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**CHANGE 5
10 USC 55
DECEMBER 2, 2014**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TITLE 10, SUBTITLE A, PART II, CHAPTER 55
MEDICAL AND DENTAL CARE
(TMA VERSION)**

The Department of Defense, Office of the Secretary, has authorized the following addition(s)/ revision(s) to 10 USC Chapter 55 (TMA Version), reissued March 2009.

CHANGE TITLE: JANUARY 2014 UPDATE

DATE LISTED: January 16, 2014.

PAGE CHANGE(S): USC Classification Table, 113th Congress, First Session (Public Laws 113-1 through 113-72 and 113-74)—Prepared by Office of the Law Revision Counsel, U.S. House of Representatives (January 16, 2014).

PAGE CHANGE(S): See page 2.

**ATTACHMENT(S): 101 PAGES
DISTRIBUTION: 10 USC 55**

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

REMOVE PAGE(S)

★ ★ ★ ★ ★ ★

Section 1071, pages 1 through 61

Section 1074, pages 7 through 30

Section 1074i, pages 1 and 2

Section 1095, pages 5 and 6

Section 1097a, pages 1 through 3

INSERT PAGE(S)

Updates, page 11

Section 1071, pages 1 through 66

Section 1074, pages 7 through 31

Section 1074i, pages 1 and 2

Section 1095, pages 5 through 7

Section 1097a, pages 1 through 4

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Updates**

Change 5 Version: Title 10 of the USC as currently published by the U.S. Government reflects the laws passed by Congress as of January 16, 2014 (113-74).

The table below lists the classification updates (<http://uscode.house.gov/classification/tables.shtml>) for the sections contained in Chapter 55—Medical And Dental Care, from February 1, 2010 to the most recent entry on Tuesday, January 16, 2014.

USC Classification Table, 113th, Second Session (Public Laws 113-1 through 113-72 and 113-74)—Prepared by Office of the Law Revision Counsel, U.S. House of Representatives (January 16, 2014).

Column 1—List USC sections in ascending order.

Column 2—Contains special information as follows:

- “nt” means note.
- “nt [tbl]” means note [table].
- “prec” means preceding.
- “fr” means a transfer from another section.
- “to” means a transfer to another section.
- “new” means a new section or new note.
- “gen amd” means the section or note generally amended.
- “omitted” means the section is omitted.
- “repealed” means the section is repealed.
- “nt ed chg” and “ed chg” -- See the Editorial Classification Change Table.

No entry or “nt” by itself means the section or note is amended.

Columns 3, 4, and 5—Contains Public Law, Section, and Statutes-at-Large citations. An item in quotes following the section citation in column 4 indicates a new section that is being added either to a positive law title or to an existing Act classified to a non-positive law title.

Section	Description of Change	Public Law		Statutes at Large
		Law	Section	Volume STAT. Page(s)
113th First Session				
1071	nt new	113-66	703	791
1071	nt new	113-66	713	794
1074	nt new	113-66	704	792
1074i	113-66	621(d)	784	
1095	nt new	113-66	712	793
1097a	nt	113-66	701	789

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Title 10 - Armed Forces
Subtitle A - General Military Law
Part II - Personnel
Chapter 55 - Medical And Dental Care

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The purpose of this chapter is to create and maintain high morale in the uniformed services by providing an improved and uniform program of medical and dental care for members and certain former members of those services, and for their dependents.

NOTES

Source

(Added Pub. L. 85-861, Sec. 1(25)(B), Sept. 2, 1958, 72 Stat. 1445; amended Pub. L. 89-614, Sec. 2(1), Sept. 30, 1966, 80 Stat. 862; Pub. L. 96-513, title V, Sec. 511(34)(A), (B), Dec. 12, 1980, 94 Stat. 2922.)

HISTORICAL AND REVISION NOTES

REVISED SECTION	SOURCE (U.S. CODE)	SOURCE (STATUTES AT LARGE)
1071	37:401.	June 7, 1956, ch. 374, Sec. 101, 70 Stat. 250.

The words "and certain former members" are inserted to reflect the fact that many of the persons entitled to retired pay are former members only. The words "and dental" are inserted to reflect the fact that members and, in certain limited situations, dependents are entitled to dental care under sections 1071-1085 of this title.

Prior Provisions

A prior section 1071, act Aug. 10, 1956, ch. 1041, 70A Stat. 81, which stated the purpose of former sections 1071 to 1086 of this title, and provided for their construction, was repealed by Pub. L. 85-861, Sec. 36B(5), Sept. 2, 1958, 72 Stat. 1570, as superseded by the Federal Voting Assistance Act of 1955 which is classified to subchapter I-D (Sec. 1973cc et seq.) of chapter 20 of Title 42, The Public Health and Welfare.

Amendments

1980—Pub. L. 96-513 substituted "Purpose of this chapter" for "Purpose of sections 1071-1087 of this title" in section catchline, and substituted reference to this chapter for reference to sections 1071-1087 of this title in text.

1966—Pub. L. 89-614 substituted "1087" for "1085" in section catchline and text.

Effective Date Of 1980 Amendment

Amendment by Pub. L. 96-513 effective Dec. 12, 1980, see section 701(b)(3) of Pub. L. 96-513, set out as a note under section 101 of this title.

Effective Date Of 1966 Amendment

Pub. L. 89-614, **Sec. 3, Sept. 30, 1966, 80 Stat. 866**, provided that: "The amendments made by this Act [see Short Title of 1966 Amendment note below] shall become effective January 1, 1967, except

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that those amendments relating to outpatient care in civilian facilities for spouses and children of members of the uniformed services who are on active duty for a period of more than 30 days shall become effective on October 1, 1966.”

Short Title Of 2008 Amendment

Pub. L. 110-181, div. A, title XVI, Sec. 1601, Jan. 28, 2008, 122 Stat. 431, provided that: “This title [enacting sections 1074l, 1216a, and 1554a of this title, amending sections 1074, 1074f, 1074i, 1145, 1201, 1203, 1212, and 1599c of this title and section 6333 of Title 5, Government Organization and Employees, and enacting provisions set out as notes under this section, sections 1074, 1074f, 1074i, 1074l, 1212, and 1554a of this title, and section 6333 of Title 5] may be cited as the ‘Wounded Warrior Act.’”

Short Title Of 1987 Amendment

Pub. L. 100-180, div. A, title VII, Sec. 701, Dec. 4, 1987, 101 Stat. 1108, provided that: “This title [enacting sections 1103, 2128 to 2130 [now 16201 to 16203], and 6392 of this title, amending sections 533, 591, 1079, 1086, 1251, 2120, 2122, 2123, 2124, 2127, 2172 [now 16302], 3353, 3855, 5600, 8353, and 8855 of this title, section 302 of Title 37, Pay and Allowances of the Uniformed Services, and section 460 of Title 50, Appendix, War and National Defense, enacting provisions set out as notes under sections 1073, 1074, 1079, 1092, 1103, 2121, 2124, 12201, and 16201 of this title, amending provisions set out as notes under sections 1073 and 1101 of this title, and repealing provisions set out as notes under sections 2121 and 2124 of this title] may be cited as the ‘Military Health Care Amendments of 1987.’”

Short Title Of 1966 Amendment

Pub. L. 89-614, Sec. 1, Sept. 30, 1966, 80 Stat. 862, provided: “That this Act [enacting sections 1086 and 1087 of this title, amending this section and sections 1072 to 1074, 1076 to 1079, 1082, and 1084 of this title, and enacting provisions set out as a note under this section] may be cited as the ‘Military Medical Benefits Amendments of 1966.’”

Comprehensive Policy on Improvements to Care and Transition of Members of the Armed Forces With Urotrauma

Pub. L. 113-66, div. A, title VII, §703, Dec. 26, 2013, 127 Stat. 791, provided that:

“(a) Comprehensive Policy Required.—

“(1) In general.—Not later than 180 days after the date of the enactment of this Act [Dec. 26, 2013], the Secretary of Defense and the Secretary of Veterans Affairs shall jointly develop and implement a comprehensive policy on improvements to the care, management, and transition of recovering members of the Armed Forces with urotrauma.

“(2) Scope of policy.—The policy shall cover each of the following:

“(A) The care and management of the specific needs of members who are urotrauma patients, including eligibility for the Recovery Care Coordinator Program pursuant to the Wounded Warrior Act [title XVI of div. A of Pub. L. 110-181] (10 U.S.C. 1071 note).

“(B) The return of members who have recovered to active duty when appropriate.

“(C) The transition of recovering members from receipt of care and services through the Department of Defense to receipt of care and services through the Department of Veterans Affairs.

“(b) Report.—

“(1) In general.—Not later than one year after implementing the policy under subsection (a)(1), the Secretary of Defense and the Secretary of Veterans Affairs shall jointly submit to the appropriate congressional committees a report that includes—

- “(A) a review that identifies gaps in the care of members who are urotrauma patients; and
 - “(B) suggested options to respond to such gaps.
- “(2) Appropriate congressional committees defined.—In this subsection, the term “appropriate congressional committees” means the following:
- “(A) The Committees on Armed Services of the Senate and the House of Representatives.
 - “(B) The Committees on Veterans’ Affairs of the Senate and the House of Representatives.

Electronic Health Records of the Department of Defense and the Department of Veterans Affairs

Pub. L. 113-66, div. A, title VII, §713, Dec. 26, 2013, 127 Stat. 794, provided that:

- “(a) Sense of Congress.—It is the sense of Congress that—
- “(1) the Secretary of Defense and the Secretary of Veterans Affairs have failed to implement a solution that allows for seamless electronic sharing of medical health care data; and
 - “(2) despite the significant amount of read-only information shared between the Department of Defense and Department of Veterans Affairs, most of the information shared as of the date of the enactment of this Act [Dec. 26, 2013] is not standardized or available in real time to support all clinical decisions.
- “(b) Implementation.—The Secretary of Defense and the Secretary of Veterans Affairs—
- “(1) shall each ensure that the electronic health record systems of the Department of Defense and the Department of Veterans Affairs are interoperable with an integrated display of data, or a single electronic health record, by complying with the national standards and architectural requirements identified by the Interagency Program Office of the Departments (in this section referred to as the “Office”), in collaboration with the Office of the National Coordinator for Health Information Technology of the Department of Health and Human Services; and
 - “(2) shall each deploy modernized electronic health record software supporting clinicians of the Departments by no later than December 31, 2016, while ensuring continued support and compatibility with the interoperability platform and full standards-based interoperability.
- “(c) Design Principles.—The interoperable electronic health records with integrated display of data, or a single electronic health record, established under subsection (b) shall adhere to the following principles:
- “(1) To the extent practicable, efforts to establish such records shall be based on objectives, activities, and milestones established by the Joint Executive Committee Joint Strategic Plan Fiscal Years 2013-2015, as well as future addendums or revisions.
 - “(2) Transition the current data exchanges between the Departments and private sector health care providers where practical to modern, open-architecture frameworks that use computable data mapped to national standards to make data available for determining medical trends and for enhanced clinician decision support.
 - “(3) Principles with respect to open architecture standards, including—
 - “(A) adoption of national data standards;
 - “(B) if such national standards do not exist as of the date on which the record is being established, adoption of the articulation of data of the Health Data Dictionary until such national standards are established;
 - “(C) use of enterprise investment strategies that maximize the use of commercial best practices to ensure robust competition and best value;

“(D) aggressive life-cycle sustainment planning that uses proven technology insertion strategies and product upgrade techniques;

“(E) enforcement of system design transparency, continuous design disclosure and improvement, and peer reviews that align with the requirements of the Federal Acquisition Regulation; and

“(F) strategies for data management rights to ensure a level competitive playing field and access to alternative solutions and sources across the life-cycle of the programs.

“(4) By the point of deployment, such record must be at a generation 3 level or better for a health information technology system.

“(5) To the extent the Secretaries consider feasible and advisable, principles with respect to—

“(A) the creation of a health data authoritative source by the Department of Defense and the Department of Veterans Affairs that can be accessed by multiple providers and standardizes the input of new medical information;

“(B) the ability of patients of both the Department of Defense and the Department of Veterans Affairs to download, or otherwise receive electronically, the medical records of the patient; and

“(C) the feasibility of establishing a secure, remote, network-accessible computer storage system to provide members of the Armed Forces and veterans the ability to upload the health care records of the member or veteran if the member or veteran elects to do so and allow medical providers of the Department of Defense and the Department of Veterans Affairs to access such records in the course of providing care to the member or veteran.

“(d) Programs Plan.—Not later than January 31, 2014, the Secretaries shall prepare and brief the appropriate congressional committees with a detailed programs plan for the oversight and execution of the interoperable electronic health records with an integrated display of data, or a single electronic health record, established under subsection (b). This briefing and supporting documentation shall include—

“(1) programs objectives;

“(2) organization;

“(3) responsibilities of the Departments;

“(4) technical objectives and design principles;

“(5) milestones, including a schedule for the development, acquisition, or industry competitions for capabilities needed to satisfy the technical system requirements;

“(6) data standards being adopted by the programs;

“(7) outcome-based metrics proposed to measure the performance and effectiveness of the programs; and

“(8) the level of funding for fiscal years 2014 through 2017.

“(e) Limitation on Funds.—Not more than 25 percent of the amounts authorized to be appropriated by this Act or otherwise made available for development, procurement, modernization, or enhancement of the interoperable electronic health records with an integrated display of data, or a single electronic health record, established under subsection (b) for the Department of Defense or the Department of Veterans Affairs may be obligated or expended until the date on which the Secretaries brief the appropriate congressional committees of the programs plan under subsection (d).

“(f) Reporting.—

“(1) Quarterly reporting.—On a quarterly basis, the Secretaries shall submit to the appropriate congressional committees a detailed financial summary.

“(2) Notification.—The Secretary of Defense and Secretary of Veterans Affairs shall submit to the appropriate congressional committees written notification prior to obligating funds

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for any contract or task order for electronic health record system modernization efforts that is in excess of \$5,000,000.

“(g) Requirements.—

“(1) In general.—Not later than October 1, 2014, all health care data contained in the Department of Defense AHLTA and the Department of Veterans Affairs VistA systems shall be computable in real time and comply with the existing national data standards and have a process in place to ensure data is standardized as national standards continue to evolve. On a quarterly basis, the Secretaries shall submit to the appropriate congressional committees updates on the progress of data sharing.

“(2) Certification.—At such time as the operational capability described in subsection (b)(1) is achieved, the Secretaries shall jointly certify to the appropriate congressional committees that the Secretaries have complied with such data standards described in paragraph (1).

“(3) Responsible official.—The Secretaries shall each identify a senior official to be responsible for the modern platforms supporting an interoperable electronic health record with an integrated display of data, or a single electronic health record, established under subsection (b). The Secretaries shall also each identify a senior official to be responsible for modernizing the electronic health record software of the respective Department. Such official shall have included within their performance evaluation performance metrics related to the execution of the responsibilities under this paragraph. Not later than 30 days after the date of the enactment of this Act [Dec. 26, 2013], each Secretary shall submit to the appropriate congressional committees the name of each senior official selected under this paragraph.

“(4) Comptroller general assessment.—If both Secretaries do not meet the requirements under paragraph (1), the Comptroller General of the United States shall submit to the appropriate congressional committees an assessment of the performance of the compliance of both Secretaries of such requirements.

“(h) Executive Committee.—

“(1) Establishment.—Not later than 60 days after the date of the enactment of this Act [Dec. 26, 2013], the Secretaries shall jointly establish an executive committee to support the development and validation of adopted standards, required architectural platforms and structure, and the capacity to enforce such standards, platforms, and structure as the Secretaries execute requirements and develop programmatic assessment as needed by the Secretaries to ensure interoperable electronic health records with an integrated display of data, or a single electronic health record, are established pursuant to the requirements of subsection (b). The Executive Committee shall annually certify to the appropriate congressional committees that such record meets the definition of "integrated" as specified in subsection (k)(4).

“(2) Membership.—The Executive Committee established under paragraph (1) shall consist of not more than 6 members, appointed by the Secretaries as follows:

“(A) Two co-chairs, one appointed by each of the Secretaries.

“(B) One member from the technical community of the Department of Defense appointed by the Secretary of Defense.

“(C) One member from the technical community of the Department of Veterans Affairs appointed by the Secretary of Veterans Affairs.

“(D) One member from the clinical community of the Department of Defense appointed by the Secretary of Defense.

“(E) One member from the clinical community of the Department of Veterans Affairs appointed by the Secretary of Veterans Affairs.

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“(3) Reporting.—Not later than June 1, 2014, and on a quarterly basis thereafter, the Executive Committee shall submit to the appropriate congressional committees a report on the activities of the Committee.

“(i) Independent Review.—The Secretary of Defense shall request the Defense Science Board to conduct an annual review of the progress of the Secretary toward achieving the requirements in paragraphs (1) and (2) of subsection (b). The Defense Science Board shall submit to the Secretary a report of the findings of the review. Not later than 30 days after receiving the report, the Secretary shall submit to the appropriate congressional committees the report with any comments considered appropriate by the Secretary.

“(j) Deadline for Completion of Implementation of the Healthcare Artifact and Image Management Solution Program.—

“(1) Deadline.—The Secretary of Defense shall complete the implementation of the Healthcare Artifact and Image Management Solution program of the Department of Defense by not later than the date that is 180 days after the date of the enactment of this Act [Dec. 26, 2013].

“(2) Report.—Upon completion of the implementation of the Healthcare Artifact and Image Management Solution program, the Secretary shall submit to the appropriate congressional committees a report describing the extent of the interoperability between the Healthcare Artifact and Image Management Solution program and the Veterans Benefits Management System of the Department of Veterans Affairs.

“(k) Definitions.—In this section:

“(1) Appropriate congressional committees.—The term “appropriate congressional committees” means—

“(A) the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives]; and

“(B) the Committees on Veterans’ Affairs of the Senate and the House of Representatives.

“(2) Generation 3.—The term “generation 3” means, with respect to an electronic health system, a system that has the technical capability to bring evidence-based medicine to the point of care and provide functionality for multiple care venues.

“(3) Interoperable.—The term “interoperable” refers to the ability of different electronic health records systems or software to meaningfully exchange information in real time and provide useful results to one or more systems.

“(4) Integrated.—The term “integrated” refers to the integration of health data from the Department of Defense and the Department of Veterans Affairs and outside providers to provide clinicians with a comprehensive medical record that allows data existing on disparate systems to be shared or accessed across functional or system boundaries in order to make the most informed decisions when treating patients.

Enhancement Of Oversight And Management Of Department Of Defense Suicide Prevention And Resilience Programs

Pub. L. 112-239, div. A, title V, Sec. 580, Jan. 2, 2013, 126 Stat. 1764, provided that:

“(a) In General.—The Secretary of Defense shall, acting through the Under Secretary of Defense for Personnel and Readiness, establish within the Office of the Secretary of Defense a position with responsibility for oversight of all suicide prevention and resilience programs of the Department of Defense (including those of the military departments and the Armed Forces).

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“(b) Scope of Responsibilities.—The individual serving in the position established under subsection (a) shall have the responsibilities as follows:

“(1) To establish a uniform definition of resiliency for use in the suicide prevention and resilience programs and preventative behavioral health programs of the Department of Defense (including those of the military departments and the Armed Forces).

“(2) To oversee the implementation of the comprehensive policy on the prevention of suicide among members of the Armed Forces required by section 582.”

Comprehensive Policy On Prevention Of Suicide Among Members Of The Armed Forces

Pub. L. 112-239, div. A, title V, Sec. 582, Jan. 2, 2013, 126 Stat. 1766, provided that:

“(a) Comprehensive Policy Required.—Not later than 180 days after the date of the enactment of this Act [Jan. 2, 2013], the Secretary of Defense shall, acting through the Under Secretary of Defense for Personnel and Readiness, develop within the Department of Defense a comprehensive policy on the prevention of suicide among members of the Armed Forces. In developing the policy, the Secretary shall consider recommendations from the operational elements of the Armed Forces regarding the feasibility of the implementation and execution of particular elements of the policy.

“(b) Elements.—The policy required by subsection (a) shall cover each of the following:

“(1) Increased awareness among members of the Armed Forces about mental health conditions and the stigma associated with mental health conditions and mental health care.

“(2) The means of identifying members who are at risk for suicide (including enhanced means for early identification and treatment of such members).

“(3) The continuous access by members to suicide prevention services, including suicide crisis services.

“(4) The means to evaluate and assess the effectiveness of the suicide prevention and resilience programs and preventative behavioral health programs of the Department of Defense (including those of the military departments and the Armed Forces), including the development of metrics for that purpose.

“(5) The means to evaluate and assess the current diagnostic tools and treatment methods in the programs referred to in paragraph (4) to ensure clinical best practices are used in such programs.

“(6) The standard of care for suicide prevention to be used throughout the Department.

“(7) The training of mental health care providers on suicide prevention.

“(8) The training standards for behavioral health care providers to ensure that such providers receive training on clinical best practices and evidence-based treatments as information on such practices and treatments becomes available.

“(9) The integration of mental health screenings and suicide risk and prevention for members into the delivery of primary care for such members.

“(10) The standards for responding to attempted or completed suicides among members, including guidance and training to assist commanders in addressing incidents of attempted or completed suicide within their units.

“(11) The means to ensure the protection of the privacy of members seeking or receiving treatment relating to suicide.

“(12) Such other matters as the Secretary considers appropriate in connection with the prevention of suicide among members.”

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Research And Medical Practice On Mental Health Conditions

Pub. L. 112-239, div. A, title VII, Sec. 725, Jan. 2, 2013, 126 Stat. 1806, provided that:

“(a) Research and Practice.—The Secretary of Defense shall provide for the translation of research on the diagnosis and treatment of mental health conditions into policy on medical practices.

“(b) Report.—Not later than 180 days after the date of the enactment of this Act [Jan. 2, 2013], the Secretary shall submit to the Committees on Armed Services of the House of Representatives and the Senate a report on the translation of research into policy as described in subsection (a). The report shall include the following:

“(1) A summary of the efforts of the Department of Defense to carry out such translation.

“(2) A description of any policy established pursuant to subsection (a).

“(3) Additional legislative or administrative actions the Secretary considers appropriate with respect to such translation.”

Plan For Reform Of The Administration Of The Military Health System

Pub. L. 112-239, div. A, title VII, Sec. 731, Jan. 2, 2013, 126 Stat. 1815, provided that:

“(a) Detailed Plan.—In implementing reforms to the governance of the military health system described in the memorandum of the Deputy Secretary of Defense dated March 2012, the Secretary of Defense shall develop a detailed plan to carry out such reform.

“(b) Elements.—The plan developed under subsection (a) shall include the following:

“(1) Goals to achieve while carrying out the reform described in subsection (a), including goals with respect to improving clinical and business practices, cost reductions, infrastructure reductions, and personnel reductions, achieved by establishing the Defense Health Agency, carrying out shared services, and modifying the governance of the National Capital Region.

“(2) Metrics to evaluate the achievement of each goal under paragraph (1) with respect to the purpose, objective, and improvements made by each such goal.

“(3) The personnel levels required for the Defense Health Agency and the National Capital Region Medical Directorate.

“(4) A detailed schedule to carry out the reform described in subsection (a), including a schedule for meeting the goals under paragraph (1).

“(5) Detailed information describing the initial operating capability of the Defense Health Agency.

“(6) With respect to each shared service that the Secretary will implement during fiscal year 2013 or 2014—

“(A) a timeline for such implementation; and

“(B) a business case analysis detailing—

“(i) the services that will be consolidated into the shared service;

“(ii) the purpose of the shared service;

“(iii) the scope of the responsibilities and goals for the shared service;

“(iv) the cost of implementing the shared service, including the costs regarding personnel severance, relocation, military construction, information technology, and contractor support; and

“(v) the anticipated cost savings to be realized by implementing the shared service.

“(c) Submission.—The Secretary of Defense shall submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] the plan developed under subsection (a) as follows:

“(1) The contents of the plan described in paragraphs (1) and (4) of subsection (b) shall be submitted not later than March 31, 2013.

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“(2) The contents of the plan described in paragraphs (2) and (3) of subsection (b) and paragraph (6) of such subsection with respect to shared services implemented during fiscal year 2013 shall be submitted not later than June 30, 2013.

“(3) The contents of the plan described in paragraph (6) of such subsection with respect to shared services implemented during fiscal year 2014 shall be submitted not later than September 30, 2013.

“(d) Limitations.—

“(1) First submission.—Of the funds authorized to be appropriated by this Act [see Tables for classification] or otherwise made available for fiscal year 2013 for the accounts and activities described in paragraph (4), not more than 50 percent may be obligated or expended until the date on which the Secretary of Defense submits to the congressional defense committees the contents of the plan under subsection (c)(1).

“(2) Second submission.—Of the funds authorized to be appropriated by this Act or otherwise made available for fiscal year 2013 for the accounts and activities described in paragraph (4), not more than 75 percent may be obligated or expended until the date on which the Secretary of Defense submits to the congressional defense committees the contents of the plan under subsection (c)(2).

“(3) Comptroller general review.—The Comptroller General of the United States shall submit to the congressional defense committees a review of the contents of the plan submitted under each of paragraphs (1) and (2) to assess whether the Secretary of Defense meets the requirements of such contents.

“(4) Accounts and activities described.—The accounts and activities described in this paragraph are as follows:

“(A) Operation and maintenance, Defense-wide, for the Office of the Secretary of Defense for travel.

“(B) Operation and maintenance, Defense-wide, for the Office of the Secretary of Defense for management professional support services.

“(C) Operation and maintenance, Defense Health Program, for travel.

“(D) Operation and maintenance, Defense Health Program, for management professional support services.

“(e) Shared Services Defined.—In this section, the term ‘shared services’ means the common services required for each military department to provide medical support to the Armed Forces and authorized beneficiaries.”

Performance Metrics And Reports On Warriors In Transition Programs Of The Military Departments

Pub. L. 112-239, div. A, title VII, Sec. 738, Jan. 2, 2013, 126 Stat. 1820, provided that:

“(a) Metrics Required.—The Secretary of Defense shall establish a policy containing uniform performance outcome measurements to be used by each Secretary of a military department in tracking and monitoring members of the Armed Forces in Warriors in Transition programs.

“(b) Elements.—The policy established under subsection (a) shall identify outcome measurements with respect to the following:

“(1) Physical health and behavioral health.

“(2) Rehabilitation.

“(3) Educational and vocational preparation.

“(4) Such other matters as the Secretary considers appropriate.

“(c) Milestones.—In establishing the policy under subsection (a), the Secretary of Defense shall establish metrics and milestones for members in Warriors in Transition programs. Such metrics

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and milestones shall cover members throughout the course of care and rehabilitation in Warriors in Transitions programs by applying to the following occasions:

- "(1) When the member commences participation in the program.
 - "(2) At least once each year the member participates in the program.
 - "(3) When the member ceases participation in the program or is transferred to the jurisdiction of the Secretary of Veterans Affairs.
- "(d) Cohort Groups and Parameters.—The policy established under subsection (a)—
- "(1) may differentiate among cohort groups within the population of members in Warriors in Transition programs, as appropriate; and
 - "(2) shall include parameters for specific outcome measurements in each element under subsection (b) and each metric and milestone under subsection (c).
- "(e) Reports Required.—
- "(1) Initial report.—Not later than 180 days after the date of the enactment of this Act [Jan. 2, 2013], the Secretary of Defense shall submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] a report on the policy established under subsection (a), including the outcome measurements for each element under subsection (b) and each metric and milestone under subsection (c).
 - "(2) Annual reports.—Not later than February of each year beginning in 2014 and ending in 2018, the Secretary of Defense shall submit to the congressional defense committees a report on the performance of the military departments with respect to the policy established under subsection (a). Each report shall include—
 - "(A) an analysis of—
 - "(i) data on improvements in the progress of members in Warriors in Transition programs in each specific area identified in the policy;
 - "(ii) access to health and rehabilitation services by such members, including average appointment waiting times by specialty;
 - "(iii) effectiveness of the programs in assisting in the transition of such members to military duty or civilian life through education and vocational assistance;
 - "(iv) any differences in outcomes in Warriors in Transition programs, and the reason for any such differences; and
 - "(v) the quantities and effectiveness of medical and nonmedical case managers, legal support and physical evaluation board liaison officers, mental health care providers, and medical evaluation physicians in comparison to the actual number of members requiring such services; and
 - "(B) such other results and analyses as the Secretary considers appropriate, including any recommendations for legislation if needed.
- "(f) Warriors in Transition Program Defined.—In this section, the term 'Warriors in Transition program' means any major support program of the Armed Forces for members of the Armed Forces with severe wounds, illnesses, or injuries that is intended to provide such members with nonmedical case management service and care coordination services, and includes the programs as follows:
- "(1) Warrior Transition Units and the Wounded Warrior Program of the Army.
 - "(2) The Wounded Warrior Safe Harbor program of the Navy.
 - "(3) The Wounded Warrior Regiment of the Marine Corps.
 - "(4) The Recovery Care Program and the Wounded Warrior programs of the Air Force.
 - "(5) The Care Coalition of the United States Special Operations Command."

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Department Of Defense Suicide Prevention Program

Pub. L. 112-81, div. A, title V, Sec. 533(a), (b), Dec. 31, 2011, 125 Stat. 1404, provided that:

“(a) Program Enhancement. —The Secretary of Defense shall take appropriate actions to enhance the suicide prevention program of the Department of Defense through the provision of suicide prevention information and resources to members of the Armed Forces from their initial enlistment or appointment through their final retirement or separation.

“(b) Cooperative Effort.—The Secretary of Defense shall develop suicide prevention information and resources in consultation with—

“(1) the Secretary of Veterans Affairs, the National Institute of Mental Health, and the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services; and

“(2) to the extent appropriate, institutions of higher education and other public and private entities, including international entities, with expertise regarding suicide prevention.”

Treatment Of Wounded Warriors

Pub. L. 112-81, div. A, title VII, Sec. 722, Dec. 31, 2011, 125 Stat. 1479, provided that: “The Secretary of Defense may establish a program to enter into partnerships to enable coordinated, rapid clinical evaluation and the application of evidence-based treatment strategies for wounded service members, with an emphasis on the most common musculoskeletal injuries, that will address the priorities of the Armed Forces with respect to retention and readiness.”

Comprehensive Plan On Prevention, Diagnosis, And Treatment Of Substance Use Disorders And Disposition Of Substance Abuse Offenders In The Armed Forces

Pub. L. 111-84, div. A, title V, Sec. 596, Oct. 28, 2009, 123 Stat. 2339, provided that:

“(a) Review and Assessment of Current Capabilities.—

“(1) In general.—Not later than 180 days after the date of the enactment of this Act [Oct. 28, 2009], the Secretary of Defense, in consultation with the Secretaries of the military departments, shall conduct a comprehensive review of the following:

“(A) The programs and activities of the Department of Defense for the prevention, diagnosis, and treatment of substance use disorders in members of the Armed Forces.

“(B) The policies of the Department of Defense relating to the disposition of substance abuse offenders in the Armed Forces, including disciplinary action and administrative separation.

“(2) Elements.—The review conducted under paragraph (1) shall include an assessment of each of the following:

“(A) The current state and effectiveness of the programs of the Department of Defense and the military departments relating to the prevention, diagnosis, and treatment of substance use disorders.

“(B) The adequacy of the availability of care, and access to care, for substance abuse in military medical treatment facilities and under the TRICARE program.

“(C) The adequacy of oversight by the Department of Defense of programs relating to the prevention, diagnosis, and treatment of substance abuse in members of the Armed Forces.

“(D) The adequacy and appropriateness of current credentials and other requirements for healthcare professionals treating members of the Armed Forces with substance use disorders.

“(E) The advisable ratio of physician and nonphysician care providers for substance use disorders to members of the Armed Forces with such disorders.

“(F) The adequacy and appropriateness of protocols and directives for the diagnosis and treatment of substance use disorders in members of the Armed Forces and for the

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disposition, including disciplinary action and administrative separation, of members of the Armed Forces for substance abuse.

“(G) The adequacy of the availability of and access to care for substance use disorders for members of the reserve components of the Armed Forces, including an identification of any obstacles that are unique to the prevention, diagnosis, and treatment of substance use disorders among members of the reserve components, and the appropriate disposition, including disciplinary action and administrative separation, of members of the reserve components for substance abuse.

“(H) The adequacy of the prevention, diagnosis, and treatment of substance use disorders in dependents of members of the Armed Forces.

“(I) Any gaps in the current capabilities of the Department of Defense for the prevention, diagnosis, and treatment of substance use disorders in members of the Armed Forces.

“(3) Report.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report setting forth the findings and recommendations of the Secretary as a result of the review conducted under paragraph (1). The report shall—

“(A) set forth the findings and recommendations of the Secretary regarding each element of the review specified in paragraph (2);

“(B) set forth relevant statistics on the frequency of substance use disorders, disciplinary actions, and administrative separations for substance abuse in members of the regular components of the Armed Forces, members of the reserve component of the Armed Forces, and to the extent applicable, dependents of such members (including spouses and children); and

“(C) include such other findings and recommendations on improvements to the current capabilities of the Department of Defense for the prevention, diagnosis, and treatment of substance use disorders in members of the Armed Forces and the policies relating to the disposition, including disciplinary action and administrative separation, of members of the Armed Forces for substance abuse, as the Secretary considers appropriate.

