52090

into the areas served by the USTFs to stimulate competition" among health care provider organizations "for the cost-effective provision of quality health care services." We have determined that it is most appropriate to use the Uniform HMO Benefit for the USTF Managed -Care Program. This action will stimulate competition between the USTFs and firms operating the other DoD managed care program to which the Uniform HMO Benefit applies. Based on these considerations, we proposed to include the USTF Managed Care Program under the Uniform HMO Benefits, effective October 1, 1995.

# 2. Analysis of Major Public Comments

One commenter asked if Medicareeligible beneficiaries currently enrolled in the USTF managed care program will continue to be enrolled after October 1, 1995.

One commenter suggested that tying the USTF program to TRICARE was inappropriate, arbitrary, and should be done only after direct notice to those beneficiaries who would be affected. Another commenter indicated that it was inappropriate to increase cost sharing for USTFs while exempting PRIMUS and NAVCARE clinics.

One commenter suggested that the use of the rulemaking process for establishing cost sharing in Uniformed Services Treatment Facilities (USTFs) commits DoD to using the rulemaking process for addressing USTF cost sharing in the future.

One commenter took issue with the applicability of Section 731 of the National Defense Authorization Act for Fiscal Year 1994 to USTFs, since it applies to "health care initiatives undertaken \* \* \* after the date of enactment of the act," and services were initiated under the USTF managed care program prior to that time. Also, the commenter questioned whether Congressional Conference report language recommending the introduction of competitive managed care into areas now served by USTFs justifies imposing the TRICARE costs shares (i.e., the Uniform HMO Benefits) on USTFs.

One commenter suggested that the statute directing the Uniform HMO Benefit provides latitude for differences in cost sharing requirements, because it specifies only reduced out of pocket costs for enrollees, and mandates uniformity in the range of health care services to be available to enrollee. Focusing on the requirement for reduced out-of-pocket costs, the commenter notes that out-of-pocket costs for USTF enrollees would be increased substantially under the

Uniform HMO Benefit. Because applying the Uniform HMO Benefit cost sharing to USTFs would be inappropriate and unnecessary, and because the range of health care services in CHAMPUS and the USTF program are similar, the commenter suggests that proposed § 199.18(g) not be included in the final rule.

One commenter suggested that the separate, capitated arrangements between the Government and USTFs meet the requirement that the costs incurred by the Secretary under each managed care initiative be no greater than would otherwise be incurred. It is argued that, because USTFs are fully at risk for excess health care costs, the Uniform HMO Benefit cost sharing is unnecessary for the USTF program.

### 3. Provisions of the Final Rule

We have deleted as unnecessary this provision of the final rule. The USTF managed care plan agreements provide for adoption of the DoD policy for cost sharing under managed care programs. Thus, incorporation of the Uniform HMO Benefit, which now has been promulgated as DoD policy for managed care programs, into the USTF managed care plan has already been provided for through contractual agreement and need not be repeated in this regulation.

DoD's policy is to phase the uniform HMO benefit into the USTF program, coincident with implementation of the TRICARE regional managed care contract in the respective area. This will assure equitable treatment for beneficiaries within a region and nationality. Eventually, USTFs would be fully integrated into the TRICARE system, on an equal footing with other contract providers of health care. The intention is to provide a level playing field for the operation of managed care programs, and to assure equity among beneficiaries.

## IV. Provisions of the Rule Concerning Other Regulatory Changes

The rule makes a number of additional changes to support implementation of TRICARE.

A. Nonavailability Statements (Revisions to Sections 199.4(a)(9) and 199.15)

### 1. Provisions of Proposed Rule

Proposed revisions to section 199.4 relate to the issuance of NASs by designated military clinics. Beneficiaries residing near such designated clinics would have to obtain a nonavailability statement for the selected outpatient services subject to NAS requirements under section 199.4(a)(9)(i)(C).

In a notice of proposed rule making published on May 11, 1993, we proposed a new provision to allow consideration of availability of care in civilian preferred provider networks in connection with issuance of nonavailiability statements; in conjunction with this, a considerable expansion of the list of outpatient services for which an NAS is required was proposed. That proposal was not finalized. In the proposed rule, we outlined a more limited program, covering only inpatient care. Recently, a demonstration program was established in California and Hawaii, allowing consideration of availability of care in civilian preferred provider networks in connection with issuance of nonavailability statements for inpatient services only. The results of the demonstration will be incorporated into a Report to Congress on the expanded use of NASs, as required by section 735 of the National Defense Authorization Act for FY 1995.

Finally, proposed revisions to section 199.4(a)(9) would apply NAS requirements in cases where military providers serving at designated military outpatient clinics also provide inpatient care to beneficiaries at civilian hospitals, under External Partnership or Resource Sharing Agreements.

#### 2. Analysis of Major Public Comments

Several commenters objected to the notion of employing non-availability statements under TRICARE, since beneficiaries are being given the choice of enrolling the TRICARE Prime or exercising their benefit under TRICARE Standard with higher cost shares accompanied by freedom of choice.

One commenter recommended that NAS requirements be uniform throughout the nation, to avoid confusing the highly mobile beneficiary population.

Several commenters suggested that requiring non-enrolled beneficiaries to use network providers or civilian facilities with an external partnership or resource sharing agreement, through issuance of a "restricted" NAS, was unfair to those unable to enroll in TRICARE Prime, and to those with chronic conditions who might have long-standing provider relationships.

One commenter sought clarification of the applicability of the restricted NAS provisions to beneficiaries under TRICARE Prime, Extra, and Standard and suggested that restricting use of non-network care by TRICARE Standard beneficiaries is an unreasonable curb on their freedom of choice, as well arbitrarily preventing an authorized CHAMPUS provider from furnishing