

**BEFORE THE  
DEPARTMENT OF VETERANS AFFAIRS  
OFFICE OF THE SECRETARY**

In the Matter of:

*The Authority of Department of Veterans Affairs Health Care  
Professionals to Practice Health Care via Telehealth,  
38 C.F.R. § 17.417*

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**PETITION FOR RULEMAKING**

**PURSUANT TO 5 U.S.C. § 553(e)**

**Submitted by:**

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**Date: May 13, 2026**

**I. INTRODUCTION AND SUMMARY OF PETITION**

1. Pursuant to the right of interested persons to petition for the issuance, amendment, or repeal of a rule under section 553(e) of the Administrative Procedure Act, 5 U.S.C. § 553(e), the Institute for Veterans Health & Social Policy (“IVHSP” or “Petitioner”) respectfully petitions the Secretary of Veterans Affairs to initiate rulemaking to amend 38 C.F.R. § 17.417 to extend the Federal licensure preemption presently applicable to Department-employed health care professionals to mental health professionals delivering services to enrolled veterans through the Veterans Community Care Program (“VCCP”).

2. The relief Petitioner requests is narrow, specific, and entirely within the Department’s existing statutory authority under 38 U.S.C. § 1730C. The contractor exclusion that this Petition seeks to remove is a regulatory construction adopted by the Department, not a constraint imposed by the statute. The current statute reaches contractors through the authorization-based pathway in § 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.” The Department’s regulatory exclusion of contractors at 38 C.F.R. § 17.417(b)(2)(iii) narrows that statutory grant by agency choice. What the Department created by rulemaking it can amend by rulemaking.

3. Congress has now twice enacted the precise mechanism this Petition requests. Section 581 of the National Defense Authorization Act for Fiscal Year 2024 (Public Law 118-31) extended cross-State licensure flexibility to Department of Defense-contracted mental health counselors. Section 714 of the Servicemember Quality of Life Improvement and National Defense Authorization Act for Fiscal Year 2025 (Public Law 118-159) extended licensure portability to mental health providers practicing through the civilian network of the TRICARE program, reaching the full population entitled to health care under 10 U.S.C. § 1076 — including military retirees, retiree dependents, and survivors. Veterans enrolled in VHA care, many of whom are concurrently TRICARE-eligible, remain the only category of military-connected mental health care recipients excluded from cross-State licensure protection. The Department has the regulatory authority to close that gap. The Department’s consideration of this matter further implicates affirmative obligations under section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, addressed in Section IV.F below.

4. This Petition includes proposed regulatory text, set forth in Section VII below, that the Department may adopt without further substantive development. The proposed text is modeled on the structure Congress has twice enacted for analogous populations and is calibrated to preserve all existing safety, disciplinary, and controlled-substance protections under Federal law.

5. Petitioner respectfully requests that the Department initiate rulemaking under 5 U.S.C. § 553 within 180 days of the date of this Petition and provide notice of its disposition under 5 U.S.C. § 555(e).

## **II. STATEMENT OF AUTHORITY, JURISDICTION, AND OPERATION OF THE PETITION PROCESS**

### ***A. Statutory Authority for the Petition***

6. Section 553(e) of the Administrative Procedure Act provides: “Each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule.” 5 U.S.C. § 553(e). The petition right is mandatory, not discretionary; the agency has no authority to decline to receive a petition properly submitted. The Supreme Court has confirmed that this right extends to the issuance, amendment, and repeal of agency regulations, and that an agency’s denial of such a petition constitutes final agency action subject to judicial review. See *Massachusetts v. EPA*, 549 U.S. 497, 527-28 (2007).

7. The Department’s receipt and disposition of this Petition is governed by 5 U.S.C. § 555(e), which requires that “[p]rompt notice shall be given of the denial in whole or in part of a written application, petition, or other request of an interested person made in connection with any agency

proceeding,” and that “[e]xcept in affirming a prior denial or when the denial is self-explanatory, the notice shall be accompanied by a brief statement of the grounds for denial.”

8. The Department has authority to amend 38 C.F.R. § 17.417 under 38 U.S.C. § 501(a), which authorizes the Secretary to prescribe regulations necessary to administer the laws administered by the Department, and under 38 U.S.C. § 1730C, which is the substantive statutory basis for the regulation at issue. The Secretary has previously exercised this authority to promulgate, amend, and revise § 17.417 — most recently by final rule published October 2, 2025, 90 Fed. Reg. 47595, effective November 3, 2025, approved by the Secretary on September 23, 2025.

### ***B. Standing of the Petitioner***

9. IVHSP is an “interested person” within the meaning of 5 U.S.C. § 553(e). The petition right under § 553(e) is broadly construed and does not require the showing of injury that Article III standing requires for judicial review. See *WWHT, Inc. v. FCC*, 656 F.2d 807, 813 (D.C. Cir. 1981) (recognizing the broad availability of the § 553(e) petition mechanism to interested persons).