“(b) Plan for Improvement and Enhancement of Programs and Policies.—

“(1) Plan required.—Not later than 270 days after the date of the enactment of this Act [Oct. 28, 2009], the Secretary of Defense shall submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] a comprehensive plan for the improvement and enhancement of the following:

“(A) The programs and activities of the Department of Defense for the prevention, diagnosis, and treatment of substance use disorders in members of the Armed Forces and their dependents.

“(B) The policies of the Department of Defense relating to the disposition of substance abuse offenders in the Armed Forces, including disciplinary action and administrative separation.

“(2) Basis.—The comprehensive plan required by paragraph (1) shall take into account the following:

“(A) The results of the review and assessment conducted under subsection (a).

“(B) Similar initiatives of the Secretary of Veterans Affairs to expand and improve care for substance use disorders among veterans, including the programs and activities conducted under title I of the Veterans’ Mental Health and Other Care Improvements Act of 2008 (Public Law 110-387; 112 Stat. 4112) [see Tables for classification].

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“(3) Comprehensive statement of policy.—The comprehensive plan required by paragraph (1) shall include a comprehensive statement of the following:

“(A) The policy of the Department of Defense regarding the prevention, diagnosis, and treatment of substance use disorders in members of the Armed Forces and their dependents.

“(B) The policies of the Department of Defense relating to the disposition of substance abuse offenders in the Armed Forces, including disciplinary action and administrative separation.

“(4) Availability of services and treatment.—The comprehensive plan required by paragraph (1) shall include mechanisms to ensure the availability to members of the Armed Forces and their dependents of a core of evidence-based practices across the spectrum of medical and non-medical services and treatments for substance use disorders, including the reestablishment of regional long-term inpatient substance abuse treatment programs. The Secretary may use contracted services for not longer than three years after the date of the enactment of this Act to perform such inpatient substance abuse treatment until the Department of Defense reestablishes this capability within the military health care system.

“(5) Prevention and reduction of disorders.—The comprehensive plan required by paragraph (1) shall include mechanisms to facilitate the prevention and reduction of substance use disorders in members of the Armed Forces through science-based initiatives, including education programs, for members of the Armed Forces and their dependents.

“(6) Specific instructions.—The comprehensive plan required by paragraph (1) shall include each of the following:

“(A) Substances of abuse.—Instructions on the prevention, diagnosis, and treatment of substance abuse in members of the Armed Forces, including the abuse of alcohol, illicit drugs, and nonmedical use and abuse of prescription drugs.

“(B) Healthcare professionals.—Instructions on—

“(i) appropriate training of healthcare professionals in the prevention, screening, diagnosis, and treatment of substance use disorders in members of the Armed Forces;

“(ii) appropriate staffing levels for healthcare professionals at military medical treatment facilities for the prevention, screening, diagnosis, and treatment of substance use disorders in members of the Armed Forces; and

“(iii) such uniform training and credentialing requirements for physician and nonphysician healthcare professionals in the prevention, screening, diagnosis, and treatment of substance use disorders in members of the Armed Forces as the Secretary considers appropriate.

“(C) Services for dependents.—Instructions on the availability of services for substance use disorders for dependents of members of the Armed Forces, including instructions on making such services available to dependents to the maximum extent practicable.

“(D) Relationship between disciplinary action and treatment.—Policy on the relationship between disciplinary actions and administrative separation processing and prevention and treatment of substance use disorders in members of the Armed Forces.

“(E) Confidentiality.—Recommendations regarding policies pertaining to confidentiality for members of the Armed Forces in seeking or receiving services or treatment for substance use disorders.

“(F) Participation of chain of command.—Policy on appropriate consultation, reference to, and involvement of the chain of command of members of the Armed Forces in matters relating to the diagnosis and treatment of substance abuse and disposition of members of the Armed Forces for substance abuse.

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“(G) Consideration of gender.—Instructions on gender specific requirements, if appropriate, in the prevention, diagnosis, treatment, and management of substance use disorders in members of the Armed Forces, including gender specific care and treatment requirements.

“(H) Coordination with other healthcare initiatives.—Instructions on the integration of efforts on the prevention, diagnosis, treatment, and management of substance use disorders in members of the Armed Forces with efforts to address co- occurring health care disorders (such as post-traumatic stress disorder and depression) and suicide prevention.

“(7) Other elements.—In addition to the matters specified in paragraph (3), the comprehensive plan required by paragraph (1) shall include the following:

“(A) Implementation plan.—An implementation plan for the achievement of the goals of the comprehensive plan, including goals relating to the following:

“(i) Enhanced education of members of the Armed Forces and their dependents regarding substance use disorders.

“(ii) Enhanced and improved identification and diagnosis of substance use disorders in members of the Armed Forces and their dependents.

“(iii) Enhanced and improved access of members of the Armed Forces to services and treatment for and management of substance use disorders.

“(iv) Appropriate staffing of military medical treatment facilities and other facilities for the treatment of substance use disorders in members of the Armed Forces.

“(B) Best practices.—The incorporation of evidence-based best practices utilized in current military and civilian approaches to the prevention, diagnosis, treatment, and management of substance use disorders.

“(C) Available research.—The incorporation of applicable results of available studies, research, and academic reviews on the prevention, diagnosis, treatment, and management of substance use disorders.

“(8) Update in light of independent study.—Upon the completion of the study required by subsection (c), the Secretary of Defense shall—

“(A) in consultation with the Secretaries of the military departments, make such modifications and improvements to the comprehensive plan required by paragraph (1) as the Secretary of Defense considers appropriate in light of the findings and recommendations of the study; and

“(B) submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] a report setting forth the comprehensive plan as modified and improved under subparagraph (A).

“(c) Independent Report on Substance Use Disorders Programs for Members of the Armed Forces.—

“(1) Study required.—Upon completion of the policy review required by subsection (a), the Secretary of Defense shall provide for a study on substance use disorders programs for members of the Armed Forces to be conducted by the Institute of Medicine of the National Academies of Sciences or such other independent entity as the Secretary shall select for purposes of the study.

“(2) Elements.—The study required by paragraph (1) shall include a review and assessment of the following:

“(A) The adequacy and appropriateness of protocols for the diagnosis, treatment, and management of substance use disorders in members of the Armed Forces.

“(B) The adequacy of the availability of and access to care for substance use disorders in military medical treatment facilities and under the TRICARE program.

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“(C) The adequacy and appropriateness of current credentials and other requirements for physician and non-physician healthcare professionals treating members of the Armed Forces with substance use disorders.

“(D) The advisable ratio of physician and non-physician care providers for substance use disorders to members of the Armed Forces with such disorders.

“(E) The adequacy of the availability of and access to care for substance use disorders for members of the reserve components of the Armed Forces when compared with the availability of and access to care for substance use disorders for members of the regular components of the Armed Forces.

“(F) The adequacy of the prevention, diagnosis, treatment, and management of substance use disorders programs for dependents of members of the Armed Forces, whether such dependents suffer from their own substance use disorder or because of the substance use disorder of a member of the Armed Forces.

“(G) Such other matters as the Secretary considers appropriate for purposes of the study.

“(3) Report.—Not later than two years after the date of the enactment of this Act [Oct. 28, 2009], the entity conducting the study required by paragraph (1) shall submit to the Secretary of Defense and the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] a report on the results of the study. The report shall set forth the findings and recommendations of the entity as a result of the study.”

Comprehensive Policy On Pain Management By The Military Health Care System

Pub. L. 111-84, div. A, title VII, Sec. 711, Oct. 28, 2009, 123 Stat. 2378, provided that:

“(a) Comprehensive Policy Required.—Not later than March 31, 2011, the Secretary of Defense shall develop and implement a comprehensive policy on pain management by the military health care system.

“(b) Scope of Policy.—The policy required by subsection (a) shall cover each of the following:

“(1) The management of acute and chronic pain.

“(2) The standard of care for pain management to be used throughout the Department of Defense.

“(3) The consistent application of pain assessments throughout the Department of Defense.

“(4) The assurance of prompt and appropriate pain care treatment and management by the Department when medically necessary.

“(5) Programs of research related to acute and chronic pain, including pain attributable to central and peripheral nervous system damage characteristic of injuries incurred in modern warfare, brain injuries, and chronic migraine headache.

“(6) Programs of pain care education and training for health care personnel of the Department.

“(7) Programs of patient education for members suffering from acute or chronic pain and their families.

“(c) Updates.—The Secretary shall revise the policy required by subsection (a) on a periodic basis in accordance with experience and evolving best practice guidelines.

“(d) Annual Report.—

“(1) In general.—Not later than 180 days after the date of the commencement of the implementation of the policy required by subsection (a), and on October 1 each year thereafter through 2018, the Secretary shall submit to the Committee on Armed Services of the Senate and the Committee on Armed Services of the House of Representatives a report on the policy.

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- “(2) Elements.—Each report required by paragraph (1) shall include the following:
- “(A) A description of the policy implemented under subsection (a), and any revisions to such policy under subsection (c).
 - “(B) A description of the performance measures used to determine the effectiveness of the policy in improving pain care for beneficiaries enrolled in the military health care system.
 - “(C) An assessment of the adequacy of Department pain management services based on a current survey of patients managed in Department clinics.
 - “(D) An assessment of the research projects of the Department relevant to the treatment of the types of acute and chronic pain suffered by members of the Armed Forces and their families.
 - “(E) An assessment of the training provided to Department health care personnel with respect to the diagnosis, treatment, and management of acute and chronic pain.
 - “(F) An assessment of the pain care education programs of the Department.
 - “(G) An assessment of the dissemination of information on pain management to beneficiaries enrolled in the military health care system.”

Plan To Increase The Mental Health Capabilities Of The Department Of Defense

Pub. L. 111-84, div. A, title VII, Sec. 714, Oct. 28, 2009, 123 Stat. 2381, as amended by Pub. L. 111-383, div. A, title X, Sec. 1075(d)(8), Jan. 7, 2011, 124 Stat. 4373, provided that:

- “(a) Increased Authorizations.—Not later than 180 days after the date of the enactment of this Act [Oct. 28, 2009], the Secretary of each military department shall increase the number of active duty mental health personnel authorized for the department under the jurisdiction of the Secretary in an amount equal to the sum of the following amounts:
- “(1) The greater of—
 - “(A) the amount identified on personnel authorization documents as required but not authorized to be filled; or
 - “(B) the amount that is 25 percent of the amount identified on personnel authorization documents as authorized.
 - “(2) The amount required to fulfill the requirements of section 708 [10 U.S.C. 1074f note], as determined by the Secretary concerned.
- “(b) Report and Plan on the Required Number of Mental Health Personnel.—
- “(1) In general.—Not later than one year after the date of the enactment of this Act [Oct. 28, 2009], the Secretary of Defense shall submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] a report on the appropriate number of mental health personnel required to meet the mental health care needs of members of the Armed Forces, retired members, and dependents. The report shall include, at a minimum, the following:
 - “(A) An evaluation of the recommendation titled ‘Ensure an Adequate Supply of Uniformed Providers’ made by the Department of Defense Task Force on Mental Health established by section 723 of the National Defense Authorization Act for Fiscal Year 2006 (Public Law 109-163; 119 Stat. 3348).
 - “(B) The criteria and models used to determine the appropriate number of mental health personnel.
 - “(C) The plan under paragraph (2).
 - “(2) Plan.—The Secretary shall develop and implement a plan to significantly increase the number of military and civilian mental health personnel of the Department of Defense by September 30, 2013. The plan may include the following:
 - “(A) The allocation of scholarships and financial assistance under the Health Professions Scholarship and Financial Assistance Program under subchapter I of chapter 105 of title

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10, United States Code, to students pursuing advanced degrees in clinical psychology and other mental health professions.

“(B) The offering of accession and retention bonuses for psychologists pursuant to section 620 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110-417; 122 Stat. 4489) [enacting section 302c-1 of Title 37, Pay and Allowances of the Uniformed Services, and provisions set out as a note under section 335 of Title 37].

“(C) An expansion of the capacity for training doctoral-level clinical psychologists at the Uniformed Services University of the Health Sciences.

“(D) An expansion of the capacity of the Department of Defense for training masters-level clinical psychologists and social workers with expertise in deployment-related mental health disorders, such as post-traumatic stress disorder.

“(E) The detail of commissioned officers of the Armed Forces to accredited schools of psychology for training leading to a doctoral degree in clinical psychology or social work.

“(F) The reassignment of military mental health personnel from administrative positions to clinical positions in support of military units.

“(G) The offering of civilian hiring incentives and bonuses and the use of direct hiring authority to increase the number of mental health personnel of the Department of Defense.

“(H) Such other mechanisms to increase the number of mental health personnel of the Department of Defense as the Secretary considers appropriate.

“(c) Report on Additional Officer or Enlisted Military Specialties for Mental Health.—

“(1) Report.—Not later than 120 days after the date of the enactment of this Act [Oct. 28, 2009], the Secretary shall submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] a report setting forth the assessment of the Secretary of the feasibility and advisability of establishing one or more military mental health specialties for officers or enlisted members of the Armed Forces in order to better meet the mental health care needs of members of the Armed Forces and their families.

“(2) Elements.—The report required by paragraph (1) shall set forth the following:

“(A) A recommendation as to the feasibility and advisability of establishing one or more military mental health specialties for officers or enlisted members of the Armed Forces.

“(B) For each military specialty recommended to be established under subparagraph (A)—

“(i) a description of the qualifications required for such specialty [sic], which shall reflect lessons learned from best practices in academia and the civilian health care industry regarding positions analogous to such specialty; and

“(ii) a description of the incentives or other mechanisms, if any, that would be advisable to facilitate recruitment and retention of individuals to and in such specialty.

Study And Plan To Improve Military Health Care

Pub. L. 111-84, div. A, title VII, Sec. 721, Oct. 28, 2009, 123 Stat. 2385, provided that:

“(a) Study and Report Required.—Not later than one year after the date of the enactment of this Act [Oct. 28, 2009], the Secretary of Defense shall submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House

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of Representatives] a report on the health care needs of dependents (as defined in section 1072(2) of title 10, United States Code). The report shall include, at a minimum, the following:

“(1) With respect to both the direct care system and the purchased care system, an analysis of the type of health care facility in which dependents seek care.

“(2) The 10 most common medical conditions for which dependents seek care.

“(3) The availability of and access to health care providers to treat the conditions identified under paragraph (2), both in the direct care system and the purchased care system.

“(4) Any shortfalls in the ability of dependents to obtain required health care services.

“(5) Recommendations on how to improve access to care for dependents.

“(6) With respect to dependents accompanying a member stationed at a military installation outside of the United States, the need for and availability of mental health care services.

“(b) Enhanced Military Health System and Improved TRICARE.—

“(1) In general.—The Secretary of Defense, in consultation with the other administering Secretaries, shall undertake actions to enhance the capability of the military health system and improve the TRICARE program.

“(2) Elements.—In undertaking actions to enhance the capability of the military health system and improve the TRICARE program under paragraph (1), the Secretary shall consider the following actions:

“(A) Actions to guarantee the availability of care within established access standards for eligible beneficiaries, based on the results of the study required by subsection (a).

“(B) Actions to expand and enhance sharing of health care resources among Federal health care programs, including designated providers (as that term is defined in section 721(5) of the National Defense Authorization Act for Fiscal Year 1997 (Public Law 104-201; 110 Stat. 2593; 10 U.S.C. 1073 note)).

“(C) Actions using medical technology to speed and simplify referrals for specialty care.

“(D) Actions to improve regional or national staffing capabilities in order to enhance support provided to military medical treatment facilities facing staff shortages.

“(E) Actions to improve health care access for members of the reserve components and their families, including such access with respect to mental health care and consideration of access issues for members and their families located in rural areas.

“(F) Actions to ensure consistency throughout the TRICARE program to comply with access standards, which are applicable to both commanders of military treatment facilities and managed care support contractors.

“(G) Actions to create new budgeting and resource allocation methodologies to fully support and incentivize care provided by military treatment facilities.

“(H) Actions regarding additional financing options for health care provided by civilian providers.

“(I) Actions to reduce administrative costs.

“(J) Actions to control the cost of health care and pharmaceuticals.

“(K) Actions to audit the Defense Enrollment Eligibility Reporting System to improve system checks on the eligibility of TRICARE beneficiaries.

“(L) Actions, including a comprehensive plan, for the enhanced availability of prevention and wellness care.

“(M) Actions using technology to improve direct communication with beneficiaries regarding health and preventive care.

“(N) Actions to create performance metrics by which to measure improvement in the TRICARE program.

“(O) Such other actions as the Secretary, in consultation with the other administering Secretaries, considers appropriate.

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“(c) Quality Assurance.—In undertaking actions under this section, the Secretary of Defense and the other administering Secretaries shall continue or enhance the current level of quality health care provided by the Department of Defense and the military departments with no adverse impact to cost, access, or care.

“(d) Consultation.—In considering actions to be undertaken under this section, and in undertaking such actions, the Secretary shall consult with a broad range of national health care and military advocacy organizations.

“(e) Reports Required.—

“(1) Initial report.—Not later than 180 days after the date of the enactment of this Act [Oct. 28, 2009], the Secretary shall submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] an initial report on the progress made in undertaking actions under this section and future plans for improvement of the military health system.

“(2) Report required with fiscal year 2012 budget proposal.—Together with the budget justification materials submitted to Congress in support of the Department of Defense budget for fiscal year 2012 (as submitted with the budget of the President under section 1105(a) of title 31, United States Code), the Secretary shall submit to the congressional defense committees a report setting forth the following:

“(A) Updates on the progress made in undertaking actions under this section.

“(B) Future plans for improvement of the military health system.

“(C) An explanation of how the budget submission may reflect such progress and plans.

“(3) Periodic reports.—The Secretary shall, on a periodic basis, submit to the congressional defense committees a report on the progress being made in the improvement of the TRICARE program under this section.

“(4) Elements.—Each report under this subsection shall include the following:

“(A) A description and assessment of the progress made as of the date of such report in the improvement of the TRICARE program.

“(B) Such recommendations for administrative or legislative action as the Secretary considers appropriate to expedite and enhance the improvement of the TRICARE program.

“(f) Definitions.—In this section:

“(1) The term ‘administering Secretaries’ has the meaning given that term in section 1072(3) of title 10, United States Code.

“(2) The term ‘TRICARE program’ has the meaning given that term in section 1072(7) of title 10, United States Code.”

Program For Health Care Delivery At Military Installations With Projected Growth

Pub. L. 110-417, [div. A], title VII, Sec. 705, Oct. 14, 2008, 122 Stat. 4499, provided that:

“(a) Program.—The Secretary of Defense is authorized to develop a plan to establish a program to build cooperative health care arrangements and agreements between military installations projected to grow and local and regional non-military health care systems.

“(b) Requirements of Plan.—In developing the plan, the Secretary of Defense shall—

“(1) identify and analyze health care delivery options involving the private sector and health care services in military facilities located on military installations;

“(2) develop methods for determining the cost avoidance or savings resulting from innovative partnerships between the Department of Defense and the private sector;

“(3) develop requirements for Department of Defense health care providers to deliver health care in civilian community hospitals; and

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- “(4) collaborate with State and local authorities to create an arrangement to share and exchange, between the Department of Defense and nonmilitary health care systems, personal health information, and data of military personnel and their families.
- “(c) Coordination With Other Entities.—The plan shall include requirements for coordination with Federal, State, and local entities, TRICARE managed care support contractors, and other contracted assets around installations selected for participation in the program.
- “(d) Consultation Requirements.—The Secretary of Defense shall develop the plan in consultation with the Secretaries of the military departments.
- “(e) Selection of Military Installations.—Each selected military installation shall meet the following criteria:
- “(1) The military installation has members of the Armed Forces on active duty and members of reserve components of the Armed Forces that use the installation as a training and operational base, with members routinely deploying in support of the global war on terrorism.
 - “(2) The military population of an installation will significantly increase by 2013 due to actions related to either Grow the Force initiatives or recommendations of the Defense Base Realignment and Closure Commission.
 - “(3) There is a military treatment facility on the installation that has—
 - “(A) no inpatient or trauma center care capabilities; and
 - “(B) no current or planned capacity that would satisfy the proposed increase in military personnel at the installation.
 - “(4) There is a civilian community hospital near the military installation, and the military treatment facility has—
 - “(A) no inpatient services or limited capability to expand inpatient care beds, intensive care, and specialty services; and
 - “(B) limited or no capability to provide trauma care.
- “(f) Reports.—Not later than one year after the date of the enactment of this Act [Oct. 14, 2008], and every year thereafter, the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and House of Representatives an annual report on any plan developed under subsection (a).”

Center Of Excellence In Prevention, Diagnosis, Mitigation, Treatment, And Rehabilitation Of Hearing Loss And Auditory System Injuries

Pub. L. 110-417, [div. A], title VII, Sec. 721, Oct. 14, 2008, 122 Stat. 4506, provided that:

- “(a) In General.—The Secretary of Defense shall establish within the Department of Defense a center of excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of hearing loss and auditory system injury to carry out the responsibilities specified in subsection (c).
- “(b) Partnerships.—The Secretary shall ensure that the center collaborates to the maximum extent practicable with the Secretary of Veterans Affairs, institutions of higher education, and other appropriate public and private entities (including international entities) to carry out the responsibilities specified in subsection (c).
- “(c) Responsibilities.—
- “(1) In general.—The center shall—
 - “(A) implement a comprehensive plan and strategy for the Department of Defense, as developed by the Secretary of Defense, for a registry of information for the tracking of the diagnosis, surgical intervention or other operative procedure, other treatment, and follow up for each case of hearing loss and auditory system injury incurred by a member of the Armed Forces while serving on active duty;

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- “(B) ensure the electronic exchange with the Secretary of Veterans Affairs of information obtained through tracking under subparagraph (A); and
- “(C) enable the Secretary of Veterans Affairs to access the registry and add information pertaining to additional treatments or surgical procedures and eventual hearing outcomes for veterans who were entered into the registry and subsequently received treatment through the Veterans Health Administration.
- “(2) Designation of registry.—The registry under this subsection shall be known as the ‘Hearing Loss and Auditory System Injury Registry’ (hereinafter referred to as the ‘Registry’).
- “(3) Consultation in development.—The center shall develop the Registry in consultation with audiologists, speech and language pathologists, otolaryngologists, and other specialist personnel of the Department of Defense and the audiologists, speech and language pathologists, otolaryngologists, and other specialist personnel of the Department of Veterans Affairs. The mechanisms and procedures of the Registry shall reflect applicable expert research on military and other hearing loss.
- “(4) Mechanisms.—The mechanisms of the Registry for tracking under paragraph (1)(A) shall ensure that each military medical treatment facility or other medical facility shall submit to the center for inclusion in the Registry information on the diagnosis, surgical intervention or other operative procedure, other treatment, and follow up for each case of hearing loss and auditory system injury described in that paragraph as follows (to the extent applicable):
- “(A) Not later than 30 days after surgery or other operative intervention, including a surgery or other operative intervention carried out as a result of a follow-up examination.
- “(B) Not later than 180 days after the hearing loss and auditory system injury is reported or recorded in the medical record.
- “(5) Coordination of care and benefits.—
- “(A) The center shall provide notice to the National Center for Rehabilitative Auditory Research (NCRAR) of the Department of Veterans Affairs and to the auditory system impairment services of the Veterans Health Administration on each member of the Armed Forces described in subparagraph (B) for purposes of ensuring the coordination of the provision of ongoing auditory system rehabilitation benefits and services by the Department of Veterans Affairs after the separation or release of such member from the Armed Forces.
- “(B) A member of the Armed Forces described in this subparagraph is a member of the Armed Forces with significant hearing loss or auditory system injury incurred while serving on active duty, including a member with auditory dysfunction related to traumatic brain injury.
- “(d) Utilization of Registry Information.—The Secretary of Defense and the Secretary of Veterans Affairs shall jointly ensure that information in the Registry is available to appropriate audiologists, speech and language pathologists, otolaryngologists, and other specialist personnel of the Department of Defense and the Department of Veterans Affairs for purposes of encouraging and facilitating the conduct of research, and the development of best practices and clinical education, on hearing loss or auditory system injury incurred by members of the Armed Forces.
- “(e) Inclusion of Records of OIF/OEF Veterans.—The Secretary of Defense shall take appropriate actions to include in the Registry such records of members of the Armed Forces who incurred a hearing loss or auditory system injury while serving on active duty on or after September 11, 2001, but before the establishment of the Registry, as the Secretary considers appropriate for purposes of the Registry.”

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Wounded Warrior Health Care Improvements

Pub. L. 110-181, div. A, title XVI, Secs. 1602, 1603, 1611-1614, 1616, 1618, 1621-1623, 1631, 1635, 1644, 1648, 1651, 1662, 1671, 1672, 1676, Jan. 28, 2008, 122 Stat. 431-443, 447, 450-455, 458, 460, 467, 473, 476, 479, 481, 484, as amended by Pub. L. 110-417, [div. A], title II, Sec. 252, title VII, Secs. 722, 724, title X, Sec. 1061(b)(13), Oct. 14, 2008, 122 Stat. 4400, 4508, 4509, 4613; Pub. L. 111-84, div. A, title VI, Sec. 632(h), Oct. 28, 2009, 123 Stat. 2362; Pub. L. 112-56, title II, Sec. 231, Nov. 21, 2011, 125 Stat. 719; Pub. L. 112-81, div. A, title VI, Sec. 631(f)(4)(B), title VII, Sec. 707, Dec. 31, 2011, 125 Stat. 1465, 1474, Pub. L. 112-239, div. A, title X, Sec. 1076(a)(9), Jan. 2, 2013, 126 Stat. 1948, provided that:

“SEC. 1602. GENERAL DEFINITIONS.

“In this title [see Short Title of 2008 Amendment note above]:

“(1) Appropriate committees of congress.—The term ‘appropriate committees of Congress’ means—

“(A) the Committees on Armed Services, Veterans’ Affairs, and Appropriations of the Senate; and

“(B) the Committees on Armed Services, Veterans’ Affairs, and Appropriations of the House of Representatives.

“(2) Benefits delivery at discharge program.—The term ‘Benefits Delivery at Discharge Program’ means a program administered jointly by the Secretary of Defense and the Secretary of Veterans Affairs to provide information and assistance on available benefits and other transition assistance to members of the Armed Forces who are separating from the Armed Forces, including assistance to obtain any disability benefits for which such members may be eligible.

“(3) Disability evaluation system.—The term ‘Disability Evaluation System’ means the following:

“(A) A system or process of the Department of Defense for evaluating the nature and extent of disabilities affecting members of the Armed Forces that is operated by the Secretaries of the military departments and is comprised of medical evaluation boards, physical evaluation boards, counseling of members, and mechanisms for the final disposition of disability evaluations by appropriate personnel.

“(B) A system or process of the Coast Guard for evaluating the nature and extent of disabilities affecting members of the Coast Guard that is operated by the Secretary of Homeland Security and is similar to the system or process of the Department of Defense described in subparagraph (A).

“(4) Eligible family member.—The term ‘eligible family member’, with respect to a recovering service member, means a family member (as defined in section 481h(b)(3)(B) of title 37, United States Code) who is on invitational travel orders or serving as a non-medical attendee while caring for the recovering service member for more than 45 days during a one-year period.

“(5) Medical care.—The term ‘medical care’ includes mental health care.

“(6) Outpatient status.—The term ‘outpatient status’, with respect to a recovering service member, means the status of a recovering service member assigned to—

“(A) a military medical treatment facility as an outpatient; or

“(B) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

“(7) Recovering service member.—The term ‘recovering service member’ means a member of the Armed Forces, including a member of the National Guard or a Reserve, who is undergoing medical treatment, recuperation, or therapy and is in an outpatient status while recovering from a serious injury or illness related to the member’s military service.

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“(8) Serious injury or illness.—The term ‘serious injury or illness’, in the case of a member of the Armed Forces, means an injury or illness incurred by the member in line of duty on active duty in the Armed Forces that may render the member medically unfit to perform the duties of the member’s office, grade, rank, or rating.

“(9) TRICARE program.—The term ‘TRICARE program’ has the meaning given that term in section 1072(7) of title 10, United States Code. [As amended Pub. L. 110-417, [div. A], title X, Sec. 1061(b)(13), Oct. 14, 2008, 122 Stat. 4613; Pub. L. 111-84, div. A, title VI, Sec. 632(h), Oct. 28, 2009, 123 Stat. 2362.]

“SEC. 1603. CONSIDERATION OF GENDER-SPECIFIC NEEDS OF RECOVERING SERVICE MEMBERS AND VETERANS.

“(a) In General.—In developing and implementing the policy required by section 1611(a), and in otherwise carrying out any other provision of this title [see Short Title of 2008 Amendment note above] or any amendment made by this title, the Secretary of Defense and the Secretary of Veterans Affairs shall take into account and fully address any unique gender-specific needs of recovering service members and veterans under such policy or other provision.

“(b) Reports.—In submitting any report required by this title or an amendment made by this title, the Secretary of Defense and the Secretary of Veterans Affairs shall, to the extent applicable, include a description of the manner in which the matters covered by such report address the unique gender-specific needs of recovering service members and veterans.

“SEC. 1611. COMPREHENSIVE POLICY ON IMPROVEMENTS TO CARE, MANAGEMENT, AND TRANSITION OF RECOVERING SERVICE MEMBERS.

“(a) Comprehensive Policy Required.—

“(1) In general.—Not later than July 1, 2008, the Secretary of Defense and the Secretary of Veterans Affairs shall, to the extent feasible, jointly develop and implement a comprehensive policy on improvements to the care, management, and transition of recovering service members.

“(2) Scope of policy.—The policy shall cover each of the following:

“(A) The care and management of recovering service members.

“(B) The medical evaluation and disability evaluation of recovering service members.

“(C) The return of service members who have recovered to active duty when appropriate.

“(D) The transition of recovering service members from receipt of care and services through the Department of Defense to receipt of care and services through the Department of Veterans Affairs.

“(3) Consultation.—The Secretary of Defense and the Secretary of Veterans Affairs shall develop the policy in consultation with the heads of other appropriate departments and agencies of the Federal Government and with appropriate non-governmental organizations having an expertise in matters relating to the policy.

“(4) Update.—The Secretary of Defense and the Secretary of Veterans Affairs shall jointly update the policy on a periodic basis, but not less often than annually, in order to incorporate in the policy, as appropriate, the following:

“(A) The results of the reviews required under subsections (b) and (c).

“(B) Best practices identified through pilot programs carried out under this title.

“(C) Improvements to matters under the policy otherwise identified and agreed upon by the Secretary of Defense and the Secretary of Veterans Affairs.

“(b) Review of Current Policies and Procedures.—

“(1) Review required.—In developing the policy required by subsection (a), the Secretary of Defense and the Secretary of Veterans Affairs shall, to the extent necessary, jointly and

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separately conduct a review of all policies and procedures of the Department of Defense and the Department of Veterans Affairs that apply to, or shall be covered by, the policy.

“(2) Purpose.—The purpose of the review shall be to identify the most effective and patient-oriented approaches to care and management of recovering service members for purposes of—

“(A) incorporating such approaches into the policy; and

“(B) extending such approaches, where applicable, to the care and management of other injured or ill members of the Armed Forces and veterans.

“(3) Elements.—In conducting the review, the Secretary of Defense and the Secretary of Veterans Affairs shall—

“(A) identify among the policies and procedures described in paragraph (1) best practices in approaches to the care and management of recovering service members;

“(B) identify among such policies and procedures existing and potential shortfalls in the care and management of recovering service members (including care and management of recovering service members on the temporary disability retired list), and determine means of addressing any shortfalls so identified;

“(C) determine potential modifications of such policies and procedures in order to ensure consistency and uniformity, where appropriate, in the application of such policies and procedures—

“(i) among the military departments;

“(ii) among the Veterans Integrated Services Networks (VISNs) of the Department of Veterans Affairs; and

“(iii) between the military departments and the Veterans Integrated Services Networks; and

“(D) develop recommendations for legislative and administrative action necessary to implement the results of the review.

“(4) Deadline for completion.—The review shall be completed not later than 90 days after the date of the enactment of this Act [Jan. 28, 2008].

“(c) Consideration of Existing Findings, Recommendations, and Practices.—In developing the policy required by subsection (a), the Secretary of Defense and the Secretary of Veterans Affairs shall take into account the following:

“(1) The findings and recommendations of applicable studies, reviews, reports, and evaluations that address matters relating to the policy, including, but not limited, to the following:

“(A) The Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center, appointed by the Secretary of Defense.

“(B) The Secretary of Veterans Affairs Task Force on Returning Global War on Terror Heroes, appointed by the President.

“(C) The President’s Commission on Care for America’s Returning Wounded Warriors.

“(D) The Veterans’ Disability Benefits Commission established by title XV of the National Defense Authorization Act for Fiscal Year 2004 (Public Law 108-136; 117 Stat. 1676; 38 U.S.C. 1101 note).

“(E) The President’s Task Force to Improve Health Care Delivery for Our Nation’s Veterans, of March 2003.

“(F) The Report of the Congressional Commission on Service members and Veterans Transition Assistance, of 1999, chaired by Anthony J. Principi.

“(G) The President’s Commission on Veterans’ Pensions, of 1956, chaired by General Omar N. Bradley.

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“(2) The experience and best practices of the Department of Defense and the military departments on matters relating to the policy.

