DEPAR 8320-01

38 CFR Part 17

RIN 2900-AR50

Emergent Suicide Care

AGENCY: Department of Veterans Affairs.

ACTION: Interim final rule.

SUMMARY: The Department of Veterans Affairs (VA) amends its medical regulations to implement section 201 of the Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020, which directs VA to furnish, reimburse, and pay for emergent suicide care for certain individuals, to include the provision of emergency transportation necessary for such care.

DATES: *Effective date*: This interim final rule is effective on [insert date of publication in the FEDERAL REGISTER].

Comments: Comments must be received on or before [insert date 60 days after date of publication in the FEDERAL REGISTER].

ADDRESSES: Comments must be submitted through www.regulations.gov. Except as provided below, comments received before the close of the comment period will be available at www.regulations.gov for public viewing, inspection, or copying, including any personally identifiable or confidential business information that is included in a comment. We post the comments received before the close of the comment period on the following website as soon as possible after they have been received: http://www.regulations.gov. VA will not post on Regulations.gov public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm the individual. VA encourages individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments. Any

public comment received after the comment period's closing date is considered late and will not be considered in the final rulemaking.

FOR FURTHER INFORMATION CONTACT: Joseph Duran, Office of Integrated Veteran Care (16EO3), Veterans Health Administration, Department of Veterans Affairs, Ptarmigan at Cherry Creek, Denver, CO, 80209; (303) 370-1637. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: On December 5, 2020, the Veterans Comprehensive Preventions, Access to Care and Treatment Act of 2020, Public Law (Pub. L.) 116-214 (the Act), was enacted into law. Section 201 of the Act created a new section 1720J in title 38, United States Code (U.S.C.), to authorize VA to provide emergent suicide care to certain individuals. Section 1720J(b) of 38 U.S.C. provides that an individual is eligible for emergent suicide care if they are in acute suicidal crisis and are either (1) a veteran as defined in 38 U.S.C. 101, or (2) an individual described in 38 U.S.C. 1720I(b). Individuals described in section 1720I(b) are (1) former members of the Armed Forces, including the reserve components; who, (2) while serving in the active military, naval, air, or space services, were discharged or released therefrom under a condition that is not honorable but is also not (A) a dishonorable discharge or (B) a discharge by court-martial; who (3) is not enrolled in the health care system established by section 1705 of title 38 U.S.C.; and (4)(A)(i) served in the Armed Forces for a period of more than 100 cumulative days; and (ii) was deployed in a theater of combat operations, in support of a contingency operation, or in an area at a time during which hostilities are occurring in that area during such service, including by controlling an unmanned aerial vehicle from a location other than such theater or area; or (B) while serving in the Armed Forces, was the victim of a physical assault of a sexual nature, a battery of a sexual nature, or sexual harassment (as defined in section 1720D(f) of title 38 U.S.C.).

Section 1720J(a) requires VA to (1) furnish emergent suicide care to an eligible individual at a medical facility of the Department; (2) pay for emergent suicide care provided to an eligible individual at a non-Department facility; and (3) reimburse an eligible individual for emergent suicide care provided to the eligible individual at a non-Department facility. This interim final rule will establish new regulations in title 17, Code of Federal Regulations (CFR), at 38 CFR 17.1200 through 17.1230, to implement the provisions of 38 U.S.C. 1720J as described above as well as implement other substantive provisions as required by 38 U.S.C. 1720J to include: the duration of emergent suicide care that VA must provide; prohibition on charge for such care provided; rates VA will pay or reimburse for emergent suicide care (to include for emergency transportation required for such care); and required definitions.

17.1200 Purpose and Scope

Section 17.1200 explains the purpose and scope of these new regulations. Paragraph (a) states that §§ 17.1200 through 17.1230 implement VA's authority under 38 U.S.C. 1720J to provide emergent suicide care. This language will use the term provide, which VA will define in § 17.1205 to mean furnished directly by VA, paid for by VA, or reimbursed by VA. This language will both expressly recognize in regulation VA's statutory authority to provide this care, as well as the three means by which VA must provide this care, consistent with 38 U.S.C. 1720J(a). We will explain at a later point in this preamble (in the section regarding payments) the different considerations that apply when VA provides care directly in a VA facility compared to when VA pays or reimburses for care provided in a non-VA facility.

Paragraph (b) states that §§ 17.1200 through 17.1230 establish criteria specific to VA's provision of emergent suicide care under 38 U.S.C. 1720J, which do not affect eligibility for other care under chapter 17 of title 38, U.S.C., that may otherwise be

received by an individual eligible under § 17.1210 (where § 17.1210 will establish eligibility for emergent suicide care, as explained later in this preamble). We believe this language is necessary to clarify that VA's provision of emergent suicide care under section 1720J is distinct from other care under chapter 17 of title 38 U.S.C., because VA has been providing the same types of care to veterans under the authority of section 1710 and 38 CFR 17.38 as part of the medical benefits package. However, we note that section 1720J not only expands eligibility for this care to individuals who would not be eligible to receive the same care under section 1710, but also offers the additional benefits of (1) having such care be at no cost to the individual (e.g., not subject to otherwise applicable VA copayments), and (2) having VA pay the cost of emergency transportation necessary to receive the care, without the individual having to meet otherwise applicable transportation criteria in VA regulations. Because emergent suicide care offered under section 1720J offers benefits in addition to those already administered by VA under other authorities (e.g., section 1720J provides that there will be no charges for such care, and provides for coverage of emergency transportation necessary to receive such care), § 17.1200(b) will state that if an individual is eligible under § 17.1210, they will receive emergent suicide care in accordance with §§ 17.1200-17.1230 and not under other regulations through which emergent or other care may be provided. We believe this will ensure that the additional benefits under section 1720J as stated above will be available to individuals eligible under § 17.1210. However, language in § 17.1200(b) will also clarify that eligibility under § 17.1210 does not affect eligibility for other care under chapter 17 of title 38 U.S.C. We believe this language will ensure that receipt of care under §§ 17.1200 through 17.1230 does not impact the receipt of other care.

17.1205 Definitions

Section 17.1205 will define key terms that apply to §§ 17.1200-17.1230. The definitions are listed in alphabetical order, beginning with the term acute suicidal crisis, and are consistent with the terms defined in 38 U.S.C. 1720J(h).

The term acute suicidal crisis is defined to mean an individual was determined to be at imminent risk of self-harm by a trained crisis responder or health care provider. This definition is necessary to qualify when an individual is eligible to have VA provide emergent suicide care, as required by section 1720J(b), and is identical to the definition of acute suicidal crisis in section 1720J(h)(1). We will further define the terms trained crisis responder and health care provider to clarify who may make the determination that an individual is in acute suicidal crisis. We will more comprehensively discuss the determination of acute suicidal crisis in the section of the preamble that addresses eligibility criteria. The term acute suicidal crisis will be used in a regulatory section related to eligibility for emergent suicide care, as explained later in this preamble.

The term crisis residential care is defined as emergent suicide care provided in a residential facility other than a hospital (that is not a personal residence) that provides 24-hour medical supervision. This definition is necessary to qualify a type of setting in which VA can provide emergent suicide care in section 1720J(c)(1)(A). This definition is also consistent with the definition of crisis residential care in section 1720J(h)(2), although VA's definition would add that the facility other than a hospital must not be a personal residence and must be able to provide 24-hour medical supervision. The additional criterion related to 24-hour medical supervision will clarify that VA only provides emergent suicide care in a residential facility setting that can adequately monitor the safety and medical condition of an individual that has been determined to be in acute suicidal crisis. Such crisis residential settings could include but not be limited to crisis residential programs (such as residential treatment centers) administered by either a State or private business but would not include any care that could be received

in a personal residence because section 1720J(h)(2)(B) requires that emergent suicide care be provided in a facility. We will not define more specific types of modality, therapies, or treatments that may be received as part of crisis residential care, as that would be unduly limiting given that care and treatment for individuals in acute suicidal crisis will vary. This term will be used in a regulatory section related to the duration of emergent suicide care, as explained later in this preamble.

