

Tuesday, January 3, 1995 (60 FR 82). The proposed regulations define self-dealing by private foundations.

FOR FURTHER INFORMATION CONTACT: Terri Harris or Paul Accettura at (202) 622-6070 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

The proposed regulations that are the subject of this correction are under section 4941 of the Internal Revenue Code.

Need for Correction

As published, the notice of proposed rulemaking contains a typographical error that is in need of correction.

Correction of Publication

Accordingly, the publication of the notice of proposed rulemaking that is the subject of FR Doc. 94-31666, is corrected as follows:

On page 83, column 2, § 53.4941(d)-2, paragraph (f)(3)(ii), line 11, the language "pursuant to this paragraph (f)(3)(ii)." is corrected to read "pursuant to this paragraph (f)(3).".

Cynthia E. Grigsby,

Chief, Regulations Unit, Assistant Chief Counsel (Corporate).

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DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

RIN 0720-AA21

[DoD 6010.8-R]

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); TRICARE Program; Uniform HMO Benefit; Special Health Care Delivery Programs

AGENCY: Office of the Secretary, DoD.

ACTION: Proposed rule.

SUMMARY: This proposed rule establishes requirements and procedures for implementation of the TRICARE Program, the purpose of which is to move toward a comprehensive managed health care delivery system in military medical treatment facilities and CHAMPUS. Principal components of the proposed rule include: establishment of a comprehensive enrollment system; creation of a triple option benefit, including a Uniform HMO Benefit required by law; a series of initiatives to coordinate care between military and

civilian delivery systems, including Resource Sharing Agreements, Health Care Finders, PRIMUS and NAVCARE Clinics, and new prescription pharmacy services; and a consolidated schedule of charges, incorporating steps to reduce differences in charges between military and civilian services. This proposed rule also includes provisions expanding use of nonavailability statement authorities to require use of designated civilian network providers for inpatient hospital care, establishing a special civilian provider program authority for active duty dependents overseas, and implementing revisions to the Managed Care Program of the former Public Health Service hospitals that now function as Uniformed Services Treatment Facilities. The TRICARE Program is a major reform of the Military Health Services System that will improve services to beneficiaries and help sustain the system during this period of significant budgetary limitations.

DATES: Written comments must be received on or before April 10, 1995.

ADDRESSES: Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), Office of Program Development, Aurora, CO 80045-6900.

FOR FURTHER INFORMATION CONTACT: Steve Lillie, Office of the Assistant Secretary of Defense (Health Affairs), telephone (703) 695-3350.

Questions regarding payment of specific claims under the CHAMPUS allowable charge method should be addressed to the appropriate CHAMPUS contractor.

SUPPLEMENTARY INFORMATION:

I. Overview of the TRICARE Program

The medical mission of the Department of Defense is to provide, and maintain readiness to provide, medical services and support to the armed forces during military operations, and to provide medical services and support to members of the armed forces, their family members, and others entitled to DoD medical care.

Under the current Military Health Services System (MHSS), CHAMPUS-eligible beneficiaries may receive care in the direct care system (that is, care provided in military hospitals or clinics) or seek care from civilian health care providers; the government shares in the cost of such civilian care under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), or for some beneficiaries, the Medicare program. The substantial majority of care for military beneficiaries is provided within catchment areas of

inpatient military treatment facilities (MTFs), a catchment area being roughly defined as the area within a 40-mile radius around an MTF.

Recently DoD has embarked on a new program, called TRICARE, which will improve the quality, cost, and accessibility of services for its beneficiaries. Because of the size and complexity of the military health services system, TRICARE is being phased over a period of several years. The principal mechanisms for the implementation of TRICARE are the designation of the commanders of selected military medical centers as Lead Agents for 12 TRICARE regions across the country, operational enhancements to the Military Health Services System, and the procurement of managed care support contracts for the provision of civilian health care services in those regions.

Sound management of the MHSS requires a great degree of coordination between the direct care system and CHAMPUS-funded civilian care, which, unfortunately, has not always been present. The TRICARE Program recognizes that "step one" of any process aimed at improving management is to identify the beneficiaries for whom the health program is responsible. Indeed, the dominant feature in some private sector health plans, enrollment of beneficiaries in their respective health care plans, is an essential element. This proposed rule moves toward establishment of a basic structure of health care enrollment for the MHSS. Under this structure, all health care beneficiaries become enrolled in TRICARE and classified into one of five enrollment categories:

1. Active duty members, all of whom are automatically enrolled in TRICARE Prime, an HMO-type option;
2. TRICARE Prime enrollees, who (except for active duty members) must be CHAMPUS eligible;
3. TRICARE Standard enrollees, which covers all CHAMPUS-eligible beneficiaries who do not enroll in TRICARE Prime or another managed care program affiliated with TRICARE;
4. Medicare-eligible beneficiaries, who, although not eligible for TRICARE Prime, may participate in many features of TRICARE; and
5. Participants in other managed care programs affiliated with TRICARE.

The second major feature of the TRICARE Program will be the establishment of a triple option benefit. CHAMPUS-eligible beneficiaries will be offered three options: They may enroll to receive health care in an HMO-type program called "TRICARE Prime;" they may use the civilian preferred provider

network on a case-by-case basis, under "TRICARE Extra;" or they may remain in the standard CHAMPUS benefit plan, called "TRICARE Standard." Enrollees in Prime will obtain most of their care within the network, and pay substantially reduced CHAMPUS cost shares when they receive care from civilian network providers. Enrollees in Prime will retain freedom to utilize non-network civilian providers, but they will have to pay cost sharing considerably higher than under Standard CHAMPUS if they do so. Beneficiaries who choose not to enroll in TRICARE Prime will preserve their freedom of choice of provider for the most part by remaining in TRICARE Standard. These beneficiaries will face standard CHAMPUS cost sharing requirements, except that their coinsurance percentage will be lower when they opt to use the preferred provider network under TRICARE Extra. All beneficiaries continue to be eligible to receive care in military facilities. Active duty dependents who enroll in TRICARE Prime will have a priority over other beneficiaries.

A third major feature of the TRICARE program is a series of initiatives, affecting all beneficiary enrollment categories, designed to coordinate care between military and civilian health care systems. Among these is a program of resource sharing agreements, under which a TRICARE contractor provides to a military treatment facility, personnel and other resources to increase the availability of services from military facilities and providers. Another initiative is establishment of Health Care Finders, which are administrative offices to facilitate referrals to appropriate services in the military facility or civilian provider network. In addition, integrated quality and utilization management services for military and civilian sector providers will be instituted. Still another initiative is establishment of special pharmacy programs for areas affected by base realignment and closure actions. These pharmacy programs will include special eligibility for some Medicare-eligible beneficiaries. TRICARE also makes permanent authority for PRIMUS and NAVCAREclinics, which are dedicated contractor-owned and operated clinics. These initiatives will have a major impact on military health care delivery systems, improving services for all beneficiary enrollment categories.

The fourth major component of TRICARE is the implementation of a consolidated schedule of charges, incorporating steps to reduce differences in charges between military and civilian services. In general, the

TRICARE Program reduces out-of-pocket costs for civilian sector care. For example, the current CHAMPUS cost sharing requirements for outpatient care for active duty dependents include a deductible of \$150 per person or \$300 per family (\$50/\$100 for dependents of sponsors in pay grades E-4 and below) and a copayment of 20 percent of the allowable cost of the services. Under TRICARE Prime, which incorporates the "Uniform HMO Benefit," these cost sharing requirements will be replaced by a standard charge for most outpatient visits of \$12.00 per visit, or \$6.00 per visit for dependents of E-4 and below sponsors.

For retirees, their dependents and survivors, the current deductible of \$150 per person or \$300 per family and 25 percent cost sharing will also be replaced by a standard charge, which is likewise \$12.00 for most outpatient visits.

Beneficiaries who are not under TRICARE Prime will also have significant opportunities to reduce expected out-of-pocket costs under CHAMPUS. These opportunities include increased availability of MTF services by virtue of resource sharing agreements, the new special pharmacy programs, and access to PRIMUS and NAVCARE Clinics.

With respect to military hospitals, for retirees, their dependents, and survivors, consideration may be given in the future to establishment of nominal per-visit fees, for some or all retirees, their family members, and survivors, and for some or all types of services for those beneficiaries. Fees would be considered to help control demand for military facility care, to free up capacity and reduce waiting times, and lower the costs of health care.

A user fee can be structured in many different ways, for example, exempting lower income segments of the covered population. Most importantly, the motivation for a fee is to encourage the more efficient provision of lower cost health care, and not to produce budgetary savings. Accordingly, analysis of alternatives would be based on the assumption that revenue produced by a user fee will be allocated to other benefits or quality of life programs. When this issue is considered for possible implementation in fiscal year 1998, if the Department decides to establish a nominal fee for some or all outpatient services provided to some or all retirees, their family members, and survivors, a proposed rule will then be issued for public comment. Again, it should be noted that this suggestion of a possible outpatient fee does not

include active duty service members or their family members.

Taken as a whole, the TRICARE Program is a major reform of the Military Health Services System—one that will accomplish the transition to a comprehensive managed health care system that will help to achieve DoD's medical mission into the next century.

II. Provisions of Proposed Rule Regarding the TRICARE Program

These regulatory changes are being published as an amendment to the 32 CFR part 199 because the operating details of CHAMPUS will be altered significantly. Our regulatory approach is to leave the existing CHAMPUS rules largely intact and to create new §§ 199.17 and 199.18 to describe the TRICARE Program and the uniform HMO benefit. The major provisions of the proposed new § 199.17 regarding the TRICARE Program are summarized below.

A. Establishment of the TRICARE Program (proposed § 199.17(a))

This paragraph introduces the TRICARE Program, and describes its purpose, statutory authority, and scope. It is explained that certain usual CHAMPUS and MHSS rules do not apply under the TRICARE Program, and that implementation of the Program occurs in a specific geographic area, such as a local catchment area or a region. Public notice of initiation of a Program will include a notice published in the **Federal Register**.

With respect to statutory authority, major statutory provisions are title 10, U.S.C. sections 1099 (which calls for a health care enrollment system), 1097 (which authorizes alternative contracts for health care delivery and financing), and 1096 (which allows for resource sharing agreements). Significantly, the National Defense Authorization Act for Fiscal Year 1995 amended section 1097 to authorize the Secretary of Defense to provide for the coordination of health care services provided pursuant to any contract of agreement with a civilian managed care contractor with those services provided in military medical treatment facilities. This amendment set the stage for many features of TRICARE, including initiatives to improve coordination between military and civilian health care delivery components and the consolidated schedule of beneficiary charges.

B. Triple Option (proposed § 199.17(b))

This paragraph presents an overview of the triple option feature of the TRICARE Program. Most beneficiaries are offered enrollment in the TRICARE

Prime Plan, or "Prime." They are free to choose to enroll to obtain the benefits of Prime, or not to enroll and remain in the TRICARE Standard Plan, or "Standard," with the option of using the preferred provider network under the TRICARE Extra Plan, or "Extra." When the TRICARE Program is implemented in an area, active duty members will be enrolled in Prime.

C. Eligibility for Enrollment in Prime (proposed § 199.17(c))

This paragraph describes who may enroll in the Program. All active duty members are automatically enrolled; all CHAMPUS-eligible beneficiaries may enroll. Since it is likely that priorities for enrollment will be necessary owing to limited availability of Prime, the order of priority for enrollment will be as follows: First priority will be active duty members; second priority will be active duty family members; and third priority will be CHAMPUS-eligible retirees, family members of retirees, and survivors. At this time, TRICARE Prime will not offer enrollment to non-CHAMPUS-eligible beneficiaries.

D. Health Benefits Under Prime (proposed § 199.17(d))

This paragraph states that the benefits established for the Uniform HMO Benefit option (see § 199.18, Uniform HMO Benefit option) are applicable to CHAMPUS eligible enrollees in TRICARE Prime.

Under TRICARE, all enrollees in Prime and all beneficiaries who do not enroll remain eligible for care in MTFs. Active duty family members who enroll in TRICARE Prime would be given priority for MTF access over non-enrollees; priorities for other categories of beneficiary would be unaffected by their enrollment. Regarding civilian sector care, active duty member care will continue to be arranged as needed and paid for through the supplemental care program.