“(3) The experience and best practices of the Department of Veterans Affairs on matters relating to the policy.

“(4) Such other matters as the Secretary of Defense and the Secretary of Veterans Affairs consider appropriate.

“(d) Training and Skills of Health Care Professionals, Recovery Care Coordinators, Medical Care Case Managers, and Non-Medical Care Managers for Recovering Service Members.—

“(1) In general.—The policy required by subsection (a) shall provide for uniform standards among the military departments for the training and skills of health care professionals, recovery care coordinators, medical care case managers, and non-medical care managers for recovering service members under subsection (e) in order to ensure that such personnel are able to—

“(A) detect early warning signs of post-traumatic stress disorder (PTSD), suicidal or homicidal thoughts or behaviors, and other behavioral health concerns among recovering service members; and

“(B) promptly notify appropriate health care professionals following detection of such signs.

“(2) Tracking of notifications.—In providing for uniform standards under paragraph (1), the policy shall include a mechanism or system to track the number of notifications made by recovery care coordinators, medical care case managers, and non-medical care managers to health care professionals under paragraph (1)(A) regarding early warning signs of post-traumatic stress disorder and suicide in recovering service members.

“(e) Services for Recovering Service Members.—The policy required by subsection (a) shall provide for improvements as follows with respect to the care, management, and transition of recovering service members:

“(1) Comprehensive recovery plan for recovering service members.—The policy shall provide for uniform standards and procedures for the development of a comprehensive recovery plan for each recovering service member that covers the full spectrum of care, management, transition, and rehabilitation of the service member during recovery.

“(2) Recovery care coordinators for recovering service members.—

“(A) In general.—The policy shall provide for a uniform program for the assignment to recovering service members of recovery care coordinators having the duties specified in subparagraph (B).

“(B) Duties.—The duties under the program of a recovery care coordinator for a recovering service member shall include, but not be limited to, overseeing and assisting the service member in the service member’s course through the entire spectrum of care, management, transition, and rehabilitation services available from the Federal Government, including services provided by the Department of Defense, the Department of Veterans Affairs, the Department of Labor, and the Social Security Administration.

“(C) Limitation on number of service members managed by coordinators.—The maximum number of recovering service members whose cases may be assigned to a recovery care coordinator under the program at any one time shall be such number as the policy shall specify, except that the Secretary of the military department concerned may waive such limitation with respect to a given coordinator for not more than 120 days in the event of unforeseen circumstances (as specified in the policy).

“(D) Training.—The policy shall specify standard training requirements and curricula for recovery care coordinators under the program, including a requirement for successful

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completion of the training program before a person may assume the duties of such a coordinator.

“(E) Resources.—The policy shall include mechanisms to ensure that recovery care coordinators under the program have the resources necessary to expeditiously carry out the duties of such coordinators under the program.

“(F) Supervision.—The policy shall specify requirements for the appropriate rank or grade, and appropriate occupation, for persons appointed to head and supervise recovery care coordinators.

“(3) Medical care case managers for recovering service members.—

“(A) In general.—The policy shall provide for a uniform program among the military departments for the assignment to recovering service members of medical care case managers having the duties specified in subparagraph (B).

“(B) Duties.—The duties under the program of a medical care case manager for a recovering service member (or the service member’s immediate family or other designee if the service member is incapable of making judgments about personal medical care) shall include, at a minimum, the following:

“(i) Assisting in understanding the service member’s medical status during the care, recovery, and transition of the service member.

“(ii) Assisting in the receipt by the service member of prescribed medical care during the care, recovery, and transition of the service member.

“(iii) Conducting a periodic review of the medical status of the service member, which review shall be conducted, to the extent practicable, in person with the service member, or, whenever the conduct of the review in person is not practicable, with the medical care case manager submitting to the manager’s supervisor a written explanation why the review in person was not practicable (if the Secretary of the military department concerned elects to require such written explanations for purposes of the program).

“(C) Limitation on number of service members managed by managers.—The maximum number of recovering service members whose cases may be assigned to a medical care case manager under the program at any one time shall be such number as the policy shall specify, except that the Secretary of the military department concerned may waive such limitation with respect to a given manager for not more than 120 days in the event of unforeseen circumstances (as specified in the policy).

“(D) Training.—The policy shall specify standard training requirements and curricula for medical care case managers under the program, including a requirement for successful completion of the training program before a person may assume the duties of such a manager.

“(E) Resources.—The policy shall include mechanisms to ensure that medical care case managers under the program have the resources necessary to expeditiously carry out the duties of such managers under the program.

“(F) Supervision at armed forces medical facilities.—The policy shall specify requirements for the appropriate rank or grade, and appropriate occupation, for persons appointed to head and supervise the medical care case managers at each medical facility of the Armed Forces. Persons so appointed may be appointed from the Army Medical Corps, Army Medical Service Corps, Army Nurse Corps, Navy Medical Corps, Navy Medical Service Corps, Navy Nurse Corps, Air Force Medical Service, or other corps or civilian health care professional, as applicable, at the discretion of the Secretary of Defense.

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- “(4) Non-medical care managers for recovering service members.—
- “(A) In general.—The policy shall provide for a uniform program among the military departments for the assignment to recovering service members of non-medical care managers having the duties specified in subparagraph (B).
- “(B) Duties.—The duties under the program of a non-medical care manager for a recovering service member shall include, at a minimum, the following:
- “(i) Communicating with the service member and with the service member’s family or other individuals designated by the service member regarding non-medical matters that arise during the care, recovery, and transition of the service member.
- “(ii) Assisting with oversight of the service member’s welfare and quality of life.
- “(iii) Assisting the service member in resolving problems involving financial, administrative, personnel, transitional, and other matters that arise during the care, recovery, and transition of the service member.
- “(C) Duration of duties.—The policy shall provide that a non-medical care manager shall perform duties under the program for a recovering service member until the service member is returned to active duty or retired or separated from the Armed Forces.
- “(D) Limitation on number of service members managed by managers.—The maximum number of recovering service members whose cases may be assigned to a non-medical care manager under the program at any one time shall be such number as the policy shall specify, except that the Secretary of the military department concerned may waive such limitation with respect to a given manager for not more than 120 days in the event of unforeseen circumstances (as specified in the policy).
- “(E) Training.—The policy shall specify standard training requirements and curricula among the military departments for non-medical care managers under the program, including a requirement for successful completion of the training program before a person may assume the duties of such a manager.
- “(F) Resources.—The policy shall include mechanisms to ensure that non-medical care managers under the program have the resources necessary to expeditiously carry out the duties of such managers under the program.
- “(G) Supervision at armed forces medical facilities.—The policy shall specify requirements for the appropriate rank and occupational speciality for persons appointed to head and supervise the non-medical care managers at each medical facility of the Armed Forces.
- “(5) Access of recovering service members to non-urgent health care from the department of defense or other providers under TRICARE.—
- “(A) In general.—The policy shall provide for appropriate minimum standards for access of recovering service members to non-urgent medical care and other health care services as follows:
- “(i) In medical facilities of the Department of Defense.
- “(ii) Through the TRICARE program.
- “(B) Maximum waiting times for certain care.—The standards for access under subparagraph (A) shall include such standards on maximum waiting times of recovering service members as the policy shall specify for care that includes, but is not limited to, the following:
- “(i) Follow-up care.
- “(ii) Specialty care.
- “(iii) Diagnostic referrals and studies.
- “(iv) Surgery based on a physician’s determination of medical necessity.

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“(C) Waiver by recovering service members.—The policy shall permit any recovering service member to waive a standard for access under this paragraph under such circumstances and conditions as the policy shall specify.

“(6) Assignment of recovering service members to locations of care.—

“(A) In general.—The policy shall provide for uniform guidelines among the military departments for the assignment of recovering service members to a location of care, including guidelines that provide for the assignment of recovering service members, when medically appropriate, to care and residential facilities closest to their duty station or home of record or the location of their designated care giver at the earliest possible time.

“(B) Reassignment from deficient facilities.—The policy shall provide for uniform guidelines and procedures among the military departments for the reassignment of recovering service members from a medical or medical-related support facility determined by the Secretary of Defense to violate the standards required by section 1648 to another appropriate medical or medical-related support facility until the correction of violations of such standards at the medical or medical-related support facility from which such service members are reassigned.

“(7) Transportation and subsistence for recovering service members.—The policy shall provide for uniform standards among the military departments on the availability of appropriate transportation and subsistence for recovering service members to facilitate their obtaining needed medical care and services.

“(8) Work and duty assignments for recovering service members.—The policy shall provide for uniform criteria among the military departments for the assignment of recovering service members to work and duty assignments that are compatible with their medical conditions.

“(9) Access of recovering service members to educational and vocational training and rehabilitation.—The policy shall provide for uniform standards among the military departments on the provision of educational and vocational training and rehabilitation opportunities for recovering service members at the earliest possible point in their recovery.

“(10) Tracking of recovering service members.—The policy shall provide for uniform procedures among the military departments on tracking recovering service members to facilitate—

“(A) locating each recovering service member; and

“(B) tracking medical care appointments of recovering service members to ensure timeliness and compliance of recovering service members with appointments, and other physical and evaluation timelines, and to provide any other information needed to conduct oversight of the care, management, and transition of recovering service members.

“(11) Referrals of recovering service members to other care and services providers.—The policy shall provide for uniform policies, procedures, and criteria among the military departments on the referral of recovering service members to the Department of Veterans Affairs and other private and public entities (including universities and rehabilitation hospitals, centers, and clinics) in order to secure the most appropriate care for recovering service members, which policies, procedures, and criteria shall take into account, but not be limited to, the medical needs of recovering service members and the geographic location of available necessary recovery care services.

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“(f) Services for Families of Recovering Service Members.—The policy required by subsection (a) shall provide for improvements as follows with respect to services for families of recovering service members:

“(1) Support for family members of recovering service members.—The policy shall provide for uniform guidelines among the military departments on the provision by the military departments of support for family members of recovering service members who are not otherwise eligible for care under section 1672 in caring for such service members during their recovery.

“(2) Advice and training for family members of recovering service members.—The policy shall provide for uniform requirements and standards among the military departments on the provision by the military departments of advice and training, as appropriate, to family members of recovering service members with respect to care for such service members during their recovery.

“(3) Measurement of satisfaction of family members of recovering service members with quality of health care services.—The policy shall provide for uniform procedures among the military departments on the measurement of the satisfaction of family members of recovering service members with the quality of health care services provided to such service members during their recovery.

“(4) Job placement services for family members of recovering service members.—The policy shall provide for procedures for application by eligible family members during a one-year period for job placement services otherwise offered by the Department of Defense.

“(g) Outreach to Recovering Service Members and Their Families on Comprehensive Policy.—The policy required by subsection (a) shall include procedures and mechanisms to ensure that recovering service members and their families are fully informed of the policies required by this section, including policies on medical care for recovering service members, on the management and transition of recovering service members, and on the responsibilities of recovering service members and their family members throughout the continuum of care and services for recovering service members under this section.

“(h) Applicability of Comprehensive Policy to Recovering Service Members on Temporary Disability Retired List.—Appropriate elements of the policy required by this section shall apply to recovering service members whose names are placed on the temporary disability retired list in such manner, and subject to such terms and conditions, as the Secretary of Defense shall prescribe in regulations for purposes of this subsection.

“SEC. 1612. MEDICAL EVALUATIONS AND PHYSICAL DISABILITY EVALUATIONS OF RECOVERING SERVICE MEMBERS.

“(a) Medical Evaluations of Recovering Service Members.—

“(1) In general.—Not later than July 1, 2008, the Secretary of Defense shall develop a policy on improvements to the processes, procedures, and standards for the conduct by the military departments of medical evaluations of recovering service members.

“(2) Elements.—The policy on improvements to processes, procedures, and standards required under this subsection shall include and address the following:

“(A) Processes for medical evaluations of recovering service members that—

“(i) apply uniformly throughout the military departments; and

“(ii) apply uniformly with respect to recovering service members who are members of the regular components of the Armed Forces and recovering service members who are members of the National Guard and Reserve.

“(B) Standard criteria and definitions for determining the achievement for recovering service members of the maximum medical benefit from treatment and rehabilitation.

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- “(C) Standard timelines for each of the following:
 - “(i) Determinations of fitness for duty of recovering service members.
 - “(ii) Specialty care consultations for recovering service members.
 - “(iii) Preparation of medical documents for recovering service members.
 - “(iv) Appeals by recovering service members of medical evaluation determinations, including determinations of fitness for duty.
 - “(D) Procedures for ensuring that—
 - “(i) upon request of a recovering service member being considered by a medical evaluation board, a physician or other appropriate health care professional who is independent of the medical evaluation board is assigned to the service member; and
 - “(ii) the physician or other health care professional assigned to a recovering service member under clause (i)—
 - “(I) serves as an independent source for review of the findings and recommendations of the medical evaluation board;
 - “(II) provides the service member with advice and counsel regarding the findings and recommendations of the medical evaluation board; and
 - “(III) advises the service member on whether the findings of the medical evaluation board adequately reflect the complete spectrum of injuries and illness of the service member.
 - “(E) Standards for qualifications and training of medical evaluation board personnel, including physicians, case workers, and physical disability evaluation board liaison officers, in conducting medical evaluations of recovering service members.
 - “(F) Standards for the maximum number of medical evaluation cases of recovering service members that are pending before a medical evaluation board at any one time, and requirements for the establishment of additional medical evaluation boards in the event such number is exceeded.
 - “(G) Standards for information for recovering service members, and their families, on the medical evaluation board process and the rights and responsibilities of recovering service members under that process, including a standard handbook on such information (which handbook shall also be available electronically).
- “(b) Physical Disability Evaluations of Recovering Service Members.—
- “(1) In general.—Not later than July 1, 2008, the Secretary of Defense and the Secretary of Veterans Affairs shall develop a policy on improvements to the processes, procedures, and standards for the conduct of physical disability evaluations of recovering service members by the military departments and by the Department of Veterans Affairs.
 - “(2) Elements.—The policy on improvements to processes, procedures, and standards required under this subsection shall include and address the following:
 - “(A) A clearly-defined process of the Department of Defense and the Department of Veterans Affairs for disability determinations of recovering service members.
 - “(B) To the extent feasible, procedures to eliminate unacceptable discrepancies and improve consistency among disability ratings assigned by the military departments and the Department of Veterans Affairs, particularly in the disability evaluation of recovering service members, which procedures shall be subject to the following requirements and limitations:
 - “(i) Such procedures shall apply uniformly with respect to recovering service members who are members of the regular components of the Armed Forces and recovering service members who are members of the National Guard and Reserve.
 - “(ii) Under such procedures, each Secretary of a military department shall, to the extent feasible, utilize the standard schedule for rating disabilities in use by the

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Department of Veterans Affairs, including any applicable interpretation of such schedule by the United States Court of Appeals for Veterans Claims, in making any determination of disability of a recovering service member, except as otherwise authorized by section 1216a of title 10, United States Code (as added by section 1642 of this Act).

“(C) Uniform timelines among the military departments for appeals of determinations of disability of recovering service members, including timelines for presentation, consideration, and disposition of appeals.

“(D) Uniform standards among the military departments for qualifications and training of physical disability evaluation board personnel, including physical evaluation board liaison personnel, in conducting physical disability evaluations of recovering service members.

“(E) Uniform standards among the military departments for the maximum number of physical disability evaluation cases of recovering service members that are pending before a physical disability evaluation board at any one time, and requirements for the establishment of additional physical disability evaluation boards in the event such number is exceeded.

“(F) Uniform standards and procedures among the military departments for the provision of legal counsel to recovering service members while undergoing evaluation by a physical disability evaluation board.

“(G) Uniform standards among the military departments on the roles and responsibilities of non-medical care managers under section 1611(e)(4) and judge advocates assigned to recovering service members undergoing evaluation by a physical disability board, and uniform standards on the maximum number of cases involving such service members that are to be assigned to judge advocates at any one time.

“(c) Assessment of Consolidation of Department of Defense and Department of Veterans Affairs Disability Evaluation Systems.—

“(1) In general.—The Secretary of Defense and the Secretary of Veterans Affairs shall jointly submit to the appropriate committees of Congress a report on the feasibility [sic] and advisability of consolidating the disability evaluation systems of the military departments and the disability evaluation system of the Department of Veterans Affairs into a single disability evaluation system. The report shall be submitted together with the report required by section 1611(a).

“(2) Elements.—The report required by paragraph (1) shall include the following:

“(A) An assessment of the feasibility [sic] and advisability of consolidating the disability evaluation systems described in paragraph (1) as specified in that paragraph.

“(B) If the consolidation of the systems is considered feasible and advisable—

“(i) recommendations for various options for consolidating the systems as specified in paragraph (1); and

“(ii) recommendations for mechanisms to evaluate and assess any progress made in consolidating the systems as specified in that paragraph.

“SEC. 1613. RETURN OF RECOVERING SERVICE MEMBERS TO ACTIVE DUTY IN THE ARMED FORCES.

“The Secretary of Defense shall establish standards for determinations by the military departments on the return of recovering service members to active duty in the Armed Forces.

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“SEC. 1614. TRANSITION OF RECOVERING SERVICE MEMBERS FROM CARE AND TREATMENT THROUGH THE DEPARTMENT OF DEFENSE TO CARE, TREATMENT, AND REHABILITATION THROUGH THE DEPARTMENT OF VETERANS AFFAIRS.

“(a) In General.—Not later than July 1, 2008, the Secretary of Defense and the Secretary of Veterans Affairs shall jointly develop and implement processes, procedures, and standards for the transition of recovering service members from care and treatment through the Department of Defense to care, treatment, and rehabilitation through the Department of Veterans Affairs.

“(b) Elements.—The processes, procedures, and standards required under this section shall include the following:

“(1) Uniform, patient-focused procedures to ensure that the transition described in subsection (a) occurs without gaps in medical care and in the quality of medical care, benefits, and services.

“(2) Procedures for the identification and tracking of recovering service members during the transition, and for the coordination of care and treatment of recovering service members during the transition, including a system of cooperative case management of recovering service members by the Department of Defense and the Department of Veterans Affairs during the transition.

“(3) Procedures for the notification of Department of Veterans Affairs liaison personnel of the commencement by recovering service members of the medical evaluation process and the physical disability evaluation process.

“(4) Procedures and timelines for the enrollment of recovering service members in applicable enrollment or application systems of the Department of Veterans Affairs with respect to health care, disability, education, vocational rehabilitation, or other benefits.

“(5) Procedures to ensure the access of recovering service members during the transition to vocational, educational, and rehabilitation benefits available through the Department of Veterans Affairs.

“(6) Standards for the optimal location of Department of Defense and Department of Veterans Affairs liaison and case management personnel at military medical treatment facilities, medical centers, and other medical facilities of the Department of Defense.

“(7) Standards and procedures for integrated medical care and management of recovering service members during the transition, including procedures for the assignment of medical personnel of the Department of Veterans Affairs to Department of Defense facilities to participate in the needs assessments of recovering service members before, during, and after their separation from military service.

“(8) Standards for the preparation of detailed plans for the transition of recovering service members from care and treatment by the Department of Defense to care, treatment, and rehabilitation by the Department of Veterans Affairs, which plans shall—

“(A) be based on standardized elements with respect to care and treatment requirements and other applicable requirements; and

“(B) take into account the comprehensive recovery plan for the recovering service member concerned as developed under section 1611(e)(1).

“(9) Procedures to ensure that each recovering service member who is being retired or separated under chapter 61 of title 10, United States Code, receives a written transition plan, prior to the time of retirement or separation, that—

“(A) specifies the recommended schedule and milestones for the transition of the service member from military service;

“(B) provides for a coordinated transition of the service member from the Department of Defense disability evaluation system to the Department of Veterans Affairs disability system; and

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“(C) includes information and guidance designed to assist the service member in understanding and meeting the schedule and milestones specified under subparagraph (A) for the service member’s transition.

“(10) Procedures for the transmittal from the Department of Defense to the Department of Veterans Affairs of records and any other required information on each recovering service member described in paragraph (9), which procedures shall provide for the transmission from the Department of Defense to the Department of Veterans Affairs of records and information on the service member as follows:

“(A) The address and contact information of the service member.

“(B) The DD-214 discharge form of the service member, which shall be transmitted under such procedures electronically.

“(C) A copy of the military service record of the service member, including medical records and any results of a physical evaluation board.

“(D) Information on whether the service member is entitled to transitional health care, a conversion health policy, or other health benefits through the Department of Defense under section 1145 of title 10, United States Code.

“(E) A copy of any request of the service member for assistance in enrolling in, or completed applications for enrollment in, the health care system of the Department of Veterans Affairs for health care benefits for which the service member may be eligible under laws administered by the Secretary of Veterans Affairs.

“(F) A copy of any request by the service member for assistance in applying for, or completed applications for, compensation and vocational rehabilitation benefits to which the service member may be entitled under laws administered by the Secretary of Veterans Affairs.

“(11) A process to ensure that, before transmittal of medical records of a recovering service member to the Department of Veterans Affairs, the Secretary of Defense ensures that the service member (or an individual legally recognized to make medical decisions on behalf of the service member) authorizes the transfer of the medical records of the service member from the Department of Defense to the Department of Veterans Affairs pursuant to the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191, see Tables for classification].

“(12) Procedures to ensure that, with the consent of the recovering service member concerned, the address and contact information of the service member is transmitted to the department or agency for veterans affairs of the State in which the service member intends to reside after the retirement or separation of the service member from the Armed Forces.

“(13) Procedures to ensure that, before the transmittal of records and other information with respect to a recovering service member under this section, a meeting regarding the transmittal of such records and other information occurs among the service member, appropriate family members of the service member, representatives of the Secretary of the military department concerned, and representatives of the Secretary of Veterans Affairs, with at least 30 days advance notice of the meeting being given to the service member unless the service member waives the advance notice requirement in order to accelerate transmission of the service member’s records and other information to the Department of Veterans Affairs.

“(14) Procedures to ensure that the Secretary of Veterans Affairs gives appropriate consideration to a written statement submitted to the Secretary by a recovering service member regarding the transition.

“(15) Procedures to provide access for the Department of Veterans Affairs to the military health records of recovering service members who are receiving care and treatment, or are

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anticipating receipt of care and treatment, in Department of Veterans Affairs health care facilities, which procedures shall be consistent with the procedures and requirements in paragraphs (11) and (13).

“(16) A process for the utilization of a joint separation and evaluation physical examination that meets the requirements of both the Department of Defense and the Department of Veterans Affairs in connection with the medical separation or retirement of a recovering service member from military service and for use by the Department of Veterans Affairs in disability evaluations.

“(17) Procedures for surveys and other mechanisms to measure patient and family satisfaction with the provision by the Department of Defense and the Department of Veterans Affairs of care and services for recovering service members, and to facilitate appropriate oversight by supervisory personnel of the provision of such care and services.

“(18) Procedures to ensure the participation of recovering service members who are members of the National Guard or Reserve in the Benefits Delivery at Discharge Program, including procedures to ensure that, to the maximum extent feasible, services under the Benefits Delivery at Discharge Program are provided to recovering service members at—

“(A) appropriate military installations;

“(B) appropriate armories and military family support centers of the National Guard;

“(C) appropriate military medical care facilities at which members of the Armed Forces are separated or discharged from the Armed Forces; and

“(D) in the case of a member on the temporary disability retired list under section 1202 or 1205 of title 10, United States Code, who is being retired under another provision of such title or is being discharged, at a location reasonably convenient to the member.

“SEC. 1616. ESTABLISHMENT OF A WOUNDED WARRIOR RESOURCE CENTER.

“(a) Establishment.—The Secretary of Defense shall establish a wounded warrior resource center (in this section referred to as the ‘center’) to provide wounded warriors, their families, and their primary caregivers with a single point of contact for assistance with reporting deficiencies in covered military facilities, obtaining health care services, receiving benefits information, receiving legal assistance referral information (where appropriate), receiving other appropriate referral information, and any other difficulties encountered while supporting wounded warriors. The Secretary shall widely disseminate information regarding the existence and availability of the center, including contact information, to members of the Armed Forces and their dependents. In carrying out this subsection, the Secretary may use existing infrastructure and organizations but shall ensure that the center has the ability to separately keep track of calls from wounded warriors.

“(b) Access.—The center shall provide multiple methods of access, including at a minimum an Internet website and a toll-free telephone number (commonly referred to as a ‘hot line’) at which personnel are accessible at all times to receive reports of deficiencies or provide information about covered military facilities, health care services, or military benefits.

“(c) Confidentiality.—

“(1) Notification.—Individuals who seek to provide information through the center under subsection (a) shall be notified, immediately before they provide such information, of their option to elect, at their discretion, to have their identity remain confidential.

“(2) Prohibition on further disclosure.—In the case of information provided through use of the toll-free telephone number by an individual who elects to maintain the confidentiality of his or her identity, any individual who, by necessity, has had access to such information for purposes of investigating or responding to the call as required under subsection (d) may not disclose the identity of the individual who provided the information.

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- “(d) Functions.—The center shall perform the following functions:
- “(1) Call tracking.—The center shall be responsible for documenting receipt of a call, referring the call to the appropriate office within a military department for answer or investigation, and tracking the formulation and notification of the response to the call.
 - “(2) Investigation and response.—The center shall be responsible for ensuring that, not later than 96 hours after a call—
 - “(A) if a report of deficiencies is received in a call—
 - “(i) any deficiencies referred to in the call are investigated;
 - “(ii) if substantiated, a plan of action for remediation of the deficiencies is developed and implemented; and
 - “(iii) if requested, the individual who made the report is notified of the current status of the report; or
 - “(B) if a request for information is received in a call—
 - “(i) the information requested by the caller is provided by the center;
 - “(ii) all requests for information from the call are referred to the appropriate office or offices of a military department for response; and
 - “(iii) the individual who made the report is notified, at a minimum, of the current status of the query.
 - “(3) Final notification.—The center shall be responsible for ensuring that, if requested, the caller is notified when the deficiency has been corrected or when the request for information has been fulfilled to the maximum extent practicable, as determined by the Secretary.
- “(e) Definitions.—In this section:
- “(1) Covered military facility.—The term ‘covered military facility’ has the meaning provided in section 1648(b) of this Act.
 - “(2) Call.—The term ‘call’ means any query or report that is received by the center by means of the toll-free telephone number or other source.
- “(f) Effective Dates.—
- “(1) Toll-free telephone number.—The toll-free telephone number required to be established by subsection (a), shall be fully operational not later than April 1, 2008.
 - “(2) Internet website.—The Internet website required to be established by subsection (a), shall be fully operational not later than July 1, 2008. [As amended Pub. L. 110-417, [div. A], title VII, Sec. 724, Oct. 14, 2008, 122 Stat. 4509.]
- “SEC. 1618. COMPREHENSIVE PLAN ON PREVENTION, DIAGNOSIS, MITIGATION, TREATMENT, AND REHABILITATION OF, AND RESEARCH ON, TRAUMATIC BRAIN INJURY, POST-TRAUMATIC STRESS DISORDER, AND OTHER MENTAL HEALTH CONDITIONS IN MEMBERS OF THE ARMED FORCES.
- “(a) Comprehensive Statement of Policy.—The Secretary of Defense and the Secretary of Veterans Affairs shall direct joint planning among the Department of Defense, the military departments, and the Department of Veterans Affairs for the prevention, diagnosis, mitigation, treatment, and rehabilitation of, and research on, traumatic brain injury, post-traumatic stress disorder, and other mental health conditions in members of the Armed Forces, including planning for the seamless transition of such members from care through the Department of Defense to care through the Department of Veterans Affairs.
 - “(b) Comprehensive Plan Required.—Not later than 180 days after the date of the enactment of this Act [Jan. 28, 2008], the Secretary of Defense shall, in consultation with the Secretary of Veterans Affairs, submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] a comprehensive plan for programs and activities of the Department of Defense to prevent, diagnose, mitigate,

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treat, research, and otherwise respond to traumatic brain injury, post-traumatic stress disorder, and other mental health conditions in members of the Armed Forces, including—

“(1) an assessment of the current capabilities of the Department for the prevention, diagnosis, mitigation, treatment, and rehabilitation of, and research on, traumatic brain injury, post-traumatic stress disorder, and other mental health conditions in members of the Armed Forces;

“(2) the identification of gaps in current capabilities of the Department for the prevention, diagnosis, mitigation, treatment, and rehabilitation of, and research on, traumatic brain injury, post-traumatic stress disorder, and other mental health conditions in members of the Armed Forces; and

“(3) the identification of the resources required for the Department in fiscal years 2009 through 2013 to address the gaps in capabilities identified under paragraph (2).

“(c) Program Required.—One of the programs contained in the comprehensive plan submitted under subsection (b) shall be a Department of Defense program, developed in collaboration with the Department of Veterans Affairs, under which each member of the Armed Forces who incurs a traumatic brain injury or post-traumatic stress disorder during service in the Armed Forces—

“(1) is enrolled in the program; and

“(2) receives treatment and rehabilitation meeting a standard of care such that each individual who qualifies for care under the program shall—

“(A) be provided the highest quality, evidence-based care in facilities that most appropriately meet the specific needs of the individual; and

“(B) be rehabilitated to the fullest extent possible using up-to-date evidence-based medical technology, and physical and medical rehabilitation practices and expertise.

“(d) Provision of Information Required.—The comprehensive plan submitted under subsection (b) shall require the provision of information by the Secretary of Defense to members of the Armed Forces with traumatic brain injury, post-traumatic stress disorder, or other mental health conditions and their families about their options with respect to the following:

“(1) The receipt of medical and mental health care from the Department of Defense and the Department of Veterans Affairs.

“(2) Additional options available to such members for treatment and rehabilitation of traumatic brain injury, post-traumatic stress disorder, and other mental health conditions.

“(3) The options available, including obtaining a second opinion, to such members for a referral to an authorized provider under chapter 55 of title 10, United States Code, as determined under regulations prescribed by the Secretary of Defense.

“(e) Additional Elements of Plan.—The comprehensive plan submitted under subsection (b) shall include comprehensive proposals of the Department on the following:

“(1) Lead agent.—The designation by the Secretary of Defense of a lead agent or executive agent for the Department to coordinate development and implementation of the plan.

“(2) Detection and treatment.—The improvement of methods and mechanisms for the detection and treatment of traumatic brain injury, post-traumatic stress disorder, and other mental health conditions in members of the Armed Forces in the field.

“(3) Reduction of PTSD.—The development of a plan for reducing post traumatic-stress disorder, incorporating evidence-based preventive and early-intervention measures, practices, or procedures that reduce the likelihood that personnel in combat will develop post-traumatic stress disorder or other stress-related conditions (including substance abuse conditions) into—

“(A) basic and pre-deployment training for enlisted members of the Armed Forces, noncommissioned officers, and officers;

“(B) combat theater operations; and

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- “(C) post-deployment service.
- “(4) Research.—Requirements for research on traumatic brain injury, post-traumatic stress disorder, and other mental health conditions including (in particular) research on pharmacological and other approaches to treatment for traumatic brain injury, post-traumatic stress disorder, or other mental health conditions, as applicable, and the allocation of priorities among such research.
- “(5) Diagnostic criteria.—The development, adoption, and deployment of joint Department of Defense-Department of Veterans Affairs evidence-based diagnostic criteria for the detection and evaluation of the range of traumatic brain injury, post-traumatic stress disorder, and other mental health conditions in members of the Armed Forces, which criteria shall be employed uniformly across the military departments in all applicable circumstances, including provision of clinical care and assessment of future deployability of members of the Armed Forces.
- “(6) Assessment.—The development and deployment of evidence- based means of assessing traumatic brain injury, post-traumatic stress disorder, and other mental health conditions in members of the Armed Forces, including a system of pre-deployment and post- deployment screenings of cognitive ability in members for the detection of cognitive impairment.
- “(7) Managing and monitoring.—The development and deployment of effective means of managing and monitoring members of the Armed Forces with traumatic brain injury, post-traumatic stress disorder, or other mental health conditions in the receipt of care for traumatic brain injury, post-traumatic stress disorder, or other mental health conditions, as applicable, including the monitoring and assessment of treatment and outcomes.
- “(8) Education and awareness.—The development and deployment of an education and awareness training initiative designed to reduce the negative stigma associated with traumatic brain injury, post-traumatic stress disorder, and other mental health conditions, and mental health treatment.
- “(9) Education and outreach.—The provision of education and outreach to families of members of the Armed Forces with traumatic brain injury, post-traumatic stress disorder, or other mental health conditions on a range of matters relating to traumatic brain injury, post-traumatic stress disorder, or other mental health conditions, as applicable, including detection, mitigation, and treatment.
- “(10) Recording of blasts.—A requirement that exposure to a blast or blasts be recorded in the records of members of the Armed Forces.
- “(11) Guidelines for blast injuries.—The development of clinical practice guidelines for the diagnosis and treatment of blast injuries in members of the Armed Forces, including, but not limited to, traumatic brain injury.
- “(12) Gender- and ethnic group-specific services and treatment.—The development of requirements, as appropriate, for gender- and ethnic group-specific medical care services and treatment for members of the Armed Forces who experience mental health problems and conditions, including post-traumatic stress disorder, with specific regard to the availability of, access to, and research and development requirements of such needs.
- “(f) Coordination in Development.—The comprehensive plan submitted under subsection (b) shall be developed in coordination with the Secretary of the Army (who was designated by the Secretary of Defense as executive agent for the prevention, mitigation, and treatment of blast injuries under section 256 of the National Defense Authorization Act for Fiscal Year 2006 (Public Law 109-163; 119 Stat. 3181; 10 U.S.C. 1071 note)).