The term crisis stabilization care is defined to mean, with respect to an individual in acute suicidal crisis, care that ensures, to the extent practicable, immediate safety and reduces: the severity of distress; the need for urgent care; or the likelihood that the severity of distress or need for urgent care will increase during the transfer of that individual from a facility at which the individual has received care for that acute suicidal crisis. This definition is necessary to provide context for VA's provision of care under section 1720J(a) and is identical to the definition of crisis stabilization care in section 1720J(h)(3). This term also qualifies the term emergent suicide care, as discussed below.

The term emergent suicide care is defined to mean crisis stabilization care provided to an individual eligible under §17.1210 pursuant to a recommendation from the Veterans Crisis Line or when such individual has presented at a VA or non-VA facility in an acute suicidal crisis. This definition is necessary to provide context for VA's provision of care under section 1720J(a) and is consistent with the definition of emergent suicide care in 1720J(h)(4). A section of this preamble related to § 17.1220 will discuss some examples of care that we envision being provided as emergent suicide care, but we do note here that we do not intend to define such care more specifically by identifying distinct modalities, therapies, or treatments—we do not want the definition of emergent suicide care to unduly limit potentially stabilizing services that will vary based on the unique needs of the individuals in acute suicidal crisis.

The term health care provider is defined as a VA or non-VA provider who is licensed to practice health care by a State and who is performing within the scope of their practice as defined by a State or VA practice standard. This definition is necessary to qualify who may make the determination of whether an individual is in acute suicidal crisis as required by section 1720J(b) and (h)(1). This term is not defined in section 1720J, so we have based the definition on a similar definition used in VHA Directive 1100.20, which relates to the credentialing of VA health care providers. Such providers will include but not be limited to physicians and registered nurses. This term will be used in a regulatory section related to eligibility for emergent suicide care, as explained later in this preamble.

The term health plan contract is defined as having the same meaning as that term is defined in 38 U.S.C. 1725(f)(2). This definition is necessary because section 1720J(f)(3) provides that VA may recover the costs of emergent suicide care it provides, other than for such care for a service-connected disability, if the eligible individual that received such care was entitled to the care or payment for such care under a health-plan contract. This term will be used in a regulatory section related to VA's payment for emergent suicide care, as explained later in this preamble.

The term inpatient care is defined to mean care received by an individual during their admission to a hospital. This definition is necessary to qualify the types of settings in which VA can provide emergent suicide care in section 1720J(c)(1)(A). The term inpatient care is not defined in section 1720J, and VA has based its definition on plain language that we believe is clearly understandable. This term will be used in a regulatory section related to the duration of emergent suicide care that VA provides, as explained later in this preamble.

Non-VA facility is defined to mean a facility that meets the definition in 38 U.S.C. 1701(4). This definition is necessary to qualify a type of facility in which emergent

suicide care may be provided and where VA must pay or reimburse for such care under section 1720J(a)(2) and (3). We note that the term non-VA facility is intended to be equivalent to the term "non-Department facilities" that will be cross referenced in section 1701(4). Because the term in section 1701(4) is further dependent on the definition of "facilities of the Department" in section 1701(3), we will further define the term VA facility later in the definitions (to cross reference section 1701(3)). We recognize that defining non-VA facility to cross reference the definition in section 1701(4) will essentially qualify any facility type that is not owned or operated by VA. However, we will not further characterize the types of non-VA facilities (e.g., hospitals, or outpatient clinics), as 1720J authorizes VA to provide for both inpatient and outpatient care.

The term outpatient care is defined to mean care received by an individual that is not described within the definition of inpatient care under § 17.1205 to include telehealth, and without the provision of room or board. This term is not defined in section 1720J, and VA has based its definition on plain language that we believe is clearly understandable. We will not define more specific types of modality, therapies, or treatments that may be received as outpatient care, as that would be unduly limiting. This term will be used in a regulatory section related to the duration of emergent suicide care that VA provides, as explained later in this preamble.

The terms provide, provided, or provision are defined to mean furnished directly by VA, paid for by VA, or reimbursed by VA. These terms will simplify mention of VA's obligations under section 1720J(a)(1)-(3) for ease of understanding as appropriate throughout the regulations.

The term trained crisis responder is defined as an individual who responds to emergency situations in the ordinary course of their employment and therefore can be presumed to possess adequate training in crisis intervention. This definition is necessary to qualify who may make the determination of whether an individual is in

acute suicidal crisis as required by section 1720J(b) and (h)(1). This term is not defined in section 1720J, and VA only has expertise in the training levels of its own Veterans Crisis Line (VCL) responders. VA considered but ultimately decided against defining the term trained crisis responder to be limited to only VCL responders, as that would have unnecessarily limited those individuals that may, in the ordinary course of their employment, have the knowledge and expertise to assess suicidal crisis and in fact direct individuals in such crisis to seek care. Instead, the definition of trained crisis responder uses plain language to qualify training that would be expected of individuals who respond to emergencies, where such individuals include but are not limited to Veteran Crisis Line responders, law enforcement or police officers, firefighters, and emergency medical technicians. We note that a determination of acute suicidal crisis is a qualifier for eligibility for VA's provision of emergent suicide care, and that determination can be made by either a health care provider or a trained crisis responder under section 1720J(b). However, the level and duration of emergent suicide care to be provided to individuals eligible for such care is a medical determination to be made only by health care providers, as will be discussed later in the section of the preamble related to duration of care.

VA facility is defined to mean a facility that meets the definition in 38 U.S.C. 1701(3). This definition is necessary to qualify a type of facility in which emergent suicide care must be directly furnished by VA under section 1720J(a)(1). We note that the definition that will be cross referenced in section 1701(3) is for "facilities of the Department," which is equivalent to a VA facility. We will not more specifically list the types of VA facilities (e.g., VA Medical Center or VA Community Based Outpatient Clinic) in which emergent suicide care will be directly furnished by VA, as this will be too limiting if VA nomenclature for types of VA facilities changes or if level of services available in types of VA facilities changes. VA will be able to internally track those

facilities that meet the definition in section 1701(3) for purposes of directly furnishing emergent suicide care.

Veterans Crisis Line is defined to mean the hotline under 38 U.S.C. 1720F(h). This definition is consistent with section 1720J(h)(6) and is necessary to provide context for the use of this same term in the definition of emergent suicide care.

17.1210 Eligibility

Section 17.1210 will establish criteria to determine an individual's eligibility for emergent suicide care. Paragraph (a) will establish that an individual is eligible if they were determined to be in acute suicidal crisis and are either: (1) a veteran as that term is defined in 38 U.S.C. 101, or (2) an individual described in 38 U.S.C. 1720I(b). Language in § 17.1210(a) will mirror eligibility language from section 1720J(b), as we believe such language is clear and does not require further interpretation through regulation. Particularly, we will not regulate characteristics of how acute suicidal crisis may appear or present in an individual or other parameters that must be met, beyond the definition of acute suicidal crisis in § 17.1205 to mean the individual was determined to be at imminent risk of self-harm by a trained crisis responder or health care provider. The determination of imminent risk of self-harm could vary greatly based on the individual and be based on a totality of circumstances and information as assessed by the trained crisis responder or health care provider, to include but not be limited to direct statements from an individual, as well as other pertinent information such as knowledge of an individual's past or present behaviors that signal a risk of self-harm, or even an individual's past suicide attempts that could evidence additional risk of self-harm. We will not regulate, however, that an individual must communicate any particular language, or that their behavior must meet any particular parameters, or that they must have any type of diagnosis to indicate that they are in acute suicidal crisis.

Regarding language in section 1720J(b)(1) and § 17.1210(a)(1), a veteran as defined in section 101, means a person who served in the active military, naval, air, or space service, and who was discharged or released therefrom under conditions other than dishonorable. Rather than restating this definition from 38 U.S.C. 101, § 17.1210(a)(1) will reference section 101 in the event the definition of veteran under the statute may change (for instance, the definition of veteran in section 101 was amended by sec. 926(a)(1) of Public Law 116-283 on January 1, 2021, to substitute “air, or space service" for "or air service"). We note that section 1720J(b)(1) does not establish that a veteran must be enrolled in VA healthcare in accordance with VA’s healthcare enrollment authority in section 1705 and as regulated in § 17.36. We therefore will also amend § 17.37, VA’s regulation related to veteran enrollment not being required to receive certain health care and services, to add a new paragraph (l) to establish that a veteran need not be enrolled to receive emergent suicide care pursuant to 38 CFR 17.1200-17.1230.

