



DEFENSE  
HEALTH AGENCY

**MB&RS**

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS  
16401 EAST CENTRETECH PARKWAY  
AURORA, CO 80011-9066**

**CHANGE 7  
10 USC 55  
JUNE 8, 2016**

**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 2016 UPDATE

**DATE LISTED:** January 3, 2016.

**PAGE CHANGE(S):** USC Classification Table, 114th, First Session (Public Laws 114-1 through 114-115)—Prepared by Office of the Law Revision Counsel, U.S. House of Representatives (January 3, 2016).

**PAGE CHANGE(S):** See page 2.

**ATTACHMENT(S):** 151 PAGES  
**DISTRIBUTION:** 10 USC 55

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

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**Title 10 - Armed Forces**  
**Subtitle A - General Military Law**  
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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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## Amendments

2015—Pub. L. 114-92, div. A, title VII, §711(b), Nov. 25, 2015, 129 Stat. 864, added item 1095g.

2014—Pub. L. 113-291, div. A, title VII, §§701(a)(2), 704(b), 711(b), Dec. 19, 2014, 128 Stat. 3408, 3413, 3414, added items 1074n, 1079c, and 1097d.

2011—Pub. L. 112-81, div. A, title VII, Secs. 702(a)(2), 704(b), 711(a)(2), Dec. 31, 2011, 125 Stat. 1471, 1473, 1476, added items 1074m, 1078b, and 1090a.

Pub. L. 111-383, div. A, title VII, Sec. 702(a)(2), Jan. 7, 2011, 124 Stat. 4245, added item 1110b.

2009—Pub. L. 111-84, div. A, title VII, Secs. 705(b), 707(b), Oct. 28, 2009, 123 Stat. 2375, 2376, added items 1076e and 1110a.

2008—Pub. L. 110-181, div. A, title XVI, Sec. 1617(b), Jan. 28, 2008, 122 Stat. 449, as amended by Pub. L. 110-417, [div. A], title X, Sec. 1061(b)(14), Oct. 14, 2008, 122 Stat. 4613, added item 1074l.

2006—Pub. L. 109-364, div. A, title VII, Sec. 707(b), Oct. 17, 2006, 120 Stat. 2284, added item 1097c.

Pub. L. 109-364, div. A, title VII, Sec. 706(e), Oct. 17, 2006, 120 Stat. 2282, struck out item 1076b “TRICARE program: TRICARE Standard coverage for members of the Selected Reserve” and substituted “TRICARE program: TRICARE Standard coverage for members of the Selected Reserve” for “TRICARE program: coverage for members of reserve components who commit to continued service in the Selected Reserve after release from active duty in support of a contingency operation” in item 1076d, effective Oct. 1, 2007.

Pub. L. 109-163, div. A, title VII, Secs. 701(f)(2), 702(a)(2), Jan. 6, 2006, 119 Stat. 3340, 3342, substituted “TRICARE program: TRICARE Standard coverage for members of the Selected Reserve” for “TRICARE program: coverage for members of the Ready Reserve” in item 1076b and “TRICARE program: coverage for members of reserve components who commit to continued service in the Selected Reserve after release from active duty in support of a contingency operation” for “TRICARE program: coverage for members of reserve components who commit to continued service in the Selected Reserve after release from active duty” in item 1076d.

2004—Pub. L. 108-375, div. A, title V, Sec. 555(a)(2), title VI, Sec. 607(a)(2), title VII, Secs. 701(a)(2), 733(a)(2), 739(a)(2), title X, Sec. 1084(d)(7), Oct. 28, 2004, 118 Stat. 1914, 1946, 1981, 1998, 2002, 2061, added items 1073b, 1074b, 1076d, and 1092a, reenacted item 1076b without change, and struck out item 1075 “Officers and certain enlisted members: subsistence charges”.

2003—Pub. L. 108-136, div. A, title XVI, Sec. 1603(b)(2), Nov. 24, 2003, 117 Stat. 1690, added item 1107a.

Pub. L. 108-106, title I, Sec. 1115(b), Nov. 6, 2003, 117 Stat. 1218, added item 1076b.

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2001—Pub. L. 107-107, div. A, title VII, Secs. 701(a)(2), (f)(2), 731(b), 732(a)(2), 736(c)(2), title X, Sec. 1048(a)(10), Dec. 28, 2001, 115 Stat. 1158, 1161, 1169, 1173, 1223, struck out item 1074b “Transitional medical and dental care: members on active duty in support of contingency operations”; transferred item 1074i to appear after item 1074h, and added items 1074j, 1074k, 1079b, and 1086b.

2000—Pub. L. 106-398, Sec. 1 [[div. A], title VII, Secs. 706(a)(2), 728(a)(2), 751(b)(2), 758(b)], Oct. 30, 2000, 114 Stat. 1654, 1654A-175, 1654A-189, 1654A-194, 1654A-200, added items 1074h, 1074i, 1095f, and 1110.

1999—Pub. L. 106-65, div. A, title VII, Secs. 701(a)(2), 711(b), 713(a)(2), 714(b), 715(a)(2), 716(a)(2), 722(b), Oct. 5, 1999, 113 Stat. 680, 687, 689-691, 695, added items 1073a, 1074g, 1076a, 1095c, 1095d, 1095e, and 1097b and struck out former items 1076a “Dependents’ dental program” and 1076b “Selected Reserve dental insurance”.

1998—Pub. L. 105-261, div. A, title VII, Secs. 711(b), 712(a)(2), 721(a)(2), 734(b)(2), 741(b)(2), Oct. 17, 1998, 112 Stat. 2058, 2059, 2065, 2073, 2074, added items 1094a, 1095b, 1097a, 1108, and 1109.

1997—Pub. L. 105-85, div. A, title VII, Secs. 738(b), 764(b), 765(a)(2), 766(b), Nov. 18, 1997, 111 Stat. 1815, 1826-1828, added items 1074e, 1074f, 1106, and 1107 and struck out former item 1106 “Submittal of claims under CHAMPUS”.

1996—Pub. L. 104-201, div. A, title VII, Secs. 701(a)(2)(B), 703(a)(2), 733(a)(2), Sept. 23, 1996, 110 Stat. 2587, 2590, 2598, substituted “Certain primary and preventive health care services” for “Primary and preventive health care services for women” in item 1074d and added items 1076c and 1079a.

Pub. L. 104-106, div. A, title VII, Secs. 705(a)(2), 735(d)(2), 738(b)(2), Feb. 10, 1996, 110 Stat. 373, 383, added item 1076b and substituted “Performance of abortions: restrictions” for “Restriction on use of funds for abortions” in item 1093 and “Defense Health Program Account” for “Military Health Care Account” in item 1100.

1993—Pub. L. 103-160, div. A, title VII, Secs. 701(a)(2), 712(a)(2), 714(b)(2), 716(a)(2), Nov. 30, 1993, 107 Stat. 1686, 1689, 1690, 1692, added item 1074d, substituted “Personal services contracts” for “Contracts for direct health care providers” in item 1091 and “Resource allocation methods: capitation or diagnosis-related groups” for “Diagnosis-related groups” in item 1101, added item 1105, and struck out former item 1105 “Issuance of nonavailability of health care statements”.

1992—Pub. L. 102-484, div. D, title XLIV, Sec. 4408(a)(2), Oct. 23, 1992, 106 Stat. 2712, added item 1078a.

1991—Pub. L. 102-190, div. A, title VI, Sec. 640(b), title VII, Secs. 715(b), 716(a)(2), Dec. 5, 1991, 105 Stat. 1385, 1403, 1404, added item 1074b, redesignated former item 1074b as 1074c, and added items 1105 and 1106.

1990—Pub. L. 101-510, div. A, title VII, Sec. 713(d)(2)[(3)], Nov. 5, 1990, 104 Stat. 1584, 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 item 1095.

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Section	Description of Change	Public Law		Statutes at Large
		Law	Section	Volume STAT. Page(s)
1074g		113-291	702(a)-(c)(1)	3410
1074g	nt	113-291	702(c)(2)	3411
1074g	nt new	113-291	726	3419
1074m		113-291	701(a)(5), (b)	3409
1074m		113-291	1071(f)(13)	3510
1074n	new	113-291	701(a)(1) "1074n"	3408
1074n	nt new	113-291	701(a)(3)	3409
1078b		113-291	705	3413
1079		113-291	703(a)	3411
1079		113-291	703(c)(1)	3412
1079		113-291	706	3413
1079c	new	113-291	704(a) "1079c"	3412
1086		113-291	703(c)(2)	3412
1091	nt new	113-291	725	3418
1097a	nt	113-291	723	3417
1097d	new	113-291	711(a) "1097d"	3413
1105		113-291	703(c)(3)	3412

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**Change 7 Version:** Title 10 of the USC as currently published by the U.S. Government reflects the laws passed by Congress as of January 3, 2016.

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 Sunday, January 3, 2016.

**USC Classification Table, 114th, First Session** (Public Laws 114-1 through 114-115)—Prepared by Office of the Law Revision Counsel, U.S. House of Representatives (January 3, 2016).

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)
<b>114th First Session</b>				
1071	prec	114-92	711(b)	864
1071	nt	114-58	204	533
1071	nt	114-58	411	536
1071	nt	114-92	1072(e), (f)	995
1071	nt new	114-92	591	832
1073	nt	114-92	713	865
1073	nt	114-92	1072(g)	995
1073	nt new	114-92	704	863
1073	nt new	114-92	714	865
1073	nt new	114-92	716	867
1073	nt new	114-92	717	868
1073	nt new	114-92	725	870

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Section	Description of Change	Public Law		Statutes at Large
		Law	Section	Volume STAT. Page(s)
1073b	114-92	712	864	
1074	nt	114-92	705	863
1074d	nt new	114-92	718	868
1074g	114-92	702	860	
1074g	114-92	715(f)	867	
1074g	nt new	114-92	715	866
1078a	114-92	703	861	
1092	nt new	114-92	726	871
1095g	new	114-92	711(a) "1095g"	864
1097a	nt	114-92	701	860

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## § 1071. Purpose of this chapter

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.

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### NOTES

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#### 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 **was** classified to subchapter I-D (Sec. 1973cc et seq.) of chapter 20 of Title 42, The Public Health and Welfare, **prior to repeal by Pub. L. 99-410, title II, §203, Aug. 28, 1986, 100 Stat. 930.**

#### 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 3809 of Title 50, 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.’”

**Coordination With Non-Government Suicide Prevention Organizations and Agencies To Assist in Reducing Suicides by Members of the Armed Forces**

Pub. L. 114-92, div. A, title V, §591, Nov. 25, 2015, 129 Stat. 832, provided that:

“(a) Development of Policy.—The Secretary of Defense, in consultation with the Secretaries of the military departments, may develop a policy to coordinate the efforts of the Department of Defense and non-government suicide prevention organizations regarding—

“(1) the use of such non-government organizations to reduce the number of suicides among members of the Armed Forces by comprehensively addressing the needs of members of the Armed Forces who have been identified as being at risk of suicide;

“(2) the delineation of the responsibilities within the Department of Defense regarding interaction with such organizations;

“(3) the collection of data regarding the efficacy and cost of coordinating with such organizations; and

“(4) the preparation and preservation of any reporting material the Secretary determines necessary to carry out the policy.

“(b) Suicide Prevention Efforts.—The Secretary of Defense is authorized to take any necessary measures to prevent suicides by members of the Armed Forces, including by facilitating the access of members of the Armed Forces to successful non-governmental treatment regimen.”

**Provision Of Information To Members Of The Armed Forces On Privacy Rights Relating To Receipt Of Mental Health Services**

Pub. L. 113–291, div. A, title V, §523, Dec. 19, 2014, 128 Stat. 3361, provided that:

“(a) Provision of Information Required.—The Secretaries of the military departments shall ensure that the information described in subsection (b) is provided—

“(1) to each officer candidate during initial training;

“(2) to each recruit during basic training; and

“(3) to other members of the Armed Forces at such times as the Secretary of Defense considers appropriate.

“(b) Required Information.—The information required to be provided under subsection (a) shall include information on the applicability of the Department of Defense Instruction on Privacy of Individually Identifiable Health Information in DoD Health Care Programs and other regulations regarding privacy prescribed pursuant to the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) to records regarding a member of the Armed Forces seeking and receiving mental health services.”

**Improved Consistency In Data Collection And Reporting In Armed Forces Suicide Prevention Efforts**

Pub. L. 113–291, div. A, title V, §567, Dec. 19, 2014, 128 Stat. 3385, provided that:

“(a) Policy for Standard Suicide Data Collection, Reporting, and Assessment.—

“(1) Policy required.—The Secretary of Defense shall prescribe a policy for the development of a standard method for collecting, reporting, and assessing information regarding—

“(A) any suicide or attempted suicide involving a member of the Armed Forces, including reserve components thereof; and

“(B) any death that is reported as a suicide involving a dependent of a member of the Armed Forces.

“(2) Purpose of policy.—The purpose of the policy required by this subsection is to improve the consistency and comprehensiveness of—

“(A) the suicide prevention policy developed pursuant to section 582 of the National Defense Authorization Act for Fiscal Year 2013 (Public Law 112–239; 10 U.S.C. 1071 note); and

“(B) the suicide prevention and resilience program for the National Guard and Reserves established pursuant to section 10219 of title 10, United States Code.

“(3) Consultation.—The Secretary of Defense shall develop the policy required by this subsection in consultation with the Secretaries of the military departments and the Chief of the National Guard Bureau.

“(b) Submission and Implementation of Policy.—

“(1) Submission.—Not later than 180 days after the date of the enactment of this Act [Dec. 19, 2014], the Secretary of Defense shall submit the policy developed under subsection (a) to the Committees on Armed Services of the Senate and the House of Representatives.

“(2) Implementation.—The Secretaries of the military departments shall implement the policy developed under subsection (a) not later than 180 days after the date of the submittal of the policy under paragraph (1).

“(c) Dependent Defined.—In this section, the term ‘dependent’, with respect to a member of the Armed Forces, means a person described in section 1072(2) of title 10, United States Code, except that, in the case of a parent or parent-in-law of the member, the income requirements of subparagraph (E) of such section do not apply.”

**Antimicrobial Stewardship Program At Medical Facilities Of The Department Of Defense**

Pub. L. 113-291, div. A, title VII, §727, Dec. 19, 2014, 128 Stat. 3420, provided that:

“(a) In General.—Not later than one year after the date of the enactment of this Act [Dec. 19, 2014], the Secretary of Defense shall carry out an antimicrobial stewardship program at medical facilities of the Department of Defense.

“(b) Collection and Analysis of Data.—In carrying out the antimicrobial stewardship program required by subsection (a), the Secretary shall develop a consistent manner in which to collect and analyze data on antibiotic usage, health issues related to antibiotic usage, and antimicrobial resistance trends at medical facilities of the Department.

“(c) Plan.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall submit to the Committees on Armed Services of the House of Representatives and the Senate a plan for carrying out the antimicrobial stewardship program required by subsection (a).”

**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

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“(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

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“(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 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

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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.

“(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

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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).

“(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.

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- "(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."

**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

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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.

“(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:

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“(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 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;

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“(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.”

**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.”

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**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 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

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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].

“(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.

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“(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.

“(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.

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“(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.

“(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

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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.
  - “(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.”

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**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 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.

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“(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 speciality [sic], which shall reflect lessons learned from best practices in academia and the civilian health care industry regarding positions analogous to such speciality; 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 speciality.

**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 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:

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- “(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.
- “(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.

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- "(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
  - "(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.

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“(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;

“(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):

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“(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.”

**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; Pub. L. 113-175, title I, §105, Sept. 26, 2014, 128 Stat. 1903; Pub. L. 113-291, div. A, title V, §591, title VII, §724, Dec. 19, 2014, 128 Stat. 3394, 3418; **Pub. L. 114-58, title II, §204, title IV, §411, Sept. 30, 2015, 129 Stat. 533, 536; Pub. L. 114-92, div. A, title X, §1072(e), (f), Nov. 25, 2015, 129 Stat. 995**, 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.

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“(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.

“(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

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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 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;**

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- “(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.
  - “(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

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“(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 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

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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.

“(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

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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.

“(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

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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.

“(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.

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“(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.