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“SEC. 1621. CENTER OF EXCELLENCE IN THE PREVENTION, DIAGNOSIS, MITIGATION, TREATMENT, AND REHABILITATION OF TRAUMATIC BRAIN INJURY.

“(a) In General.—The Secretary of Defense shall establish within the Department of Defense a center of excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of traumatic brain injury, including mild, moderate, and severe traumatic brain injury, to carry out the responsibilities specified in subsection (c).

“(b) Partnerships.—The Secretary shall ensure that the Center collaborates to the maximum extent practicable with the Department of Veterans Affairs, institutions of higher education, and other appropriate public and private entities (including international entities) to carry out the responsibilities specified in subsection (c).

“(c) Responsibilities.—The Center shall have responsibilities as follows:

“(1) To implement the comprehensive plan and strategy for the Department of Defense, required by section 1618 of this Act, for the prevention, diagnosis, mitigation, treatment, and rehabilitation of traumatic brain injury, including research on gender and ethnic group-specific health needs related to traumatic brain injury.

“(2) To provide for the development, testing, and dissemination within the Department of best practices for the treatment of traumatic brain injury.

“(3) To provide guidance for the mental health system of the Department in determining the mental health and neurological health personnel required to provide quality mental health care for members of the Armed Forces with traumatic brain injury.

“(4) To establish, implement, and oversee a comprehensive program to train mental health and neurological health professionals of the Department in the treatment of traumatic brain injury.

“(5) To facilitate advancements in the study of the short-term and long-term psychological effects of traumatic brain injury.

“(6) To disseminate within the military medical treatment facilities of the Department best practices for training mental health professionals, including neurological health professionals, with respect to traumatic brain injury.

“(7) To conduct basic science and translational research on traumatic brain injury for the purposes of understanding the etiology of traumatic brain injury and developing preventive interventions and new treatments.

“(8) To develop programs and outreach strategies for families of members of the Armed Forces with traumatic brain injury in order to mitigate the negative impacts of traumatic brain injury on such family members and to support the recovery of such members from traumatic brain injury.

“(9) To conduct research on the mental health needs of families of members of the Armed Forces with traumatic brain injury and develop protocols to address any needs identified through such research.

“(10) To conduct longitudinal studies (using imaging technology and other proven research methods) on members of the Armed Forces with traumatic brain injury to identify early signs of Alzheimer’s disease, Parkinson’s disease, or other manifestations of neurodegeneration, as well as epilepsy, in such members, in coordination with the studies authorized by section 721 of the John Warner National Defense Authorization Act for Fiscal Year 2007 (Public Law 109-364; 120 Stat. 2294) [10 U.S.C. 1074 note] and other studies of the Department of Defense and the Department of Veterans Affairs that address the connection between exposure to combat and the development of Alzheimer’s disease, Parkinson’s disease, and other neurodegenerative disorders, as well as epilepsy.

“(11) To develop and oversee a long-term plan to increase the number of mental health and neurological health professionals within the Department in order to facilitate the meeting

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by the Department of the needs of members of the Armed Forces with traumatic brain injury until their transition to care and treatment from the Department of Veterans Affairs.

“(12) To develop a program on comprehensive pain management, including management of acute and chronic pain, to utilize current and develop new treatments for pain, and to identify and disseminate best practices on pain management related to traumatic brain injury.

“(13) Such other responsibilities as the Secretary shall specify.

“SEC. 1622. CENTER OF EXCELLENCE IN PREVENTION, DIAGNOSIS, MITIGATION, TREATMENT, AND REHABILITATION OF POST-TRAUMATIC STRESS DISORDER AND OTHER MENTAL HEALTH CONDITIONS.

“(a) In General.—The Secretary of Defense shall establish within the Department of Defense a center of excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of post-traumatic stress disorder (PTSD) and other mental health conditions, including mild, moderate, and severe post-traumatic stress disorder and other mental health conditions, to carry out the responsibilities specified in subsection (c).

“(b) Partnerships.—The Secretary shall ensure that the center collaborates to the maximum extent practicable with the National Center on Post-Traumatic Stress Disorder of the Department of Veterans Affairs, institutions of higher education, and other appropriate public and private entities (including international entities) to carry out the responsibilities specified in subsection (c).

“(c) Responsibilities.—The center shall have responsibilities as follows:

“(1) To implement the comprehensive plan and strategy for the Department of Defense, required by section 1618 of this Act, for the prevention, diagnosis, mitigation, treatment, and rehabilitation of post-traumatic stress disorder and other mental health conditions, including research on gender- and ethnic group- specific health needs related to post-traumatic stress disorder and other mental health conditions.

“(2) To provide for the development, testing, and dissemination within the Department of best practices for the treatment of post- traumatic stress disorder.

“(3) To provide guidance for the mental health system of the Department in determining the mental health and neurological health personnel required to provide quality mental health care for members of the Armed Forces with post-traumatic stress disorder and other mental health conditions.

“(4) To establish, implement, and oversee a comprehensive program to train mental health and neurological health professionals of the Department in the treatment of post-traumatic stress disorder and other mental health conditions.

“(5) To facilitate advancements in the study of the short-term and long-term psychological effects of post-traumatic stress disorder and other mental health conditions.

“(6) To disseminate within the military medical treatment facilities of the Department best practices for training mental health professionals, including neurological health professionals, with respect to post-traumatic stress disorder and other mental health conditions.

“(7) To conduct basic science and translational research on post-traumatic stress disorder for the purposes of understanding the etiology of post-traumatic stress disorder and developing preventive interventions and new treatments.

“(8) To develop programs and outreach strategies for families of members of the Armed Forces with post-traumatic stress disorder and other mental health conditions in order to mitigate the negative impacts of post-traumatic stress disorder and other mental health conditions on such family members and to support the recovery of such members from post-traumatic stress disorder and other mental health conditions.

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“(9) To conduct research on the mental health needs of families of members of the Armed Forces with post-traumatic stress disorder and other mental health conditions and develop protocols to address any needs identified through such research.

“(10) To develop and oversee a long-term plan to increase the number of mental health and neurological health professionals within the Department in order to facilitate the meeting by the Department of the needs of members of the Armed Forces with post-traumatic stress disorder and other mental health conditions until their transition to care and treatment from the Department of Veterans Affairs.

“SEC. 1623. CENTER OF EXCELLENCE IN PREVENTION, DIAGNOSIS, MITIGATION, TREATMENT, AND REHABILITATION OF MILITARY EYE INJURIES.

“(a) In General.—The Secretary of Defense shall establish within the Department of Defense a center of excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries to carry out the responsibilities specified in subsection (c).

“(b) Partnerships.—The Secretary shall ensure that the center collaborates to the maximum extent practicable with the Secretary of Veterans Affairs, institutions of higher education, and other appropriate public and private entities (including international entities) to carry out the responsibilities specified in subsection (c).

“(c) Responsibilities.—

“(1) In general.—The center shall—

“(A) implement a comprehensive plan and strategy for the Department of Defense, as developed by the Secretary of Defense, for a registry of information for the tracking of the diagnosis, surgical intervention or other operative procedure, other treatment, and follow up for each case of significant eye injury incurred by a member of the Armed Forces while serving on active duty;

“(B) ensure the electronic exchange with the Secretary of Veterans Affairs of information obtained through tracking under subparagraph (A); and

“(C) enable the Secretary of Veterans Affairs to access the registry and add information pertaining to additional treatments or surgical procedures and eventual visual outcomes for veterans who were entered into the registry and subsequently received treatment through the Veterans Health Administration.

“(2) Designation of registry.—The registry under this subsection shall be known as the ‘Military Eye Injury Registry’ (hereinafter referred to as the ‘Registry’).

“(3) Consultation in development.—The center shall develop the Registry in consultation with the ophthalmological specialist personnel and optometric specialist personnel of the Department of Defense and the ophthalmological specialist personnel and optometric specialist personnel of the Department of Veterans Affairs. The mechanisms and procedures of the Registry shall reflect applicable expert research on military and other eye injuries.

“(4) Mechanisms.—The mechanisms of the Registry for tracking under paragraph (1)(A) shall ensure that each military medical treatment facility or other medical facility shall submit to the center for inclusion in the Registry information on the diagnosis, surgical intervention or other operative procedure, other treatment, and follow up for each case of eye injury described in that paragraph as follows (to the extent applicable):

“(A) Not later than 30 days after surgery or other operative intervention, including a surgery or other operative intervention carried out as a result of a follow-up examination.

“(B) Not later than 180 days after the significant eye injury is reported or recorded in the medical record.

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“(5) Coordination of care and benefits.—

“(A) The center shall provide notice to the Blind Rehabilitation Service of the Department of Veterans Affairs and to the eye care services of the Veterans Health Administration on each member of the Armed Forces described in subparagraph (B) for purposes of ensuring the coordination of the provision of ongoing eye care and visual rehabilitation benefits and services by the Department of Veterans Affairs after the separation or release of such member from the Armed Forces.

“(B) A member of the Armed Forces described in this subparagraph is a member of the Armed Forces as follows:

“(i) A member with a significant eye injury incurred while serving on active duty, including a member with visual dysfunction related to traumatic brain injury.

“(ii) A member with an eye injury incurred while serving on active duty who has a visual acuity of 20/200 or less in the injured eye.

“(iii) A member with an eye injury incurred while serving on active duty who has a loss of peripheral vision resulting in 20 degrees or less of visual field in the injured eye.

“(d) Utilization of Registry Information.—The Secretary of Defense and the Secretary of Veterans Affairs shall jointly ensure that information in the Registry is available to appropriate ophthalmological and optometric personnel of the Department of Defense and the Department of Veterans Affairs for purposes of encouraging and facilitating the conduct of research, and the development of best practices and clinical education, on eye injuries incurred by members of the Armed Forces.

“(e) Inclusion of Records of OIF/OEF Veterans.—The Secretary of Defense shall take appropriate actions to include in the Registry such records of members of the Armed Forces who incurred an eye injury while serving on active duty on or after September 11, 2001, but before the establishment of the Registry, as the Secretary considers appropriate for purposes of the Registry.

“(f) Traumatic Brain Injury Post Traumatic Visual Syndrome.—In carrying out the program at Walter Reed Army Medical Center, District of Columbia, on traumatic brain injury post traumatic visual syndrome, the Secretary of Defense and the Department of Veterans Affairs shall jointly provide for the conduct of a cooperative program for members of the Armed Forces and veterans with traumatic brain injury by military medical treatment facilities of the Department of Defense and medical centers of the Department of Veterans Affairs selected for purposes of this subsection for purposes of vision screening, diagnosis, rehabilitative management, and vision research, including research on prevention, on visual dysfunction related to traumatic brain injury. [As amended Pub. L. 110-417, [div. A], title VII, Sec. 722, Oct. 14, 2008, 122 Stat. 4508.]

“SEC. 1631. MEDICAL CARE AND OTHER BENEFITS FOR MEMBERS AND FORMER MEMBERS OF THE ARMED FORCES WITH SEVERE INJURIES OR ILLNESSES.

“(a) Medical and Dental Care for Former Members.—

“(1) In general.—Effective as of the date of the enactment of this Act [Jan. 28, 2008] and subject to regulations prescribed by the Secretary of Defense, the Secretary may authorize that any former member of the Armed Forces with a serious injury or illness may receive the same medical and dental care as a member of the Armed Forces on active duty for medical and dental care not reasonably available to such former member in the Department of Veterans Affairs.

“(2) Sunset.—The Secretary of Defense may not provide medical or dental care to a former member of the Armed Forces under this subsection after December 31, 2012, if the

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Secretary has not provided medical or dental care to the former member under this subsection before that date.

“(b) Rehabilitation and Vocational Benefits.—

“(1) In general.—Effective as of the date of the enactment of this Act [Jan. 28, 2008], a member of the Armed Forces with a severe injury or illness is entitled to such benefits (including rehabilitation and vocational benefits, but not including compensation) from the Secretary of Veterans Affairs to facilitate the recovery and rehabilitation of such member as the Secretary otherwise provides to veterans of the Armed Forces receiving medical care in medical facilities of the Department of Veterans Affairs facilities in order to facilitate the recovery and rehabilitation of such members.

“(2) Sunset.—The Secretary of Veterans Affairs may not provide benefits to a member of the Armed Forces under this subsection after December 31, 2014, if the Secretary has not provided benefits to the member under this subsection before that date.

“(c) Rehabilitative Equipment for Members of the Armed Forces.—

“(1) In general.—Subject to the availability of appropriations for such purpose, the Secretary of Defense may provide an active duty member of the Armed Forces with a severe injury or illness with rehabilitative equipment, including recreational sports equipment that provide an adaption or accommodation for the member, regardless of whether such equipment is intentionally designed to be adaptive equipment.

“(2) Consultation.—In carrying out this subsection, the Secretary of Defense shall consult with the Secretary of Veterans Affairs regarding similar programs carried out by the Secretary of Veterans Affairs.

“SEC. 1635. FULLY INTEROPERABLE ELECTRONIC PERSONAL HEALTH INFORMATION FOR THE DEPARTMENT OF DEFENSE AND DEPARTMENT OF VETERANS AFFAIRS.

“(a) In General.—The Secretary of Defense and the Secretary of Veterans Affairs shall jointly—

“(1) develop and implement electronic health record systems or capabilities that allow for full interoperability of personal health care information between the Department of Defense and the Department of Veterans Affairs; and

“(2) accelerate the exchange of health care information between the Department of Defense and the Department of Veterans Affairs in order to support the delivery of health care by both Departments.

“(b) Department of Defense-Department of Veterans Affairs Interagency Program Office.—

“(1) In general.—There is hereby established an interagency program office of the Department of Defense and the Department of Veterans Affairs (in this section referred to as the ‘Office’) for the purposes described in paragraph (2).

“(2) Purposes.—The purposes of the Office shall be as follows:

“(A) To act as a single point of accountability for the Department of Defense and the Department of Veterans Affairs in the rapid development and implementation of electronic health record systems or capabilities that allow for full interoperability of personal health care information between the Department of Defense and the Department of Veterans Affairs.

“(B) To accelerate the exchange of health care information between the Department of Defense and the Department of Veterans Affairs in order to support the delivery of health care by both Departments.

“(c) Leadership.—

“(1) Director.—The Director of the Office shall be the head of the Office.

“(2) Deputy director.—The Deputy Director of the Office shall be the deputy head of the Office and shall assist the Director in carrying out the duties of the Director.

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“(3) Appointments.—

“(A) The Director shall be appointed by the Secretary of Defense, with the concurrence of the Secretary of Veterans Affairs, from among persons who are qualified to direct the development, acquisition, and integration of major information technology capabilities.

“(B) The Deputy Director shall be appointed by the Secretary of Veterans Affairs, with the concurrence of the Secretary of Defense, from among employees of the Department of Defense and the Department of Veterans Affairs in the Senior Executive Service who are qualified to direct the development, acquisition, and integration of major information technology capabilities.

“(4) Additional guidance.—In addition to the direction, supervision, and control provided by the Secretary of Defense and the Secretary of Veterans Affairs, the Office shall also receive guidance from the Department of Veterans Affairs-Department of Defense Joint Executive Committee under section 320 of title 38, United States Code, in the discharge of the functions of the Office under this section.

“(5) Testimony.—Upon request by any of the appropriate committees of Congress, the Director and the Deputy Director shall testify before such committee regarding the discharge of the functions of the Office under this section.

“(d) Function.—The function of the Office shall be to implement, by not later than September 30, 2009, electronic health record systems or capabilities that allow for full interoperability of personal health care information between the Department of Defense and the Department of Veterans Affairs, which health records shall comply with applicable interoperability standards, implementation specifications, and certification criteria (including for the reporting of quality measures) of the Federal Government.

“(e) Schedules and Benchmarks.—Not later than 30 days after the date of the enactment of this Act [Jan. 28, 2008], the Secretary of Defense and the Secretary of Veterans Affairs shall jointly establish a schedule and benchmarks for the discharge by the Office of its function under this section, including each of the following:

“(1) A schedule for the establishment of the Office.

“(2) A schedule and deadline for the establishment of the requirements for electronic health record systems or capabilities described in subsection (d), including coordination with the Office of the National Coordinator for Health Information Technology in the development of a nationwide interoperable health information technology infrastructure.

“(3) A schedule and associated deadlines for any acquisition and testing required in the implementation of electronic health record systems or capabilities that allow for full interoperability of personal health care information between the Department of Defense and the Department of Veterans Affairs.

“(4) A schedule and associated deadlines and requirements for the implementation of electronic health record systems or capabilities that allow for full interoperability of personal health care information between the Department of Defense and the Department of Veterans Affairs.

“(f) Pilot Projects.—

“(1) Authority.—In order to assist the Office in the discharge of its function under this section, the Secretary of Defense and the Secretary of Veterans Affairs may, acting jointly, carry out one or more pilot projects to assess the feasibility and advisability of various technological approaches to the achievement of the electronic health record systems or capabilities described in subsection (d).

“(2) Sharing of protected health information.—For purposes of each pilot project carried out under this subsection, the Secretary of Defense and the Secretary of Veterans Affairs shall, for purposes of the regulations promulgated under section 264(c) of the Health

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Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191] (42 U.S.C. 1320d-2 note), ensure the effective sharing of protected health information between the health care system of the Department of Defense and the health care system of the Department of Veterans Affairs as needed to provide all health care services and other benefits allowed by law.

“(g) Staff and Other Resources.—

“(1) In general.—The Secretary of Defense and the Secretary of Veterans Affairs shall assign to the Office such personnel and other resources of the Department of Defense and the Department of Veterans Affairs as are required for the discharge of its function under this section.

“(2) Additional services.—Subject to the approval of the Secretary of Defense and the Secretary of Veterans Affairs, the Director may utilize the services of private individuals and entities as consultants to the Office in the discharge of its function under this section. Amounts available to the Office shall be available for payment for such services.

“(h) Annual Reports.—

“(1) In general.—Not later than January 1, 2009, and each year thereafter through 2014, the Director shall submit to the Secretary of Defense and the Secretary of Veterans Affairs, and to the appropriate committees of Congress, a report on the activities of the Office during the preceding calendar year. Each report shall include, for the year covered by such report, the following:

“(A) A detailed description of the activities of the Office, including a detailed description of the amounts expended and the purposes for which expended.

“(B) An assessment of the progress made by the Department of Defense and the Department of Veterans Affairs in the full implementation of electronic health record systems or capabilities described in subsection (d).

“(C) A description and analysis of the level of interoperability and security of technologies for sharing healthcare information among the Department of Defense, the Department of Veterans Affairs, and their transaction partners.

“(D) A description and analysis of the problems the Department of Defense and the Department of Veterans Affairs are having with, and the progress such departments are making toward, ensuring interoperable and secure healthcare information systems and electronic healthcare records.

“(2) Availability to public.—The Secretary of Defense and the Secretary of Veterans Affairs shall make available to the public each report submitted under paragraph (1), including by posting such report on the Internet website of the Department of Defense and the Department of Veterans Affairs, respectively, that is available to the public.

“(i) Comptroller General Assessment of Implementation.—Not later than six months after the date of the enactment of this Act [Jan. 28, 2008] and every six months thereafter until the completion of the implementation of electronic health record systems or capabilities described in subsection (d), the Comptroller General of the United States shall submit to the appropriate committees of Congress a report setting forth the assessment of the Comptroller General of the progress of the Department of Defense and the Department of Veterans Affairs in implementing electronic health record systems or capabilities described in subsection (d).

“(j) Technology-Neutral Guidelines and Standards.—The Director, in consultation with industry and appropriate Federal agencies, shall develop, or shall adopt from industry, technology-neutral information technology infrastructure guidelines and standards for use by the Department of Defense and the Department of Veterans Affairs to enable those departments to effectively select and utilize information technologies to meet the requirements of this section. [As amended Pub. L. 110-417, [div. A], title II, Sec. 252, Oct. 14, 2008, 122 Stat. 4400.]

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“SEC. 1644. AUTHORIZATION OF PILOT PROGRAMS TO IMPROVE THE DISABILITY EVALUATION SYSTEM FOR MEMBERS OF THE ARMED FORCES.

“(a) Pilot Programs.—

“(1) Programs authorized.—For the purposes set forth in subsection (c), the Secretary of Defense may establish and conduct pilot programs with respect to the system of the Department of Defense for the evaluation of the disabilities of members of the Armed Forces who are being separated or retired from the Armed Forces for disability under chapter 61 of title 10, United States Code (in this section referred to as the ‘disability evaluation system’).

“(2) Types of pilot programs.—In carrying out this section, the Secretary of Defense may conduct one or more of the pilot programs described in paragraphs (1) through (3) of subsection (b) or such other pilot programs as the Secretary of Defense considers appropriate.

“(3) Consultation.—In establishing and conducting any pilot program under this section, the Secretary of Defense shall consult with the Secretary of Veterans Affairs.

“(b) Scope of Pilot Programs.—

“(1) Disability determinations by DoD utilizing VA assigned disability rating.—Under one of the pilot programs authorized by subsection (a), for purposes of making a determination of disability of a member of the Armed Forces under section 1201(b) of title 10, United States Code, for the retirement, separation, or placement of the member on the temporary disability retired list under chapter 61 of such title, upon a determination by the Secretary of the military department concerned that the member is unfit to perform the duties of the member’s office, grade, rank, or rating because of a physical disability as described in section 1201(a) of such title—

“(A) the Secretary of Veterans Affairs may—

“(i) conduct an evaluation of the member for physical disability; and

“(ii) assign the member a rating of disability in accordance with the schedule for rating disabilities utilized by the Secretary of Veterans Affairs based on all medical conditions (whether individually or collectively) that render the member unfit for duty; and

“(B) the Secretary of the military department concerned may make the determination of disability regarding the member utilizing the rating of disability assigned under subparagraph (A)(ii).

“(2) Disability determinations utilizing joint DoD/VA assigned disability rating.—Under one of the pilot programs authorized by subsection (a), in making a determination of disability of a member of the Armed Forces under section 1201(b) of title 10, United States Code, for the retirement, separation, or placement of the member on the temporary disability retired list under chapter 61 of such title, the Secretary of the military department concerned may, upon determining that the member is unfit to perform the duties of the member’s office, grade, rank, or rating because of a physical disability as described in section 1201(a) of such title—

“(A) provide for the joint evaluation of the member for disability by the Secretary of the military department concerned and the Secretary of Veterans Affairs, including the assignment of a rating of disability for the member in accordance with the schedule for rating disabilities utilized by the Secretary of Veterans Affairs based on all medical conditions (whether individually or collectively) that render the member unfit for duty; and

“(B) make the determination of disability regarding the member utilizing the rating of disability assigned under subparagraph (A).

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“(3) Electronic clearing house.—Under one of the pilot programs authorized by subsection (a), the Secretary of Defense may establish and operate a single Internet website for the disability evaluation system of the Department of Defense that enables participating members of the Armed Forces to fully utilize such system through the Internet, with such Internet website to include the following:

“(A) The availability of any forms required for the utilization of the disability evaluation system by members of the Armed Forces under the system.

“(B) Secure mechanisms for the submission of such forms by members of the Armed Forces under the system, and for the tracking of the acceptance and review of any forms so submitted.

“(C) Secure mechanisms for advising members of the Armed Forces under the system of any additional information, forms, or other items that are required for the acceptance and review of any forms so submitted.

“(D) The continuous availability of assistance to members of the Armed Forces under the system (including assistance through the caseworkers assigned to such members of the Armed Forces) in submitting and tracking such forms, including assistance in obtaining information, forms, or other items described by subparagraph (C).

“(E) Secure mechanisms to request and receive personnel files or other personnel records of members of the Armed Forces under the system that are required for submission under the disability evaluation system, including the capability to track requests for such files or records and to determine the status of such requests and of responses to such requests.

“(4) Other pilot programs.—The pilot programs authorized by subsection (a) may also provide for the development, evaluation, and identification of such practices and procedures under the disability evaluation system as the Secretary considers appropriate for purposes set forth in subsection (c).

“(c) Purposes.—A pilot program established under subsection (a) may have one or more of the following purposes:

“(1) To provide for the development, evaluation, and identification of revised and improved practices and procedures under the disability evaluation system in order to—

“(A) reduce the processing time under the disability evaluation system of members of the Armed Forces who are likely to be retired or separated for disability, and who have not requested continuation on active duty, including, in particular, members who are severely wounded;

“(B) identify and implement or seek the modification of statutory or administrative policies and requirements applicable to the disability evaluation system that—

“(i) are unnecessary or contrary to applicable best practices of civilian employers and civilian healthcare systems; or

“(ii) otherwise result in hardship, arbitrary, or inconsistent outcomes for members of the Armed Forces, or unwarranted inefficiencies and delays;

“(C) eliminate material variations in policies, interpretations, and overall performance standards among the military departments under the disability evaluation system; and

“(D) determine whether it enhances the capability of the Department of Veterans Affairs to receive and determine claims from members of the Armed Forces for compensation, pension, hospitalization, or other veterans benefits.

“(2) In conjunction with the findings and recommendations of applicable Presidential and Department of Defense study groups, to provide for the eventual development of revised and improved practices and procedures for the disability evaluation system in order to achieve the objectives set forth in paragraph (1).

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“(d) Utilization of Results in Updates of Comprehensive Policy on Care, Management, and Transition of Recovering Service Members.—The Secretary of Defense and the Secretary of Veterans Affairs, acting jointly, may incorporate responses to any findings and recommendations arising under the pilot programs conducted under subsection (a) in updating the comprehensive policy on the care and management of covered service members under section 1611(a)(4).

“(e) Construction With Other Authorities.—

“(1) In general.—Subject to paragraph (2), in carrying out a pilot program under subsection (a)—

“(A) the rules and regulations of the Department of Defense and the Department of Veterans Affairs relating to methods of determining fitness or unfitness for duty and disability ratings for members of the Armed Forces shall apply to the pilot program only to the extent provided in the report on the pilot program under subsection (g)(1); and
“(B) the Secretary of Defense and the Secretary of Veterans Affairs may waive any provision of title 10, 37, or 38, United States Code, relating to methods of determining fitness or unfitness for duty and disability ratings for members of the Armed Forces if the Secretaries determine in writing that the application of such provision would be inconsistent with the purpose of the pilot program.

“(2) Limitation.—Nothing in paragraph (1) shall be construed to authorize the waiver of any provision of section 1216a of title 10, United States Code, as added by section 1642 of this Act.

“(f) Duration.—Each pilot program conducted under subsection (a) shall be completed not later than one year after the date of the commencement of such pilot program under that subsection.

“(g) Reports.—

“(1) Initial report.—Not later than 90 days after the date of the enactment of this Act [Jan. 28, 2008], the Secretary of Defense shall submit to the appropriate committees of Congress a report on each pilot program that has been commenced as of that date under subsection (a). The report shall include—

“(A) a description of the scope and objectives of the pilot program;

“(B) a description of the methodology to be used under the pilot program to ensure rapid identification under such pilot program of revised or improved practices under the disability evaluation system in order to achieve the objectives set forth in subsection (c)(1); and

“(C) a statement of any provision described in subsection (e)(1)(B) that will not apply to the pilot program by reason of a waiver under that subsection.

“(2) Interim report.—Not later than 180 days after the date of the submittal of the report required by paragraph (1) with respect to a pilot program, the Secretary shall submit to the appropriate committees of Congress a report describing the current status of the pilot program.

“(3) Final report.—Not later than 90 days after the completion of all of the pilot programs conducted under subsection (a), the Secretary shall submit to the appropriate committees of Congress a report setting forth a final evaluation and assessment of the pilot programs. The report shall include such recommendations for legislative or administrative action as the Secretary considers appropriate in light of such pilot programs.

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“SEC. 1648. STANDARDS FOR MILITARY MEDICAL TREATMENT FACILITIES, SPECIALTY MEDICAL CARE FACILITIES, AND MILITARY QUARTERS HOUSING PATIENTS AND ANNUAL REPORT ON SUCH FACILITIES.

“(a) Establishment of Standards.—The Secretary of Defense shall establish for the military facilities of the Department of Defense and the military departments referred to in subsection (b) standards with respect to the matters set forth in subsection (c). To the maximum extent practicable, the standards shall—

“(1) be uniform and consistent for all such facilities; and

“(2) be uniform and consistent throughout the Department of Defense and the military departments.

“(b) Covered Military Facilities.—The military facilities covered by this section are the following:

“(1) Military medical treatment facilities.

“(2) Specialty medical care facilities.

“(3) Military quarters or leased housing for patients.

“(c) Scope of Standards.—The standards required by subsection (a) shall include the following:

“(1) Generally accepted standards for the accreditation of medical facilities, or for facilities used to quarter individuals that may require medical supervision, as applicable, in the United States.

“(2) To the extent not inconsistent with the standards described in paragraph (1), minimally acceptable conditions for the following:

“(A) Appearance and maintenance of facilities generally, including the structure and roofs of facilities.

“(B) Size, appearance, and maintenance of rooms housing or utilized by patients, including furniture and amenities in such rooms.

“(C) Operation and maintenance of primary and back-up facility utility systems and other systems required for patient care, including electrical systems, plumbing systems, heating, ventilation, and air conditioning systems, communications systems, fire protection systems, energy management systems, and other systems required for patient care.

“(D) Compliance of facilities, rooms, and grounds, to the maximum extent practicable, with the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.).

“(E) Such other matters relating to the appearance, size, operation, and maintenance of facilities and rooms as the Secretary considers appropriate.

“(d) Compliance With Standards.—

“(1) Deadline.—In establishing standards under subsection (a), the Secretary shall specify a deadline for compliance with such standards by each facility referred to in subsection (b). The deadline shall be at the earliest date practicable after the date of the enactment of this Act [Jan. 28, 2008], and shall, to the maximum extent practicable, be uniform across the facilities referred to in subsection (b).

“(2) Investment.—In carrying out this section, the Secretary shall also establish guidelines for investment to be utilized by the Department of Defense and the military departments in determining the allocation of financial resources to facilities referred to in subsection (b) in order to meet the deadline specified under paragraph (1).

“(e) Report on Development and Implementation of Standards.—

“(1) In general.—Not later than March 1, 2008, the Secretary shall submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] a report on the actions taken to carry out subsection (a).

“(2) Elements.—The report under paragraph (1) shall include the following:

“(A) The standards established under subsection (a).

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- “(B) An assessment of the appearance, condition, and maintenance of each facility referred to in subsection (b), including—
- “(i) an assessment of the compliance of the facility with the standards established under subsection (a); and
 - “(ii) a description of any deficiency or noncompliance in each facility with the standards.
- “(C) A description of the investment to be allocated to address each deficiency or noncompliance identified under subparagraph (B)(ii).

“(f) Annual Report.—Not later than the date on which the President submits the budget for a fiscal year to Congress pursuant to section 1105 of title 31, United States Code, the Secretary shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the adequacy, suitability, and quality of each facility referred to in subsection (b). The Secretary shall include in each report information regarding—

- “(1) any deficiencies in the adequacy, quality, or state of repair of medical-related support facilities raised as a result of information received during the period covered by the report through the toll-free hot line required by section 1616; and
- “(2) the investigations conducted and plans of action prepared under such section to respond to such deficiencies.

“SEC. 1651. HANDBOOK FOR MEMBERS OF THE ARMED FORCES ON COMPENSATION AND BENEFITS AVAILABLE FOR SERIOUS INJURIES AND ILLNESSES.

“(a) Information on Available Compensation and Benefits.—Not later than October 1, 2008, the Secretary of Defense shall develop and maintain, in handbook and electronic form, a comprehensive description of the compensation and other benefits to which a member of the Armed Forces, and the family of such member, would be entitled upon the separation or retirement of the member from the Armed Forces as a result of a serious injury or illness. The handbook shall set forth the range of such compensation and benefits based on grade, length of service, degree of disability at separation or retirement, and such other factors affecting such compensation and benefits as the Secretary considers appropriate.

“(b) Consultation.—The Secretary of Defense shall develop and maintain the comprehensive description required by subsection (a), including the handbook and electronic form of the description, in consultation with the Secretary of Veterans Affairs, the Secretary of Health and Human Services, and the Commissioner of Social Security.

“(c) Update.—The Secretary of Defense shall update the comprehensive description required by subsection (a), including the handbook and electronic form of the description, on a periodic basis, but not less often than annually.

“(d) Provision to Members.—The Secretary of the military department concerned shall provide the descriptive handbook under subsection (a) to each member of the Armed Forces described in that subsection as soon as practicable following the injury or illness qualifying the member for coverage under such subsection.

“(e) Provision to Representatives.—If a member is incapacitated or otherwise unable to receive the descriptive handbook to be provided under subsection (a), the handbook shall be provided to the next of kin or a legal representative of the member, as determined in accordance with regulations prescribed by the Secretary of the military department concerned for purposes of this section.

“SEC. 1662. ACCESS OF RECOVERING SERVICE MEMBERS TO ADEQUATE OUTPATIENT RESIDENTIAL FACILITIES.

“(a) Required Inspections of Facilities.—All quarters of the United States and housing facilities under the jurisdiction of the Armed Forces that are occupied by recovering service members

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shall be inspected on a semiannual basis for the first two years after the enactment of this Act [Jan. 28, 2008] and annually thereafter by the inspectors general of the regional medical commands.