Regarding language in section 1720J(b)(2) and § 17.1210(a)(2), individuals described in section 1720I(b) are: (1) former members of the Armed Forces, including the reserve components; who, (2) while serving in the active military, naval, air, or space services, were discharged or released therefrom under a condition that is not honorable but is also not (A) a dishonorable discharge or (B) a discharge by court-martial; who (3) is not enrolled in the health care system established by section 1705 of title 38 U.S.C.; and (4)(A)(i) served in the Armed Forces for a period of more than 100 cumulative days; and (ii) was deployed in a theater of combat operations, in support of a contingency operation, or in an area at a time during which hostilities are occurring in that area during such service, including by controlling an unmanned aerial vehicle from a location other than such theater or area; or (B) while serving in the Armed Forces, was the victim of a physical assault of a sexual nature, a battery of a sexual nature, or

sexual harassment (as defined in section 1720D(f) of title 38 U.S.C.). Rather than restating these requirements from statute, § 17.1210(a)(2) will reference section 1720I(b) in the event such qualifying eligibility under the statute may change.

VA believes it is important to avoid delays in receipt of emergent suicide care if an individual's status as a veteran or status as described in section 1720I(b) cannot be confirmed upon a determination of acute suicidal crisis or prior to the need to initiate the provision of care. Therefore, § 17.1210(b) will establish that VA may initiate the provision of emergent suicide care for an individual in acute suicidal crisis prior to that individual's status under § 17.1210(a)(1) or (2) being confirmed. If VA is unable to confirm an individual's status under paragraph (a)(1) or (2) of this section, and such individual is not otherwise eligible for care under another VA authority, VA shall charge that individual for the care provided consistent with 38 CFR 17.102(a) and (b)(1), which are regulatory provisions applicable to VA's provision of care to individuals later found to be ineligible.

17.1215 Periods of emergent suicide care

Section 17.1215 will establish criteria related to the length of time an eligible individual will be provided emergent suicide care, consistent with section 1720J(c).

Paragraph (a) will establish that, unless extended under paragraph (b), emergent suicide care will be provided to an eligible individual under § 17.1210 from the date acute suicidal crisis is determined to exist (as determined to exist by a trained crisis responder or health care provider, per the definition of acute suicidal crisis in § 17.1205): (1) through inpatient care or crisis residential care, as long as the care continues to be clinically necessary, but not to exceed 30 calendar days; or (2) If inpatient care or crisis residential care is unavailable, or if such care is not clinically appropriate, through outpatient care, as long as the care continues to be clinically

necessary, but not to exceed 90 calendar days. The 30-day limitation for a period of inpatient or crisis residential care in § 17.1215(a)(1) is required by section 1720J(c)(1)(A), and the 90-day period limitation for outpatient care in § 17.1215(a)(2) is required by section 1720J(c)(1)(B). Section 17.1215(b) will permit VA to extend either of these limited timeframes in the event VA determines that an individual continues to require care to address the effects of an acute suicidal crisis, consistent with section 1720J(c)(2).

Section 17.1215(a)(1) and (2) will establish the 30- and 90-day time limits as calendar day limits. There is no indication in section 1720J that these time limits should be measured in business days, and calendar days is the reasonable measurement in the context of furnishing emergent suicide care because the risk of self-harm and stabilization of an individual's condition continues despite weekend days or holidays. We note that § 17.1215(b) will allow an extension of the timeframes in the event VA determines the individual continues to require care to address the effects of acute suicidal crisis and, therefore, requires additional emergent suicide care.

Section 17.1215(a)(1) and (2) will establish the availability of 30 calendar days of inpatient and crisis residential care, as well as 90 days of outpatient care, instead of only one type of care (inpatient/residential versus outpatient) being available for an individual eligible under § 17.1210. We do not interpret the word "or" in section 1720J(c)(1)(A) to mean that outpatient care under section 1720J(c)(1)(B) is available only if an individual did not receive inpatient or crisis residential care. Rather, we interpret that sections 1720J(c)(1)(A) and (B) should be read together to afford an individual the opportunity to receive inpatient care (except if such care is not available or is inappropriate) but not to prevent such an individual from then receiving outpatient care to ensure they remain stable. Even if an individual is medically stable for discharge from an inpatient or crisis residential care setting, continued treatment after

discharge from a facility may be necessary to prevent immediate relapse into a new or worsened state of crisis or to otherwise provide clinically necessary care to address the effects of the acute suicidal crisis. Indeed, the definition of crisis stabilization care in § 17.1205 provides that such care is not only that which ensures, to the extent practicable, immediate safety but is also care that "reduces: the severity of stress, [and] the need for urgent care... ." . Therefore, VA will not regulate outpatient care to be solely available as an alternative to inpatient or crisis residential care, as we envision nearly all individuals in acute suicidal crisis will require some level of emergent suicide care on an inpatient basis to be followed by care on an outpatient basis.

Paragraph (b) in § 17.1215 will permit the 30 and 90 calendar day timeframes in § 17.1215(a)(1) and (2) to be extended if VA determines that an individual continues to require care to address the effects of the acute suicidal crisis. This language is consistent with section 1720J(c)(2), where only the Secretary [of VA] is authorized to extend a period of care beyond the 30 or 90 days. Although we recognize that non-VA health care providers may be able to determine if an individual continues to require care to address the effects of the acute suicidal crisis upon the expiration of a 30-day or 90-day timeframe, such an extension of care would still need to be approved by VA as clinically necessary before VA would pay or reimburse for the additional care. This would not necessarily mean that VA's approval of an extension must always occur prior to care being extended; VA would not want to create situations where administrative matters could delay the extension of required care. Rather, VA would only pay or reimburse for extensions of care if VA found such extensions to be warranted. The process of non-VA health care providers submitting claims for payment for providing emergent suicide care is discussed below in the section related to § 17.1225. In that process, we would expect that, in most cases, non-VA providers would submit requests for extensions of care to VA prior to a 30- or 90-day period of care lapsing.

§ 17.1220 Provision of emergent suicide care

As stated earlier in the preamble we will not specifically regulate any distinct modalities, therapies, or treatments as falling under or being excluded from the meaning of the term emergent suicide care, because we do not want to unduly limit the provision of care that will vary based on the needs of individuals in acute suicidal crisis. However, we do not want this lack of specificity to imply that any type of care or service that may be recommended would be provided by VA as emergent suicide care. To better characterize the types of care that will be provided, we interpret the phrases "immediate safety" and "reduce severity" from the definition of crisis stabilization care, which is incorporated into the definition of emergent suicide care in § 17.1205, to enable VA to provide care and services that are needed to immediately stabilize an individual's vital signs and ensure their physical safety, as well as care and services to reduce the severity of symptoms related to the acute suicidal crisis. Such care can include medical and surgical services as well as mental health services. For instance, an individual in acute suicidal crisis could require emergency room care to stabilize bleeding from a self-inflicted injury and then require inpatient hospitalization to further monitor vitals and personal safety. Upon discharge from the hospital, this individual could then require some level of outpatient care to attend group or individual mental health therapy, as well as receive prescription medications, to reduce the severity of symptoms related to the acute suicidal crisis.

As stated above, while VA is interpreting emergent suicide care more broadly than that which is immediately necessary to stabilize an individual, we do not want to imply that any type of care or service will be covered. Therefore, § 17.1220(a) will establish that emergent suicide care will be provided to individuals eligible under § 17.1210 only if it is determined by a health care provider to be clinically necessary and

in accord with generally accepted standards of medical practice. This language will allow clinicians to make appropriate decisions about what care should be provided. The types of care described in the preceding paragraph, for instance, would be clinically necessary and generally in accord with the standards of medical practice of emergent care and supportive care after an emergency. To further ensure the safety and appropriateness of emergent suicide care provided under these regulations, § 17.1220(b) will establish that prescription drugs, biologicals, and medical devices that may be provided during a period of emergent suicide care under § 17.1215 must be approved by the Food and Drug Administration, unless the treating VA facility or non-VA facility is conducting formal clinical trials under an Investigational Device Exemption or an Investigational New Drug application, or the drugs or biologicals are prescribed under a compassionate use exemption. VA regulates this same general restriction for FDA-approval with certain caveats under the medical benefits package available to all enrolled veterans in 38 CFR 17.38, and we find it to be reasonable to apply to this program of emergent suicide care.