10. IVHSP is a policy research organization dedicated to identifying and addressing structural barriers within Federal systems that impede veterans’ access to entitled health and social services. The regulatory provision at issue directly affects the population on behalf of which IVHSP conducts policy analysis — enrolled veterans receiving or eligible to receive mental health care under title 38 — and the Petition is grounded in IVHSP’s policy research, including the working paper *Crossing Lines: Jurisdictional Barriers, Therapeutic Disruption, and the Case for Federal Preemption in Veteran Mental Health Care*, available through the Social Science Research Network (SSRN) at <https://ssrn.com/abstract=6744578>.

### ***C. How the Petition Process Operates***

11. This Section is included so that the public record of this Petition, and any subsequent media or stakeholder examination of it, accurately reflects the legal framework within which the Department will act on the request.

12. Upon receipt, the Department is required to consider this Petition on its merits. The Department may grant the Petition by initiating notice-and-comment rulemaking under 5 U.S.C. § 553, or it may deny the Petition. If the Department denies the Petition in whole or in part, it must provide the Petitioner with a brief statement of the grounds for denial under 5 U.S.C. § 555(e). The Department may not lawfully ignore the Petition, fail to act on it indefinitely, or dispose of it through silence.

13. An agency denial of a § 553(e) petition is subject to judicial review under 5 U.S.C. § 706 as final agency action. Such review is limited but not nominal; the reviewing court considers whether the agency’s denial was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. Where an agency’s reasons for denial fail to engage with the substance of the petition,

or where the agency relies on factors outside its statutory authority, denial may be set aside. See *Massachusetts v. EPA*, 549 U.S. at 533-35.

14. This Petition does not request that the Department initiate any particular form of rulemaking acceleration or claim that any emergency exception to notice-and-comment procedures applies. Petitioner asks only that the Department initiate rulemaking under standard § 553 procedures within a reasonable period, defined for purposes of this Petition as 180 days from the date of submission.

### **III. STATUTORY AND REGULATORY BACKGROUND**

#### ***A. 38 U.S.C. § 1730C and the MISSION Act Framework***

15. Section 151 of the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (Public Law 115-182; the “MISSION Act”) enacted 38 U.S.C. § 1730C, which authorizes a “covered health care professional” to practice across State lines via telemedicine notwithstanding any contrary State licensure, registration, or certification requirement.

16. Section 1730C(b)(1) defines “covered health care professional” for purposes of section 1730C. The current text of subsection (b)(1) reflects a structural reorganization by Public Law 116-283, § 9101 (Jan. 1, 2021), which added specific provisions for postgraduate employees and health professions trainees. The current statutory text provides that a covered health care professional is an individual 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)(i) has an active, current, full, and unrestricted license, registration, or certification in a State to practice the health care profession of the health care professional; or (ii) with respect to a health care profession listed under section 7402(b) of this title, has the qualifications for such profession as set forth by the Secretary.

17. The phrase “contractor of the Department” appeared in the original 2018 enacted text of § 1730C as part of the “covered health care professional” definition but 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 an authorization-based framework. Under the current statute, the textual pathway to

contractor inclusion runs through subsection (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.” Veterans Community Care Program contractors authorized under a contract entered into pursuant to 38 U.S.C. § 1703 are authorized by the Secretary to provide health care under chapter 17 within the meaning of subsection (b)(1)(B). Congress did not foreclose contractor coverage in the 2021 restructuring; it preserved the authorization-based pathway through which the Secretary can reach contractors by regulation.

***B. 38 C.F.R. § 17.417 and the Contractor Exclusion***

18. The Department’s implementing regulation at 38 C.F.R. § 17.417 was originally promulgated by final rule published May 11, 2018, 83 Fed. Reg. 21897, effective June 11, 2018, prior to enactment of the MISSION Act. The regulation has been amended on multiple occasions, most recently by final rule published October 2, 2025, 90 Fed. Reg. 47595, effective November 3, 2025.

19. The October 2, 2025 final rule, approved by the Secretary on September 23, 2025, amended the regulation in several respects. As relevant here, the rule preserved the existing definition at 38 C.F.R. § 17.417(b)(2)(iii), which provides that a covered “health care professional” for purposes of the rule “[i]s not a VA-contracted health care professional.”

20. The Department considered, in the rulemaking proceedings preceding the original 2018 rule, the 2020 interim final rule revisions, and the 2025 final rule, public comments specifically requesting that contractors be included within the regulation’s scope. The Department declined to include contractors in each instance, principally on the rationale that contracted health care professionals do not operate within the “scope of Federal duties” framework that the Department has applied to its appointed employees.

21. The contractor exclusion at 38 C.F.R. § 17.417(b)(2)(iii) is therefore a discretionary regulatory narrowing of the statutory authority Congress provided in § 1730C — specifically, of the authorization-based pathway preserved in § 1730C(b)(1)(B). The exclusion is not required by the statute. It is the product of agency choice, and it can be modified by agency choice through the same notice-and-comment rulemaking process by which it was adopted — 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 FY 2025 NDAA.

