reference to written election, thereby recognizing the existence of the variety of methods in which an election of enrollment can be conveyed, *e.g.*, by written, telephonic, or e-mailed application. The proposed rule also clarifies the 12-month enrollment lock-out provision by specifying that the provision applies to disenrollment occurring at any time and for any reason. This includes disenrollment after the enrollee has fulfilled the 24-month initial enrollment commitment and disenrollment of the retired member to convert to dependent-only coverage.

### IV. Rulemaking Procedures

Executive Order 12866 requires certain regulatory assessments for any ''significant regulatory action,'' defined as one that 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 rule 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 rule will not impose additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35).

### List of Subjects in 32 CFR Part 199

Claims, Health insurance, Individuals with disabilities, Military personnel, and Reporting and recordkeeping requirements.

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. Chapter 55.

2. Section 199.22 is proposed to be amended by revising paragraphs (d)(1)(iii), (d)(3), and (d)(4); redesignating paragraph (d)(1)(iv) as paragraph (d)(1)(v); and adding a new paragraph (d)(1)(iv) to read as follows:

### § 199.22 TRICARE Retiree Dental Program (TRDP).

* * * * *

(d) * * *

(1) * * *

(iii) Eligible dependents of a member described in paragraph (d)(1)(i) or paragraph (d)(1)(ii) of this section who are covered by the enrollment of the member;

(iv) Eligible dependents of a member described in paragraph (d)(1)(i) or paragraph (d)(1)(ii) of this section when the member is not enrolled in the program and the member meets at least one of the conditions in paragraphs (d)(1)(iv)(A) through (C) of this section. Already enrolled members must satisfy any remaining enrollment commitment prior to enrollment of dependents becoming effective under this paragraph, at which time the dependent-only enrollment will continue on a voluntary, month-to-month basis as specified in paragraph (d)(4) of this section. Members must provide documentation to the TRDP contractor giving evidence of compliance with paragraphs (d)(1)(iv)(A), (B), or (C) of this section at the time of application for enrollment of their dependents under this paragraph.

(A) The member is enrolled under section 1705 of title 38, United States Code, to receive ongoing, comprehensive dental care from the Secretary of Veterans Affairs pursuant to section 1712 of title 38, United States Code, and §§ 17.93, 17.161, or 17.166 of title 38, Code of Federal Regulations. Authorization of such dental care must be confirmed in writing by the Department of Veterans Affairs.

(B) The member is enrolled in a dental plan that is available to the member as a result of employment of the member that is separate from the uniformed service of the member, and the dental plan is not available to dependents of the member as a result of such separate employment by the member. Enrollment in this dental plan and the exclusion of dependents from enrollment in the plan must be confirmed by documentation from the member's employer or the dental plan's administrator.

(C) The member is prevented by a current and enduring medical or dental condition from being able to obtain benefits under the TRDP. The specific medical or dental condition and reason for the inability to use the program's benefits over time, if not apparent based on the condition, must be documented by the member's physician or dentist.

* * * * *

(3) *Election of coverage.* In order to initiate dental coverage, election to enroll must be made by the retired member or eligible dependent. Enrollment in the TRICARE Retiree Dental Program is voluntary and will be accomplished by submission of an application to the TRDP contractor.

(4) *Enrollment periods.* Initial enrollment shall be for a period of 24 months followed by month-to-month enrollment as long as the enrollee chooses to continue enrollment. An enrollee's disenrollment from the TRDP at any time for any reason is subject to a lock-out period of 12 months. After any lock-out period, eligible individuals may elect to reenroll and are subject to a new initial 24-month enrollment period.

* * * * *

Dated: November 24, 1999.

**L.M. Bynum,**

*Alternate OSD Federal Register Liaison Officer, Department of Defense.*

[FR Doc. 99–31117 Filed 11–30–99; 8:45 am]

**BILLING CODE 5001–10–P**

## ENVIRONMENTAL PROTECTION AGENCY

## 40 CFR Part 52

**[CT060–7219B; A–1–FRL–6479–5]**

## Approval and Promulgation of Air Quality Implementation Plans; Connecticut; Removal of Oxygenated Gasoline Requirement for the Connecticut Portion of the New York—N. New Jersey—Long Island Area (the ''Southwest Connecticut Area'')

**AGENCY:** Environmental Protection Agency (EPA).

**ACTION:** Proposed rule.

**SUMMARY:** In today's action, EPA is proposing to approve a State Implementation Plan (SIP) revision under the Clean Air Act submitted by the State of Connecticut on October 7, 1999, to remove Connecticut's oxygenated gasoline program as a carbon monoxide control measure from the State's SIP and convert it to a contingency measure for maintaining the National Ambient Air Quality Standard for carbon monoxide. In the Final Rules Section of this **Federal Register**, EPA is approving this submittal as a direct final rule without a prior proposal because the Agency views this as a noncontroversial submittal and anticipates no adverse comments. A detailed rationale for the approval is set forth in the direct final rule. If no adverse comments are received in response to this rule, no further activity is contemplated. If EPA receives adverse comments, the direct final rule will be withdrawn and all public comments received will be addressed in a subsequent final rule

based on this proposed rule. EPA will not institute a second comment period. Any parties interested in commenting on this action should do so at this time.