E. Health Benefits Under Extra (proposed § 199.17(e))

This paragraph describes the availability of the civilian preferred provider network under Extra. When Extra is used, CHAMPUS cost sharing requirements will be reduced. See Table 2 following the preamble for a comparison of TRICARE Standard, TRICARE Extra, and TRICARE Prime cost sharing requirements.

F. Health Benefits Under Standard (proposed § 199.17(f))

This paragraph describes health benefits for beneficiaries who opt to remain in Standard. Broadly,

participants in Standard maintain their freedom of choice of civilian provider under CHAMPUS (subject to nonavailability statement requirements), and face standard CHAMPUS cost sharing requirements, except when they take advantage of the preferred provider network under Extra. The CHAMPUS benefit package applies to Standard participants.

G. Coordination With Other Health Care Programs (proposed § 199.17(g))

This paragraph provides that, for beneficiaries enrolled in managed health care programs not operated by DoD, DoD may establish a contract or agreement with the other managed health care program for the purpose of coordinating beneficiary entitlements under the other program and the military health services system. This potentially includes any private sector health maintenance organization (HMO) or competitive medical plan, and any Medicare HMO. Any contract or agreement entered into under this paragraph may integrate health care benefits, delivery, financing, and administrative features of the other managed care plan with some or all of the features of the TRICARE Program. This paragraph is based on 10 U.S.C. section 1097(d), as amended by section 714 of the National Defense Authorization Act for Fiscal Year 1995.

H. Resource Sharing Agreements (proposed § 199.17(h))

This paragraph provides that military treatment facilities may establish resource sharing agreements with the applicable managed care support contractors for the purpose of providing for the sharing of resources between the two parties. Internal and external resource sharing agreements are authorized. Under internal resource sharing agreements, beneficiary cost sharing requirements are the same as in military facilities. Under internal or external resource sharing agreements, a military treatment facility commander may authorize the provision of services pursuant to the agreement to Medicare-eligible beneficiaries, if this will promote the most cost-effective provision of services under the TRICARE Program.

I. Health Care Finder (proposed § 199.17(i))

This paragraph establishes procedures for the Health Care Finder, an administrative office that assists beneficiaries in being referred to appropriate health care providers, especially the MTF and civilian network

providers. Health Care Finder services are available to all beneficiaries.

J. General Quality Assurance, Utilization Review, and Preauthorization Requirements (proposed § 199.17(j))

This paragraph emphasizes that all requirements of the CHAMPUS basic program relating to quality assurance, utilization review, and preauthorization of care apply to the CHAMPUS component of Prime, Extra and Standard. These requirements and procedures may also be made applicable to military facility services.

K. Pharmacy Network Services in Base Realignment and Closure Sites (proposed § 199.17(k))

This paragraph establishes two special pharmacy programs, a retail pharmacy network program and a mail service pharmacy program. This proposal is made with consideration of the existing mail service pharmacy demonstration, under which features of the permanent, nationwide program are being tested at a number of sites. Proceeding to solicit public comment on design features at this point, prior to completion of the demonstration, will enable us to move most expeditiously to establish the nationwide program in the future.

An important aspect of the mail service and retail pharmacy programs is that, under the authority of section 702 of the National Defense Authorization Act for Fiscal Year 1993, Pub. L. 102-484, there is a special rule regarding eligibility for prescription services. The special rule is that Medicare-eligible beneficiaries, who are normally ineligible for CHAMPUS, are under certain special circumstances eligible for the pharmacy programs. The special circumstances are that they live in an area adversely affected by the closure of a military medical treatment facility. A provision of the National Defense Authorization Act for Fiscal Year 1995 additionally provides eligibility for Medicare eligible beneficiaries who demonstrate that they had been reliant on a former military medical treatment facility for pharmacy services.

Under the proposed rule, the area adversely affected by the closure of a facility is established as the catchment area of the treatment facility that closed. The catchment area is the existing statutory designation of the geographical area primarily served by a military hospital. The catchment area is defined in law as "the area within approximately 40 miles of a medical facility of the uniformed services." Pub. L. 100-180, sec. 721(f)(1), 10 U.S.C.A.

1092 note. This is also the geographical basis in the law for nonavailability statements that authorize CHAMPUS beneficiaries who live within areas served by military hospitals to obtain care outside the military facility. 10 U.S.C. 1079(a)(7). Because the purpose of the special eligibility rule for Medicare-eligible beneficiaries is to replace the pharmacy services lost as a consequence of the base closure, and because the 40-mile catchment area is the only geographical area designation established in law to describe the beneficiaries primarily served by a military medical facility, we believe it most appropriate to adopt the established 40-mile catchment area for purposes of the applicability of the special eligibility rule for pharmacy services. Thus, under the proposed rule, Medicare-eligible beneficiaries who live within the established 40-mile catchment area of a treatment facility that closed are eligible to use the pharmacy programs if available in that area.

There are several noteworthy special rules regarding the area that will be considered adversely affected by the closure of a military treatment facility. First, 40-mile catchment area generally will apply in the case of the closure of a military clinic, as it does in the case of the closure of a hospital. Recognizing that there may be clinic closure cases involving very small clinics that were not providing any significant amount of pharmacy services to retirees and their dependents, these cases will not be considered to be areas adversely affected by the closure of a medical treatment facility. The reason for this is simply that if the facility was not providing a significant amount of services, its closure will not have a noteworthy adverse affect in the area. Another circumstance in which a facility closure will not be considered to have an adverse affect on an area is if the area is also within the catchment area of another military medical treatment facility that remains open and available to the beneficiaries.

The Director, Office of CHAMPUS may establish other procedures for the effective operation of the pharmacy programs, dealing with issues such as encouragement of use of generic drugs for prescriptions and use of appropriate drug formularies, as well as establishment of requirements for demonstration of past reliance on a military medical treatment facility for pharmacy services.

L. PRIMUS and NAVCARE Clinics (proposed § 199.17(l))

The proposed rule would add a new § 199.17(l). Under the authority of 10 U.S.C. sections 1074(c) and 1097, this section would authorize PRIMUS and NAVCARE Clinics, which have operated to date under demonstration authority. Because these contractor owned and operated clinics have increased beneficiary access to care and become very popular with beneficiaries, this provision will make permanent the PRIMUS and NAVCARE Clinic authority.

As under the demonstration project, PRIMUS and NAVCARE Clinics will function as extensions of military treatment facilities. As such, all beneficiaries eligible for care in military treatment facilities (including active duty members, Medicare-eligible beneficiaries, and other non-CHAMPUS eligible beneficiaries) are eligible to use PRIMUS and NAVCARE Clinics. For PRIMUS and NAVCARE Clinics established prior to October 1, 1994, CHAMPUS deductibles and copayments will not apply. Rather, military hospital policy regarding beneficiary charges will apply. For PRIMUS and NAVCARE Clinics established after September 30, 1994, the provisions of the Uniform HMO Benefit regarding out patient costsharing will apply (see proposed § 199.18(d)(3)). Other CHAMPUS rules and procedures, such as coordination of benefits requirements will apply. The Director, OCHAMPUS may waive or modify CHAMPUS regulatory requirements in connection with the operation of PRIMUS and NAVCARE Clinics.

M. Consolidated Schedule of Beneficiary Charges (proposed § 199.17(m))

This paragraph establishes a consolidated schedule of beneficiary charges applicable to health care services under TRICARE for Prime enrollees (other than active duty members), Standard enrollees, and Medicare-eligible beneficiaries. The schedule of charges is summarized at Table 1, following the preamble. As demonstrated by the table, TRICARE provides for reduced beneficiary out-of-pocket costs.

Included in the consolidated schedule of beneficiary charges is the "Uniform HMO Benefit" design required by law. This is further discussed in the next section of the preamble.

N. Additional Health Care Management Requirements Under Prime (proposed § 199.17(n))

This paragraph describes additional health care management requirements

within Prime, and establishes the point-of-service option, under which CHAMPUS beneficiaries retain the right to obtain services without a referral, albeit with higher cost sharing. Each CHAMPUS-eligible enrollee will select or be assigned a Primary Care Manager who typically will be the enrollee's health care provider for most services, and will serve as a referral agent to authorize more specialized treatment if needed. Health Care Finder offices will also assist enrollees in obtain referrals to appropriate providers. Referrals for care will give first priority to the local MTF; other referral priorities and practices will be specified during the enrollment process.

O. Enrollment Procedures (proposed § 199.17(o))

This paragraph describes procedures for enrollment of beneficiaries other than active duty members, who must enroll. The Prime plan features open season periods during which enrollment is permitted. Prime enrollees will maintain participation in the plan for a 12 month period, with disenrollment only under special circumstances, such as when a beneficiary moves from the area. A complete explanation of the features, rules and procedures of the Program in the particular locality involved will be available at the time enrollment is offered. The features, rules and procedures may be revised over time, coincident with reenrollment opportunities.

P. Civilian Preferred Provider Networks (proposed § 199.17(p))

This paragraph sets forth the rules governing civilian preferred provider networks in the TRICARE Program. It includes conformity with utilization management and quality assurance program procedures, provider qualifications, and standards of access for provider networks. In addition, the methods which may be used to establish networks are identified.

DoD beneficiaries who are not CHAMPUS-eligible, such as Medicare beneficiaries, may seek civilian care under the rules and procedures of their existing health insurance program. Providers in the civilian preferred provider network generally will be required to participate in Medicare, so that when Medicare beneficiaries use a network provider they will be assured of a participating provider.

Q. Preferred Provider Network Establishment Under Any Qualified Provider Method (proposed § 199.17(q))

This paragraph describes one process that may be used to establish a preferred

provider network (the "any qualified provider method") and establishes the qualifications which providers must demonstrate in order to join the network.

R. General Fraud, Abuse, and Conflict of Interest Requirements Under TRICARE Program (proposed § 199.17(r))

This paragraph establishes that all fraud, abuse, and conflict of interest requirements for the basic CHAMPUS program are applicable to the TRICARE Program.

S. Partial Implementation of TRICARE (proposed § 199.17(s))

This paragraph explains that some portions of TRICARE may be implemented separately: A program without the HMO option, or a program covering a subset of health care services, such as mental health services.

T. Inclusion of Veterans Hospitals in TRICARE Networks (proposed § 199.17(t))

This paragraph would provide the basis for participation by Department of Veterans Affairs facilities in TRICARE networks, based on agreements between the VA and DoD.

U. Cost Sharing of Care for Family Members of Active Duty Members in Overseas Locations (proposed § 199.17(u))

This paragraph would permit establishment of special CHAMPUS cost sharing rules for family members of active duty members when they accompany the member on a tour of duty outside the United States. A recently initiated demonstration program, described in the **Federal Register** of September 2, 1994 (59 FR 45668), tests such a program for active duty family members in countries served by OCHAMPUS, Europe.

V. Administrative Procedures (proposed § 199.17(v))

This paragraph authorizes establishment of administrative procedures for the TRICARE Program.

III. Provisions of the Rule Concerning the Uniform HMO Benefit Option

A. In General. (§ 199.18(a))

This paragraph introduces the Uniform HMO Benefit option. The statutory provision that establishes the parameters for determination of the Uniform HMO Benefit option is section 731 of the National Defense Authorization Act for Fiscal Year 1994. It requires the establishment of a Uniform HMO Benefit option, which shall "to the maximum extent

practicable" be included "in all future managed health care initiatives undertaken by" DoD. This option is to provide "reduced out-of-pocket costs and a benefit structure that is as uniform as possible throughout the United States." The statute further requires a determination that, in the managed care initiative that includes the Uniform HMO Benefit, DoD costs "are no greater than the costs that would otherwise be incurred to provide health care to the covered beneficiaries who enroll in the option."

In addition to this provision of the National Defense Authorization Act for Fiscal Year 1994, a similar requirement is established by section 8025 of the DoD Appropriations Act, 1994. As part of an initiative "to implement a nationwide managed health care program for the military health services system," DoD shall establish "a uniform, stabilized benefit structure characterized by a triple option health benefit feature." Our Uniform HMO Benefit also implements this requirement of law.