§ 17.1225 Payment or reimbursement for emergent suicide care

Section 17.1225 will establish criteria related to VA's payment or reimbursement of emergent suicide care, consistent with sections 1720J(d) and (f).

We will first discuss the provisions established in 1720J(f) related to the prohibitions on charge for individuals who are eligible to receive emergent suicide care under section 1720J. Section 1720J(f)(1)(A) establishes that if VA provides care to an eligible individual under section 1720J(a) (meaning VA directly furnishes such care, pays for such care furnished in a non-VA facility, or reimburses an eligible individual for care that was furnished in a non-VA facility), VA may not charge the eligible individual for any costs of such care. Paragraph (a) of § 17.1225 will therefore state that VA may not charge individuals eligible under § 17.1210 for care received under § 17.1215, and §

17.1225(a)(1) and (a)(2) will more specifically characterize this lack of charge in the context of care VA furnishes directly in a VA facility as compared to care furnished in a non-VA facility, respectively.

Paragraph (a)(1) of § 17.1225 will state that for care furnished in a VA facility, VA will not charge any copayment or other costs that would otherwise be applicable under chapter 17 of 38 CFR. Because veterans eligible under 17.1210(a)(1) may be subject to copayments for other types of care they received from VA, we will further amend applicable VA copayment regulations at §§ 17.108 and 17.110 (related to veteran copayments for inpatient and outpatient care, and for medications, respectively) to ensure that veterans who are eligible for emergent suicide care under section 1720J(b)(1) and § 17.1210(a)(1) are not subject to charges for such care furnished in a VA facility. Former members of the Armed Forces receiving care under 38 U.S.C. 1720I are not subject to VA's copayments so no further exceptions are needed. We note that this prevention of charge to such individuals will only apply to the extent they were eligible under § 17.1210(a); if VA is not able to confirm eligibility under § 17.1210(a), then VA shall charge an individual under § 17.1210(b) (at charges consistent with 38 CFR 17.102(a) and (b)(1)).

Paragraph (a)(2) of § 17.1225 will establish that for care furnished in a non-VA facility, VA will either: (i) pay for the care furnished, subject to paragraphs (b)-(d) of § 17.1225, or (ii) reimburse an eligible individual under § 17.1210 for the costs incurred by the individual for the care received, subject to paragraph (e) of § 17.1225. The language in § 17.1225(a)(2)(i) and (ii) implements VA's payment and reimbursement of emergent suicide care under 1720J(a)(2)-(3) and the prohibition of charge under section 1720J(f)(A).

Paragraphs (b) through (d) of § 17.1225 will further outline parameters for VA's payment of care, consistent with provisions in section 1720J(f)(2). Section

1720J(f)(2)(A) requires VA to reimburse a non-VA facility for the reasonable value of emergent suicide care if VA pays for such care to be provided in a non-VA facility under section 1720J(a)(2), and section 1720J(f)(2)(B)(i) further provides that VA may determine such reimbursement amounts in a similar manner as VA determines reimbursement amounts for medical care and services provided in non-VA facilities under any other provision of chapter 17 of title 38 U.S.C. We interpret the provisions of section 1720J(f)(2)(A) and (f)(2)(B)(i) together to allow VA to establish rates it will pay for emergent suicide care provided in non-VA facilities in accordance with parameters VA has already established to pay for medical care provided in non-VA facilities. VA pays non-VA providers and facilities under the Veterans Community Care Program (VCCP) as established by 38 U.S.C. 1703. Under that authority VA is required to purchase care through negotiated agreements. Therefore, when emergent suicide care is provided pursuant to a contract, VA will pay for that care in accordance with the terms of that contract.

Unlike VCCP, it is possible that a non-VA provider or facility could provide emergent suicide care not pursuant to a contract, but still be eligible for payment from VA. In these instances, rather than looking to a different authority under which VA pays for medical care provided in non-VA facilities, VA will establish a payment structure that is substantively similar to the terms of its existing agreements for the purchase of care under VCCP when a provider or facility is not under contract with VA. This will establish parity in payments rates between contracted and non-contracted emergent suicide care, and a hierarchy of payment rates that will ensure that the public will be able to determine what the payment rates are and ensure that a rate always exists for any eligible care.

Paragraph (b) of § 17.1225 will therefore establish that the amounts paid by VA for care furnished under § 17.1225(a)(2)(i) will either: (1) be established pursuant to

contracts, or (2) if there no amount determinable under paragraph (b)(1) (e.g., there is no contract), VA will pay amounts as established in § 17.1225(b)(2)(i) through (v). Depending on where the care was provided, and what pricing schedule amounts exist for the specific services provided, VA will pay the Alaska VA Fee Schedule Amount (as calculated pursuant to 38 CFR 17.56(b)), the Medicare fee schedule or prospective payment system amount, the Critical Access Hospital rate, the VA Fee Schedule amount (as posted on VA.gov), or billed charges. The hierarchy established in § 17.1225(b)(2)(i) through (v) is substantively similar to methodologies VA uses to calculate payment rates for care purchased under an agreement and furnished to veterans by non-VA providers and facilities, and we believe is reasonable to apply when emergent suicide care is furnished not pursuant to a contract.

Paragraph (c) of § 17.1225 will establish that payment by VA under § 17.1225(a)(2)(i) (i.e., payment for emergent suicide care provided in non-VA facilities) shall, unless rejected and refunded within 30 calendar days of receipt, extinguish all liability on the part of the individual who received care, and that neither the absence of a contract or agreement between the Secretary and the provider nor any provision of a contract, agreement, or assignment to the contrary shall operate to modify, limit, or negate this requirement. This language is consistent with section 1720J(f)(2)(B)(ii), which establishes that the requirements of section 1725(c)(3) will apply with respect to payments VA makes under section 1720J(f)(2)(A) (i.e., those payments VA makes for emergent suicide care provided in a non-VA facility). Section 1725(c)(3) establishes that payment by VA on behalf of a veteran to a provider of emergency treatment shall, unless rejected and refunded by the provider within 30 days of receipt, extinguish any liability on the part of the veteran for that treatment, and that neither the absence of a contract or agreement between VA and the provider nor any provision of a contract,

agreement, or assignment to the contrary shall operate to modify, limit, or negate this requirement.

Paragraph (d) of § 17.1225 will establish criteria to obtain payment from VA for emergent suicide care provided in a non-VA facility. Although section 1720J does not contain language related to such criteria (there is no language related to the submission of any particular billing or claims information to VA, in any specific format or within a certain timeframe), minimal regulation is necessary to provide a framework for submission of information to be reviewed by VA. Notably, section 1720J only refers to VA payment for emergent suicide care to non-VA facilities (see 1720J(f)(2)). However, to ensure we capture all potential sources through which such care may be provided in non-VA facilities and for which VA may pay, § 17.1225(d) will establish that either a health care provider or a non-VA facility (as those terms are defined in § 17.1205) may obtain payment from VA. Paragraph (d)(1) will address care furnished pursuant to a contract with VA, and paragraph (d)(2) will address when care is not furnished pursuant to a contract.

Paragraph (d)(1) of § 17.1225 will establish that health care providers and non-VA facilities who provide emergent suicide care pursuant to a contract will follow all applicable provisions and instructions in such contract to receive payment. Paragraph (d)(2) will establish that if the care was not provided pursuant to a contract, providers or facilities will submit to VA a standard billing form and other information as required no later than 180 calendar days from the date the care was furnished. We will not state a specific form name or number in § 17.1225(d)(2) to avoid having to revise our regulations if the form may change in the future. However, paragraph (d)(2) will further provide a website to locate more specific procedures and instructions for submission of that form and other information within the 180-day timeframe. The 180-day timeframe in which to submit to VA information for payment is consistent with the timeframe that

non-VA entities or providers must submit claims for payment to VA for hospital care or medical services furnished in non-VA facilities under 38 U.S.C. 1703D(b). Section 1703D is applicable to all such care that VA is authorized to provide under chapter 17 of 38 U.S.C., including 1720J.