“(b) Inspector General Reports.—The inspector general for each regional medical command shall—

“(1) submit a report on each inspection of a facility conducted under subsection (a) to the post commander at such facility, the commanding officer of the hospital affiliated with such facility, the surgeon general of the military department that operates such hospital, the Secretary of the military department concerned, the Assistant Secretary of Defense for Health Affairs, and the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives]; and

“(2) post each such report on the Internet website of such regional medical command.

“SEC. 1671. PROHIBITION ON TRANSFER OF RESOURCES FROM MEDICAL CARE.

“Neither the Secretary of Defense nor the Secretaries of the military departments may transfer funds or personnel from medical care functions to administrative functions within the Department of Defense in order to comply with the new administrative requirements imposed by this title [see Short Title of 2008 Amendment note above] or the amendments made by this title.

“SEC. 1672. MEDICAL CARE FOR FAMILIES OF MEMBERS OF THE ARMED FORCES RECOVERING FROM SERIOUS INJURIES OR ILLNESSES.

“(a) Medical Care at Military Medical Facilities.—

“(1) Medical care.—A family member of a recovering service member who is not otherwise eligible for medical care at a military medical treatment facility may be eligible for such care at such facilities, on a space-available basis, if the family member is—

“(A) on invitational orders while caring for the service member;

“(B) a non-medical attendee caring for the service member; or

“(C) receiving per diem payments from the Department of Defense while caring for the service member.

“(2) Specification of family members.—The Secretary of Defense may prescribe in regulations the family members of recovering service members who shall be considered to be a family member of a service member for purposes of this subsection.

“(3) Specification of care.—The Secretary of Defense shall prescribe in regulations the medical care that may be available to family members under this subsection at military medical treatment facilities.

“(4) Recovery of costs.—The United States may recover the costs of the provision of medical care under this subsection as follows (as applicable):

“(A) From third-party payers, in the same manner as the United States may collect costs of the charges of health care provided to covered beneficiaries from third-party payers under section 1095 of title 10, United States Code.

“(B) As if such care was provided under the authority of section 1784 of title 38, United States Code.

“(b) Medical Care at Department of Veterans Affairs Medical Facilities.—

“(1) Medical care.—When a recovering service member is receiving hospital care and medical services at a medical facility of the Department of Veterans Affairs, the Secretary of Veterans Affairs may provide medical care for eligible family members under this section when that care is readily available at that Department facility and on a space-available basis.

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“(2) Regulations.—The Secretary of Veterans Affairs shall prescribe in regulations the medical care that may be available to family members under this subsection at medical facilities of the Department of Veterans Affairs.

“SEC. 1676. MORATORIUM ON CONVERSION TO CONTRACTOR PERFORMANCE OF DEPARTMENT OF DEFENSE FUNCTIONS AT MILITARY MEDICAL FACILITIES.

“(a) Moratorium.—No study or competition may be begun or announced pursuant to section 2461 of title 10, United States Code, or otherwise pursuant to Office of Management and Budget circular A-76, relating to the possible conversion to performance by a contractor of any Department of Defense function carried out at a military medical facility until the Secretary of Defense—

“(1) submits the certification required by subsection (b) to the Committee on Armed Services of the Senate and the Committee on Armed Services of the House of Representatives together with a description of the steps taken by the Secretary in accordance with the certification; and

“(2) submits the report required by subsection (c).

“(b) Certification.—The certification referred to in paragraph (a)(1) is a certification that the Secretary has taken appropriate steps to ensure that neither the quality of military medical care nor the availability of qualified personnel to carry out Department of Defense functions related to military medical care will be adversely affected by either—

“(1) the process of considering a Department of Defense function carried out at a military medical facility for possible conversion to performance by a contractor; or

“(2) the conversion of such a function to performance by a contractor.

“(c) Report Required.—Not later than 180 days after the date of the enactment of this Act [Jan. 28, 2008], the Secretary of Defense shall submit to the Committee on Armed Services of the Senate and the Committee on Armed Services of the House of Representatives a report on the public-private competitions being conducted for Department of Defense functions carried out at military medical facilities as of the date of the enactment of this Act by each military department and defense agency. Such report shall include—

“(1) for each such competition—

“(A) the cost of conducting the public-private competition;

“(B) the number of military personnel and civilian employees of the Department of Defense affected;

“(C) the estimated savings identified and the savings actually achieved;

“(D) an evaluation whether the anticipated and budgeted savings can be achieved through a public-private competition; and

“(E) the effect of converting the performance of the function to performance by a contractor on the quality of the performance of the function; and

“(2) an assessment of whether any method of business reform or reengineering other than a public-private competition could, if implemented in the future, achieve any anticipated or budgeted savings.”

Disease And Chronic Care Management

Pub. L. 109-364, div. A, title VII, Sec. 734, Oct. 17, 2006, 120 Stat. 2299, provided that:

“(a) Program Design and Development Required.—Not later than October 1, 2007, the Secretary of Defense shall design and develop a fully integrated program on disease and chronic care management for the military health care system that provides, to the extent practicable, uniform policies and practices on disease management and chronic care management throughout that system, including both military hospitals and clinics and civilian healthcare providers within the TRICARE network.

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“(b) Purposes of Program.—The purposes of the program required by subsection (a) are as follows:

“(1) To facilitate the improvement of the health status of individuals under care in the military health care system.

“(2) To ensure the availability of effective health care services in that system for individuals with diseases and other chronic conditions.

“(3) To ensure the proper allocation of health care resources for individuals who need care for disease or other chronic conditions.

“(c) Elements of Program Design.—The program design required by subsection (a) shall meet the following requirements:

“(1) Based on uniform policies prescribed by the Secretary, the program shall, at a minimum, address the following chronic diseases and conditions:

“(A) Diabetes.

“(B) Cancer.

“(C) Heart disease.

“(D) Asthma.

“(E) Chronic obstructive pulmonary disorder.

“(F) Depression and anxiety disorders.

“(2) The program shall meet nationally recognized accreditation standards for disease and chronic care management.

“(3) The program shall include specific outcome measures and objectives on disease and chronic care management.

“(4) The program shall include strategies for disease and chronic care management for all beneficiaries, including beneficiaries eligible for benefits under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), for whom the TRICARE program is not the primary payer for health care benefits.

“(5) Activities under the program shall conform to applicable laws and regulations relating to the confidentiality of health care information.

“(d) Implementation Plan Required.—Not later than February 1, 2008, the Secretary of Defense, in coordination with the Secretaries of the military departments, shall develop an implementation plan for the disease and chronic care management program. In order to facilitate the carrying out of the program, the plan developed by the Secretary shall—

“(1) require a comprehensive analysis of the disease and chronic care management opportunities within each region of the TRICARE program, including within military treatment facilities and through contractors under the TRICARE program;

“(2) ensure continuous, adequate funding of disease and chronic care management activities throughout the military health care system in order to achieve maximum health outcomes and cost avoidance;

“(3) eliminate, to the extent practicable, any financial disincentives to sustained investment by military hospitals and health care services contractors of the Department of Defense in the disease and chronic care management activities of the Department;

“(4) ensure that appropriate clinical and claims data, including pharmacy utilization data, is available for use in implementing the program;

“(5) ensure outreach to eligible beneficiaries who, on the basis of their clinical conditions, are candidates for the program utilizing print and electronic media, telephone, and personal interaction; and

“(6) provide a system for monitoring improvements in health status and clinical outcomes under the program and savings associated with the program.

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“(e) Report.—

“(1) In general.—Not later than March 1, 2008, the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the design, development, and implementation of the program on disease and chronic care management required by this section.

“(2) Report elements.—The report required by paragraph (1) shall include the following:

“(A) A description of the design and development of the program required by subsection (a).

“(B) A description of the implementation plan required by subsection (d).

“(C) A description and assessment of improvements in health status and clinical outcomes that are anticipated as a result of implementation of the program.

“(D) A description of the savings and return on investment associated with the program.

“(E) A description of an investment strategy to assure the sustainment of the disease and chronic care management programs of the Department of Defense.”

Prevention, Mitigation, And Treatment Of Blast Injuries

Pub. L. 109-163, div. A, title II, Sec. 256, Jan. 6, 2006, 119 Stat. 3181, as amended by Pub. L. 112-239, div. A, title X, Sec. 1076(c)(2)(C), Jan. 2, 2013, 126 Stat. 1950, provided that:

“(a) Designation of Executive Agent.—The Secretary of Defense shall designate an executive agent to be responsible for coordinating and managing the medical research efforts and programs of the Department of Defense relating to the prevention, mitigation, and treatment of blast injuries.

“(b) General Responsibilities.—The executive agent designated under subsection (a) shall be responsible for—

“(1) planning for the medical research and development projects, diagnostic and field treatment programs, and patient tracking and monitoring activities within the Department that relate to combat blast injuries;

“(2) efficient execution of such projects, programs, and activities;

“(3) enabling the sharing of blast injury health hazards and survivability data collected through such projects, programs, and activities with the programs of the Department of Defense;

“(4) working with the Assistant Secretary of Defense for Research and Engineering and the Secretaries of the military departments to ensure resources are adequate to also meet non-medical requirements related to blast injury prevention, mitigation, and treatment; and

“(5) ensuring that a joint combat trauma registry is established and maintained for the purposes of collection and analysis of contemporary combat casualties, including casualties with traumatic brain injury.

“(c) Medical Research Efforts.—

“(1) In general.—The executive agent designated under subsection (a) shall review and assess the adequacy of medical research efforts of the Department of Defense as of the date of the enactment of this Act [Jan. 6, 2006] relating to the following:

“(A) The characterization of blast effects leading to injury, including the injury potential of blasts in various environments.

“(B) Medical technologies and protocols to more accurately detect and diagnose blast injuries, including improved discrimination between traumatic brain injuries and mental health disorders.

“(C) Enhanced treatment of blast injuries in the field.

“(D) Integrated treatment approaches for members of the Armed Forces who have a combination of traumatic brain injuries and mental health disorders or other injuries.

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- “(E) Such other blast injury matters as the executive agent considers appropriate.
- “(2) Requirements for research efforts.—Based on the assessment under paragraph (1), the executive agent shall establish requirements for medical research efforts described in that paragraph in order to enhance and accelerate those research efforts.
- “(3) Oversight of research efforts.—The executive agent shall establish, coordinate, and oversee Department-wide medical research efforts relating to the prevention, mitigation, and treatment of blast injuries, as necessary, to fulfill requirements established under paragraph (2).
- “(d) Other Related Research Efforts.—The Assistant Secretary of Defense for Research and Engineering, in coordination with the executive agent designated under subsection (a) and the Director of the Joint IED Defeat Task Force, shall—
- “(1) review and assess the adequacy of current research efforts of the Department on the prevention and mitigation of blast injuries;
- “(2) based on subsection (c)(1), establish requirements for further research; and
- “(3) address any deficiencies identified in paragraphs (1) and (2) by establishing, coordinating, and overseeing Department-wide research and development initiatives on the prevention and mitigation of blast injuries, including explosive detection and defeat and personnel and vehicle blast protection.
- “(e) Studies.—The executive agent designated under subsection (a) shall conduct studies on the prevention, mitigation, and treatment of blast injuries, including—
- “(1) studies to improve the clinical evaluation and treatment approach for blast injuries, with an emphasis on traumatic brain injuries and other consequences of blast injury, including acoustic and eye injuries and injuries resulting from over-pressure wave;
- “(2) studies on the incidence of traumatic brain injuries attributable to blast injury in soldiers returning from combat;
- “(3) studies to develop protocols for medical tracking of members of the Armed Forces for up to five years following blast injuries; and
- “(4) studies to refine and improve educational interventions for blast injury survivors and their families.
- “(f) Training.—The executive agent designated under subsection (a), in coordination with the Director of the Joint IED Defeat Task Force, shall develop training protocols for medical and non-medical personnel on the prevention, mitigation, and treatment of blast injuries. Those protocols shall be intended to improve field and clinical training on early identification of blast injury consequences, both seen and unseen, including traumatic brain injuries, acoustic injuries, and internal injuries.
- “(g) Information Sharing.—The executive agent designated under subsection (a) shall make available the results of relevant medical research and development projects and studies to—
- “(1) Department of Defense programs focused on—
- “(A) promoting the exchange of blast health hazards data with blast characterization data and blast modeling and simulation tools; and
- “(B) encouraging the incorporation of blast hazards data into design and operational features of blast detection, mitigation, and defeat capabilities, such as comprehensive armor systems which provide blast, ballistic, and fire protection for the head, neck, ears, eyes, torso, and extremities; and
- “(2) traumatic brain injury treatment programs to enhance the evaluation and care of members of the Armed Forces with traumatic brain injuries in medical facilities in the United States and in deployed medical facilities, including those outside the Department of Defense.

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“(h) Reports on Blast Injury Matters.—

“(1) Reports required.—Not later than 270 days after the date of the enactment of this Act [Jan. 6, 2006], and annually thereafter through 2008, the Secretary of Defense shall submit to the Committee on Armed Services of the Senate and the Committee on Armed Services of the House of Representatives a report on the efforts and programs of the Department of Defense relating to the prevention, mitigation, and treatment of blast injuries.

“(2) Elements.—Each report under paragraph (1) shall include the following:

“(A) A description of the activities undertaken under this section during the two years preceding the report to improve the prevention, mitigation, and treatment of blast injuries.

“(B) A consolidated budget presentation for Department of Defense biomedical research efforts and studies related to blast injury for the two fiscal years following the year of the report.

“(C) A description of any gaps in the capabilities of the Department and any plans to address such gaps within biomedical research related to blast injury, blast injury diagnostic and treatment programs, and blast injury tracking and monitoring activities.

“(D) A description of collaboration, if any, with other departments and agencies of the Federal Government, and with other countries, during the two years preceding the report in efforts for the prevention, mitigation, and treatment of blast injuries.

“(E) A description of any efforts during the two years preceding the report to disseminate findings on the diagnosis and treatment of blast injuries through civilian and military research and medical communities.

“(F) A description of the status of efforts during the two years preceding the report to incorporate blast injury effects data into appropriate programs of the Department of Defense and into the development of comprehensive force protection systems that are effective in confronting blast, ballistic, and fire threats.

“(i) Deadline for Designation of Executive Agent.—The Secretary shall make the designation required by subsection (a) not later than 90 days after the date of the enactment of this Act [Jan. 6, 2006].

“(j) Blast Injuries Defined.—In this section, the term ‘blast injuries’ means injuries that occur as the result of the detonation of high explosives, including vehicle-borne and person-borne explosive devices, rocket-propelled grenades, and improvised explosive devices.

“(k) Executive Agent Defined.—In this section, the term ‘executive agent’ has the meaning provided such term in Department of Defense Directive 5101.1.”

Access To Health Care Services For Beneficiaries Eligible For TRICARE And Department Of Veterans Affairs Health Care

Pub. L. 107-314, div. A, title VII, Sec. 708, Dec. 2, 2002, 116 Stat. 2585, provided that:

“(a) Requirement To Establish Process.—(1) The Secretary of Defense shall prescribe in regulations a process for resolving issues relating to patient safety and continuity of care for covered beneficiaries who are concurrently entitled to health care under the TRICARE program and eligible for health care services provided by the Department of Veterans Affairs. The Secretary shall—

“(A) ensure that the process provides for coordination of, and access to, health care from the two sources in a manner that prevents diminution of access to health care from either source; and

“(B) in consultation with the Secretary of Veterans Affairs, prescribe a clear definition of an ‘episode of care’ for use in the resolution of patient safety and continuity of care issues under such process.

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“(2) Not later than May 1, 2003, the Secretary shall submit to the Committees on Armed Services of the Senate and of the House of Representatives a report describing the process prescribed under paragraph (1).

“(3) While prescribing the process under paragraph (1) and upon completion of the report under paragraph (2), the Secretary shall provide to the Comptroller General information that would be relevant in carrying out the study required by subsection (b).

“(b) Comptroller General Study and Report.—(1) The Comptroller General shall conduct a study of the health care issues of covered beneficiaries described in subsection (a). The study shall include the following:

“(A) An analysis of whether covered beneficiaries who seek services through the Department of Veterans Affairs are receiving needed health care services in a timely manner from the Department of Veterans Affairs, as compared to the timeliness of the care available to covered beneficiaries under TRICARE Prime (as set forth in access to care standards under TRICARE program policy that are applicable to the care being sought).

“(B) An evaluation of the quality of care for covered beneficiaries who do not receive needed services from the Department of Veterans Affairs within a time period that is comparable to the time period provided for under such access to care standards and who then must seek alternative care under the TRICARE program.

“(C) Recommendations to improve access to, and timeliness and quality of, care for covered beneficiaries described in subsection (a).

“(D) An evaluation of the feasibility and advisability of making access to care standards applicable jointly under the TRICARE program and the Department of Veterans Affairs health care system.

“(E) A review of the process prescribed by the Secretary of Defense under subsection (a) to determine whether the process ensures the adequacy and quality of the health care services provided to covered beneficiaries under the TRICARE program and through the Department of Veterans Affairs, together with timeliness of access to such services and patient safety.

“(2) Not later than 60 days after the congressional committees specified in subsection (a)(2) receive the report required under that subsection, the Comptroller General shall submit to those committees a report on the study conducted under this subsection.

“(c) Definitions.—In this section:

“(1) The term ‘covered beneficiary’ has the meaning provided by section 1072(5) of title 10, United States Code.

“(2) The term ‘TRICARE program’ has the meaning provided by section 1072(7) of such title.

“(3) The term ‘TRICARE Prime’ has the meaning provided by section 1097a(f) of such title.”

Pilot Program Providing For Department Of Veterans Affairs Support In The Performance Of Separation Physical Examinations

Pub. L. 107-107, div. A, title VII, Sec. 734, Dec. 28, 2001, 115 Stat. 1170, authorized the Secretary of Defense and the Secretary of Veterans Affairs to jointly carry out a pilot program, to begin not later than July 1, 2002, and terminate on Dec. 31, 2005, under which the Secretary of Veterans Affairs, in one or more geographic areas, could perform the physical examinations required for separation of members from the uniformed services, and directed the Secretaries to jointly submit to Congress interim and final reports not later than Mar. 1, 2005.

Health Care Management Demonstration Program

Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 733], Oct. 30, 2000, 114 Stat. 1654, 1654A-191, as amended by Pub. L. 107-107, div. A, title VII, Sec. 737, Dec. 28, 2001, 115 Stat. 1173, directed the

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Secretary of Defense to carry out a demonstration program on health care management, to begin not later than 180 days after Oct. 30, 2000, and terminate on Dec. 31, 2003, to explore opportunities for improving the planning, programming, budgeting systems, and management of the Department of Defense health care system, and directed the Secretary to submit a report on such program to committees of Congress not later than Mar. 15, 2004.

Processes For Patient Safety In Military And Veterans Health Care Systems

Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 742], Oct. 30, 2000, 114 Stat. 1654, 1654A-192, provided that:

“(a) Error Tracking Process.—The Secretary of Defense shall implement a centralized process for reporting, compilation, and analysis of errors in the provision of health care under the defense health program that endanger patients beyond the normal risks associated with the care and treatment of such patients. To the extent practicable, that process shall emulate the system established by the Secretary of Veterans Affairs for reporting, compilation, and analysis of errors in the provision of health care under the Department of Veterans Affairs health care system that endanger patients beyond such risks.

“(b) Sharing of Information.—The Secretary of Defense and the Secretary of Veterans Affairs—
“(1) shall share information regarding the designs of systems or protocols established to reduce errors in the provision of health care described in subsection (a); and
“(2) shall develop such protocols as the Secretaries consider necessary for the establishment and administration of effective processes for the reporting, compilation, and analysis of such errors.”

Cooperation In Developing Pharmaceutical Identification Technology

Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 743], Oct. 30, 2000, 114 Stat. 1654, 1654A-192, provided that: “The Secretary of Defense and the Secretary of Veterans Affairs shall cooperate in developing systems for the use of bar codes for the identification of pharmaceuticals in the health care programs of the Department of Defense and the Department of Veterans Affairs. In any case in which a common pharmaceutical is used in such programs, the bar codes for those pharmaceuticals shall, to the maximum extent practicable, be identical.”

Patient Care Reporting And Management System

Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 754], Oct. 30, 2000, 114 Stat. 1654, 1654A-196, as amended by Pub. L. 109-163, div. A, title VII, Sec. 741, Jan. 6, 2006, 119 Stat. 3360, provided that:

“(a) Establishment.—The Secretary of Defense shall establish a patient care error reporting and management system.

“(b) Purposes of System.—The purposes of the system are as follows:

“(1) To study the occurrences of errors in the patient care provided under chapter 55 of title 10, United States Code.

“(2) To identify the systemic factors that are associated with such occurrences.

“(3) To provide for action to be taken to correct the identified systemic factors.

“(c) Requirements for System.—The patient care error reporting and management system shall include the following:

“(1) A hospital-level patient safety center, within the quality assurance department of each health care organization of the Department of Defense, to collect, assess, and report on the nature and frequency of errors related to patient care.

“(2) For each health care organization of the Department of Defense and for the entire Defense health program, patient safety standards that are necessary for the development of a full understanding of patient safety issues in each such organization and the entire program, including the nature and types of errors and the systemic causes of the errors.

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“(3) Establishment of a Department of Defense Patient Safety Center, which shall have the following missions:

“(A) To analyze information on patient care errors that is submitted to the Center by each military health care organization.

“(B) To develop action plans for addressing patterns of patient care errors.

“(C) To execute those action plans to mitigate and control errors in patient care with a goal of ensuring that the health care organizations of the Department of Defense provide highly reliable patient care with virtually no error.

“(D) To provide, through the Assistant Secretary of Defense for Health Affairs, to the Agency for Healthcare Research and Quality of the Department of Health and Human Services any reports that the Assistant Secretary determines appropriate.

“(E) To review and integrate processes for reducing errors associated with patient care and for enhancing patient safety.

“(F) To contract with a qualified and objective external organization to manage the national patient safety database of the Department of Defense.

“(d) Medical Team Training Program.—The Secretary shall expand the health care team coordination program to integrate that program into all Department of Defense health care operations. In carrying out this subsection, the Secretary shall take the following actions:

“(1) Establish not less than two Centers of Excellence for the development, validation, proliferation, and sustainment of the health care team coordination program, one of which shall support all fixed military health care organizations, the other of which shall support all combat casualty care organizations.

“(2) Deploy the program to all fixed and combat casualty care organizations of each of the Armed Forces, at the rate of not less than 10 organizations in each fiscal year.

“(3) Expand the scope of the health care team coordination program from a focus on emergency department care to a coverage that includes care in all major medical specialties, at the rate of not less than one specialty in each fiscal year.

“(4) Continue research and development investments to improve communication, coordination, and team work in the provision of health care.

“(e) Consultation.—The Secretary shall consult with the other administering Secretaries (as defined in section 1072(3) of title 10, United States Code) in carrying out this section.”

Confidentiality Of Communications With Professionals Providing Therapeutic Or Related Services Regarding Sexual Or Domestic Abuse

Pub. L. 106-65, div. A, title V, Sec. 585, Oct. 5, 1999, 113 Stat. 636, provided that:

“(a) Study and Report.—(1) The Comptroller General of the United States shall study the policies, procedures, and practices of the military departments for protecting the confidentiality of communications between—

“(A) a dependent (as defined in section 1072(2) of title 10, United States Code, with respect to a member of the Armed Forces) of a member of the Armed Forces who—

“(i) is a victim of sexual harassment, sexual assault, or intrafamily abuse; or

“(ii) has engaged in such misconduct; and

“(B) a therapist, counselor, advocate, or other professional from whom the dependent seeks professional services in connection with effects of such misconduct.

“(2) Not later than 180 days after the date of the enactment of this Act [Oct. 5, 1999], the Comptroller General shall conclude the study and submit a report on the results of the study to Congress and the Secretary of Defense.

“(b) Regulations.—The Secretary of Defense shall prescribe in regulations the policies and procedures that the Secretary considers appropriate to provide the maximum protections for

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the confidentiality of communications described in subsection (a) relating to misconduct described in that subsection, taking into consideration—

- “(1) the findings of the Comptroller General;
- “(2) the standards of confidentiality and ethical standards issued by relevant professional organizations;
- “(3) applicable requirements of Federal and State law;
- “(4) the best interest of victims of sexual harassment, sexual assault, or intrafamily abuse;
- “(5) military necessity; and
- “(6) such other factors as the Secretary, in consultation with the Attorney General, may consider appropriate.

“(c) Report by Secretary of Defense.—Not later than January 21, 2000, the Secretary of Defense shall submit to Congress a report on the actions taken under subsection (b) and any other actions taken by the Secretary to provide the maximum possible protections for confidentiality described in that subsection.”

Health Care Quality Information And Technology Enhancement

Pub. L. 106-65, div. A, title VII, Sec. 723, Oct. 5, 1999, 113 Stat. 695, as amended by Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 753(a)], Oct. 30, 2000, 114 Stat. 1654, 1654A-195; Pub. L. 109-163, div. A, title VII, Sec. 742, Jan. 6, 2006, 119 Stat. 3360; Pub. L. 109-364, div. A, title X, Sec. 1046(e), Oct. 17, 2006, 120 Stat. 2394; Pub. L. 112-81, div. A, title X, Sec. 1062(j)(1), Dec. 31, 2011, 125 Stat. 1585, provided that:

“(a) Purpose.—The purpose of this section is to ensure that the Department of Defense addresses issues of medical quality surveillance and implements solutions for those issues in a timely manner that is consistent with national policy and industry standards.

“(b) Department of Defense Program for Medical Informatics and Data.—The Secretary of Defense shall establish a Department of Defense program, the purposes of which shall be the following:

- “(1) To develop parameters for assessing the quality of health care information.
- “(2) To develop the defense digital patient record.
- “(3) To develop a repository for data on quality of health care.
- “(4) To develop capability for conducting research on quality of health care.
- “(5) To conduct research on matters of quality of health care.
- “(6) To develop decision support tools for health care providers.
- “(7) To refine medical performance report cards.
- “(8) To conduct educational programs on medical informatics to meet identified needs.

“(c) Automation and Capture of Clinical Data.—(1) Through the program established under subsection (b), the Secretary of Defense shall accelerate the efforts of the Department of Defense to automate, capture, and exchange controlled clinical data and present providers with clinical guidance using a personal information carrier, clinical lexicon, or digital patient record.

“(2) The program shall serve as a primary resource for the Department of Defense for matters concerning the capture, processing, and dissemination of data on health care quality.

“(d) Medical Informatics Advisory Committee.—(1) The Secretary of Defense shall establish a Medical Informatics Advisory Committee (hereinafter referred to as the ‘Committee’), the members of which shall be the following:

- “(A) The Assistant Secretary of Defense for Health Affairs.
- “(B) The Director of the TRICARE Management Activity of the Department of Defense.
- “(C) The Surgeon General of the Army.
- “(D) The Surgeon General of the Navy.

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“(E) The Surgeon General of the Air Force.

“(F) Representatives of the Department of Veterans Affairs, designated by the Secretary of Veterans Affairs.

“(G) Representatives of the Department of Health and Human Services, designated by the Secretary of Health and Human Services.

“(H) Any additional members appointed by the Secretary of Defense to represent health care insurers and managed care organizations, academic health institutions, health care providers (including representatives of physicians and representatives of hospitals), and accreditors of health care plans and organizations.

“(2) The primary mission of the Committee shall be to advise the Secretary on the development, deployment, and maintenance of health care informatics systems that allow for the collection, exchange, and processing of health care quality information for the Department of Defense in coordination with other Federal departments and agencies and with the private sector.

“(3) Specific areas of responsibility of the Committee shall include advising the Secretary on the following:

“(A) The ability of the medical informatics systems at the Department of Defense and Department of Veterans Affairs to monitor, evaluate, and improve the quality of care provided to beneficiaries.

“(B) The coordination of key components of medical informatics systems, including digital patient records, both within the Federal Government and between the Federal Government and the private sector.

“(C) The development of operational capabilities for executive information systems and clinical decision support systems within the Department of Defense and Department of Veterans Affairs.

“(D) Standardization of processes used to collect, evaluate, and disseminate health care quality information.

“(E) Refinement of methodologies by which the quality of health care provided within the Department of Defense and Department of Veterans Affairs is evaluated.

“(F) Protecting the confidentiality of personal health information.

“(4) The Assistant Secretary of Defense for Health Affairs shall consult with the Committee on the issues described in paragraph (3).

“(5) Members of the Committee shall not be paid by reason of their service on the Committee.

“(6) The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Committee. [Section 1062(j)(1)(A) of Pub. L. 112-81, which directed the redesignation of pars. (6) and (7) as (5) and (6) of section 723(d) of Pub. L. 106-65, set out above, could not be executed due to the prior identical amendment by section 1046(e) of Pub. L. 109-364.]

Joint Department Of Defense And Department Of Veterans Affairs Reports Relating To Interdepartmental Cooperation In Delivery Of Medical Care

Pub. L. 105-261, div. A, title VII, Sec. 745, Oct. 17, 1998, 112 Stat. 2075, as amended by Pub. L. 106-65, div. A, title X, Sec. 1067(3), Oct. 5, 1999, 113 Stat. 774; Pub. L. 108-136, div. A, title X, Sec. 1031(g)(1), Nov. 24, 2003, 117 Stat. 1604, (1) directed the Secretary of Defense and the Secretary of Veterans Affairs to jointly conduct a survey of their respective medical care beneficiary populations to identify the expectations of, requirements for, and behavior patterns of the beneficiaries with respect to medical care, and to submit a report on the results of the survey to committees of Congress not later than Jan. 1, 2000; (2) directed the same Secretaries to jointly conduct a review to identify impediments to cooperation between the Department of Defense and the Department of Veterans Affairs regarding the delivery of medical care and to submit a report on the results of the

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review to committees of Congress not later than Mar. 1, 1999; (3) directed the Secretary of Defense to review the TRICARE program to identify opportunities for increased participation by the Department of Veterans Affairs in that program; (4) directed the Department of Defense-Department of Veterans Affairs Federal Pharmacy Executive Steering Committee to examine existing pharmaceutical benefits and programs for beneficiaries and review existing methods for contracting for and distributing medical supplies and services and to submit a report on the results of the examination to committees of Congress not later than 60 days after its completion; and (5) directed the Secretary of Defense and the Secretary of Veterans Affairs to jointly submit to committees of Congress a report, not later than Mar. 1, 1999, on the status of the efforts of the Department of Defense and the Department of Veterans Affairs to standardize physical examinations administered by the two departments for the purpose of determining or rating disabilities.

External Peer Review For Defense Health Program Extramural Medical Research Involving Human Subjects

Pub. L. 104-201, div. A, title VII, Sec. 742, Sept. 23, 1996, 110 Stat. 2600, provided that:

“(a) Establishment of External Peer Review Process.—The Secretary of Defense shall establish a peer review process that will use persons who are not officers or employees of the Government to review the research protocols of medical research projects.

“(b) Peer Review Requirements.—Funds of the Department of Defense may not be obligated or expended for any medical research project unless the research protocol for the project has been approved by the external peer review process established under subsection (a).

“(c) Medical Research Project Defined.—For purposes of this section, the term ‘medical research project’ means a research project that—

“(1) involves the participation of human subjects;

“(2) is conducted solely by a non-Federal entity; and

“(3) is funded through the Defense Health Program account.

“(d) Effective Date.—The peer review requirements of subsection (b) shall take effect on October 1, 1996, and, except as provided in subsection (e), shall apply to all medical research projects proposed funded on or after that date, including medical research projects funded pursuant to any requirement of law enacted before, on, or after that date.

“(e) Exceptions.—Only the following medical research projects shall be exempt from the peer review requirements of subsection (b):

“(1) A medical research project that the Secretary determines has been substantially completed by October 1, 1996.

“(2) A medical research project funded pursuant to any provision of law enacted on or after that date if the provision of law specifically refers to this section and specifically states that the peer review requirements do not apply.”

Annual Beneficiary Survey

Pub. L. 102-484, div. A, title VII, Sec. 724, Oct. 23, 1992, 106 Stat. 2440, as amended by Pub. L. 103-337, div. A, title VII, Sec. 717, Oct. 5, 1994, 108 Stat. 2804, provided that:

“(a) Survey Required.—The administering Secretaries shall conduct annually a formal survey of persons receiving health care under chapter 55 of title 10, United States Code, in order to determine the following:

“(1) The availability of health care services to such persons through the health care system provided for under that chapter, the types of services received, and the facilities in which the services were provided.

“(2) The familiarity of such persons with the services available under that system and with the facilities in which such services are provided.

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“(3) The health of such persons.

“(4) The level of satisfaction of such persons with that system and the quality of the health care provided through that system.

“(5) Such other matters as the administering Secretaries determine appropriate.

“(b) Exemption.—An annual survey under subsection (a) shall be treated as not a collection of information for the purposes for which such term is defined in section 3502(4) of title 44, United States Code.

“(c) Definition.—For purposes of this section, the term ‘administering Secretaries’ has the meaning given such term in section 1072(3) of title 10, United States Code.”