In fiscal year 1993, DoD implemented the expansion of the CHAMPUS Reform Initiative to the areas of Carswell and Bergstrom Air Force Bases in Texas and England Air Force Base, Louisiana. (These sites were singled out because they were military bases identified for closure in the Bare Realignment and Closure, or "BRAC" process; thus the benefit developed for them is called the "BRAC Benefit.") This expansion of the CHAMPUS Reform Initiative offers positive incentives for enrollment and preserves the basic design of the original CHAMPUS Reform Initiative program, although it is not identical to that program. The original CHAMPUS Reform Initiative design featured a \$5 per visit fee for most office visits, a very much reduced schedule of other copayments, and no deductible or enrollment fee. Although its generosity made it very popular with beneficiaries, it also caused substantial concerns regarding government budget impact. This benefit fails to meet the statutory requirement for cost neutrality to DoD.

The Carswell/Bergstrom/England HMO benefit (BRAC Benefit) model attempts partially to address these concerns, while providing enhanced benefits. It features enrollment fees for some categories of beneficiaries, \$5, \$10, or \$15 per visit fees, depending on beneficiary category, and inpatient per diems of \$125 for retirees, their family members and survivors.

A new HMO benefit is being presented in this proposed rule as the Uniform HMO Benefit. The principal features of the proposed benefit are

displayed in Table 3 following the preamble. Its most significant change from the BRAC Benefit is that inpatient cost sharing for retirees, their dependents and survivors is reduced to the levels faced by active duty dependents, with concomitant increases in enrollment fees for these beneficiaries. A second important change is that there would be no enrollment fee for dependents of active duty members. Finally, fees are set so that they may be held constant for a five-year period, rather than escalating each year with price inflation.

The development of this proposed Uniform HMO Benefit included painstaking analysis of utilization, cost, and administrative effect of potential cost sharing schedules. This analysis included a series of assumptions regarding most likely ramifications of various components of the benefit and the operation of the TRICARE Program. Based on this exhaustive analysis, the formulation of the Uniform HMO Benefit in the proposed rule is the most generous benefit DoD can offer consistent with the statutory cost-neutrality mandate.

B. Benefits Covered Under the Uniform HMO Benefit Option (§ 199.18(b))

For CHAMPUS-eligible beneficiaries, the HMO Benefit option incorporates the existing CHAMPUS benefit package, with potential additions of preventive services and a case management program to approve coverage of usually noncovered health care services (such as home health services) in special situations.

C. Deductibles, Fees, and Cost Sharing Under the HMO Benefit Option (proposed § 199.18(c) through (f))

Instead of usual CHAMPUS cost sharing requirements, Uniform HMO Benefit option participants will pay special per-service, specific dollar amounts or special reduced cost sharing percentages, which would vary by category of beneficiary.

The Uniform HMO Benefit also would include an annual enrollment fee, which would be in lieu of the CHAMPUS deductible. The current CHAMPUS deductible is \$50 per person or \$100 per family for family members of active duty members in pay grades E-1 through E-4; and \$150 per person or \$300 per family for all other beneficiaries. The enrollment fee under the Uniform HMO Benefit option would vary by beneficiary category: \$0 for active duty family members, and \$230 individual or \$460 family for retirees, their family members, and survivors.

The amount of proposed enrollment fees, outpatient charges and inpatient copayment under the uniform HMO benefit are presented in detail in § 199.18(c) through (f).

D. Applicability of the Uniform HMO Benefit to the Uniformed Service Treatment Facilities Managed Care Program (proposed § 199.18(g))

The section would apply the uniform HMO Benefit provisions to the Uniformed Services Treatment Facility Managed Care Program, beginning in fiscal year 1996. This program includes civilian contractors providing health care services under rules quite different from CHAMPUS, the CHAMPUS Reform Initiative, or other CHAMPUS-related programs.

The National Defense Authorization Act for Fiscal Year 1991, section 718(c), required implementation of a "managed-care delivery and reimbursement model that will continue to utilize the Uniformed Services Treatment Facilities" in the MHSS. This provision has been amended and supplemented several times since that Act. Most recently, section 718 of the National Defense Authorization Act for Fiscal Year 1994 authorized the establishment of "reasonable charges for inpatient and outpatient care provided to all categories of beneficiaries enrolled in the managed care program." This is a deviation from previous practice, which had tied Uniformed Services Treatment Facilities (USTF) rules to those of military hospitals. This new statutory provision also states that the schedule and application of the reasonable charges shall be in accordance with terms and conditions specified in the USTF Managed Care Plan. The USTF Managed Care Plan agreements call for implementation in the USTF Managed Care Program of cost sharing requirements based on the level and range of cost sharing required in DoD managed care initiatives.

Under section 731 of the FY-94 Authorization Act, the Uniform HMO Benefit is to apply "to the maximum extent practicable" to "all future managed care initiatives undertaken by the Secretary." The Conference Report accompanying this Act calls on DoD "to develop and implement a plan to introduce competitive managed care 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 practicable to use the Uniform HMO Benefit for the USTF Managed Care Program. In addition, 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 Congressional provisions, as well as compelling need for a uniform HMO benefit, we propose to include the USTF Managed Care Program under the Uniform HMO Benefit, effective October 1, 1995.

IV. Provisions of the Proposed Rule Concerning Other Regulatory Changes

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

A. Nonavailability Statements (proposed revisions to §§ 199.4(a)(9) and 199.15)

Proposed revisions to § 199.4(a)(9) provide the basis for administrative linkages between a determination of medical necessity and the decision to issue or deny a Nonavailability Statement (NAS). NASs are issued when an MTF lacks the capacity or capability to provide a service, but carry no imprimatur of medical necessity. Proposed revisions to § 199.15 establish ground rules for CHAMPUS PRO review of care in military medical treatment facilities, and would allow for consolidated determinations of medical necessity applicable to both the MTF and civilian contexts when the CHAMPUS PRO performs the review.

Additional 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 § 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 non-availability statements; in conjunction with this, a considerable expansion of the list of outpatient service for which an NAS is required was proposed. That proposal was not finalized. Now we propose 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 non-availability 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, due not later than December 31, 1994. Early indications are that the demonstration effort has saved money without adverse impacts; the report to Congress will provide a definitive assessment. No final action to expand the program will go into effect until well after we comply with the Congressional reporting requirement.

Finally, proposed revisions to § 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.

B. Participating Provider Program (proposed revisions to § 199.14)

Proposed revisions to § 199.14 change the Participating Provider Program from a mandatory, nationwide program to a localized, optional program. The initial intent of the program was to increase the availability of participating providers by providing a mechanism for providers to sign up as Participating Providers; a payment differential for Participating Providers was to be added as an inducement. With the advent of the TRICARE Program and its extensive networks of providers, the nationwide implementation of the Participating Provider Program would be redundant. Accordingly, this rule would eliminate the nationwide program. Where the need arises, CHAMPUS contractors will act to foster participation, including establishment of a local Participating Provider Program when needed, but not including the payment differential feature.

V. Regulatory Procedures

Executive Order 12866 requires certain regulatory assessments for any "significant regulatory action," defined as one which would result in an annual effect on the economy of \$100 million or more, or have other substantial impacts.

The Regulatory Flexibility Act (RFA) requires that each Federal agency prepare, and make available for public comment, a regulatory flexibility analysis when the agency issues a regulation which would have a significant impact on a substantial number of small entities.

This is not a significant regulatory action under the provisions of Executive Order 12866, and it would not have a significant impact on a substantial number of small entities.

This proposed rule will impose additional information collection requirements on the public under the Paperwork Reduction Act of 1980 (44

U.S.C. 3501–3511), because beneficiaries will be required to enroll. Information collection requirements are under review.

This is a proposed rule. Public comments are invited. All comments will be considered. A discussion of the major issues raised by public comments

will be included with issuance of the final rule, anticipated approximately 60 days after the end of the comment period.

TABLE 1.—CONSOLIDATED SCHEDULE OF BENEFICIARY CHARGES

	TRICARE prime	TRICARE standard	Medicare eligible beneficiaries
Services from TRICARE Network Providers.	Uniform HMO Benefit cost sharing applies (see Table 4), except unauthorized care covered by point-of-service rules.	TRICARE Extra cost sharing applies (see Table 2).	Cost sharing for Medicare participating providers generally applies.
Services from non-network providers.	TRICARE Prime point-of-service rules apply; deductible of \$300 per person or \$600 per family; cost share of 50 percent.	Standard CHAMPUS cost sharing applies.	Standard Medicare cost sharing applies.
Internal resource sharing agreements.	Same as military facility cost sharing.	Same as military facility cost sharing.	Where applicable, same as military facility cost sharing.
External resource sharing agreements.	For professional charges, same as military facility cost sharing; for facility charges, same as Uniform HMO Benefit cost sharing.	For professional charges, same as military facility cost sharing; for facility charges, same as TRICARE Extra cost sharing.	Where applicable, for professional charges, same as military facility cost sharing; for facility charges, same as standard Medicare cost sharing.
PRIMUS and NAVCARE Clinics established before October 1, 1994.	Same as military facilities	Same as military facilities	Same as military facilities.
PRIMUS and NAVCARE Clinics established after September 30, 1994.	Uniform HMO Benefit outpatient cost sharing applies.	Uniform HMO Benefit outpatient cost sharing applies.	Uniform HMO Benefit outpatient cost sharing applies.
Prescription drugs from civilian pharmacies.	As specified in Uniform HMO Benefit (see Table 4).	For retail pharmacy network, 20 percent cost share; for mail service pharmacy, \$4 per prescription for active duty dependents; \$8 per prescription for retirees, their dependents and survivors.	In facility closure cases: from retail pharmacy network, 20 percent cost share; from mail service pharmacy, \$8 per prescription; no deductible.
Outpatient services in military facilities.	No charge	Same as TRICARE Prime	Same as TRICARE Prime.
Inpatient services in military facilities.	Applicable daily subsistence charges.	Same as TRICARE Prime	Same as TRICARE Prime.

TABLE 2.—PROPOSED TRICARE TRIPLE OPTION PROGRAM

	TRICARE standard	TRICARE extra	TRICARE prime
ENROLLMENT FEE	NONE	NONE	ACT DUTY DEPS—NONE OTHERS—\$230 INDIVIDUAL, \$460 FAMILY.
OUTPATIENT DEDUCTIBLE	\$300 FAMILY (\$100 E4 & BELOW).	SAME AS STANDARD CHAMPUS.	NONE.
OUTPATIENT SERVICES COST SHARES, INCLUDING MENTAL HEALTH, EMERGENCY SERVICES, ETC.	ACT DUTY DEPS—20% COPAY AFTER DEDUCTIBLE OTHERS—25% COPAY AFTER DEDUCTIBLE.	ACT DUTY DEPS—15% COPAY AFTER DEDUCTIBLE OTHERS—20% COPAY AFTER DEDUCTIBLE.	SEE TABLE 3—SCHEDULE OF UNIFORM HMO BENEFIT COPAYMENTS.
INPATIENT COST SHARES, INCLUDING MATERNITY AND SKILLED NURSING FACILITIES, NOT INCLUDING MENTAL HEALTH.	ACT DUTY DEPS—\$25 PER ADMISSION OR CURRENT PER DIEM, WHICHEVER IS GREATER OTHERS—LESSER OF APPLICABLE PER DIEM (\$323 IN FY 1995) OR 25% OF INSTITUTIONAL CHARGES, PLUS 25% OF PROFESSIONAL CHARGES.	ACT DUTY DEPS—SAME AS STANDARD CHAMPUS OTHERS—LESSER OF \$250 PER DAY OR 25% OF INSTITUTIONAL CHARGES, PLUS 20% OF PROFESSIONAL CHARGES.	ACT DUTY DEPS—\$25 PER ADMISSION OR \$11 PER DIEM, WHICHEVER IS GREATER. OTHERS—SAME AS ACT DUTY DEPS.
AMBULATORY SURGERY	ACT DUTY DEPS—\$25 PER EPISODE OTHERS—25% OF ALLOWABLE CHARGES.	ACT DUTY DEPS—\$25 COPAY OTHERS—20% COPAY AFTER DEDUCTIBLE.	ACT DUTY DEPS—\$25 COPAY OTHERS—SAME AS ACT DUTY DEPS.
PRESCRIPTION DRUG BENEFITS.	ACT DUTY DEPS—20% COPAY AFTER DEDUCTIBLE OTHERS—25% OF ALLOWABLE CHARGES.	ACT DUTY DEPS—15% COPAY AFTER DEDUCTIBLE; NO DEDUCTIBLE IF NETWORK PHARMACY OTHERS—20% COPAY AFTER DEDUCTIBLE; NO DEDUCTIBLE IF NETWORK PHARMACY.	ACT DUTY DEPS—\$5 PER PRESCRIPTION OTHERS—\$9 PER PRESCRIPTION.