“(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

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“(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 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.

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“(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.

“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.

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- “(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
  - “(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.

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“(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 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

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“(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.

“(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

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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, 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

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- “(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
    - “(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.

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“(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)).

**“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.

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“(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 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).

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- “(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.
  - “(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).

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“(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.

“(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

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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 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, 2016, 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.

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“(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.

“(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

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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 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 2016, 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

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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.]

**“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

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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).

“(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

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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).

“(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.

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“(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.

“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.

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“(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).

“(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).

“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

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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.**

“All quarters of the United States and housing facilities under the jurisdiction of the Armed Forces that are occupied by recovering service members shall be inspected at least once every two years by the inspectors general of the regional medical commands.

**“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.

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“(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.

“(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.

“(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;

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“(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.

“(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:

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- “(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.
- “(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

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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.

“(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

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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.
- “(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.”

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**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 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.

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- “(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.
  - “(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.”

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**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 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.

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“(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.

“(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).

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“(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.]

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**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 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.

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“(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.

“(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 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

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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.

(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

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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.

(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

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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.

(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.

[Reference to the National Security Staff deemed to be a reference to the National Security Council Staff, see Ex. Ord. No. 13657, set out as a note under section 3021 of Title 50, War and National Defense.]

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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.

### Repeals

The directory language of, but not the amendment made by, Pub. L. 89-718, Sec. 8(a), Nov. 2, 1966, 80 Stat. 1117, cited as a credit to this section, was repealed by Pub. L. 97-295, Sec. 6(b), Oct. 12, 1982, 96 Stat. 1314.

### Access To Health Care Under The TRICARE Program For Beneficiaries Of TRICARE Prime

Pub. L. 114-92, div. A, title VII, §704, Nov. 25, 2015, 129 Stat. 863, provided that:

“(a) Access to Health Care.—The Secretary of Defense shall ensure that beneficiaries under TRICARE Prime who are seeking an appointment for health care under TRICARE Prime shall obtain such an appointment within the health care access standards established under subsection (b), including through the use of health care providers in the preferred provider network of TRICARE Prime.

“(b) Standards for Access to Care.—

“(1) In general.—Not later than 180 days after the date of the enactment of this Act [Nov. 25, 2015], the Secretary shall establish health care access standards for the receipt of health care under TRICARE Prime, whether received at military medical treatment facilities or from health care providers in the preferred provider network of TRICARE Prime.

“(2) Categories of care.—The health care access standards established under paragraph (1) shall include standards with respect to the following categories of health care:

“(A) Primary care, including pediatric care, maternity care, gynecological care, and other subcategories of primary care.

“(B) Specialty care, including behavioral health care and other subcategories of specialty care.

“(3) Modifications.—The Secretary may modify the health care access standards established under paragraph (1) whenever the Secretary considers the modification of such standards appropriate.

“(4) Publication.—The Secretary shall publish the health care access standards established under paragraph (1), and any modifications to such standards, in the Federal Register and on a publicly accessible Internet website of the Department of Defense.

“(c) Definitions.—In this section:

“(1) TRICARE prime.—The term ‘TRICARE Prime’ means the managed care option of the TRICARE program.

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

### Portability Of Health Plans Under The TRICARE Program

Pub. L. 114-92, div. A, title VII, §714, Nov. 25, 2015, 129 Stat. 865, provided that:

“(a) Health Plan Portability.—

“(1) In general.—The Secretary of Defense shall ensure that covered beneficiaries under the TRICARE program who are covered under a health plan under such program are able to seamlessly access health care under such health plan in each TRICARE program region.

“(2) Regulations.—Not later than 180 days after the date of the enactment of this Act [Nov. 25, 2015], the Secretary shall prescribe regulations to carry out paragraph (1).

“(b) Mechanisms To Ensure Portability.—In carrying out subsection (a), the Secretary shall—

“(1) establish a process for electronic notification of contractors responsible for administering the TRICARE program in each TRICARE region when any covered beneficiary intends to relocate between such regions;

“(2) provide for the automatic electronic transfer between such contractors of information relating to covered beneficiaries who are relocating between such regions, including demographic, enrollment, and claims information; and

“(3) ensure each such covered beneficiary is able to obtain a new primary health care provider within ten days of—

“(A) arriving at the location to which the covered beneficiary has relocated; and

“(B) initiating a request for a new primary health care provider.

“(c) Publication.—The Secretary shall—

“(1) publish information on any modifications made pursuant to subsection (a) with respect to the ability of covered beneficiaries under the TRICARE program who are covered under a health plan under such program to access health care in each TRICARE region on the primary Internet website of the Department that is available to the public; and

“(2) ensure that such information is made available on the primary Internet website that is available to the public of each current contractor responsible for administering the TRICARE program.

“(d) Definitions.—In this section, the terms ‘covered beneficiary’ and ‘TRICARE program’ have the meaning given such terms in section 1072 of title 10, United States Code.”

#### **Licensure of Mental Health Professionals in TRICARE Program**

Pub. L. 114-92, div. A, title VII, §716, Nov. 25, 2015, 129 Stat. 867, provided that:

“(a) Qualifications for TRICARE Certified Mental Health Counselors During Transition Period.—During the period preceding January 1, 2021, for purposes of determining whether a mental health care professional is eligible for reimbursement under the TRICARE program as a TRICARE certified mental health counselor, an individual who holds a masters degree or doctoral degree in counseling from a program that is accredited by a covered institution shall be treated as holding such degree from a mental health counseling program or clinical mental health counseling program that is accredited by the Council for Accreditation of Counseling and Related Educational Programs.

“(b) Definitions.—In this section:

“(1) The term ‘covered institution’ means any of the following:

“(A) The Accrediting Commission for Community and Junior Colleges Western Association of Schools and Colleges (ACCJC-WASC).

“(B) The Higher Learning Commission (HLC).

“(C) The Middle States Commission on Higher Education (MSCHE).

“(D) The New England Association of Schools and Colleges Commission on Institutions of Higher Education (NEASC-CIHE).

“(E) The Southern Association of Colleges and Schools (SACS) Commission on Colleges.

“(F) The WASC Senior College and University Commission (WASC-SCUC).

“(G) The Accrediting Bureau of Health Education Schools (ABHES).

“(H) The Accrediting Commission of Career Schools and Colleges (ACCSC).

“(I) The Accrediting Council for Independent Colleges and Schools (ACICS).

“(J) The Distance Education Accreditation Commission (DEAC).

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

**Designation Of Certain Non-department Mental Health Care Providers With Knowledge Relating To Treatment Of Members Of The Armed Forces**

Pub. L. 114-92, div. A, title VII, §717, Nov. 25, 2015, 129 Stat. 868, provided that:

“(a) Mental Health Provider Readiness Designation.—

“(1) In general.—Not later than one year after the date of the enactment of this Act [Nov. 25, 2015], the Secretary of Defense shall develop a system by which any non-Department mental health care provider that meets eligibility criteria established by the Secretary relating to the knowledge described in paragraph (2) receives a mental health provider readiness designation from the Department of Defense.

“(2) Knowledge described.—The knowledge described in this paragraph is the following:

“(A) Knowledge and understanding with respect to the culture of members of the Armed Forces and family members and caregivers of members of the Armed Forces.

“(B) Knowledge with respect to evidence-based treatments that have been approved by the Department for the treatment of mental health issues among members of the Armed Forces.

“(b) Availability of Information on Designation.—

“(1) Registry.—The Secretary of Defense shall establish and update as necessary a publically available registry of all non-Department mental health care providers that are currently designated under subsection (a)(1).

“(2) Provider list.—The Secretary shall update all lists maintained by the Secretary of non-Department mental health care providers that provide mental health care under the laws administered by the Secretary by indicating the providers that are currently designated under subsection (a)(1).

“(c) Non-Department Mental Health Care Provider Defined.—In this section, the term ‘non-Department mental health care provider’—

“(1) means a health care provider who—

“(A) specializes in mental health;

“(B) is not a health care provider of the Department of Defense at a facility of the Department; and

“(C) provides health care to members of the Armed Forces; and

“(2) includes psychiatrists, psychologists, psychiatric nurses, social workers, mental health counselors, marriage and family therapists, and other mental health care providers designated by the Secretary of Defense.”

**Pilot Program On Urgent Care Under TRICARE Program**

Pub. L. 114-92, div. A, title VII, §725, Nov. 25, 2015, 129 Stat. 870, provided that:

“(a) Pilot Program.—

“(1) In general.—Commencing not later than 180 days after the date of the enactment of this Act [Nov. 25, 2015], the Secretary of Defense shall carry out a pilot program to allow a covered beneficiary under the TRICARE program access to urgent care visits without the need for preauthorization for such visits.

“(2) Duration.—The Secretary shall carry out the pilot program for a period of three years.

“(3) Incorporation of nurse advice line.—The Secretary shall incorporate the nurse advise [sic] line of the Department into the pilot program to direct covered beneficiaries seeking access to care to the source of the most appropriate level of health care required to treat the medical conditions of the beneficiaries, including urgent care under the pilot program.

“(b) Publication.—The Secretary shall—

“(1) publish information on the pilot program under subsection (a) for the receipt of urgent care under the TRICARE program—

“(A) on the primary publically available Internet website of the Department; and

- “(B) on the primary publically available Internet website of each military medical treatment facility; and
- “(2) ensure that such information is made available on the primary publically available Internet website of each current managed care contractor that has established a health care provider network under the TRICARE program.
- “(c) Reports.—
- “(1) First report.—
- “(A) In general.—Not later than one year after the date on which the pilot program under subsection (a) commences, the Secretary shall submit to the Committees on Armed Services of the House of Representatives and the Senate a report on the pilot program.
- “(B) Elements.—The report under subparagraph (1) shall include the following:
- “(i) An analysis of urgent care use by covered beneficiaries in military medical treatment facilities and the TRICARE purchased care provider network.
- “(ii) A comparison of urgent care use by covered beneficiaries to the use by covered beneficiaries of emergency departments in military medical treatment facilities and the TRICARE purchased care provider network, including an analysis of whether the pilot program decreases the inappropriate use of medical care in emergency departments.
- “(iii) A determination of the extent to which the nurse advice line of the Department affected both urgent care and emergency department use by covered beneficiaries in military medical treatment facilities and the TRICARE purchased care provider network.
- “(iv) An analysis of any cost savings to the Department realized through the pilot program.
- “(v) A determination of the optimum number of urgent care visits available to covered beneficiaries without preauthorization.
- “(vi) An analysis of the satisfaction of covered beneficiaries with the pilot program.
- “(2) Second report.—Not later than two years after the date on which the pilot program commences, the Secretary shall submit to the committees specified in paragraph (1)(A) an update to the report required by such paragraph, including any recommendations of the Secretary with respect to extending or making permanent the pilot program and a description of any related legislative actions that the Secretary considers appropriate.
- “(3) Final report.—Not later than 180 days after the date on which the pilot program is completed, the Secretary shall submit to the committees specified in paragraph (1)(A) a final report on the pilot program that updates the report required by paragraph (2).
- “(d) Definitions.—In this section, the terms ‘covered beneficiary’ and ‘TRICARE program’ have the meaning given such terms in section 1072 of title 10, United States Code.”

**Cooperative Health Care Agreements Between Military Installations And Non-Military Health Care Systems**

Pub. L. 111-84, div. A, title VII, Sec. 713, Oct. 28, 2009, 123 Stat. 2380, provided that:

- “(a) Authority.—The Secretary of Defense may establish cooperative health care agreements between military installations and local or regional health care systems.
- “(b) Requirements.—In establishing an agreement under subsection (a), the Secretary shall—
- (1) consult with—
- (A) the Secretary of the military department concerned;
- (B) representatives from the military installation selected for the agreement, including the TRICARE managed care support contractor with responsibility for such installation; and

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- (C) Federal, State, and local government officials;
- (2) identify and analyze health care services available in the area in which the military installation is located, including such services available at a military medical treatment facility or in the private sector (or a combination thereof);
- (3) determine the cost avoidance or savings resulting from innovative partnerships between the Department of Defense and the private sector; and
- (4) determine the opportunities for and barriers to coordinating and leveraging the use of existing health care resources, including such resources of Federal, State, local, and private entities.

“(c) Annual Reports.—Not later than December 31 of each year an agreement entered into under this section is in effect, 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 each such agreement. Each report shall include, at a minimum, the following:

- (1) A description of the agreement.
- (2) Any cost avoidance, savings, or increases as a result of the agreement.
- (3) A recommendation for continuing or ending the agreement.

“(d) Rule of Construction.—Nothing in this section shall be construed as authorizing the provision of health care services at military medical treatment facilities or other facilities of the Department of Defense to individuals who are not otherwise entitled or eligible for such services under chapter 55 of title 10, United States Code.”

**Inpatient Mental Health Service**

Pub. L. 110-329, div. C, title VIII, Sec. 8095, Sept. 30, 2008, 122 Stat. 3642, provided that: “None of the funds appropriated by this Act [div. C of Pub. L. 110-329, see Tables for classification], and hereafter, available for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or TRICARE shall be available for the reimbursement of any health care provider for inpatient mental health service for care received when a patient is referred to a provider of inpatient mental health care or residential treatment care by a medical or health care professional having an economic interest in the facility to which the patient is referred: Provided, That this limitation does not apply in the case of inpatient mental health services provided under the program for persons with disabilities under subsection (d) of section 1079 of title 10, United States Code, provided as partial hospital care, or provided pursuant to a waiver authorized by the Secretary of Defense because of medical or psychological circumstances of the patient that are confirmed by a health professional who is not a Federal employee after a review, pursuant to rules prescribed by the Secretary, which takes into account the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care.”

**Surveys On Continued Viability Of TRICARE Standard And TRICARE Extra**

Pub. L. 110-181, div. A, title VII, Sec. 711, Jan. 28, 2008, 122 Stat. 190, as amended by Pub. L. 112-81, div. A, title VII, Sec. 721, Dec. 31, 2011, 125 Stat. 1478; Pub. L. 113-291, div. A, title VII, §712, Dec. 19, 2014, 128 Stat. 3414, provided that:

“(a) Requirement for Surveys.—

- (1) In general.—The Secretary of Defense shall conduct surveys of health care providers and beneficiaries who use TRICARE in the United States to determine, utilizing a reconciliation of the responses of providers and beneficiaries to such surveys, each of the following:
  - (A) How many health care providers in TRICARE Prime service areas selected under paragraph (3)(A) are accepting new patients under each of TRICARE Standard and TRICARE Extra.