Comprehensive Study Of Military Medical Care System

Pub. L. 102-190, div. A, title VII, Sec. 733, Dec. 5, 1991, 105 Stat. 1408, as amended by Pub. L. 102-484, div. A, title VII, Sec. 723, Oct. 23, 1992, 106 Stat. 2440, directed Secretary of Defense to conduct a comprehensive study of the military medical care system, not later than Dec. 15, 1992, to submit to congressional defense committees a detailed accounting on progress of the study, including preliminary results of the study, and not later than Dec. 15, 1993, submit to congressional defense committees a final report on the study.

Identification And Treatment Of Drug And Alcohol Dependent Persons In The Armed Forces

Pub. L. 92-129, title V, Sec. 501, Sept. 28, 1971, 85 Stat. 361, which directed Secretary of Defense to devise ways to identify, treat, and rehabilitate drug and alcohol dependent members of the armed forces, to identify, refuse admission to, and refer to civilian treatment facilities such persons seeking entrance to the armed forces, and to report to Congress on and suggest additional legislation concerning these matters, was repealed and restated as sections 978 and 1090 of this title by Pub. L. 97-295, Secs. 1(14)(A), (15)(A), 6(b), Oct. 12, 1982, 96 Stat. 1289, 1290, 1314.

Ex. Ord. No. 13625. Improving Access To Mental Health Services For Veterans, Service Members, And Military Families

Ex. Ord. No. 13625, Aug. 31, 2012, 77 F.R. 54783, provided: By the authority vested in me as President by the Constitution and the laws of the United States of America, I hereby order as follows:

Section 1. Policy.

Since September 11, 2001, more than two million service members have deployed to Iraq or Afghanistan. Long deployments and intense combat conditions require optimal support for the emotional and mental health needs of our service members and their families. The need for mental health services will only increase in the coming years as the Nation deals with the effects of more than a decade of conflict. Reiterating and expanding upon the commitment outlined in my Administration’s 2011 report, entitled “Strengthening Our Military Families,” we have an obligation to evaluate our progress and continue to build an integrated network of support capable of providing effective mental health services for veterans, service members, and their families. Our public health approach must encompass the practices of disease prevention and the promotion of good health for all military populations throughout their lifespans, both within the health care systems of the Departments of Defense and Veterans Affairs and in local communities. Our efforts also must focus on both outreach to veterans and their families and the provision of high quality mental health treatment to those in need. Coordination between the Departments of Veterans Affairs and Defense during service members’ transition to civilian life is essential to achieving these goals. Ensuring that all veterans, service members (Active, Guard, and Reserve alike), and their families receive the support they deserve is a top priority for my Administration. As part of our ongoing efforts to improve all facets of military mental health, this order directs the Secretaries of Defense, Health and Human

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Services, Education, Veterans Affairs, and Homeland Security to expand suicide prevention strategies and take steps to meet the current and future demand for mental health and substance abuse treatment services for veterans, service members, and their families.

Sec. 2. Suicide Prevention.

- (a) By December 31, 2012, the Department of Veterans Affairs, in continued collaboration with the Department of Health and Human Services, shall expand the capacity of the Veterans Crisis Line by 50 percent to ensure that veterans have timely access, including by telephone, text, or online chat, to qualified, caring responders who can help address immediate crises and direct veterans to appropriate care. Further, the Department of Veterans Affairs shall ensure that any veteran identifying him or herself as being in crisis connects with a mental health professional or trained mental health worker within 24 hours. The Department of Veterans Affairs also shall expand the number of mental health professionals who are available to see veterans beyond traditional business hours.
- (b) The Departments of Veterans Affairs and Defense shall jointly develop and implement a national suicide prevention campaign focused on connecting veterans and service members to mental health services. This 12-month campaign, which shall begin on September 1, 2012, will focus on the positive benefits of seeking care and encourage veterans and service members to proactively reach out to support services.
- (c) To provide the best mental health and substance abuse prevention, education, and outreach support to our military and their family members, the Department of Defense shall review all of its existing mental health and substance abuse prevention, education, and outreach programs across the military services and the Defense Health Program to identify the key program areas that produce the greatest impact on quality and outcomes, and rank programs within each of these program areas using metrics that assess their effectiveness. By the end of Fiscal Year 2014, existing program resources shall be realigned to ensure that highly ranked programs are implemented across all of the military services and less effective programs are replaced.

Sec. 3. Enhanced Partnerships Between the Department of Veterans Affairs and Community Providers.

- (a) Within 180 days of the date of this order, in those service areas where the Department of Veterans Affairs has faced challenges in hiring and placing mental health service providers and continues to have unfilled vacancies or long wait times, the Departments of Veterans Affairs and Health and Human Services shall establish pilot projects whereby the Department of Veterans Affairs contracts or develops formal arrangements with community-based providers, such as community mental health clinics, community health centers, substance abuse treatment facilities, and rural health clinics, to test the effectiveness of community partnerships in helping to meet the mental health needs of veterans in a timely way. Pilot sites shall ensure that consumers of community-based services continue to be integrated into the health care systems of the Department of Veterans Affairs. No fewer than 15 pilot projects shall be established.
- (b) The Department of Veterans Affairs shall develop guidance for its medical centers and service networks that supports the use of community mental health services, including telehealth services and substance abuse services, where appropriate, to meet demand and facilitate access to care. This guidance shall include recommendations that medical centers and service networks use community-based providers to help meet veterans' mental health needs where objective criteria, which the Department of Veterans Affairs shall define in the form of specific metrics, demonstrate such needs. Such objective criteria should include estimates of wait-times for needed care that exceed established targets.

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(c) The Departments of Health and Human Services and Veterans Affairs shall develop a plan for a rural mental health recruitment initiative to promote opportunities for the Department of Veterans Affairs and rural communities to share mental health providers when demand is insufficient for either the Department of Veterans Affairs or the communities to independently support a full-time provider.

Sec. 4. Expanded Department of Veterans Affairs Mental Health Services Staffing. The Secretary of Veterans Affairs shall, by December 31, 2013, hire and train 800 peer-to-peer counselors to empower veterans to support other veterans and help meet mental health care needs. In addition, the Secretary shall continue to use all appropriate tools, including collaborative arrangements with community-based providers, pay-setting authorities, loan repayment and scholarships, and partnerships with health care workforce training programs to accomplish the Department of Veterans Affairs' goal of recruiting, hiring, and placing 1,600 mental health professionals by June 30, 2013. The Department of Veterans Affairs also shall evaluate the reporting requirements associated with providing mental health services and reduce paperwork requirements where appropriate. In addition, the Department of Veterans Affairs shall update its management performance evaluation system to link performance to meeting mental health service demand.

Sec. 5. Improved Research and Development.

(a) The lack of full understanding of the underlying mechanisms of Post-Traumatic Stress Disorder (PTSD), other mental health conditions, and Traumatic Brain Injury (TBI) has hampered progress in prevention, diagnosis, and treatment. In order to improve the coordination of agency research into these conditions and reduce the number of affected men and women through better prevention, diagnosis, and treatment, the Departments of Defense, Veterans Affairs, Health and Human Services, and Education, in coordination with the Office of Science and Technology Policy, shall establish a National Research Action Plan within 8 months of the date of this order.

(b) The National Research Action Plan shall include strategies to establish surrogate and clinically actionable biomarkers for early diagnosis and treatment effectiveness; develop improved diagnostic criteria for TBI; enhance our understanding of the mechanisms responsible for PTSD, related injuries, and neurological disorders following TBI; foster development of new treatments for these conditions based on a better understanding of the underlying mechanisms; improve data sharing between agencies and academic and industry researchers to accelerate progress and reduce redundant efforts without compromising privacy; and make better use of electronic health records to gain insight into the risk and mitigation of PTSD, TBI, and related injuries. In addition, the National Research Action Plan shall include strategies to support collaborative research to address suicide prevention.

(c) The Departments of Defense and Health and Human Services shall engage in a comprehensive longitudinal mental health study with an emphasis on PTSD, TBI, and related injuries to develop better prevention, diagnosis, and treatment options. Agencies shall continue ongoing collaborative research efforts, with an aim to enroll at least 100,000 service members by December 31, 2012, and include a plan for long-term follow-up with enrollees through a coordinated effort with the Department of Veterans Affairs.

Sec. 6. Military and Veterans Mental Health Interagency Task Force. There is established an Interagency Task Force on Military and Veterans Mental Health (Task Force), to be co-chaired by the Secretaries of Defense, Veterans Affairs, and Health and Human Services, or their designated representatives.

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(a) Membership. In addition to the Co-Chairs, the Task Force shall consist of representatives from:

- (i) the Department of Education;
- (ii) the Office of Management and Budget;
- (iii) the Domestic Policy Council;
- (iv) the National Security Staff;
- (v) the Office of Science and Technology Policy;
- (vi) the Office of National Drug Control Policy; and
- (vii) such other executive departments, agencies, or offices as the Co-Chairs may designate. A member agency of the Task Force shall designate a full-time officer or employee of the Federal Government to perform the Task Force functions.

(b) Mission. Member agencies shall review relevant statutes, policies, and agency training and guidance to identify reforms and take actions that facilitate implementation of the strategies outlined in this order. Member agencies shall work collaboratively on these strategies and also create an inventory of mental health and substance abuse programs and activities to inform this work.

(c) Functions.

(i) Not later than 180 days after the date of this order, the Task Force shall submit recommendations to the President on strategies to improve mental health and substance abuse treatment services for veterans, service members, and their families. Every year thereafter, the Task Force shall provide to the President a review of agency actions to enhance mental health and substance abuse treatment services for veterans, service members, and their families consistent with this order, as well as provide additional recommendations for action as appropriate. The Task Force shall define specific goals and metrics that will aid in measuring progress in improving mental health strategies. The Task Force will include cost analysis in the development of all recommendations, and will ensure any new requirements are supported within existing resources.

(ii) In addition to coordinating and reviewing agency efforts to enhance veteran and military mental health services pursuant to this order, the Task Force shall evaluate:

- (1) agency efforts to improve care quality and ensure that the Departments of Defense and Veterans Affairs and community-based mental health providers are trained in the most current evidence-based methodologies for treating PTSD, TBI, depression, related mental health conditions, and substance abuse;
- (2) agency efforts to improve awareness and reduce stigma for those needing to seek care; and
- (3) agency research efforts to improve the prevention, diagnosis, and treatment of TBI, PTSD, and related injuries, and explore the need for an external research portfolio review.

(iii) In performing its functions, the Task Force shall consult with relevant nongovernmental experts and organizations as necessary.

Sec. 7. General Provisions.

(a) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(b) Nothing in this order shall be construed to impair or otherwise affect:

- (i) the authority granted by law to an executive department or agency, or the head thereof; or
- (ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

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(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

Barack Obama.

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Effective Date Of 1980 Amendment

Amendment by Pub. L. 96-513 effective Dec. 12, 1980, see section 701(b)(3) of Pub. L. 96-513, set out as a note under section 101 of this title.

Effective Date Of 1966 Amendment

For effective date of amendment by Pub. L. 89-614, see section 3 of Pub. L. 89-614, set out as a note under section 1071 of this title.

Delegation Of Functions

Authority of President under subsec. (b) to approve uniform rates of reimbursement for care provided in facilities operated by Secretary of Veterans Affairs delegated to Secretary of Veterans Affairs, see section 7(a) of Ex. Ord. No. 11609, July 22, 1971, 36 F.R. 13747, set out as a note under section 301 of Title 3, The President.

Pilot Program On Investigational Treatment Of Members Of The Armed Forces For Traumatic Brain Injury And Post-Traumatic Stress Disorder

Pub. L. 113-66, div. A, title VII, Sec. 704, Dec. 26, 2013, 127 Stat. 792, provided that:

“(a) Pilot Program Authorized.—The Secretary of Defense shall carry out a pilot program under which the Secretary shall establish a process for randomized placebo-controlled clinical trials of investigational treatments (including diagnostic testing) of traumatic brain injury or post-traumatic stress disorder received by members of the Armed Forces in health care facilities other than military treatment facilities.

“(b) Conditions for Approval.—The approval by the Secretary for a treatment pursuant to subsection (a) shall be subject to the following conditions:

“(1) Any drug or device used in the treatment must be approved, cleared, or made subject to an investigational use exemption by the Food and Drug Administration, and the use of the drug or device must comply with rules of the Food and Drug Administration applicable to investigational new drugs or investigational devices.

“(2) The treatment must be approved by the Secretary following approval by an institutional review board operating in accordance with regulations issued by the Secretary of Health and Human Services, in addition to regulations issued by the Secretary of Defense regarding institutional review boards.

“(3) The patient receiving the treatment may not be a retired member of the Armed Forces who is entitled to benefits under part A, or eligible to enroll under part B, of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

“(c) Additional Restrictions Authorized.—The Secretary may establish additional restrictions or conditions as the Secretary determines appropriate to ensure the protection of human research subjects, appropriate fiscal management, and the validity of the research results.

“(d) Data Collection and Availability.—The Secretary shall develop and maintain a database containing data from each patient case involving the use of a treatment under this section. The Secretary shall ensure that the database preserves confidentiality and that any use of the database or disclosures of such data are limited to such use and disclosures permitted by law and applicable regulations.

“(e) Reports to Congress.—Not later than 30 days after the last day of each fiscal year, the Secretary shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the implementation of this section and any available results on investigational treatment clinical trials authorized under this section during such fiscal year.

“(f) Termination.—The authority of the Secretary to carry out the pilot program authorized by subsection (a) shall terminate on December 31, 2018.”

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Department Of Defense Guidance On Environmental Exposures At Military Installations

Pub. L. 112-239, div. A, title III, Sec. 313(a), Jan. 2, 2013, 126 Stat. 1692, provided that:

“(1) In general.—Not later than 180 days after the date of the enactment of this Act [Jan. 2, 2013], the Secretary of Defense shall issue guidance to the military departments and appropriate defense agencies regarding environmental exposures on military installations.

“(2) Elements.—The guidance issued pursuant to paragraph (1) shall address, at a minimum, the following:

“(A) The criteria for when and under what circumstances public health assessments by the Agency for Toxic Substances and Disease Registry must be requested in connection with environmental contamination at military installations, including past incidents of environmental contamination.

“(B) The procedures to be used to track and document the status and nature of responses to the findings and recommendations of the public health assessments of the Agency of Toxic Substances and Disease Registry that involve contamination at military installations.

“(C) The appropriate actions to be undertaken to assess significant long-term health risks from past environmental exposures to military personnel and civilian individuals from living or working on military installations.

“(3) Submission.—Not later than 30 days after the issuance of the guidance required by paragraph (1), the Secretary of Defense shall transmit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] a copy of the guidance.”

Smoking Cessation Program Under TRICARE

Pub. L. 110-417, [div. A], title VII, Sec. 713, Oct. 14, 2008, 122 Stat. 4503, provided that:

“(a) TRICARE Smoking Cessation Program.—Not later than 180 days after the date of the enactment of this Act [Oct. 14, 2008], the Secretary of Defense shall establish a smoking cessation program under the TRICARE program, to be made available to all beneficiaries under the TRICARE program, subject to subsection (b). The Secretary may prescribe such regulations as may be necessary to implement the program.

“(b) Exclusion for Medicare-Eligible Beneficiaries.—The smoking cessation program shall not be made available to medicare-eligible beneficiaries.

“(c) Elements.—The program shall include, at a minimum, the following elements:

“(1) The availability, at no cost to the beneficiary, of pharmaceuticals used for smoking cessation, with a limitation on the availability of such pharmaceuticals to the national mail-order pharmacy program under the TRICARE program if appropriate.

“(2) Counseling.

“(3) Access to a toll-free quit line that is available 24 hours a day, 7 days a week.

“(4) Access to printed and Internet web-based tobacco cessation material.

“(d) Chain of Command Involvement.—In establishing the program, the Secretary of Defense shall provide for involvement by officers in the chain of command of participants in the program who are on active duty.

“(e) Plan.—Not later than 90 days after the date of the enactment of this Act [Oct. 14, 2008], the Secretary shall submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] a plan to implement the program.

“(f) Refund of Copayments.—

“(1) Authority.—Under regulations prescribed by the Secretary of Defense, the Secretary may pay a refund to a medicare-eligible beneficiary otherwise excluded by this section,

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subject to the availability of appropriations specifically for such refunds, consisting of an amount up to the difference between—

“(A) the amount the beneficiary pays for copayments for smoking cessation services described in subsection (c) during fiscal year 2009; and

“(B) the amount the beneficiary would have paid during such fiscal year if the beneficiary had not been excluded under subsection (b) from the smoking cessation program under subsection (a).

“(2) Copayments covered.—The refunds under paragraph (1) are available only for copayments paid by medicare-eligible beneficiaries during fiscal year 2009.

“(g) Report.—Not later than one year after the date of the enactment of this Act [Oct. 14, 2008], the Secretary shall submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] a report covering the following:

“(1) The status of the program.

“(2) The number of participants in the program.

“(3) The cost of the program.

“(4) The costs avoided that are attributed to the program.

“(5) The success rates of the program compared to other nationally recognized smoking cessation programs.

“(6) Findings regarding the success rate of participants in the program.

“(7) Recommendations to modify the policies and procedures of the program.

“(8) Recommendations concerning the future utility of the program.

“(h) Definitions.—In this section:

“(1) TRICARE program.—The term ‘TRICARE program’ has the meaning provided by section 1072(7) of title 10, United States Code.

“(2) Medicare-eligible.—The term ‘medicare-eligible’ has the meaning provided by section 1111(b) of title 10, United States Code.”

Longitudinal Study On Traumatic Brain Injury Incurred By Members Of The Armed Forces In Operation Iraqi Freedom And Operation Enduring Freedom

Pub. L. 109-364, div. A, title VII, Sec. 721, Oct. 17, 2006, 120 Stat. 2294, provided that:

“(a) Study Required.—The Secretary of Defense shall conduct a longitudinal study on the effects of traumatic brain injury incurred by members of the Armed Forces serving in Operation Iraqi Freedom or Operation Enduring Freedom on the members who incur such an injury and their families.

“(b) Duration.—The study required by subsection (a) shall be conducted for a period of 15 years.

“(c) Elements.—The study required by subsection (a) shall specifically address the following:

“(1) The long-term physical and mental health effects of traumatic brain injuries incurred by members of the Armed Forces during service in Operation Iraqi Freedom or Operation Enduring Freedom.

“(2) The health care, mental health care, and rehabilitation needs of such members for such injuries after the completion of inpatient treatment through the Department of Defense, the Department of Veterans Affairs, or both.

“(3) The type and availability of long-term care rehabilitation programs and services within and outside the Department of Defense and the Department of Veterans Affairs for such members for such injuries, including community-based programs and services and in-home programs and services.

“(4) The effect on family members of a member incurring such an injury.

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“(d) Consultation.—The Secretary of Defense shall conduct the study required by subsection (a) and prepare the reports required by subsection (e) in consultation with the Secretary of Veterans Affairs.

“(e) Periodic and Final Reports.—After the third, seventh, eleventh, and fifteenth years of the study required by subsection (a), the Secretary of Defense shall submit to Congress a comprehensive report on the results of the study during the preceding years. Each report shall include the following:

“(1) Current information on the cumulative outcomes of the study.

“(2) Such recommendations as the Secretary of Defense and the Secretary of Veterans Affairs jointly consider appropriate based on the outcomes of the study, including recommendations for legislative, programmatic, or administrative action to improve long-term care and rehabilitation programs and services for members of the Armed Forces with traumatic brain injuries.”

Standards And Tracking Of Access To Health Care Services For Wounded, Injured, Or Ill Servicemembers Returning To The United States From A Combat Zone

Pub. L. 109-364, div. A, title VII, Sec. 733, Oct. 17, 2006, 120 Stat. 2298, provided that:

“(a) Report on Uniform Standards for Access.—Not later than 90 days after the date of the enactment of this Act [Oct. 17, 2006], the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on uniform standards for the access of wounded, injured, or ill members of the Armed Forces to health care services in the United States following return from a combat zone.

“(b) Matters Covered.—The report required by subsection (a) shall describe in detail policies with respect to the following:

“(1) The access of wounded, injured, or ill members of the Armed Forces to emergency care.

“(2) The access of such members to surgical services.

“(3) Waiting times for referrals and consultations of such members by medical personnel, dental personnel, mental health specialists, and rehabilitative service specialists, including personnel and specialists with expertise in prosthetics and in the treatment of head, vision, and spinal cord injuries.

“(4) Waiting times of such members for acute care and for routine follow-up care.

“(c) Referral to Providers Outside Military Health Care System.—The Secretary shall require that health care services and rehabilitation needs of members described in subsection (a) be met through whatever means or mechanisms possible, including through the referral of members described in that subsection to health care providers outside the military health care system.

“(d) Uniform System for Tracking of Performance.—The Secretary shall establish a uniform system for tracking the performance of the military health care system in meeting the requirements for access of wounded, injured, or ill members of the Armed Forces to health care services described in subsection (a).

“(e) Reports.—

“(1) Tracking system.—Not later than 180 days after the date of the enactment of this Act [Oct. 17, 2006], the Secretary shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the system established under subsection (d).

“(2) Access.—Not later than October 1, 2006, and each quarter thereafter during fiscal year 2007, the Secretary shall submit to such committees a report on the performance of the health care system in meeting the access standards described in the report required by subsection (a).”

Pilot Projects On Early Diagnosis And Treatment Of Post Traumatic Stress Disorder And Other Mental Health Conditions

Pub. L. 109-364, div. A, title VII, Sec. 741, Oct. 17, 2006, 120 Stat. 2304, provided that:

“(a) Pilot Projects Required.—The Secretary of Defense shall carry out not less than three pilot projects to evaluate the efficacy of various approaches to improving the capability of the military and civilian health care systems to provide early diagnosis and treatment of post traumatic stress disorder and other mental health conditions.

“(b) Duration.—Any pilot project carried out under this section shall begin not later than October 1, 2007, and cease on September 30, 2008.

“(c) Pilot Project Requirements.—

“(1) Diagnostic and treatment approaches.—One of the pilot projects under this section shall be designed to evaluate effective diagnostic and treatment approaches for use by primary care providers in the military health care system in order to improve the capability of such providers to diagnose and treat post traumatic stress disorder.

“(2) National guard or reserve members.—

“(A) One of the pilot projects under this section shall be focused on members of the National Guard or Reserves who are located more than 40 miles from a military medical facility and who are served primarily by civilian community health resources.

“(B) The pilot project described in subparagraph (A) shall be designed to develop educational materials and other tools for use by members of the National Guard or Reserves who come into contact with other members of the National Guard or Reserves who may suffer from post traumatic stress disorder in order to encourage and facilitate early reporting and referral for treatment.

“(3) Outreach.—One of the pilot projects under this section shall be designed to provide outreach to the family members of the members of the Armed Forces on post traumatic stress disorder and other mental health conditions.

“(d) Evaluation of Pilot Projects.—The Secretary shall evaluate each pilot project carried out under this section in order to assess the effectiveness of the approaches taken under such pilot project—

“(1) to improve the capability of the military and civilian health care systems to provide early diagnosis and treatment of post traumatic stress disorder and other mental health conditions among members of the regular components of the Armed Forces, and among members of the National Guard and Reserves, who have returned from deployment; and

“(2) to provide outreach to the family members of the members of the Armed Forces described in paragraph (1) on post traumatic stress disorder and other mental health conditions among such members of the Armed Forces.

“(e) Report to Congress.—

“(1) Report required.—Not later than December 31, 2008, the Secretary shall submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] a report on the pilot projects carried out under this section.

“(2) Elements.—The report required by paragraph (1) shall include the following:

“(A) A description of each pilot project carried out under this section.

“(B) An assessment of the effectiveness of the approaches taken under each pilot project to improve the capability of the military and civilian health care systems to provide early diagnosis and treatment of post traumatic stress disorder and other mental health conditions among members of the Armed Forces.

“(C) Any recommendations for legislative or administrative action that the Secretary considers appropriate in light of the pilot projects, including recommendations on—

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“(i) the training of health care providers in the military and civilian health care systems on early diagnosis and treatment of post traumatic stress disorder and other mental health conditions; and

“(ii) the provision of outreach on post traumatic stress disorder and other mental health conditions to members of the National Guard and Reserves who have returned from deployment.

“(D) A plan, in light of the pilot projects, for the improvement of the health care services provided to members of the Armed Forces in order to better assure the early diagnosis and treatment of post traumatic stress disorder and other mental health conditions among members of the Armed Forces, including a specific plan for outreach on post traumatic stress disorder and other mental health conditions to members of the National Guard and Reserves who have returned from deployment in order to facilitate and enhance the early diagnosis and treatment of post traumatic stress disorder and other mental health conditions among such members of the National Guard and Reserves.”

Training Curricula For Family Caregivers On Care And Assistance For Members And Former Members Of The Armed Forces With Traumatic Brain Injury

Pub. L. 109-364, div. A, title VII, Sec. 744, Oct. 17, 2006, 120 Stat. 2308, provided that:

“(a) Traumatic Brain Injury Family Caregiver Panel.—

“(1) Establishment.—The Secretary of Defense shall establish a panel within the Department of Defense, to be known as the ‘Traumatic Brain Injury Family Caregiver Panel’, to develop coordinated, uniform, and consistent training curricula to be used in training family members in the provision of care and assistance to members and former members of the Armed Forces with traumatic brain injuries.

“(2) Members.—The Traumatic Brain Injury Family Caregiver Panel shall consist of 15 members appointed by the Secretary of Defense from among the following:

“(A) Physicians, nurses, rehabilitation therapists, and other individuals with an expertise in caring for and assisting individuals with traumatic brain injury, including persons who specialize in caring for and assisting individuals with traumatic brain injury incurred in combat.

“(B) Representatives of family caregivers or family caregiver associations.

“(C) Health and medical personnel of the Department of Defense and the Department of Veterans Affairs with expertise in traumatic brain injury and personnel and readiness representatives of the Department of Defense with expertise in traumatic brain injury.

“(D) Psychologists or other individuals with expertise in the mental health treatment and care of individuals with traumatic brain injury.

“(E) Experts in the development of training curricula.

“(F) Family members of members of the Armed Forces with traumatic brain injury.

“(G) Such other individuals the Secretary considers appropriate.

“(3) Consultation.—In establishing the Traumatic Brain Injury Family Caregiver Panel and appointing the members of the Panel, the Secretary of Defense shall consult with the Secretary of Veterans Affairs.

“(b) Development of Curricula.—

“(1) Development.—The Traumatic Brain Injury Family Caregiver Panel shall develop training curricula to be used by family members of members and former members of the Armed Forces on techniques, strategies, and skills for care and assistance for such members and former members with traumatic brain injury.

“(2) Scope of curricula.—The curricula shall—

“(A) be based on empirical research and validated techniques; and

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- “(B) shall provide for training that permits recipients to tailor caregiving to the unique circumstances of the member or former member of the Armed Forces receiving care.
- “(3) Particular requirements.—In developing the curricula, the Traumatic Brain Injury Family Caregiver Panel shall—
- “(A) specify appropriate training commensurate with the severity of traumatic brain injury; and
 - “(B) identify appropriate care and assistance to be provided for the degree of severity of traumatic brain injury for caregivers of various levels of skill and capability.
- “(4) Use of existing materials.—In developing the curricula, the Traumatic Brain Injury Family Caregiver Panel shall use and enhance any existing training curricula, materials, and resources applicable to such curricula as the Panel considers appropriate.
- “(5) Deadline for development.—The Traumatic Brain Injury Family Caregiver Panel shall develop the curricula not later than one year after the date of the enactment of this Act [Oct. 17, 2006].
- “(c) Dissemination of Curricula.—
- “(1) Dissemination mechanisms.—The Secretary of Defense shall develop mechanisms for the dissemination of the curricula developed under subsection (b)—
 - “(A) to health care professionals who treat or otherwise work with members and former members of the Armed Forces with traumatic brain injury;
 - “(B) to family members affected by the traumatic brain injury of such members and former members; and
 - “(C) to other care or support personnel who may provide service to members or former members affected by traumatic brain injury.
 - “(2) Use of existing mechanisms.—In developing such mechanisms, the Secretary may use and enhance existing mechanisms, including the Military Severely Injured Center (authorized under section 564 of this Act [10 U.S.C. 113 note]) and the programs for service to severely injured members established by the military departments.
- “(d) Report.—Not later than one year after the development of the curricula required by subsection (b), the Secretary of Defense and the Secretary of Veterans Affairs shall submit to the Committees on Armed Services and Veterans Affairs of the Senate and the House of Representatives a report on the following:
- “(1) The actions undertaken under this section.
 - “(2) Recommendations for the improvement or updating of training curriculum developed and provided under this section.”

Pilot Projects On Early Diagnosis And Treatment Of Post Traumatic Stress Disorder And Other Mental Health Conditions

Pub. L. 109-163, div. A, title VII, Sec. 722, Jan. 6, 2006, 119 Stat. 3347, provided that:

- “(a) Pilot Projects Required.—The Secretary of Defense may carry out pilot projects to evaluate the efficacy of various approaches to improving the capability of the military and civilian health care systems to provide early diagnosis and treatment of post traumatic stress disorder (PTSD) and other mental health conditions.
- “(b) Pilot Project Requirements.—
 - “(1) Mobilization-demobilization facility.—
 - “(A) In general.—A pilot project under subsection (a) may be carried out at a military medical facility at a large military installation at which the mobilization or demobilization of members of the Armed Forces occurs.
 - “(B) Elements.—The pilot project under this paragraph shall be designed to evaluate and produce effective diagnostic and treatment approaches for use by primary care providers in the military health care system in order to improve the capability of such

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providers to diagnose and treat post traumatic stress disorder in a manner that avoids the referral of patients to specialty care by a psychiatrist or other mental health professional.

“(2) National guard or reserve facility.—

“(A) In general.—A pilot project under subsection (a) may be carried out at the location of a National Guard or Reserve unit or units that are located more than 40 miles from a military medical facility and whose personnel are served primarily by civilian community health resources.

“(B) Elements.—The pilot project under this paragraph shall be designed—

“(i) to evaluate approaches for providing evidence-based clinical information on post traumatic stress disorder to civilian primary care providers; and

“(ii) to develop educational materials and other tools for use by members of the National Guard or Reserve who come into contact with other members of the National Guard or Reserve who may suffer from post traumatic stress disorder in order to encourage and facilitate early reporting and referral for treatment.

“(c) Report.—Not later than September 1, 2006, the Secretary shall submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] a report on the progress toward identifying pilot projects to be carried out under this section. To the extent possible the report shall include a description of each such pilot project, including the location of the pilot projects under paragraphs (1) and (2) of subsection (b), and the scope and objectives of each such pilot project.”

Cooperative Outreach To Members And Former Members Of The Naval Service Exposed To Environmental Factors Related To Sarcoidosis

Pub. L. 109-163, div. A, title VII, Sec. 746, Jan. 6, 2006, 119 Stat. 3362, provided that:

“(a) Outreach Program Required.—The Secretary of the Navy, in coordination with the Secretary of Veterans Affairs, shall conduct an outreach program intended to contact as many members and former members of the naval service as possible who, in connection with service aboard Navy ships, may have been exposed to aerosolized particles resulting from the removal of nonskid coating used on those ships.

“(b) Purposes of Outreach Program.—The purposes of the outreach program are as follows:

“(1) To develop additional data for use in subsequent studies aimed at determining a causative link between sarcoidosis and military service.

“(2) To inform members and former members identified in subsection (a) of the findings of Navy studies identifying an association between service aboard certain naval ships and sarcoidosis.

“(3) To provide information to assist members and former members identified in subsection (a) in getting medical evaluations to help clarify linkages between their disease and their service aboard Navy ships.

“(4) To provide the Department of Veterans Affairs with data and information for the effective evaluation of veterans who may seek care for sarcoidosis.

“(c) Implementation and Report.—Not later than six months after the date of the enactment of this Act [Jan. 6, 2006], the Secretary of the Navy shall begin the outreach program. Not later than one year after beginning the program, the Secretary shall provide to the Committees on Armed Services of the Senate and the House of Representatives and the Committees on Veterans Affairs of the Senate and House of Representatives a report on the results of the outreach program.”

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Medical Readiness Plan And Joint Medical Readiness Oversight Committee

Pub. L. 108-375, div. A, title VII, Sec. 731, Oct. 28, 2004, 118 Stat. 1993, as amended by Pub. L. 109-163, div. A, title V, Sec. 515(h), Jan. 6, 2006, 119 Stat. 3237; Pub. L. 109-364, div. A, title X, Sec. 1071(g)(8), Oct. 17, 2006, 120 Stat. 2402; Pub. L. 112-81, div. A, title X, Sec. 1062(f)(1), Dec. 31, 2011, 125 Stat. 1585, provided that:

“(a) Requirement for Plan.—The Secretary of Defense shall develop a comprehensive plan to improve medical readiness, and Department of Defense tracking of the health status, of members of the Armed Forces throughout their service in the Armed Forces, and to strengthen medical readiness and tracking before, during, and after deployment of members of the Armed Forces overseas. The matters covered by the comprehensive plan shall include all elements that are described in this subtitle [subtitle D [Secs. 731 to 740] of title VII of Pub. L. 108-375, enacting sections 1073b and 1092a of this title and enacting provisions set out as notes under this section and sections 1073b, 1074f, and 1092a of this title] and the amendments made by this subtitle and shall comply with requirements in law.

“(b) Joint Medical Readiness Oversight Committee.—

“(1) Establishment.—The Secretary of Defense shall establish a Joint Medical Readiness Oversight Committee.