TABLE 2.—PROPOSED TRICARE TRIPLE OPTION PROGRAM—Continued

	TRICARE standard	TRICARE extra	TRICARE prime
HOSPITALIZATION FOR MENTAL ILLNESS AND SUBSTANCE USE.	ACT DUTY DEPS—\$25 PER ADMISSION OR \$20 PER DIEM WHICHEVER IS GREATER OTHERS—LESSER OF APPLICABLE PER DIEM (\$132 IN FY 1995) OR 25% OF INSTITUTIONAL CHARGES, PLUS 25% OF PROFESSIONAL CHARGES.	ACT DUTY DEPS—SAME AS TRICARE STANDARD OTHERS—20% OF INSTITUTIONAL AND PROFESSIONAL CHARGES.	ACT DUTY DEPS—SAME AS TRICARE STANDARD OTHERS—\$40 PER DIEM.

Note: THIS CHART IS FOR ILLUSTRATIVE PURPOSES ONLY. IT DOES NOT INCLUDE ALL DETAILS OF BENEFITS AND COPAYMENTS.

TABLE 3.—UNIFORM HMO BENEFIT FEE AND COPAYMENT SCHEDULE

	ADDs E4 and below	ADDs E5 and above	Retirees, deps, and survivors
Annual Enrollment Fee	\$0/\$0	\$0/\$0	\$230/\$460
Outpatient Visits, Including Separate Radiology or Lab Services, Family Health, and Home Health Visits	6	12	12
Emergency Room Visits	10	30	30
Mental Health Visits, Individual	10	20	25
Mental Health Visits, Group	6	12	17
Ambulatory Surgery	25	25	25
Prescriptions	5	5	9
Ambulance Services	10	15	20
DME, Prostheses, Supplies	¹ 10	¹ 15	¹ 20
Inpatient Per Diem, General	² 11	² 11	² 11
Inpatient Per Diem, MH/Substance Use	² 20	² 20	40

¹ Percent.

² Minimum \$25 per admission.

List of Subjects in 32 CFR Part 199

Claims, Handicapped, Health insurance, and Military personnel.

Accordingly, 32 CFR part 199 is proposed to be amended as follows:

PART 199—[AMENDED]

1. The authority citation for part 199 continues to read as follows:

Authority: 5 U.S.C. 301, 10 U.S.C. 1079, 1086.

2. Section 199.1 is proposed to be amended by adding a new paragraph (r), to read as follows:

§ 199.1 General provisions.

* * * * *

(r) *TRICARE Program.* Many rules and procedures established in sections of this part are subject to revision in areas where the TRICARE Program is implemented. The TRICARE Program is the means by which managed care activities designed to improve the delivery and financing of health care services in the Military Health Services System (MHSS) are carried out. Rules and procedures for the TRICARE Program are set forth in § 199.17.

3. Section 199.2(b) is proposed to be amended by adding the following

definitions and placing them in alphabetical order to read as follows:

§ 199.2 Definitions.

* * * * *

(b) * * *

External Resource Sharing Agreement. A type of External Partnership Agreement, established in the context of the TRICARE program by agreement of a military treatment facility commander and an authorized TRICARE contractor. External Resource Sharing Agreements may incorporate TRICARE features in lieu of standard CHAMPUS features that would apply to standard External Partnership Agreements.

* * * * *

Internal Resource Sharing Agreement. A type of Internal Partnership Agreement, established in the context of the TRICARE program by agreement of a military treatment facility commander and an authorized TRICARE contractor. Internal Resource Sharing Agreements may incorporate TRICARE features in lieu of standard CHAMPUS features that would apply to standard Internal Partnership Agreements.

NAVARE Clinics. Contractor owned, staffed, and operated primary clinics exclusively serving uniformed services

beneficiaries pursuant to contracts awarded by a Military Department.

* * * * *

PRIMUS Clinics. Contractor owned, staffed, and operated primary care clinics exclusively serving uniformed services beneficiaries pursuant to contracts awarded by a Military Department.

* * * * *

TRICARE Program. The program established under § 199.17.

* * * * *

TRICARE Extra Plan. The health care option, provided as part of the TRICARE Program under § 199.17, under which beneficiaries may choose to receive care in facilities of the uniformed services, or from special civilian network providers (with reduced cost sharing), or from any other CHAMPUS-authorized provider (with standard cost sharing).

* * * * *

TRICARE Prime Plan. The health care option, provided as part of the TRICARE Program under § 199.17, under which beneficiaries enroll to receive all health care from facilities of the uniformed services and civilian network providers (with civilian care subject to substantially reduced cost sharing).

* * * * *

TRICARE Standard Plan. The health care option, provided as part of the TRICARE Program under § 199.17, under which beneficiaries are eligible for care in facilities of the uniformed services and CHAMPUS under standard rules and procedures.

* * * * *

Uniform HMO benefit. The health care benefit established by § 199.18.

* * * * *

Uniformed Services Treatment Facilities Managed Care Program. The managed care program established pursuant to section 718(c) of the National Defense Authorization Act for Fiscal Year 1991, Pub. L. 101-510, for certain former Public Health Service hospitals deemed to be facilities of the uniformed services by section 911 of the Military Construction Authorization Act, 1982, Pub. L. 97-99, 42 U.S.C. 248C. Certain rules pertaining to this program are established by § 199.18.

* * * * *

4. Section 199.4 is proposed to be amended by redesignating paragraph (a)(1) as paragraph (a)(1)(i), by adding new paragraph (a)(1)(ii), by revising paragraph (a)(9)(i)(C), and by adding new paragraphs (a)(9)(vi) and (a)(9)(vii), to read as follows:

§ 199.4 Basic program benefits.

(a) * * *

(1) * * *

(ii) *Impact of TRICARE Program.* The basic program benefits set forth in this section are applicable to the basic CHAMPUS program. In areas in which the TRICARE Program is implemented, certain provisions of § 199.17 will apply instead of the provisions of this section. In those areas, the provisions of § 199.17 will take precedence over any provisions of this section with which they conflict.

* * * * *

(9) * * *

(i) * * *

(C) An NAS is also required for selected outpatient procedures if such services are not available at a Uniformed Service facility (including selected facilities which are exclusively outpatient clinics) located within a 40-mile radius (catchment area) of the residence of the beneficiary. This does not apply to emergency services or for services for which another insurance plan or program provides the beneficiary primary coverage. Any changes to the selected outpatient procedures will be published in the **Federal Register** at least 30 days before the effective date of the change by the ASD(HA) and will be limited to the following categories: Outpatient surgery

and other selected outpatient procedures which have high unit costs and for which care may be available in military facilities generally. The selected outpatient procedures will be uniform for all CHAMPUS beneficiaries. A list of the selected outpatient clinics to which this NAS requirement applies will be published periodically in the **Federal Register**.

* * * * *

(vi) *Consideration of availability of care in civilian preferred provider networks in connection with issuance of Nonavailability Statements.*—(A) *General requirement.* With respect to any inpatient health care service subject to a Nonavailability Statement requirement under paragraph (a)(9)(B) of this section, in determining whether to issue a Nonavailability Statement, the commander of the military treatment facility may consider the availability of services from selected civilian health care facilities within the same catchment area. If the commander determines that, although the services are not available from a military treatment facility, the services are available from such a selected civilian facility, the commander may deny a Nonavailability Statement. If a Nonavailability Statement is denied on this basis, CHAMPUS cost sharing is not allowed if the services are not obtained from the designated civilian facility. Civilian facilities to which this requirement applies are those facilities that are in a preferred provider network, established under procedures specified by the Director, OCHAMPUS, within the 40-mile catchment area, able to provide the services needed.

(B) *Additional requirement under External Partnership/Resource Sharing programs.* The Assistant Secretary of Defense (Health Affairs) may designate selected military outpatient clinics for additional NAS requirements regarding inpatient hospital care available under an External Partnership or External Resources Sharing agreement. Under such an agreement, care will be provided at a civilian facility, but professional services will be provided by on or more physicians (or other individual health care providers) on staff at the military outpatient clinic. With respect to the designated military outpatient clinics and the specified services covered by such External Partnership or External Resource Sharing agreement, Nonavailability Statements will be required to the same extent as they are for inpatient military hospitals located within an approximately 40-mile radius of a beneficiary's residence. If services are

available under an External Partnership Resource Sharing agreement, the military clinic commander may deny a Nonavailability Statement. If a Nonavailability Statement is denied on this basis, CHAMPUS cost sharing is not allowed if the services are not obtained from the designated civilian facility under the External Partnership or External Resource Sharing agreement. A list of selected military outpatient clinics and services covered by the External Partnership or External Resource Sharing agreement NAS requirement will be published periodically in the **Federal Register**.

(C) *Exceptions.* A Nonavailability Statement may not be withheld on the basis of paragraphs (a)(9)(vi)(A) or (a)(9)(vi)(B) of this section in any of the following circumstances:

(1) A case-by-case waiver is granted based on a medical judgment made by the commander (or other official designated for this purpose) of the military treatment facility (or Specialized Treatment Service Center) that although the care is available from a designated civilian provider, it would be medically inappropriate because of a delay in the treatment or other special reason to require that such provider be used; or

(2) A case-by-case waiver is granted by the commander (or other official designated for this purpose) of the military treatment facility (or Specialized Treatment Service Center) that although the care is available from a designated civilian provider, use of that provider would impose exceptional hardship on the beneficiary or the beneficiary's family.

(D) *Procedures.* The waiver request and appeal procedures established pursuant to paragraph (a)(10)(vii) of this section shall be applicable to the case-by-case waivers referred to in paragraph (a)(9)(vi)(C) of this section.

(E) *Preference for military facility use.* In any case in which services subject to a Nonavailability Statement requirement under paragraph (a)(9) of this section are available from both a military treatment facility and from a designated civilian facility under paragraph (a)(9)(vi) of this section, the military treatment facility must be used unless use of the designated civilian facility is specifically authorized.

(vii) In the case of any service subject to an NAS requirement under paragraph (a)(9) of this section and also subject to a preadmission (or other pre-service) authorization requirement under § 199.4 or § 199.15, the administrative processes for the NAS and pre-service authorization may be combined.

* * * * *

§ 199.14 [Amended]

5. Section 199.14 is proposed to be amended by removing paragraph (g)(1)(i)(C) and by redesignating paragraph (g)(1)(i)(D) as paragraph (g)(1)(i)(C).

6. Section 199.15 is proposed to be amended by adding a new paragraph (n), to read as follows:

§ 199.15 Peer Review Organization Program.

* * * * *

(n) *Authority to integrate CHAMPUS PRO and military treatment facility utilization review activities.* (1) In the case of a military medical treatment facility (MTF) that has established utilization review requirements similar to those under the CHAMPUS PRO program, the PRO may, at the request of the MTF, utilize procedures comparable to the CHAMPUS PRO program procedures to render determinations or recommendations with respect to MTF utilization review requirements.

(2) In any case in which a CHAMPUS PRO has comparable responsibility and authority regarding utilization review in both an MTF (or MFTs) and CHAMPUS, determinations as to medical necessity in connection with services from an MTF or CHAMPUS-authorized provider may be consolidated.

(3) In any case in which an MFT reserves authority to separate an MTF determination on medical necessity from a CHAMPUS PRO program determination on medical necessity, the MTF determination is not binding on CHAMPUS.

7. Sections 199.17 and 199.18 are proposed to be added, to read as follows:

§ 199.17 TRICARE Program.

(a) *Establishment.* The TRICARE Program is established for the purpose of implementing a comprehensive managed health care program for the delivery and financing of health care services in the MHSS.