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- (B) How many health care providers in geographic areas in which TRICARE Prime is not offered are accepting patients under each of TRICARE Standard and TRICARE Extra.
- (C) The availability of mental health care providers in TRICARE Prime service areas selected under paragraph (3)(C) and in geographic areas in which TRICARE Prime is not offered.
- (2) Benchmarks.—The Secretary shall establish for purposes of the surveys required by paragraph (1) benchmarks for primary care and specialty care providers, including mental health care providers, to be utilized to determine the adequacy of the availability of health care providers to beneficiaries eligible for TRICARE.
- (3) Scope of surveys.—The Secretary shall carry out the surveys required by paragraph (1) as follows:
- (A) In the case of the surveys required by subparagraph (A) of that paragraph, in at least 20 TRICARE Prime service areas in the United States in each of fiscal years 2008 through 2015:
- (B) In the case of the surveys required by subparagraph (B) of that paragraph, in 20 geographic areas in which TRICARE Prime is not offered and in which significant numbers of beneficiaries who are members of the Selected Reserve reside:
- (C) In the case of the surveys required by subparagraph (C) of that paragraph, in at least 40 geographic areas:
- (4) Priority for surveys.—In prioritizing the areas which are to be surveyed under paragraph (1), the Secretary shall—
- (A) consult with representatives of TRICARE beneficiaries and health care and mental health care providers to identify locations where TRICARE Standard beneficiaries are experiencing significant levels of access-to-care problems under TRICARE Standard or TRICARE Extra;
- (B) give a high priority to surveying health care and mental health care providers in such areas; and
- (C) give a high priority to surveying beneficiaries and providers located in geographic areas with high concentrations of members of the Selected Reserve:
- (5) Information from providers.—The surveys required by paragraph (1) shall include questions seeking to determine from health care and mental health care providers the following:
- (A) Whether the provider is aware of the TRICARE program:
- (B) What percentage of the provider’s current patient population uses any form of TRICARE:
- (C) Whether the provider accepts patients for whom payment is made under the medicare program for health care and mental health care services:
- (D) If the provider accepts patients referred to in subparagraph (C), whether the provider would accept additional such patients who are not in the provider’s current patient population:
- (6) Information from beneficiaries.—The surveys required by paragraph (1) shall include questions seeking information to determine from TRICARE beneficiaries whether they have difficulties in finding health care and mental health care providers willing to provide services under TRICARE Standard or TRICARE Extra.
- “(b) GAO Review.—
- (1) Ongoing review.—The Comptroller General shall, on an ongoing basis, review—
- (A) the processes, procedures, and analysis used by the Department of Defense to determine the adequacy of the number of health care and mental health care providers—

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(i) that currently accept TRICARE Standard or TRICARE Extra beneficiaries as patients under TRICARE Standard in each TRICARE area as of the date of completion of the review; and

(ii) that would accept TRICARE Standard or TRICARE Extra beneficiaries as new patients under TRICARE Standard or TRICARE Extra, as applicable, within a reasonable time after the date of completion of the review; and

(B) the actions taken by the Department of Defense to ensure ready access of TRICARE Standard beneficiaries to health care and mental health care under TRICARE Standard in each TRICARE area, including any pending or resolved requests for waiver of payment limits in order to improve access to health care or mental health care in a specific geographic area:

(2) Reports.—The Comptroller General shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the results of the review under paragraph (1) during 2017 and 2020. Each report shall include the following:

(A) An analysis of the adequacy of the surveys under subsection (a):

(B) An identification of any impediments to achieving adequacy of availability of health care and mental health care under TRICARE Standard or TRICARE Extra:

(C) An assessment of the adequacy of Department of Defense education programs to inform health care and mental health care providers about TRICARE Standard and TRICARE Extra:

(D) An assessment of the adequacy of Department of Defense initiatives to encourage health care and mental health care providers to accept patients under TRICARE Standard and TRICARE Extra:

(E) An assessment of the adequacy of information available to TRICARE Standard beneficiaries to facilitate access by such beneficiaries to health care and mental health care under TRICARE Standard and TRICARE Extra:

(F) An assessment of any need for adjustment of health care and mental health care provider payment rates to attract participation in TRICARE Standard by appropriate numbers of health care and mental health care providers:

(G) An assessment of the adequacy of Department of Defense programs to inform members of the Selected Reserve about the TRICARE Reserve Select program:

(H) An assessment of the ability of TRICARE Reserve Select beneficiaries to receive care in their geographic area:

“(c) Effective Date.—This section shall take effect on October 1, 2007.

“(d) Repeal of Superseded Requirements and Authority.—Section 723 of the National Defense Authorization Act for Fiscal Year 2004 (10 U.S.C. 1073 note) is repealed, effective as of October 1, 2007.

“(e) Definitions.—In this section:

(1) The term ‘TRICARE Extra’ means the option of the TRICARE program under which TRICARE Standard beneficiaries may obtain discounts on cost-sharing as a result of using TRICARE network providers.

(2) The term ‘TRICARE Prime’ means the managed care option of the TRICARE program.

(3) The term ‘TRICARE Prime service area’ means a geographic area designated by the Department of Defense in which managed care support contractors develop a managed care network under TRICARE Prime.

(4) The term ‘TRICARE Standard’ means the option of the TRICARE program that is also known as the Civilian Health and Medical Program of the Uniformed Services, as defined in section 1072(4) of title 10, United States Code.

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(5) The term 'TRICARE Reserve Select' means the option of the TRICARE program that allows members of the Selected Reserve to enroll in TRICARE Standard, pursuant to section 1076d of title 10, United States Code.

(6) The term 'member of the Selected Reserve' means a member of the Selected Reserve of the Ready Reserve of a reserve component of the Armed Forces.

(7) The term 'United States' means the United States (as defined in section 101(a) of title 10, United States Code), its possessions (as defined in such section), and the Commonwealth of Puerto Rico."

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**Regulations To Establish Criteria For Licensed Or Certified Mental Health Counselors Under TRICARE**

Pub. L. 111-383, div. A, title VII, Sec. 724, Jan. 7, 2011, 124 Stat. 4252, provided that: "Not later than June 20, 2011, the Secretary of Defense shall prescribe the regulations required by section 717 of the National Defense Authorization Act for Fiscal Year 2008 (Public Law 110-181; 10 U.S.C. 1073 note)."

Pub. L. 110-181, div. A, title VII, Sec. 717(a), Jan. 28, 2008, 122 Stat. 196, provided that: "The Secretary of Defense shall prescribe regulations to establish criteria that licensed or certified mental health counselors shall meet in order to be able to independently provide care to TRICARE beneficiaries and receive payment under the TRICARE program for such services. The criteria shall include requirements for education level, licensure, certification, and clinical experience as considered appropriate by the Secretary."

**Inspection Of Military Medical Treatment Facilities, Military Quarters Housing Medical Hold Personnel, And Military Quarters Housing Medical Holdover Personnel**

Pub. L. 110-28, title III, Sec. 3307, May 25, 2007, 121 Stat. 137, **as amended by Pub. L. 114-92, div. A, title X, §1072(g), Nov. 25, 2015, 129 Stat. 995**, provided that:

"(a) Inspection of Military Medical Treatment Facilities, Military Quarters Housing Medical Hold Personnel, and Military Quarters Housing Medical Holdover Personnel.—

(1) In general.—Not later than 180 days after the date of the enactment of this Act [May 25, 2007], and annually thereafter, the Secretary of Defense shall inspect each facility of the Department of Defense as follows:

(A) Each military medical treatment facility:

(B) Each military quarters housing medical hold personnel:

(C) Each military quarters housing medical holdover personnel:

(2) Purpose.—The purpose of an inspection under this subsection is to ensure that the facility or quarters concerned meets acceptable standards for the maintenance and operation of medical facilities, quarters housing medical hold personnel, or quarters housing medical holdover personnel, as applicable.

"(b) Acceptable Standards.—For purposes of this section, acceptable standards for the operation and maintenance of military medical treatment facilities, military quarters housing medical hold personnel, or military quarters housing medical holdover personnel are each of the following:

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

(2) Where appropriate, standards under the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.).

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- “(c) Additional Inspections on Identified Deficiencies.—
- (1) In general.—In the event a deficiency is identified pursuant to subsection (a) at a facility or quarters described in paragraph (1) of that subsection—
    - (A) the commander of such facility or quarters, as applicable, shall submit to the Secretary a detailed plan to correct the deficiency; and
    - (B) the Secretary shall reinspect such facility or quarters, as applicable, not less often than once every 180 days until the deficiency is corrected:
  - (2) Construction with other inspections.—An inspection of a facility or quarters under this subsection is in addition to any inspection of such facility or quarters under subsection (a).
- “(d) Report on Standards.—In the event no standards for the maintenance and operation of military medical treatment facilities, military quarters housing medical hold personnel, or military quarters housing medical holdover personnel exist as of the date of the enactment of this Act, or such standards as do exist do not meet acceptable standards for the maintenance and operation of such facilities or quarters, as the case may be, the Secretary shall, not later than 30 days after that date, submit to the congressional defense committees a report setting forth the plan of the Secretary to ensure—
- (1) the adoption by the Department of standards for the maintenance and operation of military medical facilities, military quarters housing medical hold personnel, or military quarters housing medical holdover personnel, as applicable, that meet—
    - (A) acceptable standards for the maintenance and operation of such facilities or quarters, as the case may be; and
    - (B) where appropriate, standards under the Americans with Disabilities Act of 1990 [42 U.S.C. 12101 et seq.]; and
  - (2) the comprehensive implementation of the standards adopted under paragraph (1) at the earliest date practicable.”

**Requirements For Support Of Military Treatment Facilities By Civilian Contractors Under TRICARE**

Pub. L. 109-364, div. A, title VII, Sec. 732, Oct. 17, 2006, 120 Stat. 2296, as amended by Pub. L. 112-81, div. A, title X, Sec. 1062(d)(3), provided that:

- “(a) Annual Integrated Regional Requirements on Support.—The Regional Director of each region under the TRICARE program shall develop each year integrated, comprehensive requirements for the support of military treatment facilities in such region that is provided by contract civilian health care and administrative personnel under the TRICARE program.
- “(b) Purposes.—The purposes of the requirements established under subsection (a) shall be as follows:
- “(1) To ensure consistent standards of quality in the support of military treatment facilities by contract civilian health care personnel under the TRICARE program.
  - “(2) To identify targeted, actionable opportunities throughout each region of the TRICARE program for the most efficient and cost effective delivery of health care and support of military treatment facilities.
  - “(3) To ensure the most effective use of various available contracting methods in securing support of military treatment facilities by civilian health care personnel under the TRICARE program, including resource-sharing and clinical support agreements, direct contracting, and venture capital investments.
- “(c) Facilitation and Enhancement of Contractor Support.—
- “(1) In general.—The Secretary of Defense shall take appropriate actions to facilitate and enhance the support of military treatment facilities under the TRICARE program in order to assure maximum quality and productivity.

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- “(2) Actions.—In taking actions under paragraph (1), the Secretary shall—
- “(A) require consistent standards of quality for contract civilian health care personnel providing support of military treatment facilities under the TRICARE program, including—
    - “(i) consistent credentialing requirements among military treatment facilities;
    - “(ii) consistent performance standards for private sector companies providing health care staffing services to military treatment facilities and clinics, including, at a minimum, those standards established for accreditation of health care staffing firms by the Joint Commission on the Accreditation of Health Care Organizations Health Care Staffing Standards; and
    - “(iii) additional standards covering—
      - “(I) financial stability;
      - “(II) medical management;
      - “(III) continuity of operations;
      - “(IV) training;
      - “(V) employee retention;
      - “(VI) access to contractor data; and
      - “(VII) fraud prevention;
  - “(B) ensure the availability of adequate and sustainable funding support for projects which produce a return on investment to the military treatment facilities;
  - “(C) ensure that a portion of any return on investment is returned to the military treatment facility to which such savings are attributable;
  - “(D) remove financial disincentives for military treatment facilities and civilian contractors to initiate and sustain agreements for the support of military treatment facilities by such contractors under the TRICARE program;
  - “(E) provide for a consistent methodology across all regions of the TRICARE program for developing cost benefit analyses of agreements for the support of military treatment facilities by civilian contractors under the TRICARE program based on actual cost and utilization data within each region of the TRICARE program; and
  - “(F) provide for a system for monitoring the performance of significant projects for support of military treatment facilities by a civilian contractor under the TRICARE program.
- “[(d) Repealed. Pub. L. 112-81, div. A, title X, Sec. 1062(d)(3), Dec. 31, 2011, 125 Stat. 1585.]
- “(e) Effective Date.—This section shall take effect on October 1, 2006.”

**TRICARE Standard In TRICARE Regional Offices**

Pub. L. 109-163, div. A, title VII, Sec. 716, Jan. 6, 2006, 119 Stat. 3345, as amended by Pub. L. 112-81, div. A, title X, Sec. 1062(e), Dec. 31, 2011, 125 Stat. 1585, provided that:

- “(a) Responsibilities of TRICARE Regional Office.—The responsibilities of each TRICARE Regional Office shall include the monitoring, oversight, and improvement of the TRICARE Standard option in the TRICARE region concerned, including—
- “(1) identifying health care providers who will participate in the TRICARE program and provide the TRICARE Standard option under that program;
  - “(2) communicating with beneficiaries who receive the TRICARE Standard option;
  - “(3) outreach to community health care providers to encourage their participation in the TRICARE program; and
  - “(4) publication of information that identifies health care providers in the TRICARE region concerned who provide the TRICARE Standard option.

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“(b) Definition.—In this section, the term ‘TRICARE Standard’ or ‘TRICARE standard option’ means the Civilian Health and Medical Program of the Uniformed Services option under the TRICARE program.”

**Qualifications For Individuals Serving As TRICARE Regional Directors**

Pub. L. 109-163, div. A, title VII, Sec. 717, Jan. 6, 2006, 119 Stat. 3345, provided that:

“(a) Qualifications.—Effective as of the date of the enactment of this Act [Jan. 6, 2006], no individual may be selected to serve in the position of Regional Director under the TRICARE program unless the individual—

“(1) is—

“(A) an officer of the Armed Forces in a general or flag officer grade;

“(B) a civilian employee of the Department of Defense in the Senior Executive Service;

or

“(C) a civilian employee of the Federal Government in a department or agency other than the Department of Defense, or a civilian working in the private sector, who has experience in a position comparable to an officer described in subparagraph (A) or a civilian employee described in subparagraph (B); and

“(2) has at least 10 years of experience, or equivalent expertise or training, in the military health care system, managed care, and health care policy and administration.

“(b) Tricare Program Defined.—In this section, the term ‘TRICARE program’ has the meaning given such term in section 1072(7) of title 10, United States Code.”

**Pilot Projects On Pediatric Early Literacy Among Children Of Members Of The Armed Forces**

Pub. L. 109-163, div. A, title VII, Sec. 740, Jan. 6, 2006, 119 Stat. 3359, as amended by Pub. L. 109-364, div. A, title X, Sec. 1071(e)(8), Oct. 17, 2006, 120 Stat. 2402, provided that:

“(a) Pilot Projects Authorized.—The Secretary of Defense may conduct pilot projects to assess the feasibility, advisability, and utility of encouraging pediatric early literacy among the children of members of the Armed Forces.

“(b) Locations.—

“(1) In general.—The pilot projects conducted under subsection (a) shall be conducted at not more than 20 military medical treatment facilities designated by the Secretary for purposes of this section.

“(2) Co-location with certain installations.—In designating military medical treatment facilities under paragraph (1), the Secretary shall, to the extent practicable, designate facilities that are located on, or co-located with, military installations at which the mobilization or demobilization of members of the Armed Forces occurs.

“(c) Activities.—Activities under the pilot projects conducted under subsection (a) shall include the following:

“(1) The provision of training to health care providers and other appropriate personnel on early literacy promotion.

“(2) The purchase and distribution of children’s books to members of the Armed Forces, their spouses, and their children.

“(3) The modification of treatment facility and clinic waiting rooms to include a full selection of literature for children.

“(4) The dissemination to members of the Armed Forces and their spouses of parent education materials on pediatric early literacy.

“(5) Such other activities as the Secretary considers appropriate.

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“(d) Report.—

“(1) In general.—Not later than March 1, 2007, 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 pilot projects conducted under this section.

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

“(A) a description of the pilot projects conducted under this section, including the location of each pilot project and the activities conducted under each pilot project; and

“(B) an assessment of the feasibility, advisability, and utility of encouraging pediatric early literacy among the children of members of the Armed Forces.”

#### **Surveys On Continued Viability Of TRICARE Standard**

Pub. L. 108-136, div. A, title VII, Sec. 723, Nov. 24, 2003, 117 Stat. 1532, as amended by Pub. L. 109-163, div. A, title VII, Sec. 711, Jan. 6, 2006, 119 Stat. 3343, required the Secretary of Defense to conduct surveys in the TRICARE market areas in the United States to determine how many health care providers were accepting new patients under TRICARE Standard in each such market area, and required the Comptroller General to review the processes, procedures, and analysis used by the Department of Defense to determine the adequacy of the number of health care providers and the actions taken by the Department of Defense to ensure ready access of TRICARE Standard beneficiaries to health care under TRICARE Standard in each TRICARE market area, prior to repeal by Pub. L. 110-181, div. A, title VII, Sec. 711(d), Jan. 28, 2008, 122 Stat. 193, eff. Oct. 1, 2007.

#### **Modernization Of TRICARE Business Practices And Increase Of Use Of Military Treatment Facilities**

Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 723], Oct. 30, 2000, 114 Stat. 1654, 1654A-186, provided that:

“(a) Requirement To Implement Internet-Based System.—Not later than October 1, 2001, the Secretary of Defense shall implement a system to simplify and make accessible through the use of the Internet, through commercially available systems and products, critical administrative processes within the military health care system and the TRICARE program. The purposes of the system shall be to enhance efficiency, improve service, and achieve commercially recognized standards of performance.