***C. The Veterans Community Care Program and the Resulting Two-Tiered System***

22. The MISSION Act also established the Veterans Community Care Program under 38 U.S.C. § 1703, providing that veterans become eligible to receive care from non-Department providers under specified conditions, including when the Department cannot provide care within designated access standards. The mental-health-specific access standard, codified at 38 U.S.C. § 1703B and implemented at 38 C.F.R. § 17.4040, is twenty days.

23. The Department contracts with Third-Party Administrators — currently Optum Serve and TriWest Healthcare Alliance — to manage networks of community-based providers who deliver care to veterans referred under § 1703. These contracted community providers, despite being engaged through a Department program, funded by Department appropriations, and bound by Department clinical standards, are categorized as “VA-contracted health care professionals” under the regulation and are therefore excluded from the licensure preemption afforded their Department-employed counterparts.

24. The result is a two-tiered system. A Department-employed clinician at a Department facility may, under § 1730C and § 17.417, deliver tele-mental-health care across State lines without obtaining a license in the veteran’s State of physical location. A community provider treating the same veteran under VCCP — referred through the same program, funded through the same statutory authority, providing the same clinical service — may not. When the veteran crosses a State line, the community provider becomes legally barred from continuing care; the Department-employed provider does not. The veteran’s access to cross-State continuity of care therefore depends on which pathway the Department’s capacity constraints have routed them into — a routing decision over which the veteran exercises no control.

#### **IV. CONGRESS HAS ENACTED THE PROPOSED REMEDY TWICE FOR ANALOGOUS POPULATIONS**

25. The legal foundation for the action this Petition requests is not novel. Congress has enacted the precise mechanism — Federal licensure preemption for mental health providers serving a mobile military-connected population — twice in two consecutive National Defense Authorization Acts, with overwhelming bipartisan support.

##### ***A. Section 581 of the FY 2024 NDAA (Public Law 118-31)***

26. Section 581 of the National Defense Authorization Act for Fiscal Year 2024 (Public Law 118-31), enacted in December 2023, authorized the Secretary of Defense to extend cross-State licensure flexibility to Department of Defense-contracted mental health counselors providing services to members of the Armed Forces and their families. The provision passed both chambers of Congress with bipartisan support and has been implemented without documented adverse outcomes.

##### ***B. Section 714 of the FY 2025 NDAA (Public Law 118-159)***

27. Section 714 of the Servicemember Quality of Life Improvement and National Defense Authorization Act for Fiscal Year 2025 (Public Law 118-159), enacted in December 2024, established licensure portability for mental health providers practicing through the civilian network of the TRICARE program. The provision authorizes such providers to deliver tele-mental-health care services without regard to the location of the provider or the patient, notwithstanding contrary State licensure requirements.

28. Section 714 was carried into law as part of the FY 2025 NDAA conference report, which passed the House by a vote of 281-140 and the Senate by a vote of 85-14. Those vote margins, while reflecting passage of the conference report as a whole, evidence the bipartisan recognition that cross-State licensure barriers, when applied to mental health providers serving a mobile military-connected population through a federally-funded delivery program, produce continuity-of-care failures that the Federal government may, and should, address through preemption.

***C. The Scope of § 714 Reaches Military Retirees and Their Dependents***

29. Section 714 extends preemption to TRICARE network mental health providers serving any individual entitled to health care under 10 U.S.C. § 1076. Section 1076 governs TRICARE eligibility and extends to active-duty service members and their dependents, military retirees and their dependents, and survivors of deceased service members.

30. The scope of § 714 therefore reaches the full TRICARE-eligible population — including military retirees living in civilian life under civilian regulatory frameworks. 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.

31. Under the current regulatory framework, the same individual — a military retiree who is also a veteran enrolled in VHA care — may obtain cross-State tele-mental-health continuity from a TRICARE network provider while being denied that same continuity from a VCCP network provider. The regulatory disparity therefore falls on a single person depending solely on which Federal benefit program is used to access care on a given day. There is no policy rationale within the Department’s authority that justifies preserving that disparity, and no statutory rationale that requires it.

***D. H.R. 5357 and the Continuing Legislative Pattern***

32. The legislative pattern continues in the 119th Congress. H.R. 5357, the College Students Continuation of Mental Health Care Act of 2025, was introduced September 15, 2025 by Representative Mike Flood with original cosponsors Representatives Don Bacon and Zachary Nunn during National Suicide Prevention Month, and has since attracted additional bipartisan cosponsors. The bill would extend functionally identical licensing reciprocity to college mental health providers serving students across State lines. The bill is grounded in the same continuity-of-care principle: that geographic mobility should not sever an established and effective therapeutic relationship.

33. The legislative principle Congress has been enacting across multiple populations — that cross-State licensure barriers should not be permitted to terminate established mental health care relationships when the patient’s mobility is the product of normal life rather than provider misconduct — is not military-specific or veteran-specific. It applies wherever a mobile population’s established therapeutic relationships are severed by jurisdictional boundaries the

patient did not choose to cross. The veterans served through the VCCP pathway are presently the only category of Federally-sponsored mental health care recipients to whom this principle has not been extended.