**DATES:** Written comments must be received on or before January 3, 2000.

**ADDRESSES:** Comments may be mailed to Susan Studlien, Deputy Director, Office of Ecosystem Protection (mail code CAA), U.S. Environmental Protection Agency, Region I, One Congress Street, Suite 1100 Boston, MA 02114–2023. Copies of the documents relevant to this action are available for public inspection during normal business hours, by appointment at the Office of Ecosystem Protection, U.S. Environmental Protection Agency, Region I, One Congress Street, 11th floor, Boston, MA; Air and Radiation Docket and Information Center, U.S. Environmental Protection Agency, 401 M Street, S.W., (LE–131), Washington, D.C. 20460; and the Bureau of Air Management, Department of Environmental Protection, State Office Building, 79 Elm Street, Hartford, CT 06106–1630.

**FOR FURTHER INFORMATION CONTACT:** Jeff Butensky, Environmental Planner; (617) 918–1665; butensky.jeff@epa.gov.

**SUPPLEMENTARY INFORMATION:** For additional information, see the direct final rule which is located in the Rules section of this **Federal Register**.

Dated: November 10, 1999.

**John P. DeVillars,**

*Regional Administrator, Region I.*

[FR Doc. 99–31046 Filed 11–30–99; 8:45 am]

**BILLING CODE 6560–50–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Health Care Financing Administration

### 42 CFR Parts 433 and 438

**[HCFA–2015–P]**

**RIN 0938–AJ06**

## Medicaid Program; External Quality Review of Medicaid Managed Care Organizations

**AGENCY:** Health Care Financing Administration (HCFA), HHS.

**ACTION:** Proposed rule.

**SUMMARY:** This proposed rule would establish requirements and procedures for external quality review (EQR) of Medicaid managed care organizations (MCOs). The rule would implement section 1932(c)(2) of the Social Security Act (the Act), which was enacted in section 4705(a) of the Balanced Budget Act of 1997 (BBA), and section 1903(a)(3)(C)(ii) of the Act, which was enacted in section 4705(b) of the BBA. Under section 1932(c)(2) each contract between a State Medicaid agency (State agency) and an MCO must provide for an annual EQR of the quality outcomes, the timeliness of, and access to, the services for which the MCO is responsible under the contract. Section 1903(a)(3)(C) provides enhanced matching for these activities.

This annual external review is to be conducted by an independent entity that meets the qualifications set forth in this rule, using protocols also set forth in this rule.

In addition, these BBA provisions allow State agencies to exempt certain Medicare MCOs from all EQR requirements or from particular review activities that would duplicate review activities conducted as part of a Medicare MCO's external review or accreditation processes.

These BBA provisions require that the results of the EQR be made available to participating health care providers, enrollees and potential enrollees of the MCO, and also authorize the payment of enhanced Federal financial participation at the 75 percent rate for the administrative costs of EQRs that are conducted by approved entities.

**DATES:** *Comment date.* Comments will be considered if we receive them at the appropriate address, as provided below no later than 5 p.m. on January 31, 2000.

**ADDRESSES:** Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–2015–P, P.O. Box 7517, Baltimore, MD 21207–0517.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC, or

Room C5–16–03, 7500 Security Boulevard, Baltimore, MD.

Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–2015–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's office at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 to 5 p.m. (phone: (202) 690–7890).

**FOR FURTHER INFORMATION CONTACT:** Sharon Gilles, (410) 786–1177.

**SUPPLEMENTARY INFORMATION:**

### I. Background

In 1965, the Congress passed Title XIX of the Social Security Act (the Act) which established the Medicaid program. Under this title, we pay Federal financial participation (FFP) to State Medicaid agencies (State agencies) to assist in the costs of health care for low-income pregnant women, families, and aged, blind and disabled individuals. The Medicaid program is administered by State agencies subject to Federal statutory and regulatory requirements, which are implemented in accordance with a ''State plan'' that must be approved by the Health Care Financing Administration (HCFA).

In the early years of the Medicaid program, State agencies provided most Medicaid coverage by paying health care providers on a fee-for-service (FFS) basis. Beginning in the 1980s and continuing throughout the 1990s, State agencies have increasingly provided Medicaid coverage through managed care contracts, under which they pay a health maintenance organization (HMO) or other similar entity a fixed monthly capitation payment for each Medicaid beneficiary [1] enrolled with the entity.

As these managed care programs have grown in number and complexity, so has Federal oversight, particularly oversight of quality of care. Many studies conducted by health services researchers indicate that, with few exceptions, the quality of care furnished by managed care organizations [2] (MCO) is similar to that furnished by FFS providers. Despite these findings, the quality of managed care has received increased attention from the Congress, HCFA and the States. This has been—

- Prompted originally by the fact that, in the early years of Medicaid managed care, there were highly publicized accounts of Medicaid enrollees encountering barriers to accessing care, and other quality-related problems;
- Encouraged by developments in the private sector, such as the use of ''continuous quality improvement'' and ''value-based purchasing'', which can be applied in the public sector to obtain

[1] The term ''beneficiary'', used throughout the preamble is synonymous with the term ''recipient'', used in the text of the regulation. Both refer to an individual who is eligible for and receiving Medicaid benefits.

[2] Section 4701(b) of the Balanced Budget Act of 1997 (BBA) established this term to encompass not only HMOs but also M+C organizations, other types of organizations that may participate in the Medicare program, and other public or private organizations that meet specified statutory requirements.