, engage Congress and state licensing boards, sustain momentum across administrations, and hold the federal system accountable for closing the gaps documented here. The task force would be charged with: evaluating and recommending specific legislative language for the extension of federal preemption under 38 U.S.C. § 1730C, and preparing, for transmission by the Secretary to the Committees on Veterans' Affairs of the Senate and House of Representatives, a formal report that either announces the Department's intention to initiate rulemaking or acknowledges the systemic coherence constraint on the regulatory pathway and formally requests the targeted statutory amendment — thereby converting the Department's response to the petition into a legislative predicate regardless of whether rulemaking is initiated; developing continuity-focused

access standards for VA and VCCP pathways; coordinating with the Association of State and Provincial Psychology Boards (ASPPB), the Association of Social Work Boards, relevant state licensing authorities, and Veterans Service Organizations with direct member interest in community care continuity — including MOAA, NMFA, IAVA, and VFW — on implementation of the extended regulatory preemption and on the operation of interstate licensure compacts as an independent parallel system; ensuring mobility-aligned reforms are implemented consistently across all 18 VISNs; and producing an annual report to Congress on the state of continuity in veteran mental health care.

Conclusion

This paper has advanced a single, consistently supported argument: the Veterans Health Administration cannot reliably deliver a national statutory entitlement through a delivery system designed for a stationary population. The dual-pathway failure loop—VA capacity shortfalls redirect veterans to VCCP; VCCP referrals stall or become jurisdictionally invalid when veterans move; veterans cycle without care until they drop out or reach crisis—is not an operational anomaly. It is the product of policy choices that embedded mid-20th-century residential assumptions into a 21st-century federal benefit program serving a population characterized by significant, documentable mobility. The paper has further identified two structurally distinct failure modes within that loop: the relocation failure mode, in which an established therapeutic relationship is disrupted by a geographic transition that the system cannot accommodate; and the continuous mobility failure mode, in which the system's jurisdictional architecture cannot establish a legally viable provider relationship in the first place, because the veteran's life does not offer the stable jurisdictional footing the referral process requires.

The clinical stakes of this structural failure are high and specific. Mental health care is non-fungible. The therapeutic alliance through which effective treatment operates cannot be preserved across forced provider transitions, and the progressive disclosure on which clinical safety depends may be suppressed by veterans who rationally anticipate that their provider will become legally inaccessible when they cross a state line for work. This anticipatory non-disclosure hypothesis, advanced in this paper as a clinically plausible inference from the disclosure literature, warrants direct empirical investigation in the VA/VCCP context. For veterans subject to the continuous mobility failure mode, the more fundamental dynamic is anticipatory disengagement: the rational decision not to invest in a care-seeking process that prior experience indicates cannot be completed. Both constructs describe rational responses to system-induced instability; neither is currently captured in VA performance data. The recursive character of the failure loop compounds this burden for the most mobile veterans: a veteran who successfully establishes care following a relocation does not exit the loop — they remain subject to re-entry at the next geographic transition. Continuously mobile veterans, for whom no stable jurisdiction ever exists, face not episodic disruption but structural exclusion. They are precisely the veterans least equipped to absorb repeated re-entries — and precisely those for whom the current system has no designed response. Administrative dropout—disengagement from the care-seeking process caused by cumulative system friction rather than resolved clinical need—is the terminal outcome of the failure loop for a substantial subset of mobile veterans. Network adequacy failure at intake, the care network adequacy knowledge gap in its detection, and anticipatory disengagement prior to any enrollment are the earlier-stage manifestations that the measurement system currently cannot see. The measurement framework, through goal displacement, optimizes for administrative closure rather than clinical engagement, and in doing

so renders the very failures it should detect systematically undetectable within its current architecture.

The distributional dimension of this failure is equally clear. A facially uniform statutory entitlement is applied unequally in practice. Veterans who remain geographically stationary receive functionally superior access to a benefit Congress guaranteed equally to all enrolled veterans. Veterans whose lives require mobility—disproportionately working-class, rural, occupationally mobile, and housing-unstable—bear a disproportionate burden of structural failures they did not cause and cannot individually remedy. The statutory implementation argument is the strongest framing for this claim, and the NDAA evidence makes it decisive: Congress enacted cross-state licensure flexibility for mental health providers serving servicemembers and military families through the TRICARE pathway in the FY2025 NDAA, and for DoD-contracted counselors through the FY2024 NDAA — the same population, the same mobility problem, the same remedy — while leaving veterans served through the VCCP pathway without equivalent protection. The question is not whether the remedy is feasible, legally defensible, or fiscally sound. Congress has answered all three questions in the affirmative. The question is whether Congress will extend to veterans served through one pathway the protection it has already provided to beneficiaries served through others — and whether the system will continue to tolerate the gap.

The reform agenda presented in this paper is grounded in existing statutory authority, operationally feasible within current institutional capacity, and economically rational when evaluated against the downstream costs of inaction—though a systematic cost-benefit analysis of the specific reforms proposed remains to be conducted. Pursuing all three available tracks — regulatory amendment of 38 C.F.R. § 17.417 where the systemic coherence constraint permits,

legislative amendment of 38 U.S.C. § 1730C as the durable resolution, and judicial review of any petition denial that fails the State Farm reasoned-decisionmaking standard — along with implementing bridge-care reimbursement, redesigning network adequacy standards, strengthening consult accountability, redefining access metrics to capture continuity and administrative dropout, and building a mobility-aware data infrastructure are achievable corrections to a system whose failure modes are now well documented, whose legal basis for reform is well established, and whose continued inaction carries measurable human cost.