***E. Statutory Construction and the Limits of Agency Discretion***

34. The Department’s contractor exclusion at 38 C.F.R. § 17.417(b)(2)(iii) is in tension with the structure of the statute it implements. Section 1730C(b)(1) defines “covered health care professional” through four conjunctive elements, the second of which provides that a covered professional is one who “is authorized by the Secretary to provide health care under this chapter.” § 1730C(b)(1)(B). Veterans Community Care Program contractors authorized under a § 1703 contract are authorized by the Secretary to provide health care under chapter 17 within the meaning of subsection (b)(1)(B). The Department’s reading of subsection (b)(1) — that all four elements must be satisfied conjunctively, and that element (A)’s appointment requirement limits coverage to Department employees regardless of the independent reach of element (B) — renders subsection (b)(1)(B) surplusage in a specific sense: any employee appointed under (A) is by definition authorized by the Secretary, so element (B) does no independent work if the Department’s conjunctive reading is correct. Under settled principles of statutory construction, a reading that renders an enumerated statutory element a redundancy is disfavored. The Supreme Court has stated the rule unequivocally: “It is ‘a cardinal principle of statutory construction’ that ‘a statute ought, upon the whole, to be so construed that, if it can be prevented, no clause, sentence, or word shall be superfluous, void, or insignificant.’” *TRW Inc. v. Andrews*, 534 U.S. 19, 31 (2001) (quoting *Duncan v. Walker*, 533 U.S. 167, 174 (2001)). The companion principle is equally well established: it is “the duty of the court ‘to give effect, if possible, to every clause and word of a statute.’” *Montclair v. Ramsdell*, 107 U.S. 147, 152 (1883). Petitioner acknowledges that this argument is more inferential than a direct textual compulsion. The natural grammar of subsection (b)(1) is conjunctive, and a reviewing court could read element (B) as adding an independent authorization requirement applicable to (A)-eligible employees rather than as creating an alternative qualifying pathway. The argument is offered as one strong leg of a multi-leg case for reconsideration of the contractor exclusion, not as the dispositive textual point.

35. The Department itself has invoked these very canons. In the preamble to the October 2, 2025 final rule that this Petition asks the Department to amend, the Department applied the canon against surplusage to support 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)). The canon the Department invoked to defend its reading of subsection (d) operates with equal force against its conjunctive reading of subsection (b)(1) — specifically, the reading that renders element (B) of that subsection an empty requirement when the population otherwise satisfying (A) through (D) is limited to (A)-appointed employees. The Department cannot consistently maintain that the surplusage canon controls when it favors the agency’s interpretation of one provision of § 1730C

while disregarding the canon when it disfavors the agency’s interpretation of another provision of the same statute.

36. The Department’s distinction between contractors and employees on a “scope of Federal duties” rationale does not insulate the exclusion from the textual and structural arguments above. Even if subsection (b)(1) is read conjunctively, the Secretary retains substantial regulatory authority to define eligibility conditions for VCCP contractors. Under 38 U.S.C. § 501(a), the Secretary has general authority to prescribe regulations necessary or appropriate to carry out the laws administered by the Department. Under 38 U.S.C. § 1703, the Secretary has specific authority to enter into contracts and agreements with non-Department providers to furnish hospital care, medical services, and extended care services to eligible veterans. Under 38 U.S.C. § 1703(h), the Secretary has authority to establish standards for community care providers. These authorities, taken together with the authorization-based pathway in § 1730C(b)(1)(B), provide the regulatory basis for amending § 17.417 to bring VCCP-contracted mental health providers within the preemption framework subject to 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. The Secretary’s discretion to set the conditions under which contractors are covered does not extend to the discretion to disregard the authorization-based pathway Congress preserved in § 1730C(b)(1)(B).

37. 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 2, 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 the rulemaking this Petition requests is the appropriate forum in which to address that doctrinal shift.

38. Independent of the construction question, the Department’s preservation of the contractor exclusion in the October 2, 2025 final rule is also 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, among other things, “entirely failed to consider an important aspect of the problem.” *Id.* at 43. The October 2, 2025 final rule was promulgated after Congress had enacted both Section 581 of the FY 2024 NDAA (Public Law 118-31, December 2023) and Section 714 of the FY 2025 NDAA (Public Law 118-

159, 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 Department’s 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.

39. The line of 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 his 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 the State requirement interferes with Federal program functions and conflicts with Federal program standards. *Id.* at 189-90. *Leslie Miller* has been applied by lower Federal courts to invalidate State licensure requirements as applied to Federal contractors performing Federal work. See, e.g., *Gartrell Construction, Inc. v. Aubry*, 940 F.2d 437, 437-39 (9th Cir. 1991) (applying *Leslie Miller* to invalidate State licensure requirement against Federal contractor). The doctrinal line from *Johnson v. Maryland* through *Leslie Miller* establishes that State licensure regimes that “lay hold of” Federal personnel in the specific performance of Federal duties — whether the personnel are Federally employed or Federally contracted — yield to the Federal interest in the uninterrupted execution of Federal program functions. The Department’s existing § 17.417 preemption already implements this principle for VA-employed clinicians; the regulatory amendment this Petition requests would extend it to the contracted VCCP mental health providers performing the same Federal program function for the same Federally-entitled beneficiary population.