“(b) Elements of System.—The system required by subsection (a)—

“(1) shall comply with patient confidentiality and security requirements, and incorporate data requirements, that are currently widely used by insurers under medicare and commercial insurers;

“(2) shall be designed to achieve improvements with respect to—

“(A) the availability and scheduling of appointments;

“(B) the filing, processing, and payment of claims;

“(C) marketing and information initiatives;

“(D) the continuation of enrollments without expiration;

“(E) the portability of enrollments nationwide;

“(F) education of beneficiaries regarding the military health care system and the TRICARE program; and

“(G) education of health care providers regarding such system and program; and

“(3) may be implemented through a contractor under TRICARE Prime.

“(c) Areas of Implementation.—The Secretary shall implement the system required by subsection (a) in at least one region under the TRICARE program.

“(d) Plan for Improved Portability of Benefits.—Not later than March 15, 2001, the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of

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Representatives a plan to provide portability and reciprocity of benefits for all enrollees under the TRICARE program throughout all TRICARE regions.

“(e) Increase of Use of Military Medical Treatment Facilities.—The Secretary shall initiate a program to maximize the use of military medical treatment facilities by improving the efficiency of health care operations in such facilities.

“(f) Definition.—In this section the term ‘TRICARE program’ has the meaning given such term in section 1072 of title 10, United States Code.”

**Improvement Of Access To Health Care Under The TRICARE Program**

Pub. L. 107-107, div. A, title VII, Sec. 735(e), Dec. 28, 2001, 115 Stat. 1172, directed the Secretary of Defense to submit to committees of Congress, not later than Mar. 1, 2002, a report on the Secretary’s plans for implementing Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 721], as amended, set out below.

Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 721], Oct. 30, 2000, 114 Stat. 1654, 1654A-184, as amended by Pub. L. 107-107, div. A, title VII, Sec. 735(a)-(d), Dec. 28, 2001, 115 Stat. 1171, 1172; Pub. L. 113–291, div. A, title VII, §703(b), Dec. 19, 2014, 128 Stat. 3411, provided that:

“(a) Waiver of Nonavailability Statement or Preauthorization.—In the case of a covered beneficiary under TRICARE Standard pursuant to chapter 55 of title 10, United States Code, the Secretary of Defense may not require with regard to authorized health care services under such chapter that the beneficiary—

“(1) obtain a nonavailability statement or preauthorization from a military medical treatment facility in order to receive the services from a civilian provider; or

“(2) obtain a nonavailability statement for care in specialized treatment facilities outside the 200-mile radius of a military medical treatment facility.

“(b) Waiver Authority.—The Secretary may waive the prohibition in subsection (a) if—

“(1) the Secretary—

“(A) demonstrates that significant costs would be avoided by performing specific procedures at the affected military medical treatment facility or facilities;

“(B) determines that a specific procedure must be provided at the affected military medical treatment facility or facilities to ensure the proficiency levels of the practitioners at the facility or facilities; or

“(C) determines that the lack of nonavailability statement data would significantly interfere with TRICARE contract administration;

“(2) the Secretary provides notification of the Secretary’s intent to grant a waiver under this subsection to covered beneficiaries who receive care at the military medical treatment facility or facilities that will be affected by the decision to grant a waiver under this subsection;

“(3) the Secretary notifies the Committees on Armed Services of the House of Representatives and the Senate of the Secretary’s intent to grant a waiver under this subsection, the reason for the waiver, and the date that a nonavailability statement will be required; and

“(4) 60 days have elapsed since the date of the notification described in paragraph (3).

“(c) Waiver Exception for Maternity Care.—Subsection (b) shall not apply with respect to maternity care.

“(d) Effective Date.—This section shall take effect on the earlier of the following:

“(1) The date that a new contract entered into by the Secretary to provide health care services under TRICARE Standard takes effect.

“(2) The date that is two years after the date of the enactment of the National Defense Authorization Act for Fiscal Year 2002 [Dec. 28, 2001].”

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Pub. L. 106-65, div. A, title VII, Sec. 712(a), (b), Oct. 5, 1999, 113 Stat. 687, provided that:

“(a) Access.—The Secretary of Defense shall, to the maximum extent practicable, minimize the authorization and certification requirements imposed on covered beneficiaries under the TRICARE program as a condition of access to benefits under that program.

“(b) Report on Initiatives To Improve Access.—Not later than March 31, 2000, the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on specific actions taken to—

“(1) reduce the requirements for preauthorization for care under the TRICARE program;

“(2) reduce the requirements for beneficiaries to obtain preventive services, such as obstetric or gynecologic examinations, mammograms for females over 35 years of age, and urological examinations for males over the age of 60 without preauthorization; and

“(3) reduce the requirements for statements of nonavailability of services.”

**TRICARE Managed Care Support Contracts**

Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 724], Oct. 30, 2000, 114 Stat. 1654, 1654A-187, provided that:

“(a) Authority.—Notwithstanding any other provision of law and subject to subsection (b), any TRICARE managed care support contract in effect, or in the final stages of acquisition, on September 30, 1999, may be extended for four years.

“(b) Conditions.—Any extension of a contract under subsection (a)—

“(1) may be made only if the Secretary of Defense determines that it is in the best interest of the United States to do so; and

“(2) shall be based on the price in the final best and final offer for the last year of the existing contract as adjusted for inflation and other factors mutually agreed to by the contractor and the Federal Government.”

Pub. L. 106-259, title VIII, Sec. 8090, Aug. 9, 2000, 114 Stat. 694, provided that: “Notwithstanding any other provision of law, the TRICARE managed care support contracts in effect, or in final stages of acquisition as of September 30, 2000, may be extended for 2 years: Provided, That any such extension may only take place if the Secretary of Defense determines that it is in the best interest of the Government: Provided further, That any contract extension shall be based on the price in the final best and final offer for the last year of the existing contract as adjusted for inflation and other factors mutually agreed to by the contractor and the Government: Provided further, That notwithstanding any other provision of law, all future TRICARE managed care support contracts replacing contracts in effect, or in the final stages of acquisition as of September 30, 2000, may include a base contract period for transition and up to seven 1-year option periods.” Similar provisions were contained in the following prior appropriation act:

Pub. L. 106-79, title VIII, Sec. 8095, Oct. 25, 1999, 113 Stat. 1254.

Pub. L. 105-262, title VIII, Sec. 8107, Oct. 17, 1998, 112 Stat. 2321.

**Redesign Of Military Pharmacy System**

Pub. L. 105-261, div. A, title VII, Sec. 703, Oct. 17, 1998, 112 Stat. 2057, provided that:

“(a) Plan Required.—The Secretary of Defense shall submit to Congress a plan that would provide for a system-wide redesign of the military and contractor retail and mail-order pharmacy system of the Department of Defense by incorporating ‘best business practices’ of the private sector. The Secretary shall work with contractors of TRICARE retail pharmacy and

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national mail-order pharmacy programs to develop a plan for the redesign of the pharmacy system that—

“(1) may include a plan for an incentive-based formulary for military medical treatment facilities and contractors of TRICARE retail pharmacies and the national mail-order pharmacy; and

“(2) shall include a plan for each of the following:

“(A) A uniform formulary for such facilities and contractors:

“(B) A centralized database that integrates the patient databases of pharmacies of military medical treatment facilities and contractor retail and mail-order programs to implement automated prospective drug utilization review systems:

“(C) A system-wide drug benefit for covered beneficiaries under chapter 55 of title 10, United States Code, who are entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.):

“(b) Submission of Plan.—The Secretary shall submit the plan required under subsection (a) not later than March 1, 1999.

“(c) Suspension of Implementation of Program.—The Secretary shall suspend any plan to establish a national retail pharmacy program for the Department of Defense until—

“(1) the plan required under subsection (a) is submitted; and

“(2) the Secretary implements cost-saving reforms with respect to the military and contractor retail and mail order pharmacy system.”

Pub. L. 105-261, div. A, title VII, Sec. 723, Oct. 17, 1998, 112 Stat. 2068, as amended by Pub. L. 106-65, div. A, title X, Sec. 1067(3), Oct. 5, 1999, 113 Stat. 774; Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 711(a)], Oct. 30, 2000, 114 Stat. 1654, 1654A-175, provided that:

“(a) In General.—Not later than April 1, 2001, the Secretary of Defense shall implement, with respect to eligible individuals described in subsection (e), the redesign of the pharmacy system under TRICARE (including the mail-order and retail pharmacy benefit under TRICARE) to incorporate ‘best business practices’ of the private sector in providing pharmaceuticals, as developed under the plan described in section 703 [set out as a note above].

“(b) Program Requirements.—The same coverage for pharmacy services and the same requirements for cost sharing and reimbursement as are applicable under section 1086 of title 10, United States Code, shall apply with respect to the program required by subsection (a).

“(c) Evaluation.—The Secretary shall provide for an evaluation of the implementation of the redesign of the pharmacy system under TRICARE under this section by an appropriate person or entity that is independent of the Department of Defense. The evaluation shall include the following:

“(1) An analysis of the costs of the implementation of the redesign of the pharmacy system under TRICARE and to the eligible individuals who participate in the system.

“(2) An assessment of the extent to which the implementation of such system satisfies the requirements of the eligible individuals for the health care services available under TRICARE.

“(3) An assessment of the effect, if any, of the implementation of the system on military medical readiness.

“(4) A description of the rate of the participation in the system of the individuals who were eligible to participate.

“(5) An evaluation of any other matters that the Secretary considers appropriate.

“(d) Reports.—The Secretary shall submit two reports on the results of the evaluation under subsection (c), together with the evaluation, to the Committee on Armed Services of the Senate and the Committee on Armed Services of the House of Representatives. The first report shall be

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submitted not later than December 31, 2001, and the second report shall be submitted not later than December 31, 2003.

“(e) Eligible Individuals.—(1) An individual is eligible to participate under this section if the individual is a member or former member of the uniformed services described in section 1074(b) of title 10, United States Code, a dependent of the member described in section 1076(a)(2)(B) or 1076(b) of that title, or a dependent of a member of the uniformed services who died while on active duty for a period of more than 30 days, who—

“(A) is 65 years of age or older;

“(B) is entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.); and

“(C) except as provided in paragraph (2), is enrolled in the supplemental medical insurance program under part B of such title XVIII (42 U.S.C. 1395j et seq.).

“(2) Paragraph (1)(C) shall not apply in the case of an individual who, before April 1, 2001, has attained the age of 65 and did not enroll in the program described in such paragraph.”

**System For Tracking Data And Measuring Performance In Meeting TRICARE Access Standards**

Pub. L. 105-261, div. A, title VII, Sec. 713, Oct. 17, 1998, 112 Stat. 2060, provided that:

“(a) Requirement To Establish System.—(1) The Secretary of Defense shall establish a system—

“(A) to track data regarding access of covered beneficiaries under chapter 55 of title 10, United States Code, to primary health care under the TRICARE program; and

“(B) to measure performance in increasing such access against the primary care access standards established by the Secretary under the TRICARE program.

“(2) In implementing the system described in paragraph (1), the Secretary shall collect data on the timeliness of appointments and precise waiting times for appointments in order to measure performance in meeting the primary care access standards established under the TRICARE program.

“(b) Deadline for Establishment.—The Secretary shall establish the system described in subsection (a) not later than April 1, 1999.”

**TRICARE As Supplement To Medicare Demonstration**

Pub. L. 105-261, div. A, title VII, Sec. 722, Oct. 17, 1998, 112 Stat. 2065, as amended by Pub. L. 106-65, div. A, title X, Secs. 1066(b)(6), 1067(3), Oct. 5, 1999, 113 Stat. 773, 774, required the Secretary of Defense to carry out a demonstration project (known as the TRICARE Senior Supplement) in order to assess the feasibility and advisability of providing medical care coverage under the TRICARE program to certain members and former members of the uniformed services and their dependents and further required the Secretary to evaluate and terminate the project and submit a report on the evaluation to Congress not later than Dec. 31, 2002.

**Study Concerning Provision Of Comparative Information**

Pub. L. 105-85, div. A, title VII, Sec. 703, Nov. 18, 1997, 111 Stat. 1807, provided that:

“(a) Study.—The Secretary of Defense shall conduct a study concerning the provision of the information described in subsection (b) to beneficiaries under the TRICARE program established under the authority of chapter 55 of title 10, United States Code, and prepare and submit to Congress a report concerning such study.

“(b) Provision of Comparative Information.—Information described in this subsection, with respect to a managed care entity that contracts with the Secretary of Defense to provide medical assistance under the program described in subsection (a), shall include the following:

“(1) The benefits covered by the entity involved, including—

“(A) covered items and services beyond those provided under a traditional fee-for-service program;

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- “(B) any beneficiary cost sharing; and
- “(C) any maximum limitations on out-of-pocket expenses:
- “(2) The net monthly premium, if any, under the entity.
- “(3) The service area of the entity.
- “(4) To the extent available, quality and performance indicators for the benefits under the entity (and how they compare to such indicators under the traditional fee-for-service programs in the area involved), including—
  - “(A) disenrollment rates for enrollees electing to receive benefits through the entity for the previous two years (excluding disenrollment due to death or moving outside the service area of the entity);
  - “(B) information on enrollee satisfaction;
  - “(C) information on health process and outcomes;
  - “(D) grievance procedures;
  - “(E) the extent to which an enrollee may select the health care provider of their [sic] choice, including health care providers within the network of the entity and out-of-network health care providers (if the entity covers out-of-network items and services); and
  - “(F) an indication of enrollee exposure to balance billing and the restrictions on coverage of items and services provided to such enrollee by an out-of-network health care provider:
- “(5) Whether the entity offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.
- “(6) An overall summary description as to the method of compensation of participating physicians.”

**Disclosure Of Cautionary Information On Prescription Medications**

Pub. L. 105-85, div. A, title VII, Sec. 744, Nov. 18, 1997, 111 Stat. 1820, provided that:

- “(a) Regulations Required.—Not later than 180 days after the date of the enactment of this Act [Nov. 18, 1997], the Secretary of Defense, in consultation with the administering Secretaries referred to in section 1073 of title 10, United States Code, shall prescribe regulations to require each source described in subsection (d) that dispenses a prescription medication to a beneficiary under chapter 55 of such title to include with the medication the written cautionary information required by subsection (b).
- “(b) Information To Be Disclosed.—Information required to be disclosed about a medication under the regulations shall include appropriate cautions about usage of the medication, including possible side effects and potentially hazardous interactions with foods.
- “(c) Form of Information.—The regulations shall require that information be furnished in a form that, to the maximum extent practicable, is easily read and understood.
- “(d) Covered Sources.—The regulations shall apply to the following:
  - “(1) Pharmacies and any other dispensers of prescription medications in medical facilities of the uniformed services.
  - “(2) Sources of prescription medications under any mail order pharmaceuticals program provided by any of the administering Secretaries under chapter 55 of title 10, United States Code.
  - “(3) Pharmacies paid under the Civilian Health and Medical Program of the Uniformed Services (including the TRICARE program).
  - “(4) Pharmacies, and any other pharmaceutical dispensers, of designated providers referred to 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).”

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### **Competitive Procurement Of Ophthalmic Services**

Pub. L. 105-85, div. A, title VII, Sec. 745, Nov. 18, 1997, 111 Stat. 1820, provided that:

“(a) Competitive Procurement Required.—Beginning not later than October 1, 1998, the Secretary of Defense shall competitively procure from private-sector sources, or other sources outside of the Department of Defense, all ophthalmic services related to the provision of single vision and multivision eyewear [sic] for members of the Armed Forces, retired members, and certain covered beneficiaries under chapter 55 of title 10, United States Code, who would otherwise receive such ophthalmic services through the Department of Defense.

“(b) Exception.—Subsection (a) shall not apply to the extent that the Secretary of Defense determines that the use of sources within the Department of Defense to provide such ophthalmic services—

“(1) is necessary to meet the readiness requirements of the Armed Forces; or

“(2) is more cost effective.

“(c) Completion of Existing Orders.—Subsection (a) shall not apply to orders for ophthalmic services received on or before September 30, 1998.”