(1) *Purpose.* The TRICARE Program implements management improvements primarily through managed care support contracts that include special arrangements with civilian sector health care providers and better coordination between military treatment facilities and these civilian providers. Implementation of these management improvements includes adoption of special rules and procedures not ordinarily followed under CHAMPUS or military treatment facility requirements. This section establishes those special rules and procedures.

(2) *Statutory authority.* Many of the provisions of this section are authorized

by statutory authorities other than those which authorize the usual operation of the CHAMPUS program, especially 10 U.S.C. 1079 and 1086. The TRICARE Program also relies upon other available statutory authorities, including 10 U.S.C. 1099 (health care enrollment system), 10 U.S.C. 1097 (contracts for medical care for retirees, dependents and survivors: Alternative delivery of health care), and 10 U.S.C. 1096 (resource sharing agreements).

(3) *Scope of the program.* The TRICARE Program is applicable to all of the uniformed services. Its geographical applicability is all 50 states and the District of Columbia. In addition, if authorized by the Assistant Secretary of Defense (Health Affairs), the TRICARE Program may be implemented in areas outside the 50 states and the District of Columbia. In such cases, the Assistant Secretary of Defense (Health Affairs) may also authorize modifications to TRICARE Program rules and procedures as may be appropriate to the area involved.

(4) *MTF rules and procedures affected.* Much of this section relates to rules and procedures applicable to the delivery and financing of health care services provided by civilian providers outside military treatment facilities. This section provides that certain rules, procedures, rights and obligations set forth elsewhere in this part (and usually applicable to CHAMPUS) are different under the TRICARE Program. In addition, some rules, procedures, rights and obligations relating to health care services in military treatment facilities are also different under the TRICARE Program. In such cases, provisions of this section take precedence and are binding.

(5) *Implementation based on local action.* The TRICARE Program is not automatically implemented in all areas. Therefore, provisions of this section are not automatically implemented. Rather, implementation of the TRICARE Program and this section requires an official action by an authorized individual, such as a military treatment facility commander, a Surgeon General, the Assistant Secretary of Defense (Health Affairs), or other person authorized by the Assistant Secretary. Public notice of the initiation of the TRICARE Program will be achieved through appropriate communication and media methods and by way of an official announcement by the Director, OCHAMPUS, identifying the military treatment facility catchment area or other geographical area covered.

(6) *Major features of the TRICARE Program.* The major features of the

TRICARE Program, described in this section, include the following:

(i) *Comprehensive enrollment system.* Under the TRICARE Program, all health care beneficiaries become enrolled in TRICARE and classified into one of five enrollment categories:

(A) Active duty members, all of whom are automatically enrolled in TRICARE Prime;

(B) TRICARE Prime enrollees, who (except for active duty members) must be CHAMPUS eligible;

(C) TRICARE Standard enrollees, which covers all CHAMPUS-eligible beneficiaries who do not enroll in TRICARE Prime or another managed care program affiliated with TRICARE;

(D) Medicare-eligible beneficiaries, who, although not eligible for TRICARE Prime, may participate in many features of TRICARE; and

(E) Participants in other managed care program affiliated with TRICARE.

(ii) *Establishment of a triple option benefit.* A second major feature of TRICARE is the establishment for CHAMPUS-eligible beneficiaries of three options for receiving health care:

(A) Beneficiaries may enroll in the "TRICARE Prime Plan," which features use of military treatment facilities and substantially reduced out-of-pocket costs for CHAMPUS care. Beneficiaries generally agree to use military treatment facilities and designated civilian provider networks.

(B) Beneficiaries may participate in the "TRICARE Extra Plan" under which the preferred provider network may be used on a case-by-case basis, with somewhat reduced out-of-pocket costs. These beneficiaries also continue to be eligible for military treatment facility care.

(C) Beneficiaries may remain in the "TRICARE Standard Plan," which preserves broad freedom of choice of civilian providers (subject to nonavailability statement requirements of § 199.4), but does not offer reduced out-of-pocket costs. These beneficiaries continue to be eligible to receive care in military treatment facilities.

(iii) *Coordination between military and civilian health care delivery systems.* A third major feature of the TRICARE Program is a series of activities affecting all beneficiary enrollment categories, designed to coordinate care between military and civilian health care systems. These activities include:

(A) Resource sharing agreements, under which a TRICARE contractor provides to a military treatment facility personnel and other resources to increase the availability of services in the facility. All beneficiary enrollment

categories may benefit from this increase.

(B) Health care finder, an administrative office that facilitates referrals to appropriate health care services in the military facility and civilian provider network. All beneficiary enrollment categories may use the health care finder.

(C) Integrated quality and utilization management services, potentially standardizing reviews for military and civilian sector providers. All beneficiary categories may benefit from these services.

(D) Special pharmacy programs for areas affected by base realignment and closure actions. This includes special eligibility for Medicare-eligible beneficiaries.

(E) PRIMUS or NAVCARE Clinics, for which all beneficiary enrollment categories are eligible.

(iv) *Consolidated schedule of charges.* A fourth major feature of TRICARE is a consolidated schedule of charges, incorporating revisions that reduce differences in charges between military and civilian services. In general, the TRICARE Program reduces out-of-pocket costs for civilian sector care.

(b) *Triple option benefit in general.* Where the TRICARE Program is implemented, CHAMPUS-eligible beneficiaries are given the options of enrolling in the TRICARE Prime Plan (also referred to as "Prime"); being a participant in TRICARE Extra on a case-by-case basis (also referred to as "Extra"); or remaining in the TRICARE Standard Plan (also referred to as "Standard").

(1) *Choice voluntary.* With the exception of active duty members, the choice of whether to enroll in Prime, to participate in Extra, or to remain in Standard is voluntary for all eligible beneficiaries. This applies to active duty dependents and eligible retired members, dependents of retired members, and survivors. For dependents who are minors, the choice will be exercised by a parent or guardian.

(2) *Active duty members.* For active duty members located in areas where the TRICARE Program is implemented, enrollment in Prime is mandatory.

(c) *Eligibility for enrollment in Prime.* Where the TRICARE Program is implemented, all CHAMPUS-eligible beneficiaries are eligible to enroll. However, some rules and procedures are different for dependents of active duty members than they are for retirees, their dependents and survivors. In addition, where the TRICARE Program is implemented, a military treatment

facility commander or other authorized individual may establish priorities, consistent with paragraph (c) of this section, based on availability or other operational requirements, for when and whether to offer the enrollment opportunity.

(1) *Active duty members.* Active duty members are required to enroll in Prime when it is offered. Active duty members shall have first priority for enrollment in Prime. Because active duty members are not CHAMPUS eligible, when active duty members obtain care from civilian providers outside the military treatment facility, the supplemental care program and its requirements (including § 199.16) will apply.

(2) *Dependents of active duty members.* (i) Dependents of active duty members are eligible to enroll in Prime. After all active duty members, dependents of active duty members will have second priority for enrollment.

(ii) If all dependents of active duty members within the area concerned cannot be accepted for enrollment in Prime at the same time, the MTF Commander (or other authorized individual) may establish priorities within this beneficiary group category. The priorities may be based on first-come, first-served, or alternatively, be based on rank of sponsor, beginning with the lowest pay grade.

(3) *Retired members, dependents of retired members, and survivors.* (i) All CHAMPUS-eligible retired members, dependents of retired members, and survivors are eligible to enroll in Prime. After all active duty members are enrolled and availability of enrollment is assured for all active duty dependents wishing to enroll, this category of beneficiaries will have third priority for enrollment.

(ii) If all CHAMPUS-eligible retired members, dependents of retired members, and survivors within the area concerned cannot be accepted for enrollment in Prime at the same time, the MTF Commander (or other authorized individual) may allow enrollment within this beneficiary group category on a first come, first served basis.

(4) *Participation in Extra and Standard.* All CHAMPUS-eligible beneficiaries who do not enroll in Prime may participate in Extra on a case-by-case basis or remain in Standard.

(d) *Health benefits under Prime.* Health benefits under Prime, set forth in paragraph (d) of this section, differ from those under Extra and Standard, set forth in paragraphs (e) and (f) of this section.

(1) *Military Treatment Facility (MTF) care.* All participants in Prime are eligible to receive care in military

treatment facilities. Active duty dependents who are participants in Prime will be given priority for such care over other active duty dependents who declined the opportunity to enroll in Prime. The latter group, however, retains priority over retirees, their dependents and survivors based on enrollment status.

(2) *Non-MTF care for active duty members.* Under Prime, non-MTF care needed by active duty members continues to be arranged under the supplemental care program and subject to the rules and procedures of that program, including those set forth in § 199.16.

(3) *Benefits covered for CHAMPUS eligible beneficiaries for civilian sector care.* The provisions of § 199.18 regarding the Uniform HMO Benefit apply to TRICARE Prime enrollees.

(e) *Health benefits under the TRICARE Extra Plan.* Beneficiaries not enrolled in Prime, although not in general required to use the Prime civilian preferred provider network, are eligible to use the network on a case-by-case basis under Extra. The healthy benefits under Extra are identical to those under Standard, set forth in paragraph (f) of this section, except that the CHAMPUS cost sharing percentages are lower than usual CHAMPUS cost sharing. The lower requirements are set forth in the consolidated schedule of charges in paragraph (m) of this section.

(f) *Health benefits under the TRICARE Standard Plan.* Where the TRICARE Program is implemented, health benefits under Prime, set forth under paragraph (d) of this section, and Extra, set forth under paragraph (e) of this section, are different than health benefits under Standard, set forth in this paragraph (f).

(1) *Military Treatment Facility (MTF) care.* All participants in Standard and all nonenrollees (including beneficiaries not eligible to enroll) continue to be eligible to receive care in military treatment facilities on a space available basis.

(2) *Freedom of choice of civilian provider.* Except as stated in § 199.4(a) in connection with nonavailability statement requirements, CHAMPUS-eligible participants in Standard maintain their freedom of choice of civilian provider under CHAMPUS. All nonavailability statement requirements of § 199.4(a) apply to Standard participants.

(3) *CHAMPUS benefits apply.* The benefits, rules and procedures of the CHAMPUS basic program as set forth in this part, shall apply to CHAMPUS-eligible participants in Standard.

(4) *Preferred provider network option for Standard participants.* Standard participants, although not generally required to use the TRICARE Program preferred provider network are eligible to use the network on a case-by-case basis, under Extra.

(g) *Coordination with other health care programs.* (1) *Authority.* In the case of any beneficiary of the military health services system, other than active duty members, who is enrolled in a managed health care program not operated by the military health services system, the Director, OCHAMPUS may establish a contract or agreement with such other managed health care program for the purpose of coordinating the beneficiary's dual entitlements under such program and the military health services system.

(2) *Covered programs.* A managed health care program with which arrangements may be made under this paragraph (g) includes any health maintenance organization, competitive medical plan, health care prepayment plan, or other managed care program recognized by the Director, OCHAMPUS. This includes managed care programs that operate under the authority of the Medicare program.

(3) *Coordination activities.* Any contract or agreement entered into under this paragraph (g) may integrate health care benefits, delivery, financing, and administrative features of the other managed care plan with some or all features of the TRICARE program.

(h) *Resource sharing agreements.* Under the TRICARE Program, any military treatment facility commander may establish resource sharing agreements with the applicable managed care support contractor for the purpose of providing for the sharing of resources between the two parties. Internal resource sharing and external resource sharing agreements are authorized. The provisions of this paragraph (h) shall apply to resource sharing agreements under the TRICARE Program.

(1) In connection with internal resource sharing agreements, beneficiary cost sharing requirements shall be the same as those applicable to health care services provided in facilities of the uniformed services.

(2) Under internal resource sharing agreements, the double coverage requirements of § 199.8 may be replaced by the Third Party Collection procedures of 32 CFR part 220. In such a case, payments made to a resource sharing agreement provider through the TRICARE managed care support contractor shall be deemed to be

payments by the military treatment facility concerned.

(3) Under internal or external resource sharing agreements, the commander of the military treatment facility concerned may authorize the provision of services pursuant to the agreement to Medicare-eligible beneficiaries, if the commander determines that this will promote the most cost-effective provision of services under the TRICARE program.