Section 1720J(d) does require an eligible individual who receives emergent suicide care at a non-VA facility (or a person acting on behalf of the individual) to notify VA of such care within seven days of admission to such facility. We interpret this provision to evidence Congressional intent that, if VA will be responsible for payment of care in a non-VA facility, VA must have reasonable notice of the care having been initiated. Without such notice, VA will not be able to: confirm eligibility for such care; evaluate whether care that has or will be furnished meets the definition of emergent suicide care and is generally in accord with standards of medical practice; determine whether an extension of emergent suicide care might be warranted; or coordinate for potential continued care (for which the individual may be eligible) after emergent suicide care is no longer necessary. However, section 1720J(f)(4) also provides that VA may not charge an eligible individual for any cost of emergent suicide care provided solely by reason of VA not having been notified of such care within the seven days pursuant to section 1720J(d). We interpret the language in section 1720J(f)(4) to mean that VA may not itself charge an eligible individual or hold them liable for the costs of emergent care provided in a non-VA facility for lack of notice, such that VA may not regulate a seven-day notice requirement with regards to limiting or barring payment to non-VA providers for emergent suicide care furnished in a non-VA facility. Therefore, VA has elected not to regulate any notice requirement. However, VA will make materials available on its public facing websites to communicate the importance of timely notice to VA of emergent suicide care received at a non-VA facility (as VA does for its other programs of emergency care) for purposes of care coordination and timely

consideration of factors to support VA's payment of or reimbursement for such emergent suicide care.

Paragraph (e) of § 17.1225 will implement the requirement in section 1720J(a)(3) that VA must reimburse an eligible individual for emergent suicide care provided in a non-VA facility. Consistent with the rationale expressed above, § 17.1225(e) will mirror language in § 17.1225(d)(2), to establish that individuals eligible under § 17.1210 must submit to VA a standard billing form and other information as required no later than 180 calendar days from the date the individual paid for emergent suicide care to obtain reimbursement from VA. Paragraph (e) will also contain language to direct individuals to a VA website to obtain more specific information related to the specific billing form and other required information, as well as submission procedures, to obtain reimbursement. Although individuals eligible under § 17.1210 may not themselves be non-VA entities or providers as contemplated under the section 1703D(b) requirement to submit claims information within 180 days, we nonetheless find this timeframe reasonable, and section 1720J does not contain language that specifically addresses the timeframe in which information must be submitted to VA for purposes of reimbursement. We also note that we do not anticipate many reimbursement requests to be submitted to VA, as we believe a majority of health care providers and non-VA facilities (as those terms are defined in § 17.1205) will submit claims for payment to VA directly for emergent suicide care furnished in non-VA facilities.

Paragraph (f) of § 17.1225 will establish that VA may recover costs of care it has paid or reimbursed under § 17.1225(a)(2)(i) and (ii), other than for such care for a service-connected disability, if the individual who received the care is entitled to the care (or payment of the care) under a health plan contract (as that term is defined in section 1725(f)(2), as referenced in 1720J(h)(5) and § 17.1205). This language is consistent with section 1720J(f)(3), which authorizes VA to recover the costs of emergent suicide

care (other than for a service-connected disability) if the individual that received the care is entitled to receive it or have it paid for under a health plan contract. Paragraph (f) will further provide that such recovery would generally follow VA regulations at 38 CFR 17.100 through 17.106, which implement VA's right under 38 U.S.C. 1729 to recover from a third party the charges for care or services that VA furnished or paid under chapter 17 of title 38 U.S.C., to the extent the recipient of such services would be eligible to receive payment for the care or services from such third party if VA had not already furnished or paid. We believe reference to the regulations that implement recovery under section 1729 is reasonable to inform VA's recovery of costs for emergent suicide care because section 1729 applies to all care and services that VA is obligated by law to furnish or pay for under chapter 17 of title 38 U.S.C., and section 1720J(f)(3) does not otherwise expressly require VA to follow any specific VA statute or regulations related to recovery of costs for care and services furnished or paid.

§ 17.1230 Payment or reimbursement for emergency transportation

Section 17.1230 will establish criteria related to VA's payment or reimbursement of emergency transportation to a facility for the receipt of emergent suicide care, consistent with sections 1720J(f)(1)(B).

Section 1720J(f)(1)(B) provides that VA will pay the costs of emergency transportation to a facility for emergent suicide care, as such costs are determined pursuant to 38 U.S.C. 1725, to the extent practicable. Although section 1720J does not further define the term "emergency transportation," we believe it is reasonable to characterize it as an ambulance or air ambulance, as these are common transports for individuals to receive emergent care such as emergent suicide care. We also believe it is reasonable to interpret that emergency transport can be furnished to either a VA or a non-VA facility, as those are the two types of facilities where section 1720J authorizes

care to be furnished (see section 1720J(a), (d), and (f)). Therefore, § 17.1230(a) will state that VA will pay or reimburse for the costs of emergency transportation (i.e., ambulance or air ambulance) to a VA facility or non-VA facility for the provision of emergent suicide care to an eligible individual under § 17.1210.

The language in section 1720J(f)(1)(B) provides that VA will pay for the costs of emergency transportation as such costs are determined pursuant to 38 U.S.C. 1725, to the extent practicable. Section 1725 establishes VA's authority to pay or reimburse for the reasonable value of emergency treatment furnished in a non-VA facility to a veteran for emergency care that is not associated with a service-connected condition. Notably, section 1725 does not contain language related to VA paying or reimbursing for emergency transportation that is necessary to receive authorized emergency care. However, VA regulates the provision of emergency transportation necessary to receive emergency care furnished under section 1725 (in 38 CFR 17.1003) and regulates a methodology to calculate rates VA will pay or reimburse for such transportation (in 38 CFR 17.1005). Therefore, we interpret section 1720J(f)(1)(B) to authorize VA to calculate the costs VA will pay or reimburse for emergency transportation necessary to receive emergent suicide care under section 1720J(a) pursuant to 38 CFR 17.1005, to the extent practicable. Because VA finds it practicable to apply § 17.1005 to emergency transportation necessary to receive emergent suicide care, § 17.1230(a)(1) will establish that for claims submitted by providers of emergency transportation, rates of payment for transportation under § 17.1230(a) will be calculated as they are under 38 CFR 17.1005(a)(1) through (3). We note that § 17.1005(a) establishes the general payment limitations and parameters to calculate payments, although we believe only paragraphs (a)(1)-(a)(3) would be applicable for emergency transportation necessary to receive emergent suicide care (and the remainder of § 17.1005(b) through (d) establishes other substantive restrictions that would not apply in the context of

emergency transportation for emergent suicide care under §§ 17.1200 through 17.1230). Section 17.1230(a)(1) would further clarify that, for purposes of § 17.1230, the term emergency treatment in § 17.1005(a) should be read to mean emergency transportation. Similar to reimbursement for emergent suicide care under § 17.1225, § 17.1230(a)(2) will establish that for claims of reimbursement for emergency transportation from individuals eligible under § 17.1210, VA will reimburse the costs such individuals incurred for the emergency transportation.

To maintain parity in claims processing between the emergent suicide care and the emergency transportation necessary to receive such care, § 17.1230(b) and (c) will establish essentially the same procedures that must be followed in § 17.1225(d)(2) and (e) to be paid or reimbursed by VA for the emergent suicide care itself. Paragraphs (b) and (c) of § 17.1230 will state that, to obtain payment or reimbursement (respectively) for emergency transportation furnished under paragraph (a) of this section, the provider of such services or the individual eligible to receive reimbursement for services must submit to VA a standard billing form and other required information no later than 180 calendar days from the date the services were furnished or the date that the individual paid for the services, and that submission instructions to include required form(s) and other information can be found at www.va.gov.