### **Inclusion Of Certain Designated Providers In Uniformed Services Health Care Delivery System**

Pub. L. 104-201, div. A, title VII, subtitle C, Sept. 23, 1996, 110 Stat. 2592, as amended by Pub. L. 104-208, div. A, title I, Sec. 101(b) [title VIII, Sec. 8131(a)], Sept. 30, 1996, 110 Stat. 3009-71, 3009-117; Pub. L. 105-85, div. A, title VII, Secs. 721-723, Nov. 18, 1997, 111 Stat. 1809, 1810; Pub. L. 106-65, div. A, title VII, Sec. 707, Oct. 5, 1999, 113 Stat. 684; Pub. L. 107-296, title XVII, Sec. 1704(e)(2), Nov. 25, 2002, 116 Stat. 2315; Pub. L. 108-136, div. A, title VII, Sec. 714, Nov. 24, 2003, 117 Stat. 1531; Pub. L. 108-199, div. H, Sec. 109, Jan. 23, 2004, 118 Stat. 438; Pub. L. 112-81, div. A, title VII, Sec. 708, Dec. 31, 2011, 125 Stat. 1474; Pub. L. 113-291, div. A, title X, §1071(b)(11), Dec. 19, 2014, 128 Stat. 3507, provided that:

“SEC. 721. DEFINITIONS.

“In this subtitle:

“(1) The term ‘administering Secretaries’ means the Secretary of Defense, the Secretary of Homeland Security, and the Secretary of Health and Human Services.

“(2) The term ‘agreement’ means the agreement required under section 722(b) between the Secretary of Defense and a designated provider.

“(3) The term ‘capitation payment’ means an actuarially sound payment for a defined set of health care services that is established on a per enrollee per month basis.

“(4) The term ‘covered beneficiary’ means a beneficiary under chapter 55 of title 10, United States Code, other than a beneficiary under section 1074(a) of such title.

“(5) The term ‘designated provider’ means a public or nonprofit private entity that was a transferee of a Public Health Service hospital or other station under section 987 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35; 42 U.S.C. 248b) and that, before the date of the enactment of this Act [Sept. 23, 1996], was deemed to be a facility of the uniformed services for the purposes of chapter 55 of title 10, United States Code. The term includes any legal successor in interest of the transferee.

“(6) The term ‘enrollee’ means a covered beneficiary who enrolls with a designated provider.

“(7) The term ‘health care services’ means the health care services provided under the health plan known as the ‘TRICARE PRIME’ option under the TRICARE program.

“(8) The term ‘Secretary’ means the Secretary of Defense.

“(9) The term ‘TRICARE program’ means the managed health care program that is established by the Secretary of Defense under the authority of chapter 55 of title 10, United

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States Code, principally section 1097 of such title, and includes the competitive selection of contractors to financially underwrite the delivery of health care services under the Civilian Health and Medical Program of the Uniformed Services.

**“SEC. 722. INCLUSION OF DESIGNATED PROVIDERS IN UNIFORMED SERVICES HEALTH CARE DELIVERY SYSTEM:**

“(a) Inclusion in System.—The health care delivery system of the uniformed services shall include the designated providers.

“(b) Agreements to Provide Managed Health Care Services.—(1) After consultation with the other administering Secretaries, the Secretary of Defense shall negotiate and enter into an agreement with each designated provider under which the designated provider will provide health care services in or through managed care plans to covered beneficiaries who enroll with the designated provider.

“(2) The agreement shall be entered into on a sole source basis. The Federal Acquisition Regulation, except for those requirements regarding competition, issued pursuant to section 1303(a) of title 41, United States Code [,] shall apply to the agreements as acquisitions of commercial items.

“(3) The implementation of an agreement is subject to availability of funds for such purpose.

“(c) Effective Date of Agreements.—(1) Unless an earlier effective date is agreed upon by the Secretary and the designated provider, the agreement shall take effect upon the later of the following:

“(A) The date on which a managed care support contract under the TRICARE program is implemented in the service area of the designated provider.

“(B) October 1, 1997.

“(2) The Secretary may modify the effective date established under paragraph (1) for an agreement to permit a transition period of not more than six months between the date on which the agreement is executed by the parties and the date on which the designated provider commences the delivery of health care services under the agreement.

“(d) Temporary Continuation of Existing Participation Agreements.—The Secretary shall extend the participation agreement of a designated provider in effect immediately before the date of the enactment of this Act [Sept. 23, 1996] under section 718(c) of the National Defense Authorization Act for Fiscal Year 1991 (Public Law 101-510; [former] 42 U.S.C. 248c [note]) until the agreement required by this section takes effect under subsection (c), including any transitional period provided by the Secretary under paragraph (2) of such subsection.

“(e) Service Area.—The Secretary may not reduce the size of the service area of a designated provider below the size of the service area in effect as of September 30, 1996.

“(f) Compliance With Administrative Requirements.—(1) Unless otherwise agreed upon by the Secretary and a designated provider, the designated provider shall comply with necessary and appropriate administrative requirements established by the Secretary for other providers of health care services and requirements established by the Secretary of Health and Human Services for risk-sharing contractors under section 1876 of the Social Security Act (42 U.S.C. 1395mm). The Secretary and the designated provider shall determine and apply only such administrative requirements as are minimally necessary and appropriate. A designated provider shall not be required to comply with a law or regulation of a State government requiring licensure as a health insurer or health maintenance organization.

“(2) A designated provider may not contract out more than five percent of its primary care enrollment without the approval of the Secretary, except in the case of primary care contracts between a designated provider and a primary care contractor in force on the date of the enactment of this Act [Sept. 23, 1996].

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“(g) Continued Acquisition of Reduced-Cost Drugs.—A designated provider shall be treated as part of the Department of Defense for purposes of section 8126 of title 38, United States Code, in connection with the provision by the designated provider of health care services to covered beneficiaries pursuant to the participation agreement of the designated provider under section 718(c) of the National Defense Authorization Act for Fiscal Year 1991 (Public Law 101-510; [former] 42 U.S.C. 248c note) or pursuant to the agreement entered into under subsection (b).

**“SEC. 723. PROVISION OF UNIFORM BENEFIT BY DESIGNATED PROVIDERS:**

“(a) Uniform Benefit Required.—A designated provider shall offer to enrollees the health benefit option prescribed and implemented by the Secretary under section 731 of the National Defense Authorization Act for Fiscal Year 1994 (Public Law 103-160; 10 U.S.C. 1073 note), including accompanying cost-sharing requirements.

“(b) Time for Implementation of Benefit.—A designated provider shall offer the health benefit option described in subsection (a) to enrollees upon the later of the following:

“(1) The date on which health care services within the health care delivery system of the uniformed services are rendered through the TRICARE program in the region in which the designated provider operates.

“(2) October 1, 1997.

“(c) Adjustments.—The Secretary may establish a later date under subsection (b)(2) or prescribe reduced cost-sharing requirements for enrollees.

**“SEC. 724. ENROLLMENT OF COVERED BENEFICIARIES:**

“(a) Fiscal Year 1997 Limitation.—(1) During fiscal year 1997, the number of covered beneficiaries who are enrolled in managed care plans offered by designated providers may not exceed the number of such enrollees as of October 1, 1995.

“(2) The Secretary may waive the limitation under paragraph (1) if the Secretary determines that additional enrollment authority for a designated provider is required to accommodate covered beneficiaries who are dependents of members of the uniformed services entitled to health care under section 1074(a) of title 10, United States Code.

“(b) Permanent Limitation.—For each fiscal year beginning after September 30, 1997, the number of enrollees in managed care plans offered by designated providers may not exceed 110 percent of the number of such enrollees as of the first day of the immediately preceding fiscal year. The Secretary may waive this limitation as provided in subsection (a)(2).

“(c) Retention of Current Enrollees.—An enrollee in the managed care plan of a designated provider as of September 30, 1997, or such earlier date as the designated provider and the Secretary may agree upon, shall continue receiving services from the designated provider pursuant to the agreement entered into under section 722 unless the enrollee disenrolls from the designated provider. Except as provided in subsection (e), the administering Secretaries may not disenroll such an enrollee unless the disenrollment is agreed to by the Secretary and the designated provider.

“(d) Additional Enrollment Authority.—(1) Subject to paragraph (2), other covered beneficiaries may also receive health care services from a designated provider.

“(2)(A) The designated provider may market such services to, and enroll, covered beneficiaries who—

“(i) do not have other primary health insurance coverage (other than Medicare coverage) covering basic primary care and inpatient and outpatient services;

“(ii) subject to the limitation in subparagraph (B), have other primary health insurance coverage (other than Medicare coverage) covering basic primary care and inpatient and outpatient services; or

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“(iii) are enrolled in the direct care system under the TRICARE program, regardless of whether the covered beneficiaries were users of the health care delivery system of the uniformed services in prior years.

“(B) For each fiscal year beginning after September 30, 2003, the number of covered beneficiaries newly enrolled by designated providers pursuant to clause (ii) of subparagraph (A) during such fiscal year may not exceed 10 percent of the total number of the covered beneficiaries who are newly enrolled under such subparagraph during such fiscal year.

“(3) For purposes of this subsection, a covered beneficiary who has other primary health insurance coverage includes any covered beneficiary who has primary health insurance coverage—

“(A) on the date of enrollment with a designated provider pursuant to paragraph (2)(A)(i); or

“(B) on such date of enrollment and during the period after such date while the beneficiary is enrolled with the designated provider.

“(e) Special Rule for Medicare-Eligible Beneficiaries.—(1) Except as provided in paragraph (2), if a covered beneficiary who desires to enroll in the managed care program of a designated provider is also entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), the covered beneficiary shall elect whether to receive health care services as an enrollee or under part A of title XVIII of the Social Security Act. The Secretary may disenroll an enrollee who subsequently violates the election made under this subsection and receives benefits under part A of title XVIII of the Social Security Act.

“(2) After September 30, 2012, a covered beneficiary (other than a beneficiary under section 1079 of title 10, United States Code) who is also entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] due to age may not enroll in the managed care program of a designated provider unless the beneficiary was enrolled in that program on September 30, 2012.

“(f) Information Regarding Eligible Covered Beneficiaries.—The Secretary shall provide, in a timely manner, a designated provider with an accurate list of covered beneficiaries within the marketing area of the designated provider to whom the designated provider may offer enrollment.

“(g) Open Enrollment Demonstration Program.—(1) The Secretary of Defense shall conduct a demonstration program under which covered beneficiaries shall be permitted to enroll at any time in a managed care plan offered by a designated provider consistent with the enrollment requirements for the TRICARE Prime option under the TRICARE program, but without regard to the limitation in subsection (b). The demonstration program under this subsection shall cover designated providers, selected by the Secretary of Defense, and the service areas of the designated providers.

“(2) The demonstration program carried out under this section shall commence on October 1, 1999, and end on September 30, 2001.

“(3) Not later than March 15, 2001, the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the demonstration program carried out under this subsection. The report shall include, at a minimum, an evaluation of the benefits of the open enrollment opportunity to covered beneficiaries and a recommendation on whether to authorize open enrollments in the managed care plans of designated providers permanently.

“SEC. 725. APPLICATION OF CHAMPUS PAYMENT RULES:

“(a) Application of Payment Rules.—Subject to subsection (b), the Secretary shall require a private facility or health care provider that is a health care provider under the Civilian Health

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and Medical Program of the Uniformed Services to apply the payment rules described in section 1074(c) of title 10, United States Code, in imposing charges for health care that the private facility or provider provides to enrollees of a designated provider.

“(b) Authorized Adjustments.—The payment rules imposed under subsection (a) shall be subject to such modifications as the Secretary considers appropriate. The Secretary may authorize a lower rate than the maximum rate that would otherwise apply under subsection (a) if the lower rate is agreed to by the designated provider and the private facility or health care provider.

“(c) Regulations.—The Secretary shall prescribe regulations to implement this section after consultation with the other administering Secretaries.

“(d) Conforming Amendment.—[Amended section 1074 of this title.]

**“SEC. 726. PAYMENTS FOR SERVICES:**

“(a) Form of Payment.—Unless otherwise agreed to by the Secretary and a designated provider, the form of payment for health care services provided by a designated provider shall be on a full risk capitation payment basis. The capitation payments shall be negotiated and agreed upon by the Secretary and the designated provider. In addition to such other factors as the parties may agree to apply, the capitation payments shall be based on the utilization experience of enrollees and competitive market rates for equivalent health care services for a comparable population to such enrollees in the area in which the designated provider is located.

“(b) Limitation on Total Payments.—Total capitation payments for health care services to a designated provider shall not exceed an amount equal to the cost that would have been incurred by the Government if the enrollees had received such health care services through a military treatment facility, the TRICARE program, or the Medicare program, as the case may be. In establishing the ceiling rate for enrollees with the designated providers who are also eligible for the Civilian Health and Medical Program of the Uniformed Services, the Secretary of Defense shall take into account the health status of the enrollees.

“(c) Establishment of Payment Rates on Annual Basis.—The Secretary and a designated provider shall establish capitation payments on an annual basis, subject to periodic review for actuarial soundness and to adjustment for any adverse or favorable selection reasonably anticipated to result from the design of the program under this subtitle.

“(d) Alternative Basis for Calculating Payments.—After September 30, 1999, the Secretary and a designated provider may mutually agree upon a new basis for calculating capitation payments.

**“SEC. 727. REPEAL OF SUPERSEDED AUTHORITIES:**

“(a) Repeals.—[Repealed sections 248c and 248d of Title 42, The Public Health and Welfare, and section 718(c) of Pub. L. 101-510 and section 726 of Pub. L. 104-106, set out as notes under section 248c of Title 42.]

“(b) Effective Date.—The amendments made by paragraphs (1), (2), and (3) of subsection (a) shall take effect on October 1, 1997.”

[Pub. L. 108-199, div. H, Sec. 109, Jan. 23, 2004, 118 Stat. 438, provided that the amendment made by section 109, amending section 724 of Pub. L. 104-201, set out above, is effective immediately after the enactment of Pub. L. 108-136.

[Pub. L. 104-208, div. A, title I, Sec. 101(b) [title VIII, Sec. 8131(b)], Sept. 30, 1996, 110 Stat. 3009-71, 3009-117, provided that: “The amendments made by subsection (a) [amending section 722 of Pub. L. 104-201, set out above] shall take effect as of the date of the enactment of the National Defense

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Authorization Act for Fiscal Year 1997 [Sept. 23, 1996] as if section 722 of such Act had been enacted as so amended.”]

**Definition Of TRICARE Program**

Pub. L. 104-106, div. A, title VII, Sec. 711, Feb. 10, 1996, 110 Stat. 374, provided that: “For purposes of this subtitle [subtitle B (Secs. 711-718) of title VII of div. A of Pub. L. 104-106, amending section 1097 of this title, enacting provisions set out as notes below, and amending provisions set out as a note below], the term ‘TRICARE program’ means the managed health care program that is established by the Secretary of Defense under the authority of chapter 55 of title 10, United States Code, principally section 1097 of such title, and includes the competitive selection of contractors to financially underwrite the delivery of health care services under the Civilian Health and Medical Program of the Uniformed Services.”

**Training In Health Care Management And Administration For TRICARE Lead Agents**

Pub. L. 104-106, div. A, title VII, Sec. 715, Feb. 10, 1996, 110 Stat. 375, as amended by Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 760(a)], Oct. 30, 2000, 114 Stat. 1654, 1654A-200, provided that:

“(a) Provision of Training.—The Secretary of Defense shall implement a professional educational program to provide appropriate training in health care management and administration—

“(1) to each commander, deputy commander, and managed care coordinator of a military medical treatment facility of the Department of Defense, and any other person, who is selected to serve as a lead agent to coordinate the delivery of health care by military and civilian providers under the TRICARE program; and

“(2) to appropriate members of the support staff of the treatment facility who will be responsible for daily operation of the TRICARE program.

“(b) Limitation on Assignment Until Completion of Training.—No person may be assigned as the commander, deputy commander, or managed care coordinator of a military medical treatment facility or as a TRICARE lead agent or senior member of the staff of a TRICARE lead agent office until the Secretary of the military department concerned submits a certification to the Secretary of Defense that such person has completed the training described in subsection (a).”

[Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 760(c)], Oct. 30, 2000, 114 Stat. 1654, 1654A-200, provided that: “The amendments made by subsection (a) to section 715 of such Act [section 715 of Pub. L. 104-106, set out above]—

[“(1) shall apply to a deputy commander, a managed care coordinator of a military medical treatment facility, or a lead agent for coordinating the delivery of health care by military and civilian providers under the TRICARE program, who is assigned to such position on or after the date that is one year after the date of the enactment of this Act [Oct. 30, 2000]; and

[“(2) may apply, in the discretion of the Secretary of Defense, to a deputy commander, a managed care coordinator of such a facility, or a lead agent for coordinating the delivery of such health care, who is assigned to such position before the date that is one year after the date of the enactment of this Act.”]

**Pilot Program Of Individualized Residential Mental Health Services**

Pub. L. 104-106, div. A, title VII, Sec. 716, Feb. 10, 1996, 110 Stat. 375, provided that:

“(a) Program Required.—(1) During fiscal year 1996, the Secretary of Defense, in consultation with the other administering Secretaries under chapter 55 of title 10, United States Code, shall implement a pilot program to provide residential and wraparound services to children described in paragraph (2) who are in need of mental health services. The Secretary shall

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implement the pilot program for an initial period of at least two years in a military health care region in which the TRICARE program has been implemented.

“(2) A child shall be eligible for selection to participate in the pilot program if the child is a dependent (as described in subparagraph (D) or (I) of section 1072(2) of title 10, United States Code) who—

“(A) is eligible for health care under section 1079 or 1086 of such title; and

“(B) has a serious emotional disturbance that is generally regarded as amenable to treatment.

“(b) Wraparound Services Defined.—For purposes of this section, the term ‘wraparound services’ means individualized mental health services that are provided principally to allow a child to remain in the family home or other least-restrictive and least-costly setting, but also are provided as an aftercare planning service for children who have received acute or residential care. Such term includes nontraditional mental health services that will assist the child to be maintained in the least-restrictive and least-costly setting.

“(c) Pilot Program Agreement.—Under the pilot program the Secretary of Defense shall enter into one or more agreements that require a mental health services provider under the agreement—

“(1) to provide wraparound services to a child described in subsection (a)(2);

“(2) to continue to provide such services as needed during the period of the agreement even if the child moves to another location within the same TRICARE program region during that period; and

“(3) to share financial risk by accepting as a maximum annual payment for such services a case-rate reimbursement not in excess of the amount of the annual standard CHAMPUS residential treatment benefit payable (as determined in accordance with section 8.1 of chapter 3 of volume II of the CHAMPUS policy manual).

“(d) Report.—Not later than March 1, 1998, the Secretary of Defense shall submit to the Committee on Armed Services of the Senate and the Committee on National Security of the House of Representatives a report on the program carried out under this section. The report shall contain—

“(1) an assessment of the effectiveness of the program; and

“(2) the Secretary’s views regarding whether the program should be implemented throughout the military health care system.”

**Evaluation And Report On TRICARE Program Effectiveness**

Pub. L. 104-106, div. A, title VII, Sec. 717, Feb. 10, 1996, 110 Stat. 376, as amended by Pub. L. 112-239, div. A, title VII, Sec. 714, Jan. 2, 2013, 126 Stat. 1803; **Pub. L. 114-92, div. A, title VII, §713, Nov. 25, 2015, 129 Stat. 865**, provided that:

“(a) Evaluation Required.—The Secretary of Defense shall arrange for an on-going evaluation of the effectiveness of the TRICARE program in meeting the goals of increasing the access of covered beneficiaries under chapter 55 of title 10, United States Code, to health care and improving the quality of health care provided to covered beneficiaries, without increasing the costs incurred by the Government or covered beneficiaries. The evaluation shall specifically—

“(1) **address** the impact of the TRICARE program on members of the Armed Forces (whether in the regular or reserve components) and their dependents, military retirees and their dependents, and dependents of members on active duty with severe disabilities and chronic health care needs with regard to access, costs, and quality of health care services;

“(2) identify noncatchment areas in which the health maintenance organization option of the TRICARE program is available or is proposed to become available; **and**

“(3) **address patient safety, quality of care, and access to care at military medical treatment facilities, including—**

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“(A) an identification of the number of practitioners providing health care in military medical treatment facilities that were reported to the National Practitioner Data Bank during the year preceding the evaluation; and

“(B) with respect to each military medical treatment facility, an assessment of—

“(i) the current accreditation status of such facility, including any recommendations for corrective action made by the relevant accrediting body;

“(ii) any policies or procedures implemented during such year by the Secretary of the military department concerned that were designed to improve patient safety, quality of care, and access to care at such facility;

“(iii) data on surgical and maternity care outcomes during such year;

“(iv) data on appointment wait times during such year; and

“(v) data on patient safety, quality of care, and access to care as compared to standards established by the Department of Defense with respect to patient safety, quality of care, and access to care.

“(b) Entity To Conduct Evaluation.—The Secretary may use a federally funded research and development center to conduct the evaluation required by subsection (a).

“(c) Annual Report.—Not later than March 1, 1997, and each March 1 thereafter, the Secretary shall submit to Congress a report describing the results of the evaluation under subsection (a) during the preceding year.”

**Use Of Health Maintenance Organization Model As Option For Military Health Care**

Pub. L. 103-160, div. A, title VII, Sec. 731, Nov. 30, 1993, 107 Stat. 1696, as amended by Pub. L. 103-337, div. A, title VII, Sec. 715, Oct. 5, 1994, 108 Stat. 2803; Pub. L. 104-106, div. A, title VII, Sec. 714, Feb. 10, 1996, 110 Stat. 374, provided that:

“(a) Use of Model.—The Secretary of Defense shall prescribe and implement a health benefit option (and accompanying cost-sharing requirements) for covered beneficiaries eligible for health care under chapter 55 of title 10, United States Code, that is modelled on health maintenance organization plans offered in the private sector and other similar Government health insurance programs. The Secretary shall include, to the maximum extent practicable, the health benefit option required under this subsection as one of the options available to covered beneficiaries in all managed health care initiatives undertaken by the Secretary after December 31, 1994.

“(b) Elements of Option.—The Secretary shall offer covered beneficiaries who enroll in the health benefit option required under subsection (a) reduced out-of-pocket costs and a benefit structure that is as uniform as possible throughout the United States. The Secretary shall allow enrollees to seek health care outside of the option, except that the Secretary may prescribe higher out-of-pocket costs than are provided under section 1079 or 1086 of title 10, United States Code, for enrollees who obtain health care outside of the option.

“(c) Government Costs.—The health benefit option required under subsection (a) shall be administered so that the costs incurred by the Secretary under the TRICARE program are no greater than the costs that would otherwise be incurred to provide health care to the members of the uniformed services and covered beneficiaries who participate in the TRICARE program.

“(d) Definitions.—For purposes of this section:

“(1) The term ‘covered beneficiary’ means a beneficiary under chapter 55 of title 10, United States Code, other than a beneficiary under section 1074(a) of such title.

“(2) The term ‘TRICARE program’ means the managed health care program that is established by the Secretary of Defense under the authority of chapter 55 of title 10, United States Code, principally section 1097 of such title, and includes the competitive selection of contractors to financially underwrite the delivery of health care services under the Civilian Health and Medical Program of the Uniformed Services.

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“(e) Regulations.—Not later than December 31, 1994, the Secretary shall prescribe final regulations to implement the health benefit option required by subsection (a).

“(f) Modification of Existing Contracts.—In the case of managed health care contracts in effect or in final stages of acquisition as of December 31, 1994, the Secretary may modify such contracts to incorporate the health benefit option required under subsection (a).”

**Managed Health Care Program And Contracts For Military Health Services System**

Pub. L. 104-61, title VI, Dec. 1, 1995, 109 Stat. 649, provided in part that the date for implementation of the nation-wide managed care military health services system would be extended to Sept. 30, 1997.

Pub. L. 103-139, title VIII, Sec. 8025, Nov. 11, 1993, 107 Stat. 1443, provided that: “Notwithstanding any other provision of law, to establish region-wide, at-risk, fixed price managed care contracts possessing features similar to those of the CHAMPUS Reform Initiative, the Secretary of Defense shall submit to the Congress a plan to implement a nation-wide managed health care program for the military health services system not later than December 31, 1993: Provided, That the program shall include, but not be limited to: (1) a uniform, stabilized benefit structure characterized by a triple option health benefit feature; (2) a regionally-based health care management system; (3) cost minimization incentives including ‘gatekeeping’ and annual enrollment procedures, capitation budgeting, and at-risk managed care support contracts; and (4) full and open competition for all managed care support contracts: Provided further, That the implementation of the nation-wide managed care military health services system shall be completed by September 30, 1996: Provided further, That the Department shall competitively award contracts in fiscal year 1994 for at least four new region-wide, at-risk, fixed price managed care support contracts consistent with the nation-wide plan, that one such contract shall include the State of Florida (which may include Department of Veterans Affairs’ medical facilities with the concurrence of the Secretary of Veterans Affairs), one such contract shall include the States of Washington and Oregon, and one such contract shall include the State of Texas: Provided further, That any law or regulation of a State or local government relating to health insurance, prepaid health plans, or other health care delivery, administration, and financing methods shall be preempted and shall not apply to any region-wide, at-risk, fixed price managed care contract entered into pursuant to chapter 55 of title 10, United States Code: Provided further, That the Department shall competitively award within 13 months after the date of enactment of this Act [Nov. 11, 1993] two contracts for stand-alone, at-risk managed mental health services in high utilization, high-cost areas, consistent with the management and service delivery features in operation in Department of Defense managed mental health care contracts: Provided further, That the Assistant Secretary of Defense for Health Affairs shall, during the current fiscal year, initiate through competitive procedures a managed health care program for eligible beneficiaries in the area of Homestead Air Force Base with benefits and services substantially identical to those established to serve beneficiary populations in areas where military medical facilities have been terminated, to include retail pharmacy networks available to Medicare-eligible beneficiaries, and shall present a plan to implement this program to the House and Senate Committees on Appropriations not later than January 15, 1994.”

**Condition On Expansion Of CHAMPUS Reform Initiative To Other Locations**

Pub. L. 102-484, div. A, title VII, Sec. 712, Oct. 23, 1992, 106 Stat. 2435, as amended by Pub. L. 103-160, div. A, title VII, Sec. 720, Nov. 30, 1993, 107 Stat. 1695; Pub. L. 103-337, div. A, title VII, Sec. 714(c), Oct. 5, 1994, 108 Stat. 2803, provided that:

“(a) Condition.—(1) Except as provided in subsection (b), the Secretary of Defense may not expand the CHAMPUS reform initiative underway in the States of California and Hawaii to another location until not less than 90 days after the date on which the Secretary certifies to

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Congress that expansion of the initiative to that location is the most efficient method of providing health care to covered beneficiaries in that location. In determining whether the expansion of the CHAMPUS reform initiative to a location is the most efficient method of providing health care to covered beneficiaries in that location, the Secretary shall consider the cost-effectiveness of the initiative (while assuring that the combined cost of care in military treatment facilities and under the Civilian Health and Medical Program of the Uniformed Services will not be increased as a result of the expansion) and the effect of the expansion of the initiative on the access of covered beneficiaries to health care and on the quality of health care received by covered beneficiaries.

“(2) To the extent any revision of the CHAMPUS reform initiative is necessary in order to make the certification required by this subsection, the Secretary shall assure that enrolled covered beneficiaries may obtain health care services with reduced out-of-pocket costs, as compared to standard CHAMPUS.

“(b) Exception.—The Secretary of Defense may waive the operation of the condition on the expansion of the CHAMPUS reform initiative specified in subsection (a) in order to expand the initiative to a location adversely affected by the closure or realignment of a military installation in that location, as determined by the Secretary.

“(c) Evaluation of Certification.—The Comptroller General of the United States and the Director of the Congressional Budget Office shall evaluate each certification made by the Secretary of Defense under subsection (a) that expansion of the CHAMPUS reform initiative to another location is the most efficient method of providing health care to covered beneficiaries in that location. They shall submit their findings to Congress if these findings differ substantially from the findings upon which the Secretary made the decision to expand the CHAMPUS reform initiative.

“(d) Definitions.—For purposes of this section:

“(1) The terms ‘CHAMPUS reform initiative’ and ‘initiative’ mean the health care delivery project required by section 702 of the National Defense Authorization Act for Fiscal Year 1987 (Public Law 99-661; 10 U.S.C. 1073 note).

“(2) The term ‘covered beneficiary’ has the meaning given that term in section 1072(5) of title 10, United States Code.

“(3) The terms ‘Civilian Health and Medical Program of the Uniformed Services’ and ‘CHAMPUS’ have the meaning given the term ‘Civilian Health and Medical Program of the Uniformed Services’ in section 1072(4) of title 10, United States Code.”

**Alternative Health Care Delivery Methodologies**

Pub. L. 102-484, div. A, title VII, Sec. 713, Oct. 23, 1992, 106 Stat. 2435, as amended by Pub. L. 103-160, div. A, title VII, Sec. 719, Nov. 30, 1993, 107 Stat. 1694, directed the Secretary of Defense to continue to conduct during fiscal years 1993 through 1996 a broad array of reform initiatives for furnishing health care to persons who were eligible to receive health care under chapter 55 of this title and to submit to Congress a report regarding such initiatives not later than Sept. 30, 1994, and further directed the Secretary to take certain steps to ensure the continuation of the CHAMPUS reform initiative in the States of California and Hawaii.

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**Military Health Care For Persons Reliant On Health Care Facilities At Bases Being Closed Or Realigned**

Pub. L. 102-484, div. A, title VII, Sec. 722, Oct. 23, 1992, 106 Stat. 2439, as amended by Pub. L. 108-136, div. A, title VII, Sec. 726, Nov. 24, 2003, 117 Stat. 1535, Pub. L. 110-181, div. A, title X, Sec. 1063(i), Jan. 28, 2008, 122 Stat. 324, provided that:

“(a) Establishment.—Not later than December 31, 2003, the Secretary of Defense shall establish a working group on the provision of military health care to persons who rely for health care on health care facilities located at military installations—

“(1) inside the United States that are selected for closure or realignment in the 2005 round of realignments and closures authorized by sections 2912, 2913, and 2914 of the Defense Base Closure and Realignment Act of 1990 (part A of title XXIX of Public Law 101-510; 10 U.S.C. 2687 note), as added by title XXX of the National Defense Authorization Act for Fiscal Year 2002 (Public Law 107-107; 115 Stat. 1342); or

“(2) outside the United States that are selected for closure or realignment as a result of force posture changes.

“(b) Membership.—The members of the working group shall include, at a minimum, the following:

“(1) The Assistant Secretary of Defense for Health Affairs, or a designee of the Assistant Secretary.

“(2) The Surgeon General of the Army, or a designee of that Surgeon General.

“(3) The Surgeon General of the Navy, or a designee of that Surgeon General.

“(4) The Surgeon General of the Air Force, or a designee of that Surgeon General.

“(5) At least one independent member (appointed by the Secretary of Defense) from each TRICARE region, but not to exceed a total of 12 members appointed under this paragraph, whose experience in matters within the responsibility of the working group qualify that person to represent persons authorized health care under chapter 55 of title 10, United States Code.

“(c) Duties.—(1) In developing the recommendations for the 2005 round of realignments and closures required by sections 2913 and 2914 of the Defense Base Closure and Realignment Act of 1990 [Pub. L. 101-510, 10 U.S.C. 268 note], the Secretary of Defense shall consult with the working group.

“(2) The working group shall be available to provide assistance to the Defense Base Closure and Realignment Commission.

“(3) In the case of each military installation referred to in paragraph (1) or (2) of subsection (a) whose closure or realignment will affect the accessibility to health care services for persons entitled to such services under chapter 55 of title 10, United States Code, the working group shall provide to the Secretary of Defense a plan for the provision of the health care services to such persons.

“(d) Special Considerations.—In carrying out its duties under subsection (c), the working group—

“(1) shall conduct meetings with persons entitled to health care services under chapter 55 of title 10, United States Code, or representatives of such persons;

“(2) may use reliable sampling techniques;

“(3) may visit the areas where closures or realignments of military installations will adversely affect the accessibility of health care for such persons and may conduct public meetings; and

“(4) shall ensure that members of the uniformed services on active duty, members and former members of the uniformed services entitled to retired or retainer pay, and dependents and survivors of such members and retired personnel are afforded the opportunity to express their views.

