Report #1, p. 10. This recommendation was based on the Comptroller General's conclusion that there is a "bias toward patients receiving inpatient rather than outpatient care" because inpatient care is less expensive for dependents of active duty members than outpatient care. *Id.*, p. 8–9. These beneficiaries currently pay approximately \$10.00 per day or \$25 per admission, whichever is greater, for inpatient care. For outpatient care, dependents of active duty members pay a \$150 deductible (subject to a \$300 family limit) and 20 percent of the allowable payment for individual professional services. Consequently, as a general matter, there is a financial incentive for beneficiaries to seek services on an inpatient, rather than an outpatient basis. Under 10 U.S.C. section 1079(i)(2), DoD has authority to establish mental health copayment requirements different from those for other CHAMPUS services.

This rule establishes a per day copayment of \$20 for dependents of active duty beneficiaries. This is based on the fact that an outpatient mental health visit is generally approximately \$100, meaning that the copayment would be \$20. Thus, an inpatient day would have a roughly equal beneficiary copayment as an outpatient visit (excluding the deductible). One commenter objected to this proposal. Based on DoD experience in delivery of mental health services, information collected during utilization management reviews, and reports from the GAO, our observation is that inpatient mental health services remain vulnerable to over utilization. We believe this modest increase in inpatient cost share addresses the Comptroller General's recommendation, without impairing access to care or imposing hardship on beneficiaries. (With respect to avoidance of hardship, we note that the catastrophic cap for active duty dependents is \$1000 per family per year.) To ensure adequate notice of providers and beneficiaries we have established an effective date of October 1, 1995 for the copayment requirements as stated above.

C. Equalization of Alcoholism and Drug Abuse Benefit Provisions

The frequent coexistence of alcohol and other chemical dependency or abuse suggests existing differences in benefit structures for treatment of alcohol and drug abuse should be eliminated. Effective for admissions on or after October 1, 1995, this rule includes treatment for both alcohol and drug dependency/abuse under a broad benefit package designed to include treatment of all substance use disorders.

IV. Additional Discussion of Public Comments

The proposed rule was published in the Federal Register June 29, 1994 (59 FR Page 33465). We received 23 comment letters, all of which were from providers and provider associations. Many of the comments were quite similar in wording and content. Some were very detailed and provided helpful insight and analysis. We thank those who provided input on this important issue. Significant items raised by commenters and our analysis of the comments are summarized below.

1. GAO Recommendations are Based Upon Outdated Information. We received a significant number of comments regarding our reliance on GAO reports for developing components of the proposed rule. Findings and recommendations provided in GAO reports relied to some extent on information gathered prior to realization of impact from several DoD quality, cost and utilization management initiatives.

Response. Although substantial progress has been made as a result of earlier DoD efforts, ongoing utilization reviews and facility inspections continue to reveal departures from minimum CHAMPUS health and safety standards. Additionally, in many areas CHAMPUS continues to reimburse mental health services at significantly higher rates than many other third party payers. While the GAO analysis does not reflect the specific impact of recent initiatives, we believe the themes which emerged from their two reports remain current

2. Specificity of Standards. Several commenters asserted that standards in the proposed rule were stated too broadly, leaving excessive room for interpretation and significant doubt as to the exact CHAMPUS requirements. Examples included the absence of stated requirements for specific staff-to-patient ratios and specific numbers for professional staffing. A similar comment was that terms like "essentially stabilized" and "reasonable and observable" treatment goals should be better defined. Commenters pointed out that specific standards which provide explicit requirements for all aspects of facility certification should be published for public review and comment prior to their application in the certification process.

Response. A more detailed set of standards which provide the agency's interpretation of standards contained in the rule are available from OCHAMPUS. These were made available for public review concurrent with publication of the proposed rule. The more detailed set

of standards does not include specific requirements with respect to professional staff mix and staff-topatient ratios because these will vary depending upon the characteristics of each facility. Consistent with regulatory standards in the rule and further described in the supplemental set available from OCHAMPUS, facilities should develop staffing patterns which reflect the characteristics and special needs of the population served, the patient census, and acuity/intensity of services required. With respect to specific definitions of terms, the unique requirements brought by each patient to the treatment setting necessarily require individual assessments, and professional judgment as to required level of care for the presenting symptoms or dysfunction and progress being made in addressing the patient's specific needs. As such, we do not think it appropriate to establish a fixed list of criteria which must be applied to all

3. Requirement for Physician Medical Directors. Physician professional associations agreed with a requirement for physician medical directors, but associations representing non-physician mental health professionals objected to this. Several commenters recommended that current non-physician medical directors who are serving successfully should be exempt from this

requirement.

Response. We have reconsidered the provisions in the proposed rule regarding physician oversight of all clinical services and agree that some of the language may have had the effect of unduly restricting the scope of practice for some providers, particularly doctoral level psychologists. We are also aware that widely recognized accrediting bodies, as well as several states, permit independent practice and hospital admitting privileges for certain nonphysician providers. We have made revisions to language contained in the proposed rule to assure our standards are consistent with those of the Joint Commission on Accreditation of Hospital Organizations (JCAHO) and in keeping with changing practice patterns in the mental health community Because treatment of mental health patients often includes pharmacologic intervention and evaluation and treatment for related or co-existing medical problems, physician management for these components of therapy is still required. We require medical management of patients to be under the supervision of a physician medical director. However, we also agree that oversight of the spectrum of clinical services provided in a program