(i) *Health Care Finder.* The Health Care Finder is an administrative office that assists beneficiaries in being referred to appropriate health care providers, especially the MTF and preferred providers. Health Care Finder services are available to all beneficiaries. In the case of TRICARE Prime enrollees, the Health Care Finder will facilitate referrals in accordance with Prime rules and procedures. For Standard enrollees, the Finder will provide assistance for use of Extra. For Medicare-eligible beneficiaries, the Finder will facilitate referrals to TRICARE network providers, generally required to be Medicare participating providers. For participants in other managed care programs, the Finder will assist in referrals pursuant to the arrangements made with the other managed care program. For all beneficiary enrollment categories, the finder will assist in obtaining access to available services in the medical treatment facility.

(j) *General quality assurance, utilization review, and preauthorization requirements under TRICARE Program.* All quality assurance, utilization review, and preauthorization requirements for the basic CHAMPUS program, as set forth in this part 199 (see especially applicable provisions of §§ 199.4 and 199.15), are applicable to Prime, Extra and Standard under the TRICARE Program. Under all three options, some methods and procedures for implementing and enforcing these requirements may differ from the methods and procedures followed under the basic CHAMPUS program in areas in which the TRICARE Program has not been implemented. Pursuant to an agreement between a military treatment facility and TRICARE managed care support contractor, quality assurance, utilization review, and preauthorization requirements and procedures applicable to health care services outside the military treatment facility may be made applicable, in whole or in part, to health care services inside the military treatment facility.

(k) *Pharmacy services in base realignment and closure sites.*—(1) *In general.* TRICARE includes two special programs under which covered

beneficiaries, including Medicare-eligible beneficiaries, who live in areas adversely affected by base realignment and closure actions are given a pharmacy benefit for prescription drugs provided outside military treatment facilities. The two special programs are the retail pharmacy network program and the mail service pharmacy program.

(2) *Retail pharmacy network program.* To the maximum extent practicable, a retail pharmacy network program will be included in the TRICARE Program wherever implemented. Except for the special rules applicable to Medicare-eligible beneficiaries in areas adversely affected by military treatment facility closures, the retail pharmacy network program will function in accordance with TRICARE rules and procedures otherwise applicable. In addition, a retail pharmacy network program may on a temporary, transitional basis be established in a base realignment or closure site independent of other features of the TRICARE program. Such a program may be established through arrangements with one or more pharmacies in the area and may continue until a managed care program is established to serve the affected beneficiaries.

(3) *Mail service pharmacy program.* A mail service pharmacy program will be established to the extent required by law as part of the TRICARE Program. The special rules applicable to Medicare-eligible beneficiaries established in this paragraph (k) shall be applicable.

(4) *Medicare-eligible beneficiaries in areas adversely affected by military treatment facility closures.* Under the retail pharmacy network program and mail service pharmacy program, there is a special eligibility rule pertaining to Medicare-eligible beneficiaries in areas adversely affected by military treatment facility closures.

(i) *Medicare-eligible beneficiaries.* The special eligibility rule pertains to military system beneficiaries who are not eligible for CHAMPUS solely because of their eligibility for part A of Medicare.

(ii) *Area adversely affected by closure.* To be eligible for use of the retail pharmacy network program or mail service pharmacy program, a Medicare-eligible beneficiary must maintain a principle place of residency in the catchment area of the military medical treatment facility that closed. In addition, there must be a retail pharmacy network or mail service pharmacy established in that area. In identifying areas adversely affected by a closure, the provisions of this paragraph (k)(4)(ii) shall apply.

(A) In the case of the closure of a military hospital, the area adversely affected is the established 40-mile catchment area of the military hospital that closed.

(B) In the case of the closure of a military clinic (a military treatment facility that provided no inpatient care services), the area adversely affected is an area approximately 40 miles in radius from the clinic, established in a manner comparable to the manner in which catchment areas of military hospitals are established. However, this area will not be considered adversely affected by the closure of the clinic if the Director, OCHAMPUS determines that the clinic was not, when it had been in regular operation, providing a substantial amount of pharmacy services to retirees and their dependents.

(C) An area that is within the 40-mile catchment area of a military treatment facility that closed will not be considered adversely affected by the closure if that area is also within a 40-mile catchment area of another military medical treatment facility (inpatient or outpatient) that the Director, OCHAMPUS determines can provide a substantial amount of pharmacy services to retirees and their dependents.

(iii) *Other Medicare-eligible beneficiaries adversely affected.* In addition to beneficiaries identified in paragraph (k)(4)(ii) of this section, eligibility for the retail pharmacy network program and mail service pharmacy program is also established for Medicare-eligible beneficiaries who can demonstrate to the satisfaction of the Director, OCHAMPUS that he or she relied upon a military medical treatment facility that closed for his or her pharmaceuticals. The Director, OCHAMPUS shall establish guidelines for making such a demonstration.

(iv) *Effective date of eligibility for Medicare-eligible beneficiaries.* In any case in which, prior to the complete closure of a military treatment facility in the process of closure, the Director, OCHAMPUS determines that the area has been adversely affected by severe reductions in access to services, the Director, OCHAMPUS may establish an effective date for eligibility for the retail pharmacy network program or mail service pharmacy program for Medicare-eligible beneficiaries prior to the complete closure of the facility.

(5) *Effect of other health insurance.* The double coverage rules of § 199.8 are applicable to services provided to all beneficiaries under the retail pharmacy network program or mail service pharmacy program. For this purpose, to

the extent they provide a prescription drug benefit, Medicare supplemental insurance plans are double coverage plans and will be the primary payor.

(6) *Procedures.* The Director, OCHAMPUS shall establish procedures for the effective operation of the retail pharmacy network program and mail service pharmacy program. Such procedures may include the use of appropriate drug formularies, restrictions of the quantity of pharmaceuticals to be dispensed, encouragement of the use of generic drugs, implementation of quality assurance and utilization management activities, and other appropriate matters.

(l) *PRIMUS and NAVCARE Clinics.* (1) *Authority.* The Assistant Secretary of Defense for Health Affairs may authorize the establishment of PRIMUS and NAVCARE Clinics. These clinics are contractor owned, staffed, and operated clinics that exclusively serve uniformed services beneficiaries.

(2) *Eligible beneficiaries.* All TRICARE beneficiary enrollment categories are eligible for care in PRIMUS and NAVCARE Clinics. This includes active duty members, Medicare eligible beneficiaries and other persons not eligible for CHAMPUS.

(3) *Services and charges.* (i) For care provided PRIMUS and NAVCARE Clinics established prior to October 1, 1994, CHAMPUS rules regarding program benefits, deductibles and cost sharing requirements do not apply. Services offered and charges will be based on those applicable to care provided in military medical treatment facilities.

(ii) For care provided in PRIMUS and NAVCARE Clinics established after September 30, 1994, the provisions of § 199.18(d)(3) regarding outpatient cost sharing requirements under the Uniform HMO Benefit shall apply.

(4) *Procedures.* The Director, OCHAMPUS will establish procedures for PRIMUS and NAVCARE Clinics. Such procedures may waive normal requirements of this part that are not required by law. Except to the extent required by law, the procedures established by the Director for PRIMUS and NAVCARE Clinics may be based on rules and procedures applicable to military medical treatment facilities.

(m) *Consolidated schedule of beneficiary charges.* The following consolidated schedule of beneficiary charges is applicable to health care services provided under TRICARE for Prime enrollees, Standard enrollees and Medicare-eligible beneficiaries. (There are no charges to active duty members. Charges for participants in other managed health care programs affiliated

with TRICARE will be specified in the applicable affiliation agreements.)

(1) *Cost sharing for services from TRICARE network providers.* (i) For Prime enrollees, cost sharing is as specified in the Uniform HMO Benefit in § 199.18, except that for care not authorized by the primary care manager or Health Care Finder, rules applicable to the TRICARE point of service option (see paragraph (n)(3) of this section) are applicable. The deductible is \$300 per person and \$600 per family. The beneficiary copayment per service is 50 percent.

(ii) For Standard enrollees, TRICARE Extra cost sharing applies. The deductible is the same as standard CHAMPUS. Copayments are:

(A) For outpatient professional services, cost sharing will be reduced from 20 percent to 15 percent for dependents of active duty members.

(B) For most services for retired members, dependents of retired members, and survivors, cost sharing is reduced from 25 percent to 20 percent.

(C) In fiscal year 1995, the per diem inpatient hospital copayment for retirees, dependents of retirees, and survivors when they use a preferred provider network hospital is \$250 per day, or 25 percent of total charges, whichever is less. There is a nominal copayment for active duty dependents, which is the same as under the CHAMPUS program (see § 199.4). The per diem amount may be updated for subsequent years based on changes in the standard CHAMPUS per diem.

(D) For prescription drugs obtained from network pharmacies, the CHAMPUS deductible will not apply.

(iii) For Medicare-eligible beneficiaries, cost sharing will generally be as applicable to Medicare participating providers.

(2) *Cost sharing for non-network providers.* (i) For TRICARE Prime enrollees, rules applicable to the TRICARE point of service option (see paragraph (n)(3) of this section) are applicable. The deductible is \$300 per person and \$600 per family. The beneficiary copayment per service is 50 percent.

(ii) For Standard enrollees, cost sharing is as specified for the basic CHAMPUS program.

(iii) For Medicare eligible beneficiaries, cost sharing is as provided under the Medicare program.

(3) *Cost sharing under internal resource sharing agreements.* (i) For Prime enrollees, cost sharing is as provided in military treatment facilities.

(ii) For Standard enrollees, cost sharing is as provided in military treatment facilities.

(iii) For Medicare eligible beneficiaries, where made applicable by the commander of the military treatment facility concerned, cost sharing will be as provided in military treatment facilities.

(4) *Cost sharing under external resource sharing.* (i) For Prime enrollees, cost sharing applicable to services provided by military facility personnel shall be as applicable to services in military treatment facilities; that applicable to institutional and related ancillary charges shall be as applicable to services provided under TRICARE Prime.

(ii) For Standard enrollees, cost sharing applicable to services provided by Military facility personnel shall be as applicable to services in military treatment facilities; that applicable to institutional and related ancillary charges shall be as applicable to services provided under TRICARE Extra.

(iii) For Medicare-eligible beneficiaries, where available, cost sharing applicable to services provided by military facility personnel shall be as applicable to services in military treatment facilities; that applicable to institutional and related ancillary charges shall be as applicable to services provided under Medicare.

(5) *Prescription drugs.* (i) For Prime enrollees, cost sharing is as specified in the Uniform HMO Benefit.

(ii) For Standard enrollees, there is a 20 percent copayment for prescription drugs provided by retail pharmacy network providers. The copayment for all beneficiaries under the mail service pharmacy program is \$4.00 for active duty dependents and \$8.00 for all other covered beneficiaries per prescription; for up to a 60 day supply. There is no deductible for this program.

(iii) For Medicare-eligible beneficiaries affected by military treatment facility closures, there is a 20 percent copayment for prescriptions provided under the retail pharmacy network program, and an \$8.00 copayment per prescription, for up to a 60-day supply, for prescriptions provided by the mail service pharmacy program. There is no deductible under their programs.

(6) *Cost share for outpatient services in military treatment facilities.* (i) For dependents of active duty members in all enrollment categories, there is no charge for outpatient visits provided in military medical treatment facilities.

(ii) For retirees, their dependents, and survivors in all enrollment categories, there is no charge for outpatient visits provided in military medical treatment facilities.

(n) *Additional health care management requirements under TRICARE Prime.* Prime has additional, special health care management requirements not applicable under Extra, Standard or the CHAMPUS basic program. Such requirements must be approved by the Assistant Secretary of Defense (Health Affairs). In TRICARE, all care may be subject to review for medical necessity and appropriateness of level of care, regardless of whether the care is provided in a military treatment facility or in a civilian setting. Adverse determinations regarding care in military facilities will be appealable in accordance with established military medical department procedures, and adverse determinations regarding civilian care will be appealable in accordance with § 199.15.

(1) *Primary care manager.* All active duty members and Prime enrollees will be assigned or be allowed to select a primary care manager pursuant to a system established by the MTF Commander or other authorized official. The primary care manager may be an individual physician, a group practice, a clinic, a treatment site, or other designation. The primary care manager may be part of the MTF or the Prime civilian provider network. The enrollees will be given the opportunity to register a preference for primacy care manager from a list of choices provided by the MTF Commander. Preference requests will be honored subject to availability under the MTF beneficiary category priority system and other operational requirements established by the commander (or other authorized person).