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“(e) Application of Advisory Committee Act.—The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the working group established pursuant to this section.

“(f) Termination.—The working group established pursuant to subsection (a) shall terminate on December 31, 2006.”

**Authorization For Extension Of CHAMPUS Reform Initiative**

Pub. L. 102-190, div. A, title VII, Sec. 722, Dec. 5, 1991, 105 Stat. 1406, provided that:

“(a) Authority.—Upon the termination (for any reason) of the contract of the Department of Defense in effect on the date of the enactment of this Act [Dec. 5, 1991] under the CHAMPUS reform initiative established under section 702 of the National Defense Authorization Act for Fiscal Year 1987 [Pub. L. 99-661] (10 U.S.C. 1073 note), the Secretary of Defense may enter into a replacement or successor contract with the same or a different contractor and for such amount as may be determined in accordance with applicable procurement laws and regulations and without regard to any limitation (enacted before, on, or after the date of the enactment of this Act) on the availability of funds for that purpose.

“(b) Treatment of Limitation on Funds for Program.—No provision of law stated as a limitation on the availability of funds may be treated as constituting the extension of, or as requiring the extension of, any contract under the CHAMPUS reform initiative that would otherwise expire in accordance with its terms.”

**Extension Of CHAMPUS Reform Initiative For Certain States**

Pub. L. 102-172, title VIII, Sec. 8032, Nov. 26, 1991, 105 Stat. 1178, provided: “That notwithstanding any other provision of law, the CHAMPUS Reform Initiative contract for California and Hawaii shall be extended until February 1, 1994, within the limits and rates specified in the contract: Provided further, That the Department shall competitively award contracts for the geographic expansion of the CHAMPUS Reform Initiative in Florida (which may include Department of Veterans Affairs medical facilities with the concurrence of the Secretary of Veterans Affairs), Washington, Oregon, and the Tidewater region of Virginia: Provided further, That competitive expansion of the CHAMPUS Reform Initiative may occur in any other regions that the Assistant Secretary of Defense for Health Affairs deems appropriate.

**Conditions On Expansion Of CHAMPUS Reform Initiative**

Pub. L. 101-510, div. A, title VII, Sec. 715, Nov. 5, 1990, 104 Stat. 1584, provided that:

“(a) Certification of Cost-Effectiveness.—The Secretary of Defense may not proceed with the proposed expansion of the CHAMPUS reform initiative underway in the States of California and Hawaii until not less than 90 days after the date on which the Secretary certifies to the Congress that—

“(1) such CHAMPUS reform initiative has been demonstrated to be more cost-effective than the Civilian Health and Medical Program of the Uniformed Services or any other health care demonstration program being conducted by the Secretary;

“(2) the contractor selected to underwrite the delivery of health care under the CHAMPUS reform initiative will accomplish the expansion without the disruption of services to beneficiaries under the Civilian Health and Medical Program of the Uniformed Services or delays in the processing of claims; and

“(3) such contractor is currently, and projected to remain, financially able to underwrite the CHAMPUS reform initiative.

“(b) Report on Certification.—Not later than 30 days after the date on which the Secretary of Defense submits the certification required by subsection (a), the Comptroller General of the

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United States and the Director of the Congressional Budget Office shall jointly submit to Congress a report evaluating such certification.

“(c) CHAMPUS Reform Initiative Defined.—For purposes of this section, the term ‘CHAMPUS reform initiative’ has the meaning given that term in section 702(d)(1) of the Department of Defense Authorization Act for Fiscal Year 1987 [Pub. L. 99-661] (10 U.S.C. 1073 note).”

**Requirements Prior To Termination Of Medical Services At Military Medical Treatment Facilities**

Pub. L. 101-510, div. A, title VII, Sec. 716, Nov. 5, 1990, 104 Stat. 1585, prohibited the Secretary of a military department, during the period beginning on Nov. 5, 1990, and ending on Sept. 30, 1995, from taking any action to close a military medical facility or reduce the level of care provided at such a facility until 90 days after the Secretary had submitted to Congress a report describing the reason for the action, projected savings, impact on costs, and alternative methods of providing care. Requirement For Availability Of Additional Insurance Coverage; Funding Limitations; Definition Pub. L. 100-180, div. A, title VII, Sec. 732(e)-(g), Dec. 4, 1987, 101 Stat. 1120, 1121, provided that:

“(e) Requirement for Availability of Additional Insurance Coverage.—(1) The Secretary of Defense shall make every effort to enter into an agreement, similar to the one being negotiated with a private insurer on the date of the enactment of this Act [Dec. 4, 1987], that would provide an insurance plan that meets the requirements described in paragraph (3).

“(2) If an agreement referred to in paragraph (1) is not entered into before a request for proposals with respect to the second phase of the CHAMPUS reform initiative is issued, the Secretary shall provide for an insurance plan which meets the requirements described in paragraph (3) through either of the following means:

“(A) By including, in any request for proposals with respect to the second (and any subsequent) phase of the CHAMPUS reform initiative, a requirement for the contractor to offer an option to elect an insurance plan which meets the requirements described in paragraph (3).

“(B) By including, in any request for proposals for a contract to process claims for CHAMPUS, a requirement for the contractor (known as a fiscal intermediary) to offer an option to elect an insurance plan which meets the requirements described in paragraph (3).

“(3) The insurance plan requirements referred to in paragraphs (1) and (2) are the following:

“(A) At the election of the individual, the plan shall be available to an individual losing eligibility (by reason of discharge, release from active duty, a change in family status (including divorce or annulment, or, in the case of a child, reaching age 22), or other similar reason) to be a covered beneficiary under chapter 55 of title 10, United States Code.

“(B) The plan shall provide for coverage of benefits similar to the coverage of benefits available to the individual under CHAMPUS, regardless of any pre-existing condition.

“(C) The plan shall provide that enrollees in the plan shall pay the full periodic charges for the benefit coverage.

“(f) Funding Limitations.—(1) None of the funds appropriated or otherwise made available to the Department of Defense may be obligated or expended for the purpose of entering into a contract for the demonstration phase of the CHAMPUS reform initiative required by section 702(a)(1) of the National Defense Authorization Act for Fiscal Year 1987 [section 702(a)(1) of Pub. L. 99-661, set out as a note below] until the requirements of section 702(a)(4) of such Act (as added by subsection (a)) are met.

“(2) None of the funds appropriated or otherwise made available to the Department of Defense may be obligated or expended for the purpose of requesting a proposal for the

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second (or any subsequent) phase of the CHAMPUS reform initiative as described in section 702(c) of the National Defense Authorization Act for Fiscal Year 1987 until the requirements of paragraph (2) of section 702(c) of such Act (as added by subsection (c)) are met.

“(g) CHAMPUS Defined.—In this section, the term ‘CHAMPUS’ has the meaning given such term by section 1072(4) of title 10, United States Code.”

**CHAMPUS Reform Initiative**

Pub. L. 99-661, div. A, title VII, Sec. 702, Nov. 14, 1986, 100 Stat. 3899, as amended by Pub. L. 100-180, div. A, title VII, Sec. 732(a), (c), Dec. 4, 1987, 101 Stat. 1119, provided that:

“(a) Demonstration Project.—(1) The Secretary of Defense shall conduct a project designed to demonstrate the feasibility of improving the effectiveness of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) through the competitive selection of contractors to financially underwrite the delivery of health care services under the program.

“(2) The demonstration project required by paragraph (1)—

“(A) shall begin not later than September 30, 1988, and continue for not less than one year;

“(B) shall include not more than one-third of covered beneficiaries; and

“(C) shall include a health care enrollment system that meets the requirements specified in section 1099 of title 10, United States Code (as added by section 701(a)(1)).

“(3)(A) The Secretary shall submit to the Committees on Armed Services of the Senate and House of Representatives a report on the development of the demonstration project required by paragraph (1). Such report shall include—

“(i) a description of the scope and structure of the project;

“(ii) an estimate of the costs of the care to be provided under the project; and

“(iii) a description of the health care enrollment system included in the project.

“(B) The report required by subparagraph (A) shall be submitted—

“(i) not later than 60 days before the initiation of the project, if the project is to be restricted to a contiguous area of the United States; or

“(ii) not later than 60 days before a solicitation for bids or proposals with respect to such project is issued, if the project will not be restricted to a contiguous area of the United States.

“(4) The Secretary of Defense shall develop a methodology to be used in evaluating the results of the demonstration project required by paragraph (1) and shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on such methodology.

“(b) Study of Health Care Alternatives.—(1) The demonstration project required by subsection (a)(1) shall include a study of—

“(A) methods to guarantee the maintenance of competition among providers of health care to persons under the jurisdiction of the Secretary;

“(B) the merits of the use of a voucher system or a fee schedule for provision of health care to such persons; and

“(C) methods to guarantee that community hospitals are given equal consideration with other health care providers for provision of health care services under contracts with the Department of Defense.

“(2) The Secretary shall submit to Congress a report discussing the matters evaluated in the study required by paragraph (1) before the end of the 90-day period beginning on the date of the enactment of this Act [Nov. 14, 1986].

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“(c) Phased Implementation of CHAMPUS Reform Initiative.—(1) The Secretary of Defense may proceed with implementation of the CHAMPUS reform initiative, to be carried out in two phases during a period of not less than two years, if—

“(A) the Secretary determines, based on the results of the demonstration project required by subsection (a)(1), that such initiative should be implemented;

“(B) not less than one year elapses after the date on which the demonstration project required by subsection (a)(1) is initiated; and

“(C) 90 days elapse after the date on which the Secretary submits to the Committees on Armed Services of the Senate and House of Representatives a report that includes—

“(i) a description of the results of the demonstration project, evaluated in accordance with the methodology developed under subsection (a)(4);

“(ii) a description of any changes the Secretary intends to make in the initiative during the proposed implementation; and

“(iii) a comparison of the costs of providing health care under CHAMPUS with the costs of providing health care under the demonstration project and the estimated costs of providing health care under the CHAMPUS reform initiative if fully implemented:

“(2) The Secretary may not issue a request for proposals with respect to the second (or any subsequent) phase of the CHAMPUS reform initiative until—

“(A) all principal features of the demonstration project, including networks of providers of health care, have been in operation for not less than one year; and

“(B) the expiration of 60 days after the date on which the report described in paragraph (1)(C) has been received by the committees referred to in such paragraph.

“(d) Definitions.—In this section:

“(1) The term ‘CHAMPUS reform initiative’ means the competitive selection of contractors to financially underwrite the delivery of health care services under the Civilian Health and Medical Program of the Uniformed Services.

“(2) The term ‘Civilian Health and Medical Program of the Uniformed Services’ has the meaning given such term in section 1072(4) of title 10, United States Code (as added by section 701(b)).

“(3) The term ‘covered beneficiary’ has the meaning given such term in section 1072(5) of title 10, United States Code (as added by section 701(b)).”

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

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## § 1073b. Recurring reports

(a) Annual Report on Health Protection Quality.—(1) The Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives each year a report on the Force Health Protection Quality Assurance Program of the Department of Defense. The report shall cover the calendar year preceding the year in which the report is submitted and include the following matters:

(A) The results of an audit conducted during the calendar year covered by the report of the extent to which the blood samples required to be obtained as described in section 733(b) of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005 from members of the armed forces before and after a deployment are stored in the blood serum repository of the Department of Defense.

(B) The results of an audit conducted during the calendar year covered by the report of the extent to which the records of the health assessments required under section 1074f of this title for members of the armed forces before and after a deployment are being maintained in the electronic database of the Defense Medical Surveillance System.

(C) An analysis of the actions taken by Department of Defense personnel to respond to health concerns expressed by members of the armed forces upon return from a deployment.

(D) An analysis of the actions taken by Department of Defense personnel to evaluate or treat members of the armed forces who are confirmed to have been exposed to occupational or environmental hazards deleterious to their health during a deployment.

(2) The Secretary of Defense shall act through the Assistant Secretary of Defense for Health Affairs in carrying out this subsection.

(b) Annual Report on Recording of Health Assessment Data in Military Health Records.—The Secretary of Defense shall issue each year a report on the compliance by the military departments with applicable law and policies on the recording of health assessment data in military health records, including compliance with section 1074f(c) of this title. The report shall cover the calendar year preceding the year in which the report is submitted and include a discussion of the extent to which immunization status and predeployment and postdeployment health care data are being recorded in such records.

(c) Publication of Data on Patient Safety, Quality of Care, Satisfaction, and Health Outcome Measures.—(1) Not later than 180 days after the date of the enactment of the National Defense Authorization Act for Fiscal Year 2016, the Secretary of Defense shall publish on a publically available Internet website of the Department of Defense data on all measures that the Secretary considers appropriate that are used by the Department to assess patient safety, quality of care, patient satisfaction, and health outcomes for health care provided under the TRICARE program at each military medical treatment facility.

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(2) The Secretary shall publish an update to the data published under paragraph (1) not less frequently than once each quarter during each fiscal year.

(3) The Secretary may not include data relating to risk management activities of the Department in any publication under paragraph (1) or update under paragraph (2).

(4) The Secretary shall ensure that the data published under paragraph (1) and updated under paragraph (2) is accessible to the public through the primary Internet website of the Department and the primary Internet website of the military medical treatment facility with respect to which such data applies.

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**NOTES**

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**Source**

(Added Pub. L. 108-375, div. A, title VII, Sec. 739(a)(1), Oct. 28, 2004, 118 Stat. 2001; amended Pub. L. 114-92, div. A, title VII, §712, Nov. 25, 2015, 129 Stat. 864.)

**References In Text**

Section 733(b) of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, referred to in subsec. (a)(1)(A), is section 733(b) of Pub. L. 108-375, which is set out as a note under section 1074f of this title.

The date of the enactment of the National Defense Authorization Act for Fiscal Year 2016, referred to in subsec. (c)(1), is the date of enactment of Pub. L. 114-92, which was approved Nov. 25, 2015.

**Amendments**

2015—Subsec. (c). Pub. L. 114-92 added subsec. (c).

**Inclusion Of Dental Care**

For purposes of amendment by Pub. L. 108-375 adding this section, references to medical readiness, health status, and health care to be considered to include dental readiness, dental status, and dental care, see section 740 of Pub. L. 108-375, set out as a note under section 1074 of this title.

**Initial Reports**

Pub. L. 108-375, div. A, title VII, Sec. 739(a)(3), Oct. 28, 2004, 118 Stat. 2002, directed that the first reports under this section be completed not later than 180 days after Oct. 28, 2004.

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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, **as amended by Pub. L. 114-92, div. A, title VII, §705, Nov. 25, 2015, 129 Stat. 863**, 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); and

“(B) the amount the beneficiary would have paid 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 **after September 30, 2008**.

“(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).”

## § 1074d. Certain primary and preventive health care services

(a) Services Available.—(1) Female members and former members of the uniformed services entitled to medical care under section 1074 or 1074a of this title shall also be entitled to primary and preventive health care services for women as part of such medical care. The services described in paragraphs (1) and (2) of subsection (b) shall be provided under such procedures and at such intervals as the Secretary of Defense shall prescribe.

(2) Male members and former members of the uniformed services entitled to medical care under section 1074 or 1074a of this title shall also be entitled to preventive health care screening for colon or prostate cancer at such intervals and using such screening methods as the administering Secretaries consider appropriate.

(b) Definition.—In this section, the term “primary and preventive health care services for women” means health care services, including related counseling services, provided to women with respect to the following:

- (1) Cervical cancer screening.
- (2) Breast cancer screening.
- (3) Comprehensive obstetrical and gynecological care, including care related to pregnancy and the prevention of pregnancy.
- (4) Infertility and sexually transmitted diseases, including prevention.
- (5) Menopause, including hormone replacement therapy and counseling regarding the benefits and risks of hormone replacement therapy.
- (6) Physical or psychological conditions arising out of acts of sexual violence.
- (7) Gynecological cancers.
- (8) Colon cancer screening, at the intervals and using the screening methods prescribed under subsection (a)(2).