***F. Disability Accommodation Considerations Under Section 504 of the Rehabilitation Act***

40. The regulatory framework under consideration 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, including 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.

41. A substantial portion of the population affected by the regulatory exclusion at issue consists of qualified individuals with disabilities within the meaning of section 504. Service-connected disabled veterans receiving Department mental health care for service-connected mental health 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 determined the disability status of these individuals.

42. Section 504 has been read to require Federal agencies to make reasonable modifications to permit qualified individuals with disabilities to participate in covered programs on terms equivalent to those available to non-disabled persons, and, where the agency is itself the program administrator, to extend reasonable accommodations to disabled beneficiaries within the program. The reasonableness of an accommodation is evaluated against considerations of feasibility, fundamental alteration of the program, and undue burden.

43. The Federal government has determined, through both Department regulation and Congressional enactment, that cross-State licensure preemption for mental health providers serving federally-sponsored populations is feasible, does not fundamentally alter the program 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 FY 2024 NDAA and Section 714 of the FY 2025 NDAA implement the same determination for Department of Defense-contracted counselors and TRICARE network mental health providers, respectively. The accommodation has been provided, evaluated against operational and policy considerations, and adopted across multiple Federal programs serving military-connected populations.

44. The regulatory 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 the accommodation through other Federal programs. The regulatory exclusion thereby produces, as applied to disabled veterans, differential access to a benefit for which the accommodation has been independently determined to be reasonable.

45. The disability accommodation framework has particular force in cases where the Department's own administrative architecture causes the geographic mobility that triggers the regulatory exclusion's effect. The Department's Veterans Integrated Service Network structure is itself a source of cross-State care scenarios: of the eighteen Veterans Integrated Service Networks, the substantial majority span multiple States, with several VISNs encompassing as many as ten States within a single network. The Department's specialty care assignment practices routinely refer veterans across State lines for treatment available at specific medical centers within their VISN,

with the result that hundreds of distinct directed scenarios exist in which a veteran's State of residence differs from the State of an assigned in-VISN treatment facility. VISN 8, the VA Sunshine Healthcare Network, encompasses Florida, southern Georgia, Puerto Rico, and the U.S. Virgin Islands, with main medical centers including the Gainesville VAMC in Florida that serve veterans residing in southern Georgia. A Georgia-resident veteran assigned to a VCCP tele-mental-health provider licensed in Georgia, who is then required to travel to a Florida 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 assigned the specialty care to a different State. The veteran's mental health treatment becomes a casualty of other necessary medical care over which the veteran has no control. This pattern is not isolated; it is structural to a delivery system whose VISN architecture pre-dates and does not account for the cross-State licensure constraint the contractor exclusion preserves.

46. Petitioner does not advance section 504 in this Petition as a primary cause of action. Petitioner advances it as a substantive consideration the Department is required to address as part of its comprehensive evaluation of the regulatory exclusion. The Department's prior rulemaking proceedings concerning § 17.417, including the rulemaking that produced the October 2, 2025 final rule, did not engage with the disability accommodation framework as part of the agency's deliberation. The Department's consideration of this Petition, and any rulemaking that follows from it, must include affirmative evaluation of the Department's obligations under section 504 with respect to qualified disabled veterans whose access to continuous mental health care is affected by the contractor exclusion.

### ***G. Foreclosure of Standard Objections***

47. This enacted legislative record forecloses the three objections most commonly raised against extending preemption to VCCP providers.

48. First, the objection that the remedy is administratively novel. Congress has designed, enacted, and implemented the same mechanism twice in two consecutive NDAA's. The Department of Defense has implemented § 1094(d)(4), as added by § 714 of the FY 2025 NDAA, without documented adverse outcomes. The administrative architecture for cross-State licensure preemption in federally-funded mental health programs is established and functional.

49. Second, the objection that the remedy raises unresolved legal questions. The constitutional authority to attach licensure conditions to federally-funded health care contracts has been exercised by Congress under the Spending Clause (U.S. Const. art. I, § 8, cl. 1) and the Commerce Clause (U.S. Const. art. I, § 8, cl. 3) and has not been judicially challenged with success. The Department itself has exercised this preemption authority for its own employed clinicians since 2018, and the 2025 final rule reaffirmed the preemption framework without legal challenge.

50. Third, the objection that the remedy is fiscally expansive. Federal preemption does not change reimbursement rates. VCCP rates apply regardless of where the provider practices, just as TRICARE rates apply regardless of where the provider practices. The cost of preemption is administrative; the cost of not extending it is borne by veterans in interrupted care, by the Department in crisis utilization, and by the Federal fisc through downstream consequences of treatment discontinuity.