(2) *Restrictions on the use of providers.* The requirements of this paragraph (n)(2) shall be applicable to health care utilization under TRICARE Prime, except in cases of emergency care and under the point-of-service option (see paragraph (n)(3) of this section).

(i) Prime enrollees must obtain all primary health care from the primary care manager or from another provider to which the enrollee is referred by the primary care manager or Health Care Finder.

(ii) For any necessary specialty care and all inpatient care, the primary care manager or Health Care Finder will assist in making an appropriate referral. All such nonemergency specialty care and inpatient care must be preauthorized by the primary care manager or Health Care Finder.

(iii) The following procedures will apply to health care referrals and preauthorizations in catchment areas under TRICARE Prime:

(A) The first priority for referral for specialty care or inpatient care will be to the local MTF (or to any other MTF in which catchment area the enrollee resides).

(B) If the local MTF(s) are unavailable for the services needed, but there is another MTF at which the needed services can be provided, the enrollee may be required to obtain the services at that MTF. However, this requirement will only apply to the extent that the enrollee was informed at the time of (or prior to) enrollment that mandatory referrals might be made to the MTF involved for the service involved.

(C) If the needed services are available within civilian preferred provider network serving the area, the enrollee may be required to obtain the services from a provider within the network. Subject to availability, the enrollee will have the freedom to choose a provider from among those in the network.

(D) If the needed services are not available within the civilian preferred provider network serving the area, the enrollee may be required to obtain the services from a designated civilian provider outside the area. However, this requirement will only apply to the extent that the enrollee was informed at the time of (or prior to) enrollment that mandatory referrals might be made to the provider involved for the service involved (with the provider and service either identified specifically or in connection with some appropriate classification).

(E) In cases in which the needed health care services cannot be provided pursuant to the procedures identified in paragraphs (n)(2)(iii) (A) through (D) of this section, the enrollee will receive authorization to obtain services from a CHAMPUS-authorized civilian provider(s) of the enrollee's choice not affiliated with the civilian preferred provider network.

(iv) When Prime is operating in noncatchment areas, the requirements in paragraphs (n)(2)(iii) (B) through (E) of this section shall apply.

(v) Any health care services obtained by a Prime enrollee not obtained in accordance with the utilization management rules and procedures of the Prime will not be paid for by Prime, but may be covered by the point-of-service option (see paragraph (n)(3) of this section). However, Prime may cover such services if the enrollee did not know and could not reasonably have been expected to know that the services were not obtained in accordance with the utilization management rules and procedures of Prime.

(3) *Point-of-service option.* TRICARE Prime enrollees retain the freedom to

obtain services from civilian providers on a point-of-service basis. In such cases, all requirements applicable to standard CHAMPUS shall apply, except that there shall be higher deductible and cost sharing requirements (as set forth in paragraphs (m)(1)(i) and (m)(2)(i) of this section).

(o) *TRICARE Program enrollment procedures.* There are certain requirements pertaining to procedures for enrollment in Prime. (These procedures do not apply to active duty members, whose enrollment is mandatory.)

(1) *Open season enrollment.* Beneficiaries will be offered the opportunity to enroll in Prime during designated periods of time. Subject to exceptions for change of residence and other changes, enrollment will be limited to the open season periods announced at the time the TRICARE Program is implemented in a particular area.

(2) *Enrollment period.* The Prime enrollment period shall be 12 months. In general, enrollment will be effective on the first day of the month following expiration of the open season enrollment period. Enrollees must remain in Prime for a 12 month period, at which time they may disenroll. This requirement is subject to exceptions for change of residence and other changes announced at the time the TRICARE Program is implemented in a particular area.

(3) *Periodic revision.* Periodically, certain features, rules or procedures of Prime, Extra and/or Standard may be revised. If such revisions will have a significant effect on participants' costs or access to care, beneficiaries will be given the opportunity to change their enrollment status coincident with the revisions.

(4) *Effects of failure to enroll.* Beneficiaries offered the opportunity to enroll in Prime, who do not enroll within the time provided to enroll, will be eligible to participate in Extra on a case-by-case basis or remain in Standard.

(p) *Civilian preferred provider networks.* A major feature of the TRICARE Program is the civilian preferred provider network.

(1) *Status of network providers.* Providers in the preferred provider network are not employees or agents of the Department of Defense or the United States Government. Rather, they are independent contractors of the government (or other independent entities having business arrangements with the government). Although network providers must follow numerous rules and procedures of the

TRICARE Program, on matters of professional judgment and professional practice, the network provider is independent and not operating under the direction and control of the Department of Defense. Each preferred provider must have adequate professional liability insurance, as required by the Federal Acquisition Regulation, and must agree to indemnify the United States government for any liability that may be assessed against the United States government that is attributable to any action or omission of the provider.

(2) *Utilization management policies.* Preferred providers are required to follow the utilization management policies and procedures of the TRICARE Program. These policies and procedures are part of discretionary judgments by the Department of Defense regarding the methods of delivering and financing health care services that will best achieve health and economic policy objectives.

(3) *Quality assurance requirements.* A number of quality assurance requirements and procedures are applicable to preferred network providers. These are for the purpose of assuring that the health care services paid for with government funds meet the standards called for in the contract or provider agreement.

(4) *Provider qualifications.* All preferred providers must meet the following qualifications:

(i) They must be CHAMPUS authorized providers and CHAMPUS participating providers.

(ii) All physicians in the preferred provider network must have staff privileges in a hospital accredited by the Joint Commission on Accreditation of Health Care Organizations. This requirement may be waived in any case in which a physician's practice does not include the need for admitting privileges in such a hospital. However, in any case in which the requirement is waived, the physician must comply with alternative qualification standards as are established by the MTF Commander (or other authorized official).

(iii) All preferred providers must agree to follow all quality assurance and utilization management procedures established pursuant to this section, make available to designated DoD utilization management or quality monitoring contractors medical records and other pertinent records, and to authorize the release of information to MTF Commanders regarding such quality assurance and utilization management activities.

(iv) All preferred network providers must be Medicare participating providers, unless this requirement is waived based on extraordinary circumstances. This requirement that a provider be a Medicare participating provider does not apply to providers not eligible to be participating providers under Medicare.

(v) The provider must be available to Extra participants.

(vi) The provider must agree to accept the same payment rates negotiated for Prime enrollees for any person whose care is reimbursable by the Department of Defense, including, for example, Extra participants, supplemental care cases, and beneficiaries from outside the area.

(vii) All preferred providers must meet all other qualification requirements, and agree to comply with all other rules and procedures established for the preferred provider network.

(5) *Access standards.* Preferred provider networks will have attributes of size, composition, mix of providers and geographical distribution so that the networks, coupled with the MTF capabilities, can adequately address the health care needs of the enrollees. Before offering enrollment in Prime to a beneficiary group, the MTF Commander (or other authorized person) will assure that the capabilities of the MTF plus preferred provider network will meet the following access standards with respect to the needs of the expected number of enrollees from the beneficiary group being offered enrollment:

(i) Under normal circumstances, enrollee travel time may not exceed 30 minutes from home to primary care delivery site unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area.

(ii) The wait time for an appointment for a well-patient visit or a specialty care referral shall not exceed four weeks; for a routine visit, the wait time for an appointment for a well-patient visit shall not exceed two weeks; and for an urgent care visit the wait time for an appointment shall generally not exceed 24 hours.

(iii) Emergency services shall be available and accessible to handle emergencies (and urgent care visits if not available from other primary care providers pursuant to paragraph (p)(5)(ii) of this section), within the service area 24 hours a day, seven days a week.

(iv) The network shall include a sufficient number and mix of board certified specialists to meet reasonably

the anticipated needs of enrollees. Travel time for specialty care shall not exceed one hour under normal circumstances, unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area. This requirement does not apply under the Specialized Treatment Services Program.

(v) Office waiting times in nonemergency circumstances shall not exceed 30 minutes.

(6) *Special reimbursement methods for network providers.* The Director, OCHAMPUS may establish for preferred provider networks reimbursement rates and methods different from those established pursuant to § 199.14. Such provisions may be expressed in terms of percentage discounts off CHAMPUS allowable amounts, or in other terms. In circumstances in which payments are based on hospital-specific rates (or other rates specific to particular institutional providers), special reimbursement methods may permit payments based on discounts off national or regional prevailing payment levels, even if higher than particular institution-specific payment rates.

(7) *Methods for establishing preferred provider networks.* There are several methods under which the MTF Commander (or other authorized official) may establish a preferred provider network. These include the following:

(i) There may be an acquisition under the Federal Acquisition Regulation, either conducted locally for that catchment area, in a larger area in concert with other MTF Commanders, regionally as part of a CHAMPUS acquisition, or on some other basis.

(ii) To the extent allowed by law, there may be a modification by the Director, OCHAMPUS of an existing CHAMPUS fiscal intermediary contract to add TRICARE Program functions to the existing responsibilities of the fiscal intermediary contractor.

(iii) The MTF Commander (or other authorized official) may follow the any qualified provider method set forth in paragraph (q) of this section.

(iv) Any other method authorized by law may be used.

(q) *Preferred provider network establishment under any qualified provider method.* The any qualified provider method may be used to establish a civilian preferred provider network. Under this method, any CHAMPUS-authorized provider within the geographical area involved that meets the qualification standards established by the MTF Commander (or other authorized official) may become a

part of the preferred provider network. Such standards must be publicly announced and uniformly applied. Any provider that meets all applicable qualification standards may not be excluded from the preferred provider network. Qualifications include:

(1) The provider must meet all applicable requirements in paragraph (p)(4) of this section.

(2) The provider must agree to follow all quality assurance and utilization management procedures established pursuant to this section.

(3) The provider must be a Participating Provider under CHAMPUS for all claims.

(4) The provider must meet all other qualification requirements, and agree to all other rules and procedures, that are established, publicly announced, and uniformly applied by the commander (or other authorized official).

(5) The provider must sign a preferred provider network agreement covering all applicable requirements. Such agreements will be for a duration of one year, are renewable, and may be canceled by the provider or the MTF Commander (or other authorized official) upon appropriate notice to the other party. The Director, OCHAMPUS shall establish an agreement model or other guidelines to promote uniformity in the agreements.

(r) *General fraud, abuse, and conflict of interest requirements under TRICARE Program.* All fraud, abuse, and conflict of interest requirements for the basic CHAMPUS program, as set forth in this part 199 (see especially applicable provisions of § 199.9) are applicable to the TRICARE Program. Some methods and procedures for implementing and enforcing these requirements may differ from the methods and procedures followed under the basic CHAMPUS program in areas in which the TRICARE Program has not been implemented.

(s) *Partial implementation.* The Assistant Secretary of Defense (Health Affairs) may authorize the partial implementation of the TRICARE Program. In such cases, the TRICARE Extra Plan and the TRICARE Standard Plan may be offered without the TRICARE Prime Plan. Partial implementation may also consist of establishment of a TRICARE Program limited to particular services, such as mental health services.

(t) *Inclusion of Department of Veterans Affairs Medical Centers in TRICARE networks.* TRICARE preferred provider networks may include Department of Veterans Affairs Medical Centers pursuant to arrangements between those centers and the Director,

OCHAMPUS or designated TRICARE contractor.

(u) *Care provided outside the United States to dependents of active duty members.* The Assistant Secretary of Defense (Health Affairs) may, in conjunction with implementation of the TRICARE program, authorize a special CHAMPUS program for dependents of active duty members who accompany the members in their assignments in foreign countries. Under this special program, contracts or agreements may be made with health care providers under which services will be provided to the covered dependents with the requirements for deductibles and copayments waived or reduced.

(v) *Administrative procedures.* The Assistant Secretary of Defense (Health Affairs), the Director, OCHAMPUS, and MTF Commanders (or other authorized officials) are authorized to establish administrative requirements and procedures, consistent with this section, this part and other applicable DoD Directives or Instructions, for the implementation and operation of the TRICARE Program.

§ 199.18 Uniform HMO Benefit.