Several limitations of this analysis warrant acknowledgment. The paper does not present original empirical data; the structural failure modes identified are grounded in administrative architecture, oversight findings, and clinical literature rather than in quantitative analysis of veteran outcomes disaggregated by mobility status. The causal relationships hypothesized here — between mobility-related care disruption and clinical deterioration, anticipatory disengagement, and elevated suicide risk — are analytically plausible and consistent with the documented structural conditions, but they have not been empirically established in the published literature and require systematic investigation. The cost comparisons offered in the economic costs section are order-of-magnitude illustrations, not systematic cost-benefit analyses; rigorous cost-benefit modeling of the proposed reforms, including federal preemption extension and bridge-care reimbursement, represents an important agenda item for future work. These limitations are structural features of the policy analysis method rather than correctable omissions — the measurement section explains why direct empirical anchoring of the mobility-outcome relationship is currently impossible within VA's data architecture.

A national entitlement requires a national delivery system—one capable of following veterans wherever they live, travel, or seek safety. The gap between the entitlement Congress

created and the system that is supposed to fulfill it is not inevitable. It is the result of policy choices, and it can be closed by policy choices. The question is no longer whether these failures exist, but whether the system will continue to tolerate them. That is both the premise and the conclusion of this analysis.

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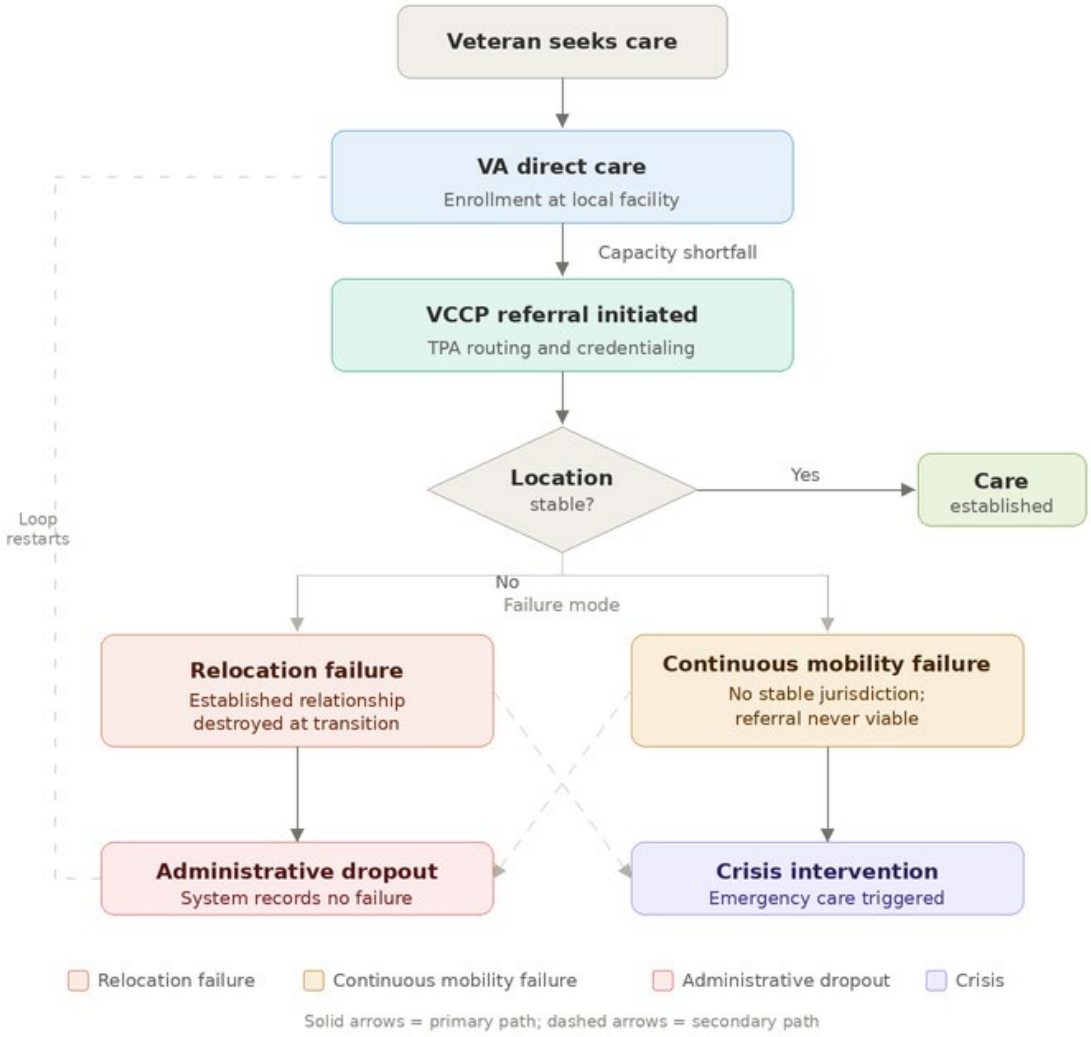
Figure 1

The Dual-Pathway Failure Loop: Two Failure Modes and Their Outcomes



Note. The loop operates through two structurally distinct failure modes. The relocation failure mode (coral) disrupts an established therapeutic relationship when a veteran crosses a state line. The continuous mobility failure mode (amber) prevents a viable provider relationship from forming at all, because the referral architecture requires a fixed jurisdiction the veteran cannot supply. Both failure modes can produce either administrative dropout (red) or crisis-level intervention (purple); solid arrows indicate the primary pathway for each mode, dashed arrows the secondary pathway. Administrative dropout is the more common terminal outcome of the

relocation failure mode; continuous mobility failure most commonly escalates to crisis through repeated failed referral cycles, but may equally produce administrative dropout when the veteran exhausts the process without receiving care. The dashed line at left indicates the restart of the loop. Under the current measurement framework, all terminal outcomes except crisis intervention are invisible in VA performance data.