## **V. THE STRUCTURAL HARM THE CURRENT EXCLUSION PRESERVES**

### ***A. The Affected Population***

51. Approximately 9.1 million veterans are enrolled in the patient enrollment system of the Veterans Health Administration as of 2026. Of these, roughly one-third reside in rural or highly rural areas, where travel distances to Department facilities often exceed sixty miles one way.

52. A substantial proportion of the enrolled population is mobile across State lines for reasons including, but not limited to: residence in border regions where the nearest provider may be located across a State line; employment in interstate transportation, in which veterans are overrepresented and are estimated, on the basis of American Community Survey data, to constitute approximately ten percent of the national truck-driving workforce — a figure that 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; caregiving travel to support family members residing in other States; housing instability, including the 32,882 veterans identified in the 2024 Point-in-Time count as experiencing homelessness on a single night; service in the National Guard or Reserve with cross-State drill obligations; seasonal employment patterns; and post-separation geographic transition, with the Department of Defense estimating that approximately 200,000 service members transition from active duty to civilian life annually.

### ***B. Two Distinct Failure Modes***

53. Petitioner's research, presented in detail in the working paper *Crossing Lines* available through SSRN at <https://ssrn.com/abstract=6744578>, identifies two structurally distinct failure modes within the current dual-pathway architecture, both preserved by the contractor exclusion at 38 C.F.R. § 17.417(b)(2)(iii).

54. The relocation failure mode disrupts an established therapeutic relationship when a veteran crosses a State line. The community provider, holding licensure in the State of treatment initiation, loses jurisdictional authority upon the veteran's relocation and is legally barred from continuing care. The therapeutic alliance — the relational bond on which mental health treatment effectiveness depends — terminates not because of any clinical or behavioral failure, but because of a regulatory boundary the veteran's mobility crossed. The veteran is returned to the referral process to begin again.

55. The continuous mobility failure mode is categorically more severe. For veterans whose location is continuously variable — long-haul truckers running multistate circuits, veterans cycling through shelter networks, seasonal workers, full-time recreational vehicle travelers, National Guard members with cross-State drill obligations — the referral architecture cannot establish a legally viable provider relationship at all. The system requires a fixed jurisdictional input; the veteran’s life cannot supply it. No therapeutic relationship forms.

56. Both failure modes are preserved by the current contractor exclusion. Both fall most heavily on populations with elevated clinical risk and reduced administrative capacity to navigate repeated referral failures.

***C. Independent Oversight Findings Corroborate the Structural Harm***

57. Independent oversight bodies have reached findings consistent with the structural harm Petitioner identifies. These findings constitute corroborating evidence that the access architecture the contractor exclusion preserves is producing measurable harm not currently being addressed through existing mechanisms.

58. The Government Accountability Office reported in July 2024 that the Department of Defense’s inTransition program — its primary mechanism for facilitating mental health continuity across the separation continuum — failed to successfully connect with more than seventy percent of eligible separating service members during the highest-risk period for suicide. GAO, DOD and VA Health Care: Actions Needed to Better Facilitate Access to Mental Health Services During Military to Civilian Transitions, GAO-24-106189 (July 15, 2024).

59. A May 2025 GAO report on community care behavioral health referrals found that only about two percent of community providers with behavioral health referrals had completed one or more of eight core Department clinical trainings, including suicide prevention training, and that the Department was not monitoring completion. GAO, Veterans’ Community Care: VA Needs Improved Oversight of Behavioral Health Medical Records and Provider Training, GAO-25-106910 (May 5, 2025).

60. An April 2024 Office of Inspector General audit found that the Department’s Office of Integrated Veteran Care did not hold Third-Party Administrators accountable for implementing network adequacy contract requirements and did not conduct analyses of facilities’ network adequacy needs to help TPAs build adequate provider networks. VA OIG, Improved Oversight Needed to Evaluate Network Adequacy and Contractor Performance, Report No. 23-00876-74 (April 9, 2024).

61. The Department’s 2024 National Veteran Suicide Prevention Annual Report identified 6,398 veteran suicides in 2023, and veterans with recent mental health or substance use diagnoses experienced suicide rates far exceeding those of the general population. While the specific causal contribution of the contractor exclusion to veteran suicide outcomes has not been empirically

isolated, the structural conditions the exclusion preserves — broken therapeutic continuity, administrative dropout, and access intervals exceeding the Department’s designated standards — are documented contributors to clinical risk in populations with elevated baseline vulnerability.

***D. Direct Operational Evidence***

62. The operational reality of the failure architecture is observable in current Department operations. As of the date of this Petition, the wait for a first appointment with a Department-employed mental health counselor in Veterans Integrated Service Network 8 is approximately 120 days — six times the Department’s twenty-day designated access standard for mental health care under 38 C.F.R. § 17.4040. Veterans in VISN 8 who require care during that interval, and who therefore become eligible for VCCP referral under 38 U.S.C. § 1703(d)(1)(D), enter the community care pathway only to encounter the jurisdictional barrier the contractor exclusion preserves.