“(2) Composition.—The members of the Committee are as follows:

“(A) The Under Secretary of Defense for Personnel and Readiness, who shall chair the Committee.

“(B) The Vice Chief of Staff of the Army, the Vice Chief of Naval Operations, the Vice Chief of Staff of the Air Force, and the Assistant Commandant of the Marine Corp.

“(C) The Assistant Secretary of Defense for Health Affairs.

“(D) The Assistant Secretary of Defense for Reserve Affairs.

“(E) The Surgeon General of each of the Army, the Navy, and the Air Force.

“(F) The Assistant Secretary of the Army for Manpower and Reserve Affairs.

“(G) The Assistant Secretary of the Navy for Manpower and Reserve Affairs.

“(H) The Assistant Secretary of the Air Force for Manpower, Reserve Affairs, Installations, and Environment.

“(I) The Chief of the National Guard Bureau.

“(J) The Chief of Army Reserve.

“(K) The Chief of Navy Reserve.

“(L) The Chief of Air Force Reserve.

“(M) The Commander, Marine Corps Reserve.

“(N) The Director of the Defense Manpower Data Center.

“(O) A representative of the Department of Veterans Affairs designated by the Secretary of Veterans Affairs.

“(3) Duties.—The duties of the Committee are as follows:

“(A) To advise the Secretary of Defense on the medical readiness and health status of the members of the active and reserve components of the Armed Forces.

“(B) To advise the Secretary of Defense on the compliance of the Armed Forces with the medical readiness tracking and health surveillance policies of the Department of Defense.

“(C) To oversee the development and implementation of the comprehensive plan required by subsection (a) and the actions required by this subtitle and the amendments made by this subtitle, including with respect to matters relating to—

“(i) the health status of the members of the reserve components of the Armed Forces;

“(ii) accountability for medical readiness;

“(iii) medical tracking and health surveillance;

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- “(iv) declassification of information on environmental hazards;
- “(v) postdeployment health care for members of the Armed Forces; and
- “(vi) compliance with Department of Defense and other applicable policies on blood serum repositories.

“(D) To ensure unity and integration of efforts across functional and organizational lines within the Department of Defense with regard to medical readiness tracking and health surveillance of members of the Armed Forces.

“(E) To establish and monitor compliance with the medical readiness standards that are applicable to members and those that are applicable to units.

“(F) To improve continuity of care in coordination with the Secretary of Veterans Affairs, for members of the Armed Forces separating from active service with service-connected medical conditions.

“(4) First meeting.—The first meeting of the Committee shall be held not later than 120 days after the date of the enactment of this Act [Oct. 28, 2004].”

Accountability For Medical Readiness Of Individuals And Units Of The Reserve Components

Pub. L. 108-375, div. A, title VII, Sec. 732(b), Oct. 28, 2004, 118 Stat. 1997, provided that:

“(1) Policy.—The Secretary of Defense shall take measures, in addition to those required by section 1074f of title 10, United States Code, to ensure that individual members and commanders of reserve component units fulfill their responsibilities and meet the requirements for medical and dental readiness of members of the units. Such measures may include—

“(A) requiring more frequent health assessments of members than is required by section 1074f(b) of title 10, United States Code, with an objective of having every member of the Selected Reserve receive a health assessment as specified in section 1074f of such title not less frequently than once every two years; and

“(B) providing additional support and information to commanders to assist them in improving the health status of members of their units.

“(2) Review and followup care.—The measures under this subsection shall provide for review of the health assessments under paragraph (1) by a medical professional and for any followup care and treatment that is otherwise authorized for medical or dental readiness.

“(3) Modification of predeployment health assessment survey.—In carrying out paragraph (1), the Secretary shall—

“(A) to the extent practicable, modify the predeployment health assessment survey to bring such survey into conformity with the detailed postdeployment health assessment survey in use as of October 1, 2004; and

“(B) ensure the use of the predeployment health assessment survey, as so modified, for predeployment health assessments after that date.”

Uniform Policy On Deferral Of Medical Treatment Pending Deployment To Theaters Of Operations

Pub. L. 108-375, div. A, title VII, Sec. 732(c), Oct. 28, 2004, 118 Stat. 1997, provided that:

“(1) Requirement for policy.—The Secretary of Defense shall prescribe, for uniform applicability throughout the Armed Forces, a policy on deferral of medical treatment of members pending deployment.

“(2) Content.—The policy prescribed under paragraph (1) may specify the following matters:

“(A) The circumstances under which treatment for medical conditions may be deferred to be provided within a theater of operations in order to prevent delay or other disruption of a deployment to that theater.

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“(B) The circumstances under which medical conditions are to be treated before deployment to that theater.”

Medical Care And Tracking And Health Surveillance In The Theater Of Operations

Pub. L. 108-375, div. A, title VII, Sec. 734, Oct. 28, 2004, 118 Stat. 1998, provided that:

“(a) Recordkeeping Policy.—The Secretary of Defense shall prescribe a policy that requires the records of all medical care provided to a member of the Armed Forces in a theater of operations to be maintained as part of a complete health record for the member.

“(b) In-Theater Medical Tracking and Health Surveillance.—

“(1) Requirement for evaluation.—The Secretary of Defense shall evaluate the system for the medical tracking and health surveillance of members of the Armed Forces in theaters of operations and take such actions as may be necessary to improve the medical tracking and health surveillance.

“(2) Report.—Not later than one year after the date of the enactment of this Act [Oct. 28, 2004], the Secretary of Defense shall submit a report on the actions taken under paragraph (1) to the Committees on Armed Services of the Senate and the House of Representatives.

The report shall include the following matters:

“(A) An analysis of the strengths and weaknesses of the medical tracking system administered under section 1074f of title 10, United States Code.

“(B) An analysis of the efficacy of health surveillance systems as a means of detecting—

“(i) any health problems (including mental health conditions) of members of the Armed Forces contemporaneous with the performance of the assessment under the system; and

“(ii) exposures of the assessed members to environmental hazards that potentially lead to future health problems.

“(C) An analysis of the strengths and weaknesses of such medical tracking and surveillance systems as a means for supporting future research on health issues.

“(D) Recommended changes to such medical tracking and health surveillance systems.

“(E) A summary of scientific literature on blood sampling procedures used for detecting and identifying exposures to environmental hazards.

“(F) An assessment of whether there is a need for changes to regulations and standards for drawing blood samples for effective tracking and health surveillance of the medical conditions of personnel before deployment, upon the end of a deployment, and for a followup period of appropriate length.

“(c) Plan To Obtain Health Care Records From Allies.—The Secretary of Defense shall develop a plan for obtaining all records of medical treatment provided to members of the Armed Forces by allies of the United States in Operation Enduring Freedom and Operation Iraqi Freedom. The plan shall specify the actions that are to be taken to obtain all such records.

“(d) Policy on In-Theater Personnel Locator Data.—Not later than one year after the date of the enactment of this Act [Oct. 28, 2004], the Secretary of Defense shall prescribe a Department of Defense policy on the collection and dissemination of in-theater individual personnel location data.”

Declassification Of Information On Exposures To Environmental Hazards

Pub. L. 108-375, div. A, title VII, Sec. 735, Oct. 28, 2004, 118 Stat. 1999, provided that:

“(a) Requirement for Review.—The Secretary of Defense shall review and, as determined appropriate, revise the classification policies of the Department of Defense with a view to facilitating the declassification of data that is potentially useful for the monitoring and

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assessment of the health of members of the Armed Forces who have been exposed to environmental hazards during deployments overseas, including the following data:

- “(1) In-theater injury rates.
- “(2) Data derived from environmental surveillance.
- “(3) Health tracking and surveillance data.

“(b) Consultation With Commanders of Theater Combatant Commands.—The Secretary shall, to the extent that the Secretary considers appropriate, consult with the senior commanders of the in-theater forces of the combatant commands in carrying out the review and revising policies under subsection (a).”

Uniform Policy For Meeting Mobilization-Related Medical Care Needs At Military Installations

Pub. L. 108-375, div. A, title VII, Sec. 737, Oct. 28, 2004, 118 Stat. 2000, provided that:

“(a) Health Care at Mobilization Installations.—The Secretary of Defense shall take such steps as necessary, including through the uniform policy established under subsection (c), to ensure that anticipated health care needs of members of the Armed Forces at mobilization installations can be met at those installations. Such steps may, within authority otherwise available to the Secretary, include the following with respect to any such installation:

- “(1) Arrangements for health care to be provided by the Secretary of Veterans Affairs.
- “(2) Procurement of services from local health care providers.
- “(3) Temporary employment of health care personnel to provide services at such installation.

“(b) Mobilization Installations.—For purposes of this section, the term ‘mobilization installation’ means a military installation at which members of the Armed Forces, in connection with a contingency operation or during a national emergency—

- “(1) are mobilized;
- “(2) are deployed; or
- “(3) are redeployed from a deployment location.

“(c) Requirement for Regulations.—

- “(1) Policy on implementation.—The Secretary of Defense shall by regulation establish a policy for the implementation of subsection (a) throughout the Department of Defense.
- “(2) Identification and analysis of needs.—As part of the policy prescribed under paragraph (1), the Secretary shall require the Secretary of each military department, with respect to each mobilization installation under the jurisdiction of that Secretary, to identify and analyze the anticipated health care needs at that installation with respect to members of the Armed Forces who may be expected to mobilize or deploy or redeploy at that installation as described in subsection (b)(1). Such identification and analysis shall be carried out so as to be completed before the arrival of such members at the installation.
- “(3) Response to needs.—The policy established by the Secretary of Defense under paragraph (1) shall require that, based on the results of the identification and analysis under paragraph (2), the Secretary of the military department concerned shall determine how to expeditiously and effectively respond to those anticipated health care needs that cannot be met within the resources otherwise available at that installation, in accordance with subsection (a).

“(4) Implementation of authority.—In implementing the policy established under paragraph (1) at any installation, the Secretary of the military department concerned shall ensure that the commander of the installation, and the officers and other personnel superior to that commander in that commander’s chain of command, have appropriate authority and responsibility for such implementation.

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- “(d) Policy.—The Secretary of Defense shall ensure—
- “(1) that the policy prescribed under subsection (c) is carried out with respect to any mobilization installation with the involvement of all agencies of the Department of Defense that have responsibility for management of the installation and all organizations of the Department that have command authority over any activity at the installation; and
 - “(2) that such policy is implemented on a uniform basis throughout the Department of Defense.”

Full Implementation Of Medical Readiness Tracking And Health Surveillance Program And Force Health Protection And Readiness Program

Pub. L. 108-375, div. A, title VII, Sec. 738, Oct. 28, 2004, 118 Stat. 2001, provided that:

- “(a) Implementation at All Levels.—The Secretary of Defense, in conjunction with the Secretaries of the military departments, shall take such actions as are necessary to ensure that the Army, Navy, Air Force, and Marine Corps fully implement at all levels—
- “(1) the Medical Readiness Tracking and Health Surveillance Program under this title [see Tables for classification] and the amendments made by this title; and
 - “(2) the Force Health Protection and Readiness Program of the Department of Defense (relating to the prevention of injury and illness and the reduction of disease and noncombat injury threats).
- “(b) Action Official.—The Secretary of Defense may act through the Under Secretary of Defense for Personnel and Readiness in carrying out subsection (a).”

Internet Accessibility Of Health Assessment Information For Members Of The Armed Forces

Pub. L. 108-375, div. A, title VII, Sec. 739(b), Oct. 28, 2004, 118 Stat. 2002, provided that: “Not later than one year after the date of the enactment of this Act [Oct. 28, 2004], the Chief Information Officer of each military department shall ensure that the online portal website of that military department includes the following information relating to health assessments:

- “(1) Information on the policies of the Department of Defense and the military department concerned regarding predeployment and postdeployment health assessments, including policies on the following matters:
- “(A) Health surveys.
 - “(B) Physical examinations.
 - “(C) Collection of blood samples and other tissue samples.
- “(2) Procedural information on compliance with such policies, including the following information:
- “(A) Information for determining whether a member is in compliance.
 - “(B) Information on how to comply.
- “(3) Health assessment surveys that are either—
- “(A) web-based; or
 - “(B) accessible (with instructions) in printer-ready form by download.”

Inclusion Of Dental Care

Pub. L. 108-375, div. A, title VII, Sec. 740, as added by Pub. L. 109-163, div. A, title VII, Sec. 745(a), Jan. 6, 2006, 119 Stat. 3362, provided that: “For purposes of the plan, this subtitle [subtitle D (Secs. 731-740) of title VII of div. A of Pub. L. 108-375, enacting sections 1073b and 1092a of this title and enacting provisions set out as notes under this section and sections 1073b, 1074f, and 1092a of this title], and the amendments made by this subtitle, references to medical readiness, health status, and health care shall be considered to include dental readiness, dental status, and dental care.”

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Pub. L. 108-136, div. A, title VII, Sec. 706, Nov. 24, 2003, 117 Stat. 1529, as amended by Pub. L. 110-181, div. A, title X, Sec. 1063(g)(1), Jan. 28, 2008, 122 Stat. 323, provided that:

“(a) Outlay Limitation.—In the administration of the temporary Reserve health care programs, the Secretary of Defense shall carry out those programs so as to limit the total Department of Defense expenditures under those programs during fiscal year 2004 to an amount not in excess \$400,000,000.

“(b) Continuity of Care.—In the administration of the temporary Reserve health care programs, the Secretary of Defense shall carry out the implementation and termination of those programs so as to ensure the least amount of disruption to the continuity of care for persons provided care under those programs.

“(c) Temporary Reserve Health Care Programs.—For purposes of this section, the term ‘temporary Reserve health care programs’ means the following:

“(1) The program under [former] section 1076b of title 10, United States Code, as amended by section 702.

“(2) The program under section 1074(d) of title 10, United States Code, as amended by section 703.

“(3) The program under section 704 [former 10 U.S.C. 1145 note].”

Disclosure Of Information On Project 112 To Department Of Veterans Affairs

Pub. L. 107-314, div. A, title VII, Sec. 709, Dec. 2, 2002, 116 Stat. 2586, provided that:

“(a) Plan for Disclosure of Information.—Not later than 90 days after the date of the enactment of this Act [Dec. 2, 2002], the Secretary of Defense shall submit to Congress and the Secretary of Veterans Affairs a comprehensive plan for the review, declassification, and submittal to the Department of Veterans Affairs of all records and information of the Department of Defense on Project 112 that are relevant to the provision of benefits by the Secretary of Veterans Affairs to members of the Armed Forces who participated in that project.

“(b) Plan Requirements.—(1) The records and information covered by the plan under subsection (a) shall be the records and information necessary to permit the identification of members of the Armed Forces who were or may have been exposed to chemical or biological agents as a result of Project 112.

“(2) The plan shall provide for completion of all activities contemplated by the plan not later than one year after the date of the enactment of this Act [Dec. 2, 2002].

“(c) Identification of Other Projects or Tests.—The Secretary of Defense also shall work with veterans and veterans service organizations to identify other projects or tests conducted by the Department of Defense that may have exposed members of the Armed Forces to chemical or biological agents.

“(d) GAO Reports on Plan and Implementation.—(1) Not later than 30 days after submission of the plan under subsection (a), the Comptroller General shall submit to Congress a report reviewing the plan. The report shall include an examination of whether adequate resources have been committed, the timeliness of the information to be released to the Department of Veterans Affairs, and the adequacy of the procedures to notify affected veterans of potential exposure.

“(2) Not later than six months after implementation of the plan begins, the Comptroller General shall submit to Congress a report evaluating the progress in the implementation of the plan.

“(e) DOD Reports on Implementation.—(1) Not later than six months after the date of the enactment of this Act [Dec. 2, 2002], and upon completion of all activities contemplated by the plan under subsection (a), the Secretary of Defense shall submit to Congress and the Secretary of Veterans Affairs a report on progress in the implementation of the plan.

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“(2) Each report under paragraph (1) shall include, for the period covered by such report—

“(A) the number of records reviewed;

“(B) each test, if any, under Project 112 identified during such review;

“(C) for each test so identified—

“(i) the test name;

“(ii) the test objective;

“(iii) the chemical or biological agent or agents involved; and

“(iv) the number of members of the Armed Forces, and civilian personnel, potentially effected by such test; and

“(D) the extent of submittal of records and information to the Secretary of Veterans Affairs under this section.

“(f) Project 112.—For purposes of this section, Project 112 refers to the chemical and biological weapons vulnerability-testing program of the Department of Defense conducted by the Deseret Test Center from 1963 to 1969. The project included the Shipboard Hazard and Defense (SHAD) project of the Navy.”

Health Care At Former Uniformed Services Treatment Facilities For Active Duty Members Stationed At Certain Remote Locations

Pub. L. 106-65, div. A, title VII, Sec. 706, Oct. 5, 1999, 113 Stat. 684, as amended by Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 722(a)(3)], Oct. 30, 2000, 114 Stat. 1654, 1654A-185, provided that:

“(a) Authority.—Health care may be furnished by a designated provider pursuant to any contract entered into by the designated provider under section 722(b) of the National Defense Authorization Act for Fiscal Year 1997 (Public Law 104-201; 10 U.S.C. 1073 note) to eligible members who reside within the service area of the designated provider.

“(b) Eligibility.—A member of the uniformed services (as defined in section 1072(1) of title 10, United States Code) is eligible for health care under subsection (a) if the member is a member described in section 731(c) of the National Defense Authorization Act for Fiscal Year 1998 (Public Law 105-85; 111 Stat. 1811; 10 U.S.C. 1074 note).

“(c) Applicable Policies.—In furnishing health care to an eligible member under subsection (a), a designated provider shall adhere to the Department of Defense policies applicable to the furnishing of care under the TRICARE Prime Remote program, including coordinating with uniformed services medical authorities for hospitalizations and all referrals for specialty care.

“(d) Reimbursement Rates.—The Secretary of Defense, in consultation with the designated providers, shall prescribe reimbursement rates for care furnished to eligible members under subsection (a). The rates prescribed for health care may not exceed the amounts allowable under the TRICARE Standard plan for the same care.”

Temporary Authority For Managed Care Expansion To Members On Active Duty At Certain Remote Locations; “TRICARE Program” And “TRICARE Prime Plan” Defined

Pub. L. 105-85, div. A, title VII, Sec. 731(b)-(f), Nov. 18, 1997, 111 Stat. 1811, 1812, as amended by Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 722(a)(2), (b)(2)], Oct. 30, 2000, 114 Stat. 1654, 1654A-185, 1654A-186, provided that:

“(b) Temporary Authority for Managed Care Expansion to Members on Active Duty at Certain Remote Locations.—(1) A member of the uniformed services described in subsection (c) is entitled to receive care under the Civilian Health and Medical Program of the Uniformed Services. In connection with such care, the Secretary of Defense shall waive the obligation of the member to pay a deductible, copayment, or annual fee that would otherwise be applicable under that program for care provided to the members under the program. A dependent of the member, as described in subparagraph (A), (D), or (I) of section 1072(2) of title 10, United States

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Code, who is residing with the member shall have the same entitlement to care and to waiver of charges as the member.

"(2) A member or dependent of the member, as the case may be, who is entitled under paragraph (1) to receive health care services under CHAMPUS shall receive such care from a network provider under the TRICARE program if such a provider is available in the service area of the member.

"(3) Paragraph (1) shall take effect on the date of the enactment of this Act [Nov. 18, 1997] and shall expire with respect to a member upon the later of the following:

"(A) The date that is one year after the date of the enactment of this Act.

"(B) The date on which the amendments made by subsection (a) [amending this section] apply with respect to the coverage of medical care for, and provision of such care to, the member.

"(4) The Secretary of Defense shall consult with the other administering Secretaries in the administration of this subsection.

"(c) Eligible Members.—A member referred to in subsection (b) is a member of the uniformed services on active duty who—

"(1) receives a duty assignment described in subsection (d); and

"(2) pursuant to the assignment of such duty, resides at a location that is more than 50 miles, or approximately one hour of driving time, from—

"(A) the nearest health care facility of the uniformed services adequate to provide the needed care under chapter 55 of title 10, United States Code; and

"(B) the nearest source of the needed care that is available to the member under the TRICARE Prime plan.

"(d) Duty Assignments Covered.—A duty assignment referred to in subsection (c)(1) means any of the following:

"(1) Permanent duty as a recruiter.

"(2) Permanent duty at an educational institution to instruct, administer a program of instruction, or provide administrative services in support of a program of instruction for the Reserve Officers' Training Corps.

"(3) Permanent duty as a full-time adviser to a unit of a reserve component of the uniformed services.

"(4) Any other permanent duty designated by the Secretary concerned for purposes of this subsection.

"(e) Payment of Costs.—Deductibles, copayments, and annual fees not payable by a member by reason of a waiver granted under the regulations prescribed pursuant to subsection (b) shall be paid out of funds available to the Department of Defense for the Defense Health Program.

"(f) Definitions.—In this section [amending this section and enacting provisions set out as a note above]:

"(1) The term 'TRICARE program' has the meaning given that term in section 1072(7) of title 10, United States Code.

"(2) The term 'TRICARE Prime plan' means a plan under the TRICARE program that provides for the voluntary enrollment of persons for the receipt of health care services to be furnished in a manner similar to the manner in which health care services are furnished by health maintenance organizations.

"(3) The terms 'uniformed services' and 'administering Secretaries' have the meanings given those terms in section 1072 of title 10, United States Code."

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[Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 722(c)(2), (3)], Oct. 30, 2000, 114 Stat. 1654, 1654A-186, provided that:

["(2) The amendments made by subsection (a)(2) [amending section 731(b)-(f) of Pub. L. 105-85, set out above], with respect to members of the uniformed services, and the amendments made by subsection (b)(2) [amending section 731(b)-(f) of Pub. L. 105-85, set out above], with respect to dependents of members, shall take effect on the date of the enactment of this Act [Oct. 30, 2000] and shall expire with respect to a member or the dependents of a member, respectively, on the later of the following:

["(A) The date that is one year after the date of the enactment of this Act.

["(B) The date on which the policies required by the amendments made by subsection (a)(1) or (b)(1) [amending this section and section 1079 of this title] are implemented with respect to the coverage of medical care for and provision of such care to the member or dependents, respectively.

["(3) Section 731(b)(3) of Public Law 105-85 [set out above] does not apply to a member of the Coast Guard, the National Oceanic and Atmospheric Administration, or the Commissioned Corps of the Public Health Service, or to a dependent of a member of a uniformed service."]

Independent Research Regarding Gulf War Syndrome

Pub. L. 104-201, div. A, title VII, Sec. 743, Sept. 23, 1996, 110 Stat. 2601, provided that:

"(a) Definitions.—For purposes of this section:

"(1) The term 'Gulf War service' means service on active duty as a member of the Armed Forces in the Southwest Asia theater of operations during the Persian Gulf War.

"(2) The term 'Gulf War syndrome' means the complex of illnesses and symptoms commonly known as Gulf War syndrome.

"(3) The term 'Persian Gulf War' has the meaning given that term in section 101(33) of title 38, United States Code.

"(b) Research.—The Secretary of Defense shall provide, by contract, grant, or other transaction, for scientific research to be carried out by entities independent of the Federal Government on possible causal relationships between Gulf War syndrome and—

"(1) the possible exposures of members of the Armed Forces to chemical warfare agents or other hazardous materials during Gulf War service; and

"(2) the use by the Department of Defense during the Persian Gulf War of combinations of various inoculations and investigational new drugs.

"(c) Procedures for Awarding Grants.—The Secretary shall prescribe the procedures to be used to make research awards under subsection (b). The procedures shall—

"(1) include a comprehensive, independent peer-review process for the evaluation of proposals for scientific research that are submitted to the Department of Defense; and

"(2) provide for the final selection of proposals for award to be based on the scientific merit and program relevance of the proposed research.

"(d) Availability of Funds.—Of the amount authorized to be appropriated under section 301(21) [110 Stat. 2475] for defense medical programs, \$10,000,000 is available for research under subsection (b)."

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Persian Gulf Illness

Pub. L. 105-85, div. A, title VII, Secs. 761, 762, 770, Nov. 18, 1997, 111 Stat. 1824, 1829, provided that:

“SEC. 761. DEFINITIONS.

“For purposes of this subtitle [subtitle F (Secs. 761-771) of title VII of Pub. L. 105-85, enacting sections 1074e, 1074f, and 1107 of this title and this note]:

“(1) The term ‘Gulf War illness’ means any one of the complex of illnesses and symptoms that might have been contracted by members of the Armed Forces as a result of service in the Southwest Asia theater of operations during the Persian Gulf War.

“(2) The term ‘Persian Gulf War’ has the meaning given that term in section 101 of title 38, United States Code.

“(3) The term ‘Persian Gulf veteran’ means an individual who served on active duty in the Armed Forces in the Southwest Asia theater of operations during the Persian Gulf War.

“(4) The term ‘contingency operation’ has the meaning given that term in section 101(a) of title 10, United States Code, and includes a humanitarian operation, peacekeeping operation, or similar operation.

“SEC. 762. PLAN FOR HEALTH CARE SERVICES FOR PERSIAN GULF VETERANS.

“(a) Plan Required.—The Secretary of Defense and the Secretary of Veterans Affairs, acting jointly, shall prepare a plan to provide appropriate health care to Persian Gulf veterans (and dependents eligible by law) who suffer from a Gulf War illness.

“(b) Contents of Plan.—In preparing the plan, the Secretaries shall—

“(1) use the presumptions of service connection and illness specified in paragraphs (1) and (2) of section 721(d) of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1074 note) to determine the Persian Gulf veterans (and dependents eligible by law) who should be covered by the plan;

“(2) consider the need and methods available to provide health care services to Persian Gulf veterans who are no longer on active duty in the Armed Forces, such as Persian Gulf veterans who are members of the reserve components and Persian Gulf veterans who have been separated from the Armed Forces; and

“(3) estimate the costs to the Government of providing full or partial health care services under the plan to covered Persian Gulf veterans (and covered dependents eligible by law).

“(c) Follow-up Treatment.—The plan required by subsection (a) shall specifically address the measures to be used to monitor the quality, appropriateness, and effectiveness of, and patient satisfaction with, health care services provided to Persian Gulf veterans after their initial medical examination as part of registration in the Persian Gulf War Veterans Health Registry or the Comprehensive Clinical Evaluation Program.

“(d) Submission of Plan.—Not later than March 1, 1998, the Secretaries shall submit to Congress the plan required by subsection (a).

“SEC. 770. PERSIAN GULF ILLNESS CLINICAL TRIALS PROGRAM.

“(a) Findings.—Congress finds the following:

“(1) There are many ongoing studies that investigate risk factors which may be associated with the health problems experienced by Persian Gulf veterans; however, there have been no studies that examine health outcomes and the effectiveness of the treatment received by such veterans.

“(2) The medical literature and testimony presented in hearings on Gulf War illnesses indicate that there are therapies, such as cognitive behavioral therapy, that have been effective in treating patients with symptoms similar to those seen in many Persian Gulf veterans.

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“(b) Establishment of Program.—The Secretary of Defense and the Secretary of Veterans Affairs, acting jointly, shall establish a program of cooperative clinical trials at multiple sites to assess the effectiveness of protocols for treating Persian Gulf veterans who suffer from ill-defined or undiagnosed conditions. Such protocols shall include a multidisciplinary treatment model, of which cognitive behavioral therapy is a component.

“(c) Funding.—Of the funds authorized to be appropriated in section 201(1) [111 Stat. 1655] for research, development, test, and evaluation for the Army, the sum of \$4,500,000 shall be available for program element 62787A (medical technology) in the budget of the Department of Defense for fiscal year 1998 to carry out the clinical trials program established pursuant to subsection (b).”

Pub. L. 103-337, div. A, title VII, Secs. 721, 722, Oct. 5, 1994, 108 Stat. 2804, 2807, as amended by Pub. L. 104-106, div. A, title XV, Sec. 1504(a)(4), (5), Feb. 10, 1996, 110 Stat. 513; Pub. L. 108-136, div. A, title X, Sec. 1031(e), Nov. 24, 2003, 117 Stat. 1604, provided that:

“SEC. 721. PROGRAMS RELATED TO DESERT STORM MYSTERY ILLNESS.

“(a) Outreach Program to Persian Gulf Veterans and Families.—The Secretary of Defense shall institute a comprehensive outreach program to inform members of the Armed Forces who served in the Southwest Asia theater of operations during the Persian Gulf Conflict, and the families of such members, of illnesses that may result from such service. The program shall be carried out through both medical and command channels, as well as any other means the Secretary considers appropriate. Under the program, the Secretary shall—

“(1) inform such individuals regarding—

“(A) common disease symptoms reported by Persian Gulf veterans that may be due to service in the Southwest Asia theater of operations;

“(B) blood donation policy;

“(C) available counseling and medical care for such members; and

“(D) possible health risks to children of Persian Gulf veterans;

“(2) inform such individuals of the procedures for registering in either the Persian Gulf Veterans Health Surveillance System of the Department of Defense or the Persian Gulf War Health Registry of the Department of Veterans Affairs; and

“(3) encourage such members to report any symptoms they may have and to register in the appropriate health surveillance registry.

“(b) Incentives to Persian Gulf Veterans To Register.—In order to encourage Persian Gulf veterans to register any symptoms they may have in one of the existing health registries, the Secretary of Defense shall provide the following:

“(1) For any Persian Gulf veteran who is on active duty and who registers with the Department of Defense’s Persian Gulf War Veterans Health Surveillance System, a full medical evaluation and any required medical care.

“(2) For any Persian Gulf War veteran who is, as of the date of the enactment of this Act [Oct. 5, 1994], a member of a reserve component, opportunity to register at a military medical facility in the Persian Gulf Veterans Health Care Surveillance System and, in the case of a Reserve who registers in that registry, a full medical evaluation by the Department of Defense. Depending on the results of the evaluation and on eligibility status, reserve personnel may be provided medical care by the Department of Defense.

“(3) For a Persian Gulf veteran who is not, as of the date of the enactment of this Act [Oct. 5, 1994], on active duty or a member of a reserve component, assistance and information at a military medical facility on registering with the Persian Gulf War Registry of the Department of Veterans Affairs and information related to support services provided by the Department of Veterans Affairs.

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“(c) Compatibility of Department of Defense and Department of Veterans Affairs Registries.—The Secretary of Defense shall take appropriate actions to ensure—

“(1) that the data collected by and the testing protocols of the Persian Gulf War Health Surveillance System maintained by the Department of Defense are compatible with the data collected by and the testing protocols of the Persian Gulf War Veterans Health Registry maintained by the Department of Veterans Affairs; and

“(2) that all information on individuals who register with the Department of Defense for purposes of the Persian Gulf War Health Surveillance System is provided to the Secretary of Veterans Affairs for incorporation into the Persian Gulf War Veterans Health Registry.

“(d) Presumptions on Behalf of Service Member.—(1) A member of the Armed Forces who is a Persian Gulf veteran, who has symptoms of illness, and who the Secretary concerned finds may have become ill as a result of serving on active duty in the Southwest Asia theater of operations during the Persian Gulf War shall be considered for Department of Defense purposes to have become ill as a result of serving in that theater of operations.

“(2) A member of the Armed Forces who is a Persian Gulf veteran and who reports being ill as a result of serving on active duty in the Southwest Asia theater of operations during the Persian Gulf War shall be considered for Department of Defense purposes to have become ill as a result of serving in that theater of operations until such time as the weight of medical evidence establishes other cause or causes of the member’s illness.

“(3) The Secretary concerned shall ensure that, for the purposes of health care treatment by the Department of Defense, health care and personnel administration, and disability evaluation by the Department of Defense, the symptoms of any member of the Armed Forces covered by paragraph (1) or (2) are examined in light of the member’s service in the Persian Gulf War and in light of the reported symptoms of other Persian Gulf veterans. The Secretary shall ensure that, in providing health care diagnosis and treatment of the member, a broad range of potential causes of the member’s symptoms are considered and that the member’s symptoms are considered collectively, as well as by type of symptom or medical specialty, and that treatment across medical specialties is coordinated appropriately.

“(4) The Secretary of Defense shall ensure that the presumptions of service connection and illness specified in paragraphs (1) and (2) are incorporated in appropriate service medical and personnel regulations and are widely disseminated throughout the Department of Defense.

“(e) Revision of the Physical Evaluation Board Criteria.—(1) The Secretary of Defense, in consultation with the Secretary of Veterans Affairs and the Secretary of Health and Human Services, shall ensure that case definitions of Persian Gulf related illnesses, as well as the Physical Evaluation Board criteria used to set disability ratings for members no longer medically qualified for continuation on active duty, are established as soon as possible to permit accurate disability ratings related to a diagnosis of Persian Gulf illnesses.

“(2) Until revised disability criteria can be implemented and members of the Armed Forces can be rated against those criteria, the Secretary of Defense shall ensure—

“(A) that any member of the Armed Forces on active duty who may be suffering from a Persian Gulf-related illness is afforded continued military medical care; and

“(B) that any member of the Armed Forces on active duty who is found by a Physical Evaluation Board to be unfit for continuation on active duty as a result of a Persian Gulf-related illness for which the board has no rating criteria (or inadequate rating criteria) for the illness or condition from which the member suffers is placed on the temporary disability retired list.

