United States Senate
COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510–6275

February 4, 2026

VIA ELECTRONIC TRANSMISSION

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services

Dear Administrator Oz:

I'm writing today with concerns regarding a recent Department of Health and Human Services Office of Inspector General (HHS OIG) report entitled, *Most Children Enrolled in Medicaid Did Not Receive Timely Suicide-Related Followup Care*.[1] The report is particularly alarming considering that Medicaid currently provides coverage to 27 million children, and suicide is currently the second leading factor of childhood deaths in America—increasing a staggering 166% between 2016 and 2022.[2]

I have long advocated for programs supporting Americans' mental health and demanded transparency from providers treating these issues. In 2022, I wrote to then-Department of Veterans Affairs (VA) Secretary Dennis McDonough raising concerns about the implementation of the *VA Mission Act*, which would ensure that veterans receive quality care in a timely manner.[3] In 2023, I re-introduced the bipartisan *Fighting Post-Traumatic Stress Disorder Act* in an effort to help first responders who face long-term effects from providing emergency aid.[4] More recently, on February 28, 2025, I wrote to then-Acting Administrator for the Centers for Medicare & Medicaid Services (CMS) Stephanie Carlton pressing for clear and accessible information on inpatient psychiatric facilities.[5] In CMS's response, the agency stated that the *Social Security Act* prohibits disclosing accreditation surveys and this limited its ability to include information from inspection reports.[6] As a result, I introduced legislation aimed at boosting transparency within psychiatric facilities by allowing the HHS Secretary to disclose hospital accreditation inspection reports.[7]

Patients with a history of suicide are at 300 times more risk of committing suicide within one week of their discharge from medical facilities, making it crucial that they be seen for a follow-up appointment within this period.[8] Experts from the American Academy of Pediatrics recommend a follow-up within 72 hours, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Lifeline requires a follow-up within 24-72 hours of the initial contact, and the National Action Alliance for Suicide Prevention recommends a follow-up within seven days after discharge.[9]

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[1] Department of Health and Human Services, Office of Inspector General, *Most Children Enrolled in Medicaid Did Not Receive Timely Suicide-Related Followup Care,* (OEI-07-23-00510), (Sep. 2, 2025), https://oig.hhs.gov/documents/evaluation/10940/OEI-07-23-00510.pdf.
[2] *Id*. at 1. (OIG reported that between 2018 and 2023, over 10,000 children committed suicide.).
[3] Letter from Sen. Charles E. Grassley, Ranking Member, Senate Committee on the Judiciary, to the Honorable Denis McDonough, Secretary, Veterans Affairs (Jan. 12, 2022), https://www.grassley.senate.gov/news/news-releases/grassley-demands-answers-from-va-on-reports-of-inadequate-access-to-care.
[4] Press Release, Office of Sen. Charles E. Grassley, *Colleagues Re-Introduce Bill to Help First Responders Cope With Stresses of Serving Communities in Moments of Crisis* (Jan. 24, 2023), https://www.grassley.senate.gov/news/news-releases/grassley-colleagues-re-introduce-bill-to-help-first-responders-cope-with-stresses-of-serving-communities-in-moments-of-crisis.
[5] Letter from Sen. Charles E. Grassley, Chaiman, Senate Committee on the Judiciary, to Ms. Stephanie Carlton, Acting Administrator, Centers for Medicare & Medicaid Services (Feb. 28, 2025), https://www.grassley.senate.gov/imo/media/doc/grassley_to_cms_-_psychiatric_facilities_on_care_compare.pdf.
[6] Letter from the Honorable Dr. Mehmet Oz, Administrator, Centers for Medicare & Medicaid Services, to Sen. Charles E. Grassley, Chairman, Senate Committee on the Judiciary (May 15, 2025), https://www.grassley.senate.gov/imo/media/doc/cms_to_grassley_-_psychiatric_facilities_on_care_compare.pdf.
[7] Press Release, Office of Sen. Charles E. Grassley, *Grassley Introduces Legislation to Boost Transparency of Inpatient Psychiatric Facilities, Empower Patients with Better Data,* (Aug. 05, 2025), https://www.grassley.senate.gov/news/news-releases/grassley-introduces-legislation-to-boost-transparency-of-inpatient-psychiatric-facilities-empower-patients-with-better-data.
[8] Department of Health and Human Services, Office of Inspector General, *Most Children Enrolled in Medicaid Did Not Receive Timely Suicide-Related Followup Care,* (OEI-07-23-00510) (Sep. 2, 2025), at 2, https://oig.hhs.gov/documents/evaluation/10940/OEI-07-23-00510.pdf.
[9] *Id*. at 3.

Alarmingly, the HHS OIG discovered that in half of the 258,458 unique hospitalizations or child emergency department visits for suicidal ideations or behaviors in 2023, children did not receive a follow-up visit in the week following being discharged.[10] In 21 percent of cases, children did not receive *any* follow-up visits 60 days after being discharged, which is particularly troubling considering the risk continues months after treatment.[11] The OIG has recommended that CMS should assist the 24 identified states, which provided less than half of children follow-up care within seven days of being treated for suicidal ideations or behaviors.[12]

Accordingly, so Congress can conduct oversight, please answer the following questions no later than February 28, 2026:

1. What steps has CMS taken to close the open recommendation from the September 2, 2025, report?[13] Provide all records.[14]

2. Will CMS require State Medicaid programs to ensure children are seen for a follow-up within 7 days of treatment for suicidal ideations? If not, why not?

3. What, if any, systems does CMS have in place for hospitals to communicate their need for additional assistance with these issues?

4. Does CMS plan to develop or promote training modules for pediatricians, family physicians, and other non-behavioral providers to recognize and manage suicidal risk among children while they await specialist care? If not, why not?

Thank you for your prompt review and response. If you have any questions, please contact Tucker Akin with my Committee staff at (202) 224-5225.

Sincerely,

Charles E. Grassley
Chairman
Committee on the Judiciary

[10] *Id*. at 5.
[11] *Id*. at 7.
[12] *Id.* at 11, 16- 17. (States include: Alabama, Alaska, Arkansas, Delaware, Florida, Georgia, Hawaii, Louisiana, Michigan, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin, and Wyoming.)
[13] According to emails from the HHS OIG, the one recommendation issues in the report is open and unimplemented.
[14] "Records" include any written, recorded, or graphic material of any kind, including letters, memoranda, reports, notes, electronic data (emails, email attachments, and any other electronically created or stored information), calendar entries, inter-office communications, meeting minutes, phone/voice mail or recordings/records of verbal communications, and drafts (whether they resulted in final documents).