63. The combination of direct-care capacity shortfalls of this magnitude with the contractor exclusion produces a system in which veterans referred to community care because Department care is unavailable encounter, in that community care, the same kind of structural barrier that made Department care unavailable to begin with. The exclusion is most consequential at precisely the moment when the alternative pathway it forecloses is most needed.

**VI. ALIGNMENT WITH DEPARTMENT PRIORITIES AND EXISTING REGULATORY POSTURE**

64. The regulatory action Petitioner requests is consonant with priorities the Department has publicly articulated. The Secretary has identified suicide prevention as a central priority of his tenure. The Department has emphasized expansion of the community care network, advancement of the External Provider Scheduling system, and reallocation of resources from administrative functions into the community care patient network. The Community Care Network Next Generation contract solicitation is structured to provide operational flexibility to deliver care more reliably to veterans who exercise the choice the MISSION Act guaranteed.

65. Each of these initiatives is impeded, in the specific context of mental health care, by the contractor exclusion at 38 C.F.R. § 17.417. Expanded community care networks cannot deliver continuity to mobile veterans when network providers are legally prevented from following them across State lines. External provider scheduling cannot resolve a referral problem that resolves into legal non-viability rather than scheduling friction. Suicide prevention efforts cannot reach veterans whose treatment relationships are repeatedly severed by jurisdictional rather than clinical considerations, or whose continuous mobility prevents such relationships from forming.

66. Removing the regulatory exclusion would materially advance each of these priorities without altering any other element of the Department’s current direction. The Secretary personally

approved the September 23, 2025 document that became the most recent revision to 38 C.F.R. § 17.417 and is therefore familiar with the regulatory framework the Petition requests be amended.

## VII. PROPOSED REGULATORY TEXT

67. Petitioner respectfully submits the following proposed amendment to 38 C.F.R. § 17.417 for the Department’s consideration. The proposed text is modeled on the structure Congress has enacted at 10 U.S.C. § 1094(d)(4) for TRICARE network mental health providers and is calibrated to preserve all existing safety, disciplinary, and controlled-substance protections under Federal law. Petitioner submits this text in the form of regulatory amendment language that may be adopted by the Department in notice-and-comment rulemaking under 5 U.S.C. § 553.

### Section 17.417 is amended as follows:

68. Paragraph (b)(2)(iii) is amended by striking the phrase “Is not a VA-contracted health care professional” and inserting in its place the following:

*“(iii) Is, except as provided in subparagraph (iv), not a VA-contracted health care professional.”*

69. Paragraph (b)(2) is further amended by adding at the end the following new subparagraph (iv):

***“(iv) Covered community care mental health professionals.***

*“(A) In general. Notwithstanding subparagraph (iii), a VA-contracted health care professional who meets the requirements of this subparagraph is a health care professional for purposes of this section.*

*“(B) Eligibility. A VA-contracted health care professional is a covered community care mental health professional if the professional —*

*“(1) holds a current, full, and unrestricted license, registration, or certification to practice as a mental health care professional in at least one State;*

*“(2) is providing mental health services to a beneficiary under a contract or agreement entered into pursuant to 38 U.S.C. § 1703 or § 1703A; and*

*“(3) is providing such services in accordance with terms and conditions specified by the Secretary in this section, in the contract or agreement, or in subsequent guidance, which shall constitute the scope of authorized Federal duties for purposes of paragraph (c) of this section.*

*“(C) Mental health care professional defined. For purposes of this subparagraph, the term ‘mental health care professional’ includes psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, and other licensed mental health practitioners as the Secretary may designate by guidance.*

*“(D) Verification. The Secretary shall require, through contract or regulation, that each Third-Party Administrator participating in the Veterans Community Care Program verify and document the licensure status of each covered community care mental health professional in its network at the time of credentialing and at each credentialing renewal.*

- “(E) Disciplinary cooperation. The Secretary shall establish procedures for —*
- “(1) prompt notification to the relevant State licensing authority of any disciplinary action taken by the Department or by a Third-Party Administrator with respect to a covered community care mental health professional acting under this subparagraph; and*
- “(2) consideration of, and appropriate action upon, credible information received from a State licensing authority regarding the conduct of such a professional.*
- “(F) Controlled substances. Nothing in this subparagraph shall be construed to authorize a covered community care mental health professional to prescribe, dispense, or administer a controlled substance in a manner inconsistent with the Controlled Substances Act, 21 U.S.C. § 801 et seq., or its implementing regulations, including but not limited to those at 21 C.F.R. Part 1300 et seq.*
- “(G) No requirement to issue license. Nothing in this subparagraph shall be construed to require any State to issue a license, registration, or certification to a covered community care mental health professional, or to alter the qualifications a State may establish for licensure of practitioners not acting under this section.*
- “(H) Effect on compacts. Nothing in this subparagraph shall be construed to limit, displace, or supersede the authority of an interstate licensure compact, including the Psychology Interjurisdictional Compact, the Counseling Compact, or the Social Work Licensure Compact, with respect to practice authorized under such compact independently of this subparagraph.”*

70. Paragraph (c) is amended to extend the preemption of conflicting State law to covered community care mental health professionals, by inserting after the phrase “when such health care providers are practicing telehealth within the scope of their VA employment” the phrase “or, in the case of covered community care mental health professionals as defined in paragraph (b)(2)(iv) of this section, within the scope of their authorized Federal duties under that paragraph.”