Lastly, we will reiterate in § 17.1230(d) the same requirement from § 17.1225(e), that payment by VA for emergency transportation shall, unless rejected and refunded within 30 calendar days of receipt, extinguish all liability on the part of the individual who received care, and that no provision of a contract, agreement, or assignment to the contrary shall operate to modify, limit, or negate this requirement. Section 17.1230(d) will apply this requirement to VA payments for emergency transportation, although the requirement in section 1720J(f)(2)(B)(ii) relates only to payments VA makes for emergent suicide care in a non-VA facility under section 1720J(f)(2)(A). However, we

do not read section 1720J to otherwise prevent VA from applying this same requirement to the emergency transportation necessary to receive emergent suicide care, and we believe is reasonable to ensure that the individual who received such care is not subject to any potential balance billing for associated emergency transportation.

Administrative Procedure Act

The Administrative Procedure Act (APA), codified in part at 5 U.S.C. 553, generally requires agencies publish substantive rules in the Federal Register for notice and comment.

However, pursuant to 5 U.S.C. 553(b)(B), general notice and the opportunity for public comment are not required with respect to a rulemaking when an ‘‘agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.’’ In accordance with 5 U.S.C. 553(b)(B), the Secretary has concluded that there is good cause to publish this rule without prior opportunity for public comment. This rule implements the mandates of 38 U.S.C. 1720J to establish a new program to provide emergent suicide care to ensure, to the extent practicable, the immediate safety and reduced distress of an eligible individual in acute suicidal crisis.

Suicide is a national public health concern, and it is preventable. The rate of veteran suicide in the United States remains high, despite great effort. As detailed in VA’s 2021 National Veteran Suicide Prevention Annual Report, the average number of veteran suicide deaths per day in 2019 was 17.2. (Available online: https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf). Of those 17.2 deaths per day, 6.8 were veterans who recently used VA health care (that is, these veterans had

received VA health care services within the preceding two years) and 10.4 were veterans who had not recently used VA health care. See https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf. There has also been an increase in call volume to the Veterans Crisis Line (VCL). In fiscal year (FY) 2019, VCL answered an average daily call volume of 1590.67 calls compared with 1765.02 in FY 2020 and 1807.52 in FY 2021, with VCL call volume increasing over 22% in direct-date comparisons from FY 2019 to FY 2021. Additionally, as of July 16, 2022, the new National Suicide Prevention Hotline number (988) has a feature to connect veterans to the Veterans Crisis Line, which may also encourage individuals who are veterans but do not seek VA care to be made aware of emergent suicide care under this program. This rule will also implement payment or reimbursement of emergent suicide care for veterans regardless of enrollment status, to include costs associated with emergency transportation to receive such care, which VA believes will assist more veterans and former service members in seeking care to prevent suicide.

Veterans, in particular, may be uniquely vulnerable to negative mental health effects of the Coronavirus Disease-2019 (COVID-19) pandemic such as suicidality due to their older age, previous trauma exposures, and higher pre-pandemic prevalence of physical and psychiatric risk factors and conditions. See Na, P. J., Tsai, J., Hill, M. L., Nichter, B., Norman, S. B., Southwick, S. M., & Pietrzak, R. H. (2021). Prevalence, risk and protective factors associated with suicidal ideation during the COVID-19 pandemic in U.S. military veterans with pre-existing psychiatric conditions. *Journal of Psychiatric Research*, *137*, 351–359. In an analysis of data from the National Health and Resilience in Veterans Study, researchers found that 19.2% of veterans screened positive for suicidal ideation during the pandemic, and such veterans had lower income, were more likely to have been infected with COVID-19, reported greater COVID-19-related financial

and social restriction stress, and increases in psychiatric symptoms and loneliness during the pandemic when compared to veterans without suicidal ideation. See the National Health and Resilience in Veterans Study. Additionally, they found that among veterans who were infected with COVID-19, those aged 45 or older and who reported lower purpose in life were more likely to endorse suicidal ideation. See the National Health and Resilience in Veterans Study. These researchers noted that monitoring for suicide risk and worsening psychiatric symptoms in older veterans who have been infected with COVID-19 may be important, and that interventions that enhance purpose in life may help protect against suicidal ideation in this population.

Furthermore, studies have shown increased rates of suicide after pandemics such as the 1918 Influenza (H1N1) pandemic and the 2003 Severe Acute Respiratory Syndrome (SARS) outbreak, in which increased risk factors associated with negative impacts of pandemics were believed to contribute to suicide. See Wasserman IM. The impact of epidemic, war, prohibition and media on suicide: United States, 1910-1920. Suicide Life Threat Behav. 1992 Summer;22(2):240-54. PMID: 1626335.; *See also*, Cheung YT., Chau PH., and Yip PS. A revisit on older adults' suicides and severe acute respiratory syndrome (SARS) epidemic in Hong Kong. Int J Geriatr Psychiatry. 2008; 23: 1231-1238. Thus, increased suicide death could occur after the COVID-19 pandemic unless action is taken. See Gunnell, D., Appleby, L., Arensman, E., Hawton, K., John, A., Kapur, N., Khan, M., O'Connor, R. C., & Pirkis, J. (2020). Suicide risk and prevention during the COVID-19 pandemic. The Lancet Psychiatry, 7(6), 468–471. Consistent with the recommendations of this research, this rule will support both VA and non-VA facilities in providing emergent suicide care, to enable more resources to reach veterans.

It is critical that this rulemaking publish without delay and that the rule be effective upon publication, as the emergent suicide care will reach a specific population

at risk of suicide, particularly those veterans who are not enrolled with VA, which is especially needed during the COVID-19 pandemic and the immediate period following this pandemic. Delay in implementing this rule would have a severe detrimental impact on the availability of health care for veterans in life threatening situations.

The expanded eligibility for this care, the associated transportation to receive such care, and the prohibition on charge for the care are all unique factors that we believe will encourage individuals to seek care where they may not have previously. These unique factors, however, also created a need for VA to take additional time beyond the Congressional deadline in section 201(c) of the Act to complete the required policy analysis and decision-making processes that preceded this rule—this is particularly true because the Act requires VA not only to directly furnish emergent suicide care, but then also to pay and reimburse for such care furnished in non-VA facilities. VA did not want to implement this program of emergent suicide care piecemeal, and additional time beyond the Congressional deadline was needed to ensure VA could simultaneously furnish this care directly, as well as enable processes whereby the care could be paid for or reimbursed when furnished in non-VA facilities. For instance, VA has had to plan and initiate multiple systems changes to ensure that copayments or other potential costs are not charged to individuals who would be eligible for this care. Systems changes were also needed to recognize expanded eligibility for this care, particularly because such eligibility changes depending on whether an acute suicidal crisis is present or whether symptoms related to such crisis continue to require care under this program.

For these reasons, the Secretary has concluded that ordinary notice and comment procedures would be impracticable and contrary to the public interest and is accordingly issuing this rule as an interim final rule. The Secretary will consider comments that are received within 60 days after the date that this interim final rule is

published in the Federal Register and address them in a subsequent Federal Register document announcing a final rule incorporating any changes made in response to the public comments.

For the reasons set forth above, the Secretary also finds that there is good cause under 5 U.S.C. 553(d)(3) to publish this rule with an effective date that is less than 30 days from the date of publication.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. The Office of Information and Regulatory Affairs has determined that this rule is a significant regulatory action under Executive Order 12866. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at www.regulations.gov.

Regulatory Flexibility Act

The Regulatory Flexibility Act, 5 U.S.C. 601-612, is not applicable to this rulemaking because notice of proposed rulemaking is not required. 5 U.S.C. 601(2), 603(a), 604(a).

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any

rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This interim final rule will have no such effect on State, local, and Tribal governments, or on the private sector.

Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (44 U.S.C. 3507) requires that VA consider the impact of paperwork and other information collection burdens imposed on the public. Under 44 U.S.C. 3507(a), an agency may not collect or sponsor the collection of information, nor may it impose an information collection requirement unless it displays a currently valid Office of Management and Budget (OMB) control number. See also 5 CFR 1320.8(b)(2)(vi).