(a) *In general.* There is established a Uniform HMO Benefit. The purpose of the Uniform HMO Benefit is to establish a health benefit option modeled on health maintenance organization plans. This benefit is intended to be uniform throughout the United States and to be included in all managed care programs under the MHSS. Most care purchased from civilian health care providers (outside a military medical treatment facility) will be under the rules of the Uniform HMO Benefit or the Basic CHAMPUS Program (see § 199.4). The Uniform HMO benefit shall apply only as specified in this section or other sections of this part, and shall be subject to any special applications indicated in such other sections.

(b) *Services covered under the Uniform HMO Benefit option.* (1) Except as specifically provided or authorized by this section, all CHAMPUS benefits provided, and benefit limitations established, pursuant to this part shall apply to the Uniform HMO Benefit.

(2) Certain preventive care services not normally provided as part of basic program benefits under CHAMPUS are covered benefits when provided to Plan enrollees by providers in the civilian provider network. Such standards shall establish a specific schedule, including frequency or age specifications for:

(i) Laboratory and x-ray tests, including blood lead, rubella, cholesterol, fecal occult blood testing, and mammography;

(ii) Pap smears;
 (iii) Eye exams;
 (iv) Immunizations;
 (v) Periodic health promotion and disease prevention exams;
 (vi) Blood pressure screening;
 (vii) Hearing exams;
 (viii) Sigmoidoscopy or colonoscopy;
 (ix) Serologic screening; and
 (x) Appropriate education and counseling services. The exact services offered shall be established under uniform standards established by the Assistant Secretary of Defense (Health Affairs).

(3) In addition to preventive care services provided pursuant to paragraph (b)(2) of this section, other benefit enhancements may be added and other benefit restrictions may be waived or relaxed in connection with health care services provided to include the Uniform HMO Benefit. Any such other enhancements or changes must be approved by the Assistant Secretary of Defense (Health Affairs) based on uniform standards.

(c) *Enrollment fee under the uniform HMO benefit.* (1) The CHAMPUS annual deductible amount (see § 199.4(f)) is waived under the Uniform HMO Benefit during the period of enrollment. In lieu of a deductible amount, an annual enrollment fee is applicable. The specific enrollment fee requirements shall be published annually by the Assistant Secretary of Defense (Health Affairs), and shall be uniform within the following groups: Dependents of active duty members in pay grades E-4 and below; active duty dependents of sponsors in pay grades E-5 and above; and retirees and their dependents.

(2) *Amount of enrollment fees.* Beginning in fiscal year 1995, the annual enrollment fees are:

- (i) for dependents of active duty members in pay grades of E-4 and below, \$0;
- (ii) for active duty dependents of sponsors in pay grades E-5 and above, \$0; and,
- (iii) for retirees and their dependents, \$230 individual, \$460 family.

(d) *Outpatient cost sharing requirements under the Uniform HMO Benefit—(1) In general.* In lieu of usual CHAMPUS cost sharing requirements (see § 199.4(f)), special reduced cost sharing percentages or per service specific dollar amounts are required. The specific requirements shall be uniform and shall be published annually by the Assistant Secretary of Defense (Health Affairs).

(2) *Structure of outpatient cost sharing.* The special cost sharing requirements for outpatient services include the following specific structural provisions:

(i) For most physician office visits and other routine services, there is a per visit fee for each of the following groups: Dependents of active duty members in pay grades E-1 through E-4; dependents of active duty members in pay grades of E-5 and above; and retirees and their dependents. This fee applies to primary care and specialty care visits, except as provided elsewhere in this paragraph (d)(2) of this section. It also applies to ancillary services (unless provided as part of an office visit for which a copayment is collected), family health services, home health care visits, eye examinations, and immunizations.

(ii) There is a copayment for outpatient mental health visits. It is a per visit fee for dependents of active duty members in pay grades E-1 through E-4; for dependents of active duty members in pay grades of E-5 and above; and for retirees and their dependents for individual visits. For group visits, there is a lower per visit fee for dependents of active duty members in pay grades E-1 through E-4; for dependents of active duty members in pay grades of E-5 and above; and for retirees and their dependents.

(iii) There is a cost share for durable medical equipment, prosthetic devices, and other authorized supplies for dependents of active duty members in pay grades E-1 through E-4; for dependents of active duty members in pay grades of E-5 and above; and for retirees and their dependents.

(iv) For emergency room services, there is a per visit fee for dependents of active duty members in pay grades E-1 through E-4; for dependents of active duty members in pay grades of E-5 and above; and for retirees and their dependents.

(v) For primary surgeon services in ambulatory surgery, there is a per service fee for dependents of active duty members in pay grades E-1 through E-4; for dependents of active duty members in pay grades of E-5 and above; and for retirees and their dependents.

(vi) There is a copayment for prescription drugs per prescription, including medical supplies necessary for administration, for dependents of active duty members in pay grades E-1 through E-4; for dependents of active duty members in pay grades of E-5 and above; and for retirees and their dependents.

(vii) There is a copayment for ambulance services for dependents of active duty members in pay grades E-1 through E-4; for dependents of active duty members in pay grades of E-5 and

above; and for retirees and their dependents.

(3) *Amount of outpatient cost sharing requirements.* Beginning in fiscal year 1995, the outpatient cost sharing requirements are as follows:

(i) For most physician office visits and other routine services, as described in paragraph (d)(2)(i) of this section, the per visit fee is as follows:

(A) For dependents of active duty members in pay grades E-1 through E-4, \$6;

(B) For dependents of active duty members in pay grades of E-5 and above, \$12; and,

(C) For retirees and their dependents, \$12.

(ii) For outpatient mental health visits, the per visit fee is as follows:

(A) For individual outpatient mental health visits:

(1) For dependents of active duty members in pay grades E-1 through E-4, \$10;

(2) For dependents of active duty members in pay grades E-5 and above, \$20; and,

(3) For retirees and their dependents, \$25.

(B) For group outpatient mental health visits, there is a lower per visit fee, as follows:

(1) For dependents of active duty members in pay grades E-1 through E-4, \$6;

(2) For dependents of active duty members in pay grades E-5 and above, \$12; and,

(3) For retirees and their dependents, \$17.

(iii) The cost share for durable medical equipment, prosthetic devices, and other authorized supplies is as follows:

(A) For dependents of active duty members in pay grades E-1 through E-4, 10 percent of the negotiated fee;

(B) For dependents of active duty members in pay grades E-5 and above, 15 percent of the negotiated fee; and,

(C) For retirees and their dependents, 20 percent of the negotiated fee.

(iv) For emergency room services, the per visit fee is as follows:

(A) For dependents of active duty members in pay grades E-1 through E-4, \$10;

(B) For dependents of active duty members in pay grades of E-5 and above, \$30; and,

(C) For retirees and their dependents, \$30.

(v) For primary surgeon services in ambulatory surgery, the per service fee is as follows:

(A) For dependents of active duty members in pay grades of E-1 through E-4, \$25;

(B) For dependents of active duty members in pay grades of E-5 and above, \$25; and,

(C) For retirees and their dependents, \$25.

(vi) The copayment for prescription drugs per prescription, for a maximum 30-day supply, is as follows:

(A) For dependents of active duty members in pay grades E-1 through E-4, \$5;

(B) For dependents of active duty members in pay grades of E-5 and above, \$5; and,

(C) For retirees and their dependents, \$9.

(vii) The copayment for ambulance services is as follows:

(A) For dependents of active duty members in pay grades of E-1 through E-4, \$10;

(B) For dependents of active duty members in pay grades of E-5 and above, \$15; and,

(C) For retirees and their dependents, \$20.

(e) *Inpatient cost sharing requirements under the Uniform HMO Benefit.*—(1) *In general.* In lieu of usual CHAMPUS cost sharing requirements (see § 199.4(f)), special cost sharing amounts are required. The specific requirements shall be uniform and shall be published as a notice annually by the Assistant Secretary of Defense (Health Affairs).

(2) *Structure of cost sharing.* For services other than mental illness or substance use treatment, there is a nominal copayment for active duty dependents and for retired members, dependents of retired members, and survivors. For inpatient mental health and substance use treatment, a separate per day charge is established.

(3) *Amount of inpatient cost sharing requirements.* Beginning in fiscal year 1995, the inpatient cost sharing requirements are as follows:

(i) For acute care admissions and other non-mental health/substance use treatment admissions, the per diem charge is as follows, with a minimum charge of \$25 per admission:

(A) For dependents of active duty members in pay grades E-1 through E-4, \$11;

(B) For dependents of active duty members in pay grades of E-5 and above, \$11; and,

(C) For retirees and their dependents, \$11.

(ii) For mental health/substance use treatment admissions, and for partial hospitalization services, the per diem charge is as follows, with a minimum charge of \$25 per admission:

(A) For dependents of active duty members in pay grades E-1 through E-4, \$20;

(B) For dependents of active duty members in pay grades of E-5 and above, \$20; and,

(C) For retirees and their dependents, \$40.

(f) *Updates.* The enrollment fees for fiscal year 1995 set under paragraph (c) of this section and the per services specific dollar amounts for fiscal year 1995 set under paragraphs (d) and (e) of this section may be updated for subsequent years to the extent necessary to maintain compliance with statutory requirements pertaining to government costs. This updating does not apply to cost sharing that is expressed as a percentage of allowable charges; these percentages will remain unchanged.

(g) *Applicability of the Uniform HMO Benefit to Uniformed Services Treatment Facilities Managed Care Program.* The provisions of this section concerning the Uniform HMO Benefit shall apply to the Uniformed Services Treatment Facilities Managed Care Program, effective October 1, 1995. Under that program, non-CHAMPUS eligible beneficiaries have the same payment responsibilities as CHAMPUS-eligible beneficiaries.

Dated: February 2, 1995.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

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ASSASSINATION RECORDS REVIEW BOARD

36 CFR Part 1400

Guidance on Interpreting and Implementing the President John F. Kennedy Assassination Records Collection Act of 1992

AGENCY: Assassination Records Review Board (ARRB).

ACTION: Proposed interpretive regulation.

SUMMARY: The ARRB proposes to issue regulations providing guidance on the interpretation of certain terms defined in and the implementation of the President John F. Kennedy Assassination Records Collection Act of 1992.

DATES: To be considered, comments must be received on or before March 10, 1995.

ADDRESSES: Comments should be mailed to the Assassination Records Review Board at 600 E Street, NW, Second floor, Washington, D.C. 20530 or delivered in person to that address

between the hours of 9:30 a.m. and 4:30 p.m., Monday through Friday (except legal holidays). Comments may also be faxed to the Board at (202) 724-0457. Comments received may be inspected in the Board's public reading room, located at the address shown above, between 10 a.m. and 3 p.m. Monday through Friday (except legal holidays). Persons wishing to inspect comments in the Board's public reading room should call the Board's office beforehand at (202) 724-0088 for further information.

FOR FURTHER INFORMATION CONTACT: Sheryl L. Walter (General Counsel), (202) 724-0088.

SUPPLEMENTARY INFORMATION:

Background

The President John F. Kennedy Assassination Records Collection Act of 1992, 44 U.S.C. 2107 note (as amended) (ARCA), established the President John F. Kennedy Assassination Records Collection (the JFK Collection) at the National Archives and Records Administration (NARA). In establishing the process for public disclosure of all records relating to the assassination, Congress created an independent agency within the executive branch, the Assassination Records Review Board (the Board), which consists of five citizens appointed by the President. Under the statute, the Board is empowered to decide "whether a record constitutes an assassination record." 44 U.S.C. 2107 note, Sec. 7(i)(2)(A). Congress further made clear its intent that the Board "issue guidance to assist in articulating the scope or universe of assassination records." President John F. Kennedy Assassination Records Collection Act of 1992, S.Rep. 102-328, 102d Cong., 2d Sess. (1992) at 21.

In constructing the proposed guidance set out here, the Board seeks to implement congressional intent that the JFK Collection contain "the most comprehensive disclosure of records related to the assassination of President Kennedy." *Id.* at 18. The Board is also mindful of Congress's instruction that the Board apply a "broad and encompassing" working definition of "assassination record" in order to achieve the goal of assembling the fullest historical record on this tragic event in American history and on the investigations that were undertaken in the assassination's aftermath. The Board recognizes that many agencies have already begun to organize and review records responsive to the ARCA even before the Board was appointed and began its work. Nevertheless, the Board's aim is that this guidance will aid in the ultimate assembly and public