## **VIII. RELIEF REQUESTED**

71. WHEREFORE, the Institute for Veterans Health & Social Policy respectfully requests that the Secretary of Veterans Affairs:

**A.** Initiate rulemaking under 5 U.S.C. § 553 to amend 38 C.F.R. § 17.417 to extend Federal licensure preemption to mental health professionals delivering services to enrolled veterans through the Veterans Community Care Program;

**B.** Adopt, or use as the foundation for further development through notice-and-comment rulemaking, the proposed regulatory text set forth in Section VII of this Petition;

**C.** Initiate the rulemaking proceeding contemplated by Paragraph A within 180 days of the date of this Petition, or, if the Secretary determines that initiation within that period is not feasible, provide Petitioner with a written statement of the basis for that determination and the anticipated timeline for action;

D. Provide Petitioner with prompt notice of the disposition of this Petition under 5 U.S.C. § 555(e), accompanied by a brief statement of the grounds for any denial or partial denial; and

E. Grant such other or further relief as the Secretary deems appropriate.

## **IX. DISCLOSURE**

72. In the interest of full transparency, Petitioner discloses the following relationships of its principal officer to the Department of Veterans Affairs:

73. Matthew A. Williams, MPA, the Founder and Chief Executive Officer of the Institute for Veterans Health & Social Policy and the signatory to this Petition, is the sole owner and member of Purchinex, LLC, a Georgia limited liability company certified by the United States Small Business Administration as a Service-Disabled Veteran-Owned Small Business and registered in the System for Award Management. Purchinex, LLC holds active contracts with the Department of Veterans Affairs and other Federal agencies in the procurement, supply, and installation of commercial and industrial laundry equipment, including washer-extractors, dryers, finishing equipment, conveyor systems, and associated plant management software, principally serving Department medical center facilities. The contracting relationship is non-clinical and is in a procurement category entirely unrelated to the provision of mental health services, community care delivery, telehealth services, or any other matter within the regulatory scope of 38 C.F.R. § 17.417 or the regulatory amendment requested in this Petition.

74. Mr. Williams is also 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 in this Petition, including documented encounters with the failure mechanisms described herein. The structural analysis presented in this Petition is informed in part by that direct personal experience, as well as by the broader policy research conducted by IVHSP.

75. Petitioner takes the position that the regulatory amendment requested in this Petition benefits enrolled veterans as a class and confers no financial or professional advantage on Mr. Williams or on Purchinex, LLC. The procurement category in which Purchinex contracts with the Department — commercial laundry equipment and related services — is not affected by the regulatory amendment requested, which is limited to the licensure preemption framework applicable to mental health professionals delivering services under the Veterans Community Care Program. These relationships are disclosed not as the basis for the Petition — the legal and policy case stands independently of the petitioner's individual circumstances — but so that the Department, and any subsequent reviewing authority or member of the public examining this Petition, may assess them as part of the complete record.

## **X. CONCLUSION**

76. The contractor exclusion at 38 C.F.R. § 17.417(b)(2)(iii) is a discretionary regulatory narrowing of the authorization-based pathway in 38 U.S.C. § 1730C(b)(1)(B). Congress has twice enacted the precise mechanism this Petition requests for analogous populations served through the Department of Defense health system. The structural harm the exclusion preserves is documented, ongoing, and concentrated on veterans the Department has identified as having elevated clinical risk. The relief Petitioner requests is within the Department's existing authority, requires no new legislation, and would advance priorities the Secretary has publicly articulated.

77. Petitioner respectfully requests that the Secretary act on this Petition by initiating rulemaking under 5 U.S.C. § 553 within the period requested in Section VIII.

Respectfully submitted,

**INSTITUTE FOR VETERANS HEALTH & SOCIAL POLICY**



**Matthew A. Williams, MPA**

Founder & Chief Executive Officer

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**Date: May 13, 2026**

**CERTIFICATE OF FILING AND SERVICE**

I hereby certify that on the date set forth below, the foregoing Petition for Rulemaking was submitted to the Department of Veterans Affairs by transmission to the Office of the Secretary at 810 Vermont Avenue, NW, Washington, DC 20420, by electronic mail to the Department's designated correspondence channels, and by United States certified mail with return receipt requested.

Date: May 13, 2026

A handwritten signature in blue ink, appearing to read 'M.A. Williams', with a long horizontal flourish extending to the right.

**Matthew A. Williams, MPA**

Founder & Chief Executive Officer

Institute for Veterans Health & Social Policy