This interim final rule will impose new collections of information requirements and burden. Accordingly, under 44 U.S.C. 3507(d), VA has submitted a copy of this rulemaking action to OMB for review and approval. Notice of OMB approval for this information collection will be published in the Federal Register.

OMB assigns control numbers to collections of information it approves. VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Sections 17.1225 and 17.1230 contain new collections of information under the Paperwork Reduction Act of 1995. If OMB does not approve the collections of information as requested, VA will immediately remove the provisions containing a collection of information or take such other action as is directed by OMB.

Comments on the new collection of information contained in this rulemaking should be submitted through www.regulations.gov. Comments should indicate that they are submitted in response to “RIN 2900-AR50 – Emergent Suicide Care” and should be sent within 60 days of publication of this rulemaking. The collection of

information associated with this rulemaking can be viewed at: www.reginfo.gov/public/do/PRAMain.

A comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication. This does not affect the deadline for the public to comment on the interim final rule.

The Department considers comments by the public on proposed collections of information in--

- Evaluating whether the proposed collections of information are necessary for the proper performance of the functions of the Department, including whether the information will have practical utility;
- Evaluating the accuracy of the Department's estimate of the burden of the proposed collections of information, including the validity of the methodology and assumptions used;
- Enhancing the quality, usefulness, and clarity of the information to be collected; and
- Minimizing the burden of the collections of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

The collections of information contained in 38 CFR 17.1225 and 17.1230 are described immediately following this paragraph, under their respective titles.

Title: Submission of Medical Record Information Under the COMPACT Act.

OMB Control No: 2900-(new)

CFR Provisions: 38 CFR 17.1225 and 17.1230

- Summary of collection of information: This amended collection requires providers of emergent suicide care in non-VA facilities, or providers of emergency

transportation necessary to receive such care, pursuant to 38 U.S.C. 1720J, to submit to VA certain information to receive payment or reimbursement for the provision of such care or transportation.

- Description of need for information and proposed use of information: This collection of information is necessary to evaluate and determine eligibility for emergent suicide care and transportation and to ensure that any payment amounts are for the provision of such care in accordance with the parameters established in 38 CFR 17.1200-17.1230.
- Description of likely respondents: Health care providers of emergent suicide care in non-VA facilities and providers of emergency transportation necessary to receive such care.
- Estimated number of respondents: 26,910 health care and transportation providers annually.
- Estimated frequency of responses: 3.4 annually.
- Estimated average burden per response: 5 minutes.
- Estimated total annual reporting and recordkeeping burden: 7624 hours.
- Estimated annual cost to respondents for the hour burdens for collections of information: $ 213,562.

Title: VA form 10-320, Claim reimbursement form.

OMB Control No: 2900-(new)

CFR Provision: 38 CFR 17.1225 and 17.1230

- Summary of collection of information: This new collection of information requires individuals eligible for emergent suicide care, and who have paid costs for such care or associated emergency transportation to receive such care, to submit to VA certain information to receive reimbursement for such costs incurred.

- Description of need for information and proposed use of information: This collection of information is necessary to evaluate and determine eligibility for emergent suicide care and to ensure that any reimbursement amounts are for the provision of such care in accordance with the parameters established in 38 CFR 17.1200-17.1230.
- Description of likely respondents: Individuals eligible under 38 CFR 17.1210 who have incurred costs for the provision of emergent suicide care in or associated emergency transportation to non-VA facilities that VA must reimburse.
- Estimated number of respondents: 155
- Estimated frequency of responses: 1
- Estimated average burden per response: 10 minutes.
- Estimated total annual reporting and recordkeeping burden: 26 hours.
- Estimated annual cost to respondents for the hour burdens for collections of information: $ 728

Assistance Listings

The Assistance listing number and title for the programs affected by this document is 64.009, Veterans Medical Care Benefits; 64.011 - Veterans Domiciliary Care; 64.012 - Veterans Dental Care; 64.013 - Veterans Prescription Service; 64.014 - Veterans Prosthetic Appliances; 64.015 - Veterans State Domiciliary Care; 64.026 - Veterans State Nursing Home Care; 64.029 - Veterans State Adult Day Health Care; 64.033 -Purchase Care Program; 64.040 - CHAMPVA; 64.041 - VHA Inpatient Medicine; 64.042 - VHA Outpatient Specialty Care; 64.043 - VHA Inpatient Surgery; 64.044 - VHA Mental Health Residential; 64.045 - VHA Home Care; 64.046 - VHA Outpatient Ancillary Services; 64.047 - VHA Inpatient Psychiatry; 64.048 - VHA Primary

Care; 64.049 - VHA Mental Health clinics; 64.050 - VHA Community Living Center; 64.053 - VHA Diagnostic Care.

Congressional Review Act

Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996, also known as the Congressional Review Act (5 U.S.C. 801 *et seq*.), the Office of Information and Regulatory Affairs designated this rule as not a major rule, as defined by 5 U.S.C. 804(2).

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on August 11, 2022, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Consuela Benjamin

Regulation Development Coordinator,
Office of Regulation Policy & Management,
Office of General Counsel,
Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs revises 38 CFR part 17 as set forth below:

PART 17 – MEDICAL

1. The authority citation for part 17 is amended to read in part as follows:

Authority: 38 U.S.C. 501, and as noted in specific sections.

* * * * *

Section 17.37 is also issued under 38 U.S.C. 101, 1701, 1705, 1710, 1720J, 1721, 1722.

* * * * *

Section 17.108 is also issued under 38 U.S.C. 501, 1703, 1710, 1725A, 1720J, and 1730A.

* * * * *

Section 17.110 is also issued under 38 U.S.C. 501, 1703, 1710, 1720D, 1720J, 1722A, and 1730A.

* * * * *

Sections 17.1200 through 17.1230 are also issued under 38 U.S.C. 1720J.

* * * * *

2. Amend § 17.37 by adding paragraph (l) and removing the authority citation at the end of the section.

The addition reads as follows:

§17.37 Enrollment not required — provision of hospital and outpatient care to veterans.

* * * * *

(l) An individual may receive emergent suicide care pursuant to 38 U.S.C. 1720J and 38 CFR 17.1200- 17.1230.

3. Amend § 17.108 by adding paragraph (e)(19) to read as follows:

§ 17.108 Copayments for inpatient hospital care and outpatient medical care.

* * * * *

(e) * * *

(19) Emergent suicide care as authorized under 38 CFR 17.1200-17.1230.

* * * * *

4. Amend § 17.110 by adding paragraph (c)(13) to read as follows:

§ 17.110 Copayments for medication.

* * * * *

(c) * * *

(13) Medication for an individual as part of emergent suicide care as authorized under 38 CFR 17.1200-17.1230.

5. Add an undesignated section heading and §§ 17.1200 through 17.1230 to read as follows:

* * * * *

Emergent Suicide Care

Sec.

* * * * *

Emergent Suicide Care

§ 17.1200 Purpose and scope.

(a) *Purpose*. Sections 17.1200 through 17.1230 implement VA's authority under 38 U.S.C. 1720J to provide emergent suicide care.

(b) *Scope*. If an individual is eligible under § 17.1210, VA will provide emergent suicide care under §§ 17.1200 through 17.1230 and not under other regulations in title 38 CFR through which emergent or other care could be provided. Eligibility under § 17.1210, however, does not affect eligibility for other care under chapter 17 of title 38, U.S.C.

§ 17.1205 Definitions.

For purposes of sections §§ 17.1200 through 17.1230:

Acute suicidal crisis means an individual was determined to be at imminent risk of self-harm by a trained crisis responder or health care provider.

Crisis residential care means emergent suicide care provided in a residential facility other than a hospital (that is not a personal residence) that provides 24-hour medical supervision.

Crisis stabilization care means, with respect to an individual in acute suicidal crisis, care that ensures, to the extent practicable, immediate safety and reduces: the severity of distress; the need for urgent care; or the likelihood that the severity of distress or need for urgent care will increase during the transfer of that individual from a facility at which the individual has received care for that acute suicidal crisis.