“(f) Review of Records and Rerating of Previously Discharged Gulf War Veterans.—(1) The Secretary of Defense, in consultation with the Secretary of Veterans Affairs, shall ensure that a

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review is made of the health and personnel records of each Persian Gulf veteran who before the date of the enactment of this Act [Oct. 5, 1994] was discharged from active duty, or was medically retired, as a result of a Physical Evaluation Board process.

“(2) The review under paragraph (1) shall be carried out to ensure that former Persian Gulf veterans who may have been suffering from a Persian Gulf-related illness at the time of discharge or retirement from active duty as a result of the Physical Evaluation Board process are reevaluated in accordance with the criteria established under subsection (e)(1) and, if appropriate, are rerated.

“(g) Persian Gulf Illness Medical Referral Centers.—The Secretary of Defense shall evaluate the feasibility of establishing one or more medical referral centers to provide uniform, coordinated medical care for Persian Gulf veterans on active duty who are or may be suffering from a Persian Gulf-related illness. The Secretary shall submit a report on such feasibility to the Committees on Armed Services of the Senate and House of Representatives not later than six months after the date of the enactment of this Act [Oct. 5, 1994].

“[(h) Repealed. Pub. L. 108-136, div. A, title X, Sec. 1031(e), Nov. 24, 2003, 117 Stat. 1604.]

“(i) Persian Gulf Veteran.—For purposes of this section, a Persian Gulf veteran is an individual who served on active duty in the Armed Forces in the Southwest Asia theater of operations during the Persian Gulf Conflict.

“SEC. 722. STUDIES OF HEALTH CONSEQUENCES OF MILITARY SERVICE OR EMPLOYMENT IN SOUTHWEST ASIA DURING THE PERSIAN GULF WAR.

“(a) In General.—The Secretary of Defense, in coordination with the Secretary of Veterans Affairs and the Secretary of Health and Human Services, shall conduct studies and administer grants for studies to determine—

“(1) the nature and causes of illnesses suffered by individuals as a consequence of service or employment by the United States in the Southwest Asia theater of operations during the Persian Gulf War; and

“(2) the appropriate treatment for those illnesses.

“(b) Nature of the Studies.—(1) Studies under subsection (a)—

“(A) shall include consideration of the range of potential exposure of individuals to environmental, battlefield, and other conditions incident to service in the theater;

“(B) shall be conducted so as to provide assessments of both short-term and long-term effects to the health of individuals as a result of those exposures; and

“(C) shall include, at a minimum, the following types of studies:

“(i) An epidemiological study or studies on the incidence, prevalence, and nature of the illness and symptoms and the risk factors associated with symptoms or illnesses.

“(ii) Studies to determine the health consequences of the use of pyridostigmine bromide as a pretreatment antidote enhancer during the Persian Gulf War, alone or in combination with exposure to pesticides, environmental toxins, and other hazardous substances.

“(iii) Clinical research and other studies on the causes, possible transmission, and treatment of Persian Gulf-related illnesses.

“(2)(A) The first project carried out under paragraph (1)(C)(ii) shall be a retrospective study of members of the Armed Forces who served in the Southwest Asia theater of operations during the Persian Gulf War.

“(B) The second project carried out under paragraph (1)(C)(ii) shall consist of animal research and nonanimal research, including in vitro systems, as required, designed to determine whether the use of pyridostigmine bromide in combination with exposure

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to pesticides or other organophosphates, carbamates, or relevant chemicals will result in increased toxicity in animals and is likely to have a similar effect on humans.

“(c) Individuals Covered by the Studies.—Studies conducted pursuant to subsections [sic] (a) shall apply to the following individuals:

“(1) Individuals who served as members of the Armed Forces in the Southwest Asia theater of operations during the Persian Gulf War.

“(2) Individuals who were civilian employees of the Department of Defense in that theater during that period.

“(3) To the extent appropriate, individuals who were employees of contractors of the Department of Defense in that theater during that period.

“(4) To the extent appropriate, the spouses and children of individuals described in paragraph (1).

“(d) Plan for the Studies.—(1) The Secretary of Defense shall prepare a coordinated plan for the studies to be conducted pursuant to subsection (a). The plan shall include plans and requirements for research grants in support of the studies. The Secretary shall submit the plan to the National Academy of Sciences for review and comment.

“(2) The plan for studies pursuant to subsection (a) shall be updated annually. The Secretary of Defense shall request an annual review by the National Academy of Sciences of the updated plan and study progress and results achieved during the preceding year.

“(3) The plan, and annual updates to the plan, shall be prepared in coordination with the Secretary of Veterans Affairs and the Secretary of Health and Human Services.

“(e) Funding.—(1) From the amount authorized to be appropriated pursuant to section 201 [108 Stat. 2690] for Defense-wide activities, the Secretary of Defense shall make available such funds as the Secretary considers necessary to support the studies conducted pursuant to subsection (a).

“(2) For each year in which activities continue in support of the studies conducted pursuant to subsection (a), the Secretary of Defense shall include in the budget request for the Department of Defense a request for such funds as the Secretary determines necessary to continue the activities during that fiscal year.

“(f) Reports.—(1) Not later than March 31, 1995, the Secretary of Defense shall submit to Congress the coordinated plan for the studies to be conducted pursuant to subsection (a) and the results of the review of that plan by the National Academy of Sciences.

“(2) Not later than October 1 of each year through 1998, the Secretary shall submit to Congress a report on the results of the studies conducted pursuant to subsection (a), plans for continuation of the studies, and the results of the annual review of the studies by the National Academy of Sciences.

“(3) Each report under this section shall be prepared in coordination with the Secretary of Veterans Affairs and the Secretary of Health and Human Services.

“(g) Definition.—In this section, the term ‘Persian Gulf War’ has the meaning given such term in section 101 of title 38, United States Code.”

[For provisions establishing the Persian Gulf War Veterans Health Registry, provisions requiring a study by the Office of Technology Assessment of the Persian Gulf Registry and the Persian Gulf War Veterans Health Registry, provisions relating to an agreement with the National Academy of Sciences for review of health consequences of service during the Persian Gulf War, and coordination of government activities on health-related research on the Persian Gulf War, see title VII of Pub. L. 102-585, set out as a note under section 527 of Title 38, Veterans’ Benefits.]

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Funding Of Fisher Houses Associated With Army Medical Treatment Facilities

Pub. L. 103-335, title VIII, Sec. 8017, Sept. 30, 1994, 108 Stat. 2620, which provided that during fiscal year 1995 and thereafter, proceeds from investment of Fisher House Investment Trust Fund were to be used to support operation and maintenance of Fisher Houses associated with Army medical treatment facilities, was repealed and restated in section 2221(c)(1) of this title by Pub. L. 104-106, div. A, title IX, Sec. 914(a)(1), (d)(4), Feb. 10, 1996, 110 Stat. 412, 413.

Mental Health Evaluations Of Members Of Armed Forces

Pub. L. 102-484, div. A, title V, Sec. 546(a)-(h), Oct. 23, 1992, 106 Stat. 2416-2419, which directed Secretary of Defense, not later than 180 days after Oct. 23, 1992, to revise applicable regulations to incorporate certain requirements with respect to mental health evaluations of members of Armed Forces and to submit a report describing process of preparing regulations, was repealed by Pub. L. 112-81, div. A, title VII, Sec. 711(b), Dec. 31, 2011, 125 Stat. 1476.

Study On Risk-Sharing Contracts For Health Care

Pub. L. 102-484, div. A, title VII, Sec. 725, Oct. 23, 1992, 106 Stat. 2440, directed Secretary of Defense, in consultation with Secretary of Health and Human Services, not later than 18 months after Oct. 23, 1992, to carry out a study of the feasibility and advisability of entering into risk-sharing contracts with eligible organizations described in 42 U.S.C. 1395mm(b) to furnish health care services to persons entitled to health care in a facility of a uniformed service under section 1074(b) or 1076(b) of this title, to develop a plan for the entry into contracts in accordance with the Secretary's determinations under the study, and to submit to Congress a report describing the results of the study and containing any plan developed.

Registry Of Members Of Armed Forces Serving In Operation Desert Storm

Pub. L. 102-190, div. A, title VII, Sec. 734, Dec. 5, 1991, 105 Stat. 1411, as amended by Pub. L. 102-585, title VII, Sec. 704, Nov. 4, 1992, 106 Stat. 4977; Pub. L. 108-136, div. A, title X, Sec. 1031(c)(1), Nov. 24, 2003, 117 Stat. 1604, provided that:

“(a) Establishment of Registry.—The Secretary of Defense shall establish and maintain a special record (in this section referred to as the ‘Registry’) relating to the following members of the Armed Forces:

“(1) Members who, as determined by the Secretary, were exposed to the fumes of burning oil in the Operation Desert Storm theater of operations during the Persian Gulf conflict.

“(2) Any other members who served in the Operation Desert Storm theater of operations during the Persian Gulf conflict.

“(b) Contents of Registry.—(1) The Registry shall include—

“(A) with respect to each class of members referred to in each of paragraphs (1) and (2) of subsection (a)—

“(i) a list containing each such member's name and other relevant identifying information with respect to the member; and

“(ii) to the extent that data are available and inclusion of the data is feasible, a description of the circumstances of the member's service during the Persian Gulf conflict, including the locations in the Operation Desert Storm theater of operations in which such service occurred and the atmospheric and other environmental circumstances in such locations at the time of such service; and

“(B) with respect to the members referred to in subsection (a)(1), a description of the circumstances of each exposure of each such member to the fumes of burning oil as described in such subsection (a)(1), including the length of time of the exposure.

“(2) The Secretary shall establish the Registry with the advice of an independent scientific organization.

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"[(c) Repealed. Pub. L. 108-136, div. A, title X, Sec. 1031(c)(1), Nov. 24, 2003, 117 Stat. 1604.]

"(d) Medical Examination.—Upon the request of any member listed in the Registry pursuant to subsection (a)(1), the Secretary of the military department concerned shall, if medically appropriate, furnish a pulmonary function examination and chest x-ray to such person.

"(e) Effective Date.—The Secretary shall establish the Registry not later than 180 days after the date of the enactment of this Act [Dec. 5, 1991].

"(f) Definitions.—For purposes of this section:

"(1) The term 'Operation Desert Storm' has the meaning given such term in section 3(1) of the Persian Gulf Conflict Supplemental Authorization and Personnel Benefits Act of 1991 (Public Law 102-25; 105 Stat. 77; 10 U.S.C. 101 note).

"(2) The term 'Persian Gulf conflict' has the meaning given such term in section 3(3) of such Act."

[For provisions relating to the Persian Gulf War Veterans Health Registry, see title VII of Pub. L. 102-585, set out as a note under section 527 of Title 38, Veterans' Benefits.]

Advisory Committee On Mental Health Evaluation Protections

Pub. L. 101-510, div. A, title V, Sec. 554, Nov. 5, 1990, 104 Stat. 1567, as amended by Pub. L. 102-484, div. A, title V, Sec. 546(j)[(i)], Oct. 23, 1992, 106 Stat. 2419, directed Secretary of Defense, not later than 60 days after Nov. 5, 1990, to establish an advisory committee to develop and recommend to the Secretary, not later than 6 months after Nov. 5, 1990, regulations on procedural protections that should be afforded to any member of the Armed Forces who is referred by a commanding officer for a mental health evaluation by a mental health professional and directed Secretary, not later than 30 days after receipt of the report, to submit to Congress the report of the advisory committee, along with such additional comments and recommendations by the Secretary as the Secretary considers appropriate.

Prohibition On Fee For Outpatient Care At Military Medical Treatment Facilities

Pub. L. 101-189, div. A, title VII, Sec. 721, Nov. 29, 1989, 103 Stat. 1477, provided that during fiscal years 1990 and 1991, the Secretary of Defense could not impose a charge for the receipt of outpatient medical or dental care at a military medical treatment facility. Similar provisions were contained in the following prior authorization act:

Pub. L. 100-180, div. A, title VII, Sec. 722, Dec. 4, 1987, 101 Stat. 1116.

Restriction On Use Of Information Obtained During Certain Epidemiologic-Assessment Interviews

Pub. L. 99-661, div. A, title VII, Sec. 705(c), Nov. 14, 1986, 100 Stat. 3904, provided that:

"(1) Information obtained by the Department of Defense during or as a result of an epidemiologic-assessment interview with a serum-positive member of the Armed Forces may not be used to support any adverse personnel action against the member.

"(2) For purposes of paragraph (1):

"(A) The term 'epidemiologic-assessment interview' means questioning of a serum-positive member of the Armed Forces for purposes of medical treatment or counseling or for epidemiologic or statistical purposes.

"(B) The term 'serum-positive member of the Armed Forces' means a member of the Armed Forces who has been identified as having been exposed to a virus associated with the acquired immune deficiency syndrome.

"(C) The term 'adverse personnel action' includes—

"(i) a court-martial;

"(ii) non-judicial punishment;

"(iii) involuntary separation (other than for medical reasons);

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- “(iv) administrative or punitive reduction in grade;
- “(v) denial of promotion;
- “(vi) an unfavorable entry in a personnel record;
- “(vii) a bar to reenlistment; and
- “(viii) any other action considered by the Secretary concerned to be an adverse personnel action.”

Study Of Medical Needs Of Armed Forces; Report To President And Congress

Pub. L. 92-129, title I, Sec. 101(c), Sept. 28, 1971, 85 Stat. 354, authorized Secretary of Defense and Secretary of Health, Education, and Welfare to conduct a joint study of means of meeting medical needs of Armed Forces through means requiring less dependence on Armed Forces medical personnel, giving consideration to providing medical care for military personnel and their dependents under contracts with clinics, hospitals, and individual members of the medical profession at or near military installations within and outside the United States. The study and recommendations were to be submitted to President and Congress no later than 6 months after Sept. 28, 1971.

Executive Order No. 13075

Ex. Ord. No. 13075, Feb. 19, 1997, 63 F.R. 9085, which established the Special Oversight Board for Department of Defense Investigations of Gulf War Chemical and Biological Incidents, was revoked by Ex. Ord. No. 13225, Sec. 3(e), Sept. 28, 2001, 66 F.R. 50292.

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§ 1074i. Reimbursement for certain travel expenses

(a) In General.—In any case in which a covered beneficiary is referred by a primary care physician to a specialty care provider who provides services more than 100 miles from the location in which the primary care provider provides services to the covered beneficiary, the Secretary of Defense shall provide travel and transportation allowances as specified in regulations prescribed under section 464 of title 37 for the covered beneficiary and, when accompaniment by an adult is necessary, for a parent or guardian of the covered beneficiary or another member of the covered beneficiary's family who is at least 21 years of age.

(b) Allowable Travel and Transportation Under Exceptional Circumstances.—The Secretary of Defense may provide travel and transportation allowances as specified in the regulations referred to in subsection (a) for travel of members of the armed forces on active duty and their dependents, and accompaniment, to a specialty care provider not otherwise authorized by subsection (a) under such exceptional circumstances as the Secretary considers appropriate for purposes of this section.

(c) Outreach Program and Travel Reimbursement for Follow-on Specialty Care and Related Services.—The Secretary concerned shall ensure that an outreach program is implemented for each member of the uniformed services who incurred a combat-related disability and is entitled to retired or retainer pay, or equivalent pay, so that—

- (1) the progress of the member is closely monitored; and
- (2) the member receives the travel reimbursement authorized by subsection (a) whenever the member requires follow-on specialty care, services, or supplies.

(d) Definitions.—In this section:

- (1) The term “specialty care provider” includes a dental specialist.
- (2) The term “dental specialist” means an oral surgeon, orthodontist, prosthodontist, periodontist, endodontist, or pediatric dentist, and includes such other providers of dental care and services as determined appropriate by the Secretary of Defense.
- (3) The term “combat-related disability” has the meaning given that term in section 1413a of this title.

NOTES

Source

(Added Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 758(a)], Oct. 30, 2000, 114 Stat. 1654, 1654A-199; amended Pub. L. 107-107, div. A, title VII, Sec. 706, Dec. 28, 2001, 115 Stat. 1163; Pub. L. 108-136, div. A, title VII, Sec. 712, Nov. 24, 2003, 117 Stat. 1530; Pub. L. 110-181, div. A, title XVI, Sec.

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1632(a), (b), Jan. 28, 2008, 122 Stat. 458, 459; Pub. L. 111-84, div. A, title VI, Sec. 634, Oct. 28, 2009, 123 Stat. 2363; Pub. L. 113-66, div. A, title VI, Sec. 621(d), Dec. 26, 2013, 127 Stat. 784.)

Amendments

2013—Subsec. (a). Pub. L. 113-66, Sec. 621(d)(1), substituted “travel and transportation allowances as specified in regulations prescribed under section 464 of title 37” for “reimbursement for reasonable travel expenses”.

Subsec. (b). Pub. L. 113-66, Sec. 621(d)(2), substituted “Allowable Travel and Transportation Under Exceptional Circumstances.—The Secretary of Defense may provide travel and transportation allowances as specified in the regulations referred to in subsection (a) for” for “Reimbursement for Travel Under Exceptional Circumstances.—The Secretary of Defense may provide reimbursement for reasonable travel expenses of”.

2009—Subsec. (a). Pub. L. 111-84, Sec. 634(b), inserted “of Defense” after “the Secretary”.
Subsecs. (b) to (d). Pub. L. 111-84, Sec. 634(a), added subsec. (b) and redesignated former subsecs. (b) and (c) as (c) and (d), respectively.

2008—Subsecs. (b), (c). Pub. L. 110-181, Sec. 1632(a), added subsec. (b) and redesignated former subsec. (b) as (c).
Subsec. (c)(3). Pub. L. 110-181, Sec. 1632(b), added par. (3).

2003—Pub. L. 108-136 inserted “(a) In General.—” before “In any case” and added subsec. (b).

2001—Pub. L. 107-107 inserted before period at end “and, when accompaniment by an adult is necessary, for a parent or guardian of the covered beneficiary or another member of the covered beneficiary’s family who is at least 21 years of age”.

Effective Date Of 2008 Amendment

Pub. L. 110-181, div. A, title XVI, Sec. 1632(c), Jan. 28, 2008, 122 Stat. 459, provided that: “Subsection (b) of section 1074i of title 10, United States Code, as added by subsection (a)(2), shall apply with respect to travel described in subsection (a) of such section that occurs on or after January 1, 2008, for follow-on specialty care, services, or supplies.”

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Pub. L. 103-160, Sec. 713(a)(1), as amended by Pub. L. 103-337, Sec. 1070(b)(6), inserted “or under any other provision of law from any other payer” after “third-party payer”.

Subsec. (h). Pub. L. 103-160, Sec. 713(b), inserted “a preferred provider organization and” after “includes” in par. (2) and added par. (3).

1991—Subsec. (a)(1). Pub. L. 102-25 inserted “a” before “covered beneficiary”.

Subsec. (i)(2). Pub. L. 102-190 struck out “or no fault insurance” before “carrier”.

1990—Pub. L. 101-510, Sec. 713(d)(2), substituted “Health care services incurred on behalf of covered beneficiaries: collection from third-party payers” for “Collection from third-party payers of reasonable inpatient hospital care costs incurred on behalf of retirees and dependents” in section catchline.

Subsec. (a)(1). Pub. L. 101-510, Sec. 713(d)(1)(A), substituted “covered beneficiary” for “covered by section 1074(b), 1076(a), or 1076(b) of this title”.

Pub. L. 101-510, Sec. 713(a)(1), substituted “health care services” for “inpatient hospital care”.

Subsec. (a)(2). Pub. L. 101-510, Sec. 713(d)(1)(B), substituted “covered beneficiary” for “person covered by section 1074(b), 1076(a), or 1076(b) of this title”.

Pub. L. 101-510, Sec. 713(a)(1), substituted “health care services” for “inpatient hospital care”.

Subsec. (c). Pub. L. 101-510, Sec. 713(a)(1), substituted “health care services” for “inpatient hospital care”.

Subsec. (f). Pub. L. 101-510, Sec. 713(a)(1), substituted “health care services” for “inpatient hospital care” in introductory provisions.

Subsec. (f)(2) to (4). Pub. L. 101-510, Sec. 713(b), added pars. (2) and (3) and redesignated former par. (2) as (4).

Subsec. (g). Pub. L. 101-510, Sec. 713(a)(1), substituted “health care services” for “inpatient hospital care”.

Subsecs. (h), (i). Pub. L. 101-510, Sec. 713(c), added subsecs. (h) and (i) and struck out former subsec. (h) which read as follows: “In this section, the term ‘third-party payer’ means an entity that provides an insurance, medical service, or health plan by contract or agreement.”

1989—Subsec. (g). Pub. L. 101-189, Sec. 727(a)(2), added subsec. (g). Former subsec. (g) redesignated (h).

Subsec. (h). Pub. L. 101-189, Sec. 1622(e)(5), which directed amendment of subsec. (g) by insertion of “the term” after “In this section,” was executed by making the insertion in subsec. (h) to reflect the probable intent of Congress and the intervening redesignation of subsec. (g) as (h) by Pub. L. 101-189, Sec. 727(a)(1), see below.

Pub. L. 101-189, Sec. 727(a)(1), redesignated subsec. (g) as (h).

Effective Date Of 1994 Amendment

Pub. L. 103-337, *div. A, title X, Sec. 1070(b), Oct. 5, 1994, 108 Stat. 2856*, provided that the amendment made by that section is effective as of Nov. 30, 1993, and as if included in the National Defense Authorization Act for Fiscal Year 1994, Pub. L. 103-160, as enacted.

Effective Date Of 1990 Amendment

Pub. L. 101-510, *div. A, title VII, Sec. 713(e), Nov. 5, 1990, 104 Stat. 1584*, provided that: “The amendments made by subsection (a) [amending this section] shall apply with respect to health care services provided in a medical facility of the uniformed services after the date of the enactment of this Act [Nov. 5, 1990], but not with respect to collection under any insurance, medical service, or health plan agreement entered into before the date of the enactment of this Act

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that the Secretary of Defense determines clearly excludes payment for such services. Such an exception shall apply until the amendment or renewal of such agreement after that date.”

Effective Date Of 1989 Amendment

Pub. L. 101-189, div. A, title VII, Sec. 727(b), Nov. 29, 1989, 103 Stat. 1480, provided that: “The amendment made by this section [amending this section] shall take effect on October 1, 1989, and shall apply to amounts collected under section 1095 of title 10, United States Code, on or after that date.”

Effective Date

Pub. L. 99-272, title II, Sec. 2001(b), Apr. 7, 1986, 100 Stat. 101, provided that: “Section 1095 of title 10, United States Code, as added by subsection (a), shall apply with respect to inpatient hospital care provided after September 30, 1986, but only with respect to an insurance, medical service, or health plan agreement entered into, amended, or renewed on or after the date of the enactment of this Act [Apr. 7, 1986].”

Pilot Program On Increased Third-Party Collection Reimbursements In Military Medical Treatment Facilities

Pub. L. 113-66, div. A, title VII, Sec. 712, Dec. 26, 2013, 127 Stat. 793, provided that:

“(a) Pilot Program.—

“(1) In general.—The Secretary of Defense, in coordination with the Secretaries of the military departments, shall carry out a pilot program to demonstrate and assess the feasibility of implementing processes described in paragraph (2) to increase the amounts collected under section 1095 of title 10, United States Code, from a third-party payer for charges for health care services incurred by the United States at a military medical treatment facility.

“(2) Processes described.—The processes described in this paragraph are commercially available enhanced recovery practices for medical payment collection, including revenue-cycle management together with rates and percentages of collection in accordance with industry standards for such practices.

“(b) Requirements.—In carrying out the pilot program under subsection (a)(1), the Secretary shall—

“(1) identify and analyze the best practice option, including commercial best practices, with respect to the processes described in subsection (a)(2) that are used in nonmilitary health care facilities; and

“(2) conduct a cost-benefit analysis to assess measurable results of the pilot program, including an analysis of—

“(A) the different processes used in the pilot program;

“(B) the amount of third-party collections that resulted from such processes;

“(C) the cost to implement and sustain such processes; and

“(D) any other factors the Secretary determines appropriate to assess the pilot program.

“(c) Locations.—The Secretary shall carry out the pilot program under subsection (a)(1)—

“(1) at military installations that have a military medical treatment facility with inpatient and outpatient capabilities; and

“(2) at a number of such installations of different military departments that the Secretary determines sufficient to fully assess the results of the pilot program.

“(d) Duration.—The Secretary shall commence the pilot program under subsection (a)(1) by not later than 270 days after the date of the enactment of this Act [Dec. 26, 2013] and shall carry out such program for three years.

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§ 1095. Health care services incurred on behalf of covered beneficiaries: collection from third-party payers

“(e) Report.—Not later than 180 days after completing the pilot program under subsection (a)(1), the Secretary shall submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] a report describing the results of the program, including—

“(1) a comparison of—

“(A) the processes described in subsection (a)(2) that were used in the military medical treatment facilities participating in the program; and

“(B) the third-party collection processes used by military medical treatment facilities not included in the program;

“(2) a cost analysis of implementing the processes described in subsection (a)(2) for third-party collections at military medical treatment facilities;

“(3) an assessment of the program, including any recommendations to improve third-party collections; and

“(4) an analysis of the methods employed by the military departments prior to the program with respect to collecting charges from third-party payers incurred at military medical treatment facilities, including specific data with respect to the dollar amount of third-party collections that resulted from each method used throughout the military departments.”

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§ 1097a. TRICARE Prime: automatic enrollments; payment options

(a) Automatic Enrollment of Certain Dependents.—(1) In the case of a dependent of a member of the uniformed services who is entitled to medical and dental care under section 1076(a)(2)(A) of this title and resides in a catchment area in which TRICARE Prime is offered, the Secretary—

(A) shall automatically enroll the dependent in TRICARE Prime if the member is in pay grade E-4 or below; and

(B) may automatically enroll the dependent in TRICARE Prime if the member is in pay grade E-5 or higher.

(2) Whenever a dependent of a member is enrolled in TRICARE Prime under paragraph (1), the Secretary concerned shall provide written notice of the enrollment to the member.

(3) The enrollment of a dependent of the member may be terminated by the member or the dependent at any time.

(b) Automatic Renewal of Enrollments of Covered Beneficiaries.—(1) An enrollment of a covered beneficiary in TRICARE Prime shall be automatically renewed upon the expiration of the enrollment unless the renewal is declined.

(2) Not later than 15 days before the expiration date for an enrollment of a covered beneficiary in TRICARE Prime, the Secretary concerned shall—

(A) transmit a written notification of the pending expiration and renewal of enrollment to the covered beneficiary or, in the case of a dependent of a member of the uniformed services, to the member; and

(B) afford the beneficiary or member, as the case may be, an opportunity to decline the renewal of enrollment.

(c) Payment Options for Retirees.—A member or former member of the uniformed services eligible for medical care and dental care under section 1074(b) of this title may elect to have any fee payable by the member or former member for an enrollment in TRICARE Prime withheld from the member's retired pay, retainer pay, or equivalent pay, as the case may be, or to be paid from a financial institution through electronic transfers of funds. The fee shall be paid in accordance with the election. A member may elect under this section to pay the fee in full at the beginning of the enrollment period or to make payments on a monthly or quarterly basis.

(d) Regulations and Exceptions.—The Secretary of Defense shall prescribe regulations, including procedures, to carry out this section. Regulations prescribed to carry out the automatic enrollment requirements under this section may include such exceptions to the automatic enrollment procedures as the Secretary determines appropriate for the effective operation of TRICARE Prime.

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(e) No Copayment for Immediate Family.—No copayment shall be charged a member for care provided under TRICARE Prime to a dependent of a member of the uniformed services described in subparagraph (A), (D), or (I) of section 1072(2) of this title.

(f) Definitions.—In this section:

(1) The term “TRICARE Prime” means the managed care option of the TRICARE program.

(2) The term “catchment area”, with respect to a facility of a uniformed service, means the service area of the facility, as designated under regulations prescribed by the administering Secretaries.

NOTES

Source

(Added Pub. L. 105-261, div. A, title VII, Sec. 712(a)(1), Oct. 17, 1998, 112 Stat. 2058; amended Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 752(a)], Oct. 30, 2000, 114 Stat. 1654, 1654A-195; Pub. L. 107-107, div. A, title X, Sec. 1048(a)(11), Dec. 28, 2001, 115 Stat. 1223; Pub. L. 112-239, div. A, title VII, Sec. 711, Jan. 2, 2013, 126 Stat. 1801.)

Amendments

2013—Subsec. (a). Pub. L. 112-239 amended subsec. (a) generally. Prior to amendment, text read as follows: “Each dependent of a member of the uniformed services in grade E4 or below who is entitled to medical and dental care under section 1076(a)(2)(A) of this title and resides in the catchment area of a facility of a uniformed service offering TRICARE Prime shall be automatically enrolled in TRICARE Prime at the facility. The Secretary concerned shall provide written notice of the enrollment to the member. The enrollment of a dependent of the member may be terminated by the member or the dependent at any time.”

2001—Subsec. (e). Pub. L. 107-107 substituted “section 1072(2)” for “section 1072”.

2000—Subsecs. (e), (f). Pub. L. 106-398 added subsec. (e) and redesignated former subsec. (e) as (f).

Effective Date Of 2000 Amendment

Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 752(b)], Oct. 30, 2000, 114 Stat. 1654, 1654A-195, provided that: “The amendments made by subsection (a) [amending this section] shall take effect 180 days after the date of the enactment of this Act [Oct. 30, 2000], and shall apply with respect to care provided on or after that date.”

Effective Date

Pub. L. 105-261, div. A, title VII, Sec. 712(b), Oct. 17, 1998, 112 Stat. 2059, provided that: “The regulations required under subsection (d) of section 1097a of title 10, United States Code (as added by subsection (a)), shall be prescribed to take effect not later than September 30, 1999. The section shall be applied under TRICARE Prime on and after the date on which the regulations take effect.”

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Future Availability Of TRICARE Prime Throughout The United States

Pub. L. 112-239, div. A, title VII, Sec. 732, Jan. 2, 2013, 126 Stat. 1816, as amended by Pub. L. 113-66, div. A, title VII, Sec. 701, Dec. 26, 2013, 127 Stat. 789, provided that:

“(a) Report Required.—

“(1) In general.—Not later than 90 days after the date of the enactment of this Act [Jan. 2, 2013], the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report setting forth the policy of the Department of Defense on the future availability of TRICARE Prime under the TRICARE program for eligible beneficiaries in all TRICARE regions throughout the United States.

“(2) Elements.—The report required by paragraph (1) shall include the following:

“(A) A description, by region, of the difference in availability of TRICARE Prime for eligible beneficiaries (other than eligible beneficiaries on active duty in the Armed Forces) under newly awarded TRICARE managed care contracts, including, in particular, an identification of the regions or areas in which TRICARE Prime will no longer be available for such beneficiaries under such contracts.

“(B) An estimate of the increased costs to be incurred by an affected eligible beneficiary for health care under the TRICARE program.

“(C) An estimate of the savings to be achieved by the Department as a result of the contracts described in subparagraph (A).

“(D) A description of the plans of the Department to continue to assess the impact on access to health care for affected eligible beneficiaries.

“(E) A description of the plan of the Department to provide assistance to affected eligible beneficiaries who are transitioning from TRICARE Prime to TRICARE Standard, including assistance with respect to identifying health care providers.

“(F) Any other matter the Secretary considers appropriate.

“(b) Access to TRICARE Prime.—

“(1) One-time election.—Subject to paragraph (3), the Secretary shall ensure that each affected eligible beneficiary who is enrolled in TRICARE Prime as of September 30, 2013, may make a one-time election to continue such enrollment in TRICARE Prime, notwithstanding that a contract described in subsection (a)(2)(A) does not allow for such enrollment based on the location in which such beneficiary resides. The beneficiary may continue such enrollment in TRICARE Prime so long as the beneficiary resides in the same ZIP code as the ZIP code in which the beneficiary resided at the time of such election.

“(2) Enrollment in caricature standard.—If an affected eligible beneficiary makes the one-time election under paragraph (1), the beneficiary may thereafter elect to enroll in TRICARE Standard at any time in accordance with a contract described in subsection (a)(2)(A).

“(3) Residence at time of election.—An affected eligible beneficiary may not make the one-time election under paragraph (1) if, at the time of such election, the beneficiary does not reside—

“(A) in a ZIP code that is in a region described in subsection (c)(1)(B); and

“(B) within 100 miles of a military medical treatment facility.

“(4) Network.—In continuing enrollment in TRICARE Prime pursuant to paragraph (1), the Secretary may determine whether to maintain a TRICARE network of providers in an area that is between 40 and 100 miles of a military medical treatment facility.

“(c) Definitions.—In this section:

“(1) The term &affectedness eligible beneficiary; means an eligible beneficiary under the TRICARE Program (other than eligible beneficiaries on active duty in the Armed Forces) who, as of the date of the enactment of this Act [Jan. 2, 2013]—

“(A) is enrolled in TRICARE Prime; and

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“(B) resides in a region of the United States in which TRICARE Prime enrollment will no longer be available for such beneficiary under a contract described in subsection (a)(2)(A) that does not allow for such enrollment because of the location in which such beneficiary resides.

“(2) The term ‘TRICARE Prime’ means the managed care option of the TRICARE program.

“(3) The term ‘TRICARE program’ has the meaning given that term in section 1072(7) of title 10, United States Code.

“(4) The term ‘TRICARE Standard’ means the fee-for-service option of the TRICARE Program.”

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