United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

March 7, 2022

Dr. David Carroll
Executive Director
Office of Mental Health and Suicide Prevention
Veterans Health Administration
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Dr. Carroll,

I write today to provide comments on the Department of Veterans Affairs' (VA) proposed rule (RIN: 2900-AQ30), published in the Federal Register on January 5, 2022, to eliminate the copayment for outpatient medical care and reduce the copayment for medications dispensed for veterans identified by VA as being at high risk for suicide.

I strongly believe all veterans at risk of suicide should be given access to the care they need, without any cost-sharing. I support VA's proposed rule to amend its regulations that govern copayments for outpatient medical care and medications for veterans determined to be at high risk for suicide.

According to a 2019 report from RAND, about one in five veterans experiences mental health problems, including posttraumatic stress disorder, major depression, and anxiety. Veterans without a documented service-connected disability or whose income exceeds the VA threshold may be subject to copayments for VA health care. These veterans may be charged between $15 to $50 for outpatient mental health care appointments, dependent on whether the visit is for primary or specialty care.

There are numerous studies showing the effect of copayments and out-of-pocket costs on deterring patients from seeking care. In addition to the studies cited in the proposed rule, a 2006 study in the American Journal of Psychiatry demonstrated that even "modest visit copayments significantly reduced initial access to mental health treatment and…copayments restricted access regardless of clinical need." Veterans at high risk of suicide may need intensive outpatient mental health visits in order to meet their care needs. Cost should not be a deterrent from ensuring veterans receive the care that is needed and recommended by their VA provider.

Further, under Section 1722A(a)(1) of title 38, United States Code, veterans are required to pay $2 for each 30-day supply of medication for the treatment of a non-service-connected disability or condition. VA highlights this medication copayment may cause providers to

prescribe higher amounts of medication than advisable for veterans at high risk of suicide. Waiving the medication copayment would allow providers to prescribe smaller amounts at a time, such as 7-day or 10-day doses, in order to reduce likelihood of prescription drug misuse and overdose, and ensure cost is not a barrier.

In implementing these revisions in access to care for veterans at high risk of suicide, I request VA consider the incorporation of calls and communications to the Veterans Crisis Line, or 988, as part of the "high risk" determination. Further, VA should work to clarify the roles of REACH VET, Suicide Prevention Coordinators, primary care providers, and mental health providers in the "high risk" determination process and rollout of these revisions. In addition, I ask VA to review the findings from a forthcoming Government Accountability Office report on how the Department handles patients at high risk for suicide to inform any improvements to this program. This was a mandate from Public Law 116-171, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act.

Further, VA notes community care providers "do not have direct access to the veteran's electronic health record (EHR), which is maintained by VA, and therefore cannot add an alert into that record." It is vitally important for VA to develop an outreach, education, and training plan for how community care providers can report back a recommended "high risk" determination for a veteran in their care. And, VA should consider the development of a process for ensuring any community care provider notes on suicide risk are expediently added to the veteran's health record and shared with their primary care provider.

Lastly, the electronic "flags" for veterans at high risk of suicide and the operation of this proposed copayment waiver program are dependent upon a properly functioning EHR system. With the EHR Modernization (EHRM) project underway, I request VA pay particular attention to the carryover of these high risk flags on veterans' health records. During the initial EHRM rollout in Spokane, there were reports of high risk flags going missing from veterans' EHRs. It is paramount for providers to have knowledge of their veteran patients who are at high risk of suicide for proper care coordination, implementation of this copayment waiver program, and overall suicide prevention.

I commend the Department for this thoughtful approach to decreasing veterans' barriers to mental health care and bolstering suicide prevention efforts. I strongly support these proposed regulations and you have my commitment to ensuring VA has the resources it needs to make these changes. Thank you for your consideration of these comments.

Sincerely,

Jon Tester
Chairman
Senate Committee on Veterans' Affairs