Emergent suicide care means crisis stabilization care provided to an individual eligible under § 17.1210 pursuant to a recommendation from the Veterans Crisis Line or when such individual has presented at a VA or non-VA facility in an acute suicidal crisis.

Health care provider means a VA or non-VA provider who is licensed to practice health care by a State and who is performing within the scope of their practice as defined by a State or VA practice standard.

Health-plan contract has the same meaning as that term is defined in 38 U.S.C. 1725(f)(2).

Inpatient care means care received by an individual during their admission to a hospital.

Non-VA facility means a facility that meets the definition in 38 U.S.C. 1701(4).

Outpatient care means care received by an individual that is not described within the definition of "inpatient care" under this section to include telehealth, and without the provision of room or board.

Provide, provided, or provision means furnished directly by VA, paid for by VA, or reimbursed by VA.

Trained crisis responder means an individual who responds to emergency situations in the ordinary course of their employment and therefore can be presumed to possess adequate training in crisis intervention.

VA facility means a facility that meets the definition in 38 U.S.C. 1701(3).

Veterans Crisis Line means the hotline under 38 U.S.C. 1720F(h).

§ 17.1210 Eligibility.

(a) An individual is eligible for emergent suicide care if they were determined to be in acute suicidal crisis and are either of the following:

(1) A veteran as that term is defined in 38 U.S.C. 101; or

(2) An individual described in 38 U.S.C. 1720I(b).

(b) VA may initiate provision of emergent suicide care for an individual in acute suicidal crisis prior to that individual's status under paragraphs (a)(1) or (2) of this section being confirmed. If VA is unable to confirm an individual's status under

paragraph (a)(1) or (2) of this section, VA shall bill that individual for the emergent suicide care provided consistent with 38 CFR 17.102(a) and (b)(1).

§ 17.1215 Periods of emergent suicide care.

(a) Unless extended under paragraph (b) of this section, emergent suicide care will be provided to an individual eligible under § 17.1210 from the date acute suicidal crisis is determined to exist:

(1) Through inpatient care or crisis residential care, as long as the care continues to be clinically necessary, but not to exceed 30 calendar days; or

(2) If care under paragraph (a)(1) of this section is unavailable, or if such care is not clinically appropriate, through outpatient care, as long as the care continues to be clinically necessary, but not to exceed 90 calendar days.

(b) VA may extend a period under paragraph (a) of this section if such period is ending and VA determines that an individual continues to require care to address the effects of the acute suicidal crisis.

§ 17.1220 Provision of emergent suicide care.

(a) Emergent suicide care will be provided to individuals eligible under § 17.1210 only if it is determined by a health care provider to be clinically necessary and in accord with generally accepted standards of medical practice.

(b) Prescription drugs, biologicals, and medical devices that may be provided during a period of emergent suicide care under § 17.1215 must be approved by the Food and Drug Administration, unless the treating VA facility or non-VA facility is conducting formal clinical trials under an Investigational Device Exemption or an Investigational New Drug application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption.

§ 17.1225 Payment or reimbursement for emergent suicide care.

(a) VA will not charge individuals eligible under § 17.1210 who receive care under § 17.1215 any costs for such care.

(1) For care furnished in a VA facility, VA will not charge any copayment or other costs that would otherwise be applicable under 38 CFR chapter 17.

(2) For care furnished in a non-VA facility, VA will either:

(i) Pay for the care furnished, subject to paragraphs (b) through (d) of this section; or

(ii) Reimburse an individual eligible under § 17.1210 for the costs incurred by the individual for the care received, subject to paragraph (e) of this section.

(b) The amounts paid by VA for care furnished under paragraph (a)(2)(i) of this section will:

(1) Be established pursuant to contracts, or agreements, or

(2) If there is no amount determinable under paragraph (b)(1) of this section, VA will pay the following amounts:

(i) For care furnished in Alaska for which a VA Alaska Fee Schedule (see 38 CFR 17.56(b)) code and amount exists: The lesser of billed charges or the VA Alaska Fee Schedule amount. The VA Alaska Fee Schedule only applies to physician and non-physician professional services. The schedule uses the Health Insurance Portability and Accountability Act mandated national standard coding sets.

(ii) For care not within the scope of paragraph (b)(2)(i) of this section, and for which an applicable Medicare fee schedule or prospective payment system amount exists for the period in which the service was provided (without any changes based on the subsequent development of information under Medicare authorities) (hereafter “Medicare rate”): The lesser of billed charges or the applicable Medicare rate.

(iii) For care not within the scope of paragraph (b)(2)(i) of this section, furnished by a facility currently designated as a Critical Access Hospital (CAH) by CMS, and for

which a specific amount is determinable under the following methodology: The lesser of billed charges or the applicable CAH rate verified by VA. Data requested by VA to support the applicable CAH rate shall be provided upon request. Billed charges are not relevant for purposes of determining whether a specific amount is determinable under the above methodology.

(iv) For care not within the scope of paragraphs (b)(2)(i) through (iii) of this section and for which there exists a VA Fee Schedule amount for the period in which the service was performed: The lesser of billed charges or the VA Fee Schedule amount for the period in which the service was performed, as posted on VA.gov.

(v) For care not within the scope of paragraphs (b)(2)(i) through (iv) of this section: Billed charges.

(c) Payment by VA under paragraph (a)(2)(i) of this section shall, unless rejected and refunded within 30 calendar days of receipt, extinguish all liability on the part of the individual who received care. Neither the absence of a contract or agreement between the Secretary and the provider nor any provision of a contact, agreement, or assignment to the contrary shall operate to modify, limit, or negate this requirement.

(d) To obtain payment under paragraph (a)(2)(i) of this section, a health care provider or non-VA facility must:

(1) If the care was provided pursuant to a contract, follow all applicable provisions and instructions in such contract to receive payment.

(2) If the care was not provided pursuant to a contract with VA, submit to VA a standard billing form and other information as required no later than 180 calendar days from the date services were furnished. Submission instructions, to include required forms and other information, can be found at www.va.gov.

(e) To obtain reimbursement under paragraph (a)(2)(ii) of this section, an individual eligible under § 17.1210 must submit to VA a standard billing form and other

information as required no later than 180 calendar days from the date the individual paid for emergent suicide care. Submission instructions, to include required forms and other information, can be found at www.va.gov.

(f) VA may recover costs of care it has paid or reimbursed under paragraphs (a)(2)(i) and (ii) of this section, other than for such care for a service-connected disability, if the individual who received the care is entitled to the care (or payment of the care) under a health plan contract. Such recovery procedures will generally comply with 38 CFR 17.100-17.106.

§ 17.1230 Payment or reimbursement of emergency transportation.

(a) VA will pay or reimburse for the costs of emergency transportation (i.e., ambulance or air ambulance) to a VA facility or non-VA facility for the provision of emergent suicide care to an eligible individual under § 17.1210.

(1) For claims submitted by providers of emergency transportation, rates of payment for emergency transportation under paragraph (a) of this section will be calculated as they are under 38 CFR 17.1005(a)(1) through (3). For purposes of this section, the term “emergency treatment” in § 17.1005(a) should be read to mean “emergency transportation.”

(2) For claims submitted by an individual eligible under § 17.1210, VA will reimburse for emergency transportation under paragraph (a) of this section the costs such individual incurred for the emergency transportation.

(b) To obtain payment for emergency transportation furnished under paragraph (a) of this section, the provider of such transportation must submit to VA a standard billing form and other information as required no later than 180 calendar days from the date transportation was furnished. Submission instructions, to include required forms and other information, can be found at www.va.gov.

(c) To obtain reimbursement for emergency transportation under paragraph (a) of this section, an individual eligible under § 17.1210 must submit to VA a standard billing form and other information as required no later than 180 calendar days from the date the individual paid for such transportation. Submission instructions, to include required forms and other information, can be found at www.va.gov.

(d) Payment by VA under paragraph (a) of this section shall, unless rejected and refunded within 30 calendar days of receipt, extinguish all liability on the part of the individual who received care. No provision of a contact, agreement, or assignment to the contrary shall operate to modify, limit, or negate this requirement.

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