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### NOTES

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#### Source

(Added Pub. L. 103-160, div. A, title VII, Sec. 701(a)(1), Nov. 30, 1993, 107 Stat. 1685; amended Pub. L. 104-201, div. A, title VII, Sec. 701(a)(1), (2)(A), Sept. 23, 1996, 110 Stat. 2587; Pub. L. 109-364, div. A, title VII, Sec. 703(a), Oct. 17, 2006, 120 Stat. 2279.)

**Amendments**

2006—Subsec. (a)(1). Pub. L. 109-364, Sec. 703(a)(1), inserted at end “The services described in paragraphs (1) and (2) of subsection (b) shall be provided under such procedures and at such intervals as the Secretary of Defense shall prescribe.”

Subsec. (b)(1). Pub. L. 109-364, Sec. 703(a)(2)(A), substituted “Cervical cancer screening” for “Papanicolaou tests (pap smear)”.

Subsec. (b)(2). Pub. L. 109-364, Sec. 703(a)(2)(B), substituted “Breast cancer screening” for “Breast examinations and mammography”.

1996—Pub. L. 104-201, Sec. 701(a)(2)(A), amended catchline generally, substituting “Certain primary and preventive health care services” for “Primary and preventive health care services for women”.

Subsec. (a). Pub. L. 104-201, Sec. 701(a)(1)(A), designated existing provisions as par. (1) and added par. (2).

Subsec. (b)(8). Pub. L. 104-201, Sec. 701(a)(1)(B), added par. (8).

**Comprehensive Standards And Access To Contraception Counseling For Members Of The Armed Forces**

Pub. L. 114-92, div. A, title VII, §718, Nov. 25, 2015, 129 Stat. 868, provided that:

“(a) Clinical Practice Guidelines.—

“(1) Establishment.—Not later than one year after the date of the enactment of this Act [Nov. 25, 2015], the Secretary of Defense shall establish clinical practice guidelines for health care providers employed by the Department of Defense on standards of care with respect to methods of contraception and counseling on methods of contraception for members of the Armed Forces.

“(2) Updates.—The Secretary shall from time to time update the clinical practice guidelines established under paragraph (1) to incorporate into such guidelines new or updated standards of care with respect to methods of contraception and counseling on methods of contraception.

“(b) Dissemination.—

“(1) Initial dissemination.—As soon as practicable, but commencing not later than one year after the date of the enactment of this Act, the Secretary shall provide for rapid dissemination of the clinical practice guidelines to health care providers described in subsection (a)(1).

“(2) Dissemination of updates.—As soon as practicable after each update to the clinical practice guidelines made by the Secretary pursuant to paragraph (2) of subsection (a), the Secretary shall provide for the rapid dissemination of such updated clinical practice guidelines to health care providers described in paragraph (1) of such subsection.

“(3) Protocols.—The Secretary shall disseminate the clinical practice guidelines under paragraph (1) and any updates to such guidelines under paragraph (2) in accordance with administrative protocols developed by the Secretary for such purpose.

“(c) Access to Contraception Counseling.—As soon as practicable after the date of the enactment of this Act, the Secretary shall ensure that women members of the Armed Forces have access to comprehensive counseling on the full range of methods of contraception provided by health care providers described in subsection (a)(1) during health care visits, including visits as follows:

“(1) During predeployment health care visits, including counseling that provides specific information women need regarding the interaction between anticipated deployment conditions and various methods of contraception.

- “(2) During health care visits during deployment.
- “(3) During annual physical examinations.”

#### Defense Women’s Health Research Program

Pub. L. 103-337, div. A, title II, Sec. 241, Oct. 5, 1994, 108 Stat. 2701, provided that:

“(a) Continuation of Program.—The Secretary of Defense shall continue the Defense Women’s Health Research Program established in fiscal year 1994 pursuant to the authority in section 251 of the National Defense Authorization Act for Fiscal Year 1994 (Public Law 103-160; 107 Stat. 1606) [set out below]. The program shall continue to serve as the coordinating agent for multi-disciplinary and multi-institutional research within the Department of Defense on women’s health issues related to service in the Armed Forces. The program also shall continue to coordinate with research supported by other Federal agencies that is aimed at improving the health of women.

“(b) Participation by All Military Departments.—The Departments of the Army, Navy, and Air Force shall each participate in the activities under the program.

“(c) Army To Be Executive Agent.—The Secretary of Defense shall designate the Secretary of the Army to be the executive agent for administering the program.

“(d) Implementation Plan.—If the Secretary of Defense intends to change the plan for the implementation of the program previously submitted to the Committees on Armed Services of the Senate and House of Representatives, the amended plan shall be submitted to such committees before implementation.

“(e) Program Activities.—The program shall include the following activities regarding health risks and health care for women in the Armed Forces:

“(1) The coordination and support activities described in section 251 of Public Law 103-160 [set out below].

“(2) Epidemiologic research regarding women deployed for military operations, including research on patterns of illness and injury, environmental and occupational hazards (including exposure to toxins), side-effects of pharmaceuticals used by women so deployed, psychological stress associated with military training, deployment, combat and other traumatic incidents, and other conditions of life, and human factor research regarding women so deployed.

“(3) Development of a data base to facilitate long-term research studies on issues related to the health of women in military service, and continued development and support of a women’s health information clearinghouse to serve as an information resource for clinical, research, and policy issues affecting women in the Armed Forces.

“(4) Research on policies and standards issues, including research supporting the development of military standards related to training, operations, deployment, and retention and the relationship between such activities and factors affecting women’s health.

“(5) Research on interventions having a potential for addressing conditions of military service that adversely affect the health of women in the Armed Forces.

“(f) Funding.—Of the amount authorized to be appropriated pursuant to section 201 [108 Stat. 2690], \$40,000,000 shall be available for the Defense Women’s Health Research Program referred to in subsection (a).”

Pub. L. 103-160, div. A, title II, Sec. 251, Nov. 30, 1993, 107 Stat. 1606, provided that:

“(a) Authority To Establish Center.—The Secretary of Defense may establish a Defense Women’s Health Research Center (hereinafter in this section referred to as the ‘Center’) at an existing Department of Defense medical center to serve as the coordinating agent for multidisciplinary and multi-institutional research within the Department of Defense on women’s health issues

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related to service in the Armed Forces. The Secretary shall determine whether or not to establish the Center not later than May 1, 1994. If established, the Center shall also coordinate with research supported by the Department of Health and Human Services and other agencies that is aimed at improving the health of women.

“(b) Support of Research.—The Center shall support health research into matters relating to the service of women in the military, including the following matters:

“(1) Combat stress and trauma.

“(2) Exposure to toxins and other environmental hazards associated with military equipment.

“(3) Psychology related stress in warfare situations.

“(4) Mental health, including post-traumatic stress disorder and depression.

“(5) Human factor studies related to women in combat areas.

“(c) Competition Requirement Relating to Establishment of Center.—The Center may be established only pursuant to a competition among existing Department of Defense medical centers.

“(d) Implementation Plan.—The Secretary of Defense shall prepare a plan for the implementation of subsection (a). The plan shall be submitted to the Committees on Armed Services of the Senate and House of Representatives before May 1, 1994.

“(e) Activities for Fiscal Year 1994.—During fiscal year 1994, the Center may address the following:

“(1) Program planning, infrastructure development, baseline information gathering, technology infusion, and connectivity.

“(2) Management and technical staffing.

“(3) Data base development of health issues related to service by women on active duty as compared to service by women in the National Guard or Reserves.

“(4) Research protocols, cohort development, health surveillance, and epidemiologic studies, to be developed in coordination with the Centers for Disease Control and the National Institutes of Health whenever possible.

“(f) Funding.—Of the funds authorized to be appropriated pursuant to section 201 [107 Stat. 1583], \$20,000,000 shall be available for the establishment of the Center or for medical research at existing Department of Defense medical centers into matters relating to service by women in the military.

“(g) Report.—(1) If the Secretary of Defense determines not to establish a women’s health center under subsection (a), the Secretary shall submit to the Committees on Armed Services of the Senate and House of Representatives, not later than May 1, 1994, a report on the plans of the Secretary for the use of the funds described in subsection (f).

“(2) If the Secretary determines to establish the Center, the Secretary shall, not less than 60 days before the establishment of the Center, submit to those committees a report describing the planned location for the Center and the competitive process used in the selection of that location.”

**Report On Provision Of Primary And Preventative Health Care Services For Women**

Pub. L. 103-160, div. A, title VII, Sec. 735, Nov. 30, 1993, 107 Stat. 1698, directed the Secretary of Defense to prepare a report evaluating the provision of primary and preventive health care services through military medical treatment facilities and the Civilian Health and Medical Program of the Uniformed Services to female members of the uniformed services and female covered beneficiaries eligible for health care under this chapter, and directed the Secretary, as part of such report, to conduct a study to determine the health care needs of female members and female covered beneficiaries, and to submit such report to Congress not later than Oct. 1, 1994, and a revised report not later than Oct. 1, 1999.

## § 1074g. Pharmacy benefits program

(a) Pharmacy Benefits.—(1) The Secretary of Defense, after consulting with the other administering Secretaries, shall establish an effective, efficient, integrated pharmacy benefits program under this chapter (hereinafter in this section referred to as the “pharmacy benefits program”).

(2)(A) The pharmacy benefits program shall include a uniform formulary of pharmaceutical agents, which shall assure the availability of pharmaceutical agents in the complete range of therapeutic classes. The selection for inclusion on the uniform formulary of particular pharmaceutical agents in each therapeutic class shall be based on the relative clinical and cost effectiveness of the agents in such class. **With respect to members of the uniformed services, such uniform formulary shall include pharmaceutical agents on the joint uniform formulary established under section 715 of the National Defense Authorization Act for Fiscal Year 2016.**

(B) In considering the relative clinical effectiveness of agents under subparagraph (A), the Secretary shall presume inclusion in a therapeutic class of a pharmaceutical agent, unless the Pharmacy and Therapeutics Committee established under subsection (b) finds that a pharmaceutical agent does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome over the other drugs included on the uniform formulary.

(C) In considering the relative cost effectiveness of agents under subparagraph (A), the Secretary shall rely on the evaluation by the Pharmacy and Therapeutics Committee of the costs of agents in a therapeutic class in relation to the safety, effectiveness, and clinical outcomes of such agents.

(D) The Secretary shall establish procedures for the selection of particular pharmaceutical agents for the uniform formulary. Such procedures shall be established so as best to accomplish, in the judgment of the Secretary, the objectives set forth in paragraph (1). Except as provided in subparagraph (F), no pharmaceutical agent may be excluded from the uniform formulary except upon the recommendation of the Pharmacy and Therapeutics Committee.

(E) Pharmaceutical agents included on the uniform formulary shall be available to eligible covered beneficiaries through—

(i) facilities of the uniformed services, consistent with the scope of health care services offered in such facilities and additional determinations by the Pharmacy and Therapeutics Committee of the relative clinical and cost effectiveness of the agents;

(ii) retail pharmacies designated or eligible under the TRICARE program or the Civilian Health and Medical Program of the Uniformed Services to provide pharmaceutical agents to covered beneficiaries; or

(iii) the national mail-order pharmacy program.

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(F)(i) The Secretary may implement procedures to place selected over-the-counter drugs on the uniform formulary and to make such drugs available to eligible covered beneficiaries. An over-the-counter drug may be included on the uniform formulary only if the Pharmacy and Therapeutics Committee established under subsection (b) finds that the over-the-counter drug is cost effective and clinically effective. If the Pharmacy and Therapeutics Committee recommends an over-the-counter drug for inclusion on the uniform formulary, the drug shall be considered to be in the same therapeutic class of pharmaceutical agents, as determined by the Committee, as similar prescription drugs.

(ii) Regulations prescribed by the Secretary to carry out clause (i) shall include the following with respect to over-the-counter drugs included on the uniform formulary:

(I) A determination of the means and conditions under paragraphs (5) and (6) through which over-the-counter drugs will be available to eligible covered beneficiaries and the amount of cost sharing that such beneficiaries will be required to pay for over-the-counter drugs, if any, except that no such cost sharing may be required for a member of a uniformed service on active duty.

(II) Any terms and conditions for the dispensing of over-the-counter drugs to eligible covered beneficiaries.

(3) The pharmacy benefits program shall assure the availability of clinically appropriate pharmaceutical agents to members of the armed forces, including, where appropriate, agents not included on the uniform formulary described in paragraph (2).

(4) The pharmacy benefits program may provide that prior authorization be required for certain pharmaceutical agents to assure that the use of such agents is clinically appropriate.

(5) The pharmacy benefits program shall assure the availability to eligible covered beneficiaries of pharmaceutical agents not included on the uniform formulary. Such pharmaceutical agents shall be available through the national mail-order pharmacy program under terms and conditions that shall include cost-sharing by the eligible covered beneficiary as specified in paragraph (6).

(6)(A) The Secretary, in the regulations prescribed under subsection (h), shall establish cost-sharing requirements under the pharmacy benefits program. In accordance with subparagraph (C), such cost-sharing requirements shall consist of the following:

(i) With respect to each supply of a prescription covering not more than 30 days that is obtained by a covered beneficiary under the TRICARE retail pharmacy program—

(I) in the case of generic agents, \$10;<sup>1</sup>

(II) in the case of formulary agents, \$24.

(ii) With respect to each supply of a prescription covering not more than 90 days that is obtained by a covered beneficiary under the national mail-order pharmacy program—

(I) in the case of generic agents, \$0;

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(II) in the case of formulary agents, \$20; and

(III) in the case of nonformulary agents, \$49.

(B) For a medicare-eligible beneficiary, the cost-sharing requirements may not be in excess of the cost-sharing requirements applicable to all other beneficiaries covered by section 1086 of this title. For purposes of the preceding sentence, a medicare-eligible beneficiary is a beneficiary eligible for health benefits under section 1086 of this title pursuant to subsection (d)(2) of such section.

(C)(i) Beginning October 1, 2016, the amount of any increase in a cost-sharing amount specified in subparagraph (A) in a year may not exceed the amount equal to the percentage of such cost-sharing amount at the time of such increase equal to the percentage by which retired pay is increased under section 1401a of this title in that year.

(ii) The amount of the increase otherwise provided for a year by clause (i) shall be computed as follows:

(I) If the amount of the increase is equal to or greater than 50 cents, the amount of the increase shall be rounded to the nearest multiple of \$1.

(II) If the amount of the increase is less than 50 cents, the increase shall not be made for such year, but shall be carried over to, and accumulated with, the amount of the increase for the subsequent year or years and made when the aggregate amount of increases under this clause for a year is equal to or greater than 50 cents.

(iii) The provisions of this subparagraph shall not apply to any increase in cost-sharing amounts described in clause (i) that is made by the Secretary of Defense on or after October 1, 2022. The Secretary may increase copayments, as considered appropriate by the Secretary, beginning on October 1, 2022.

(7) The Secretary shall establish procedures for eligible covered beneficiaries to receive pharmaceutical agents that are not included on the uniform formulary but that are considered to be clinically necessary. Such procedures shall include peer review procedures under which the Secretary may determine that there is a clinical justification for the use of a pharmaceutical agent that is not on the uniform formulary, in which case the pharmaceutical agent shall be provided under the same terms and conditions as an agent on the uniform formulary. Such procedures shall also include an expeditious appeals process for an eligible covered beneficiary, or a network or uniformed provider on behalf of the beneficiary, to establish clinical justification for the use of a pharmaceutical agent that is not on the uniform formulary.

(8) In carrying out this subsection, the Secretary shall ensure that an eligible covered beneficiary may continue to receive coverage for any maintenance pharmaceutical that is not on the uniform formulary and that was prescribed for the beneficiary before October 5, 1999, and stabilized the medical condition of the beneficiary.

(9)(A) Beginning on October 1, 2015, the pharmacy benefits program shall require eligible covered beneficiaries generally to refill non-generic prescription maintenance medications through military treatment facility pharmacies or the national mail-order pharmacy program.

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(B) The Secretary shall determine the maintenance medications subject to the requirement under subparagraph (A). The Secretary shall ensure that—

(i) such medications are generally available to eligible covered beneficiaries through retail pharmacies only for an initial filling of a 30-day or less supply; and

(ii) any refills of such medications are obtained through a military treatment facility pharmacy or the national mail-order pharmacy program.

(C) The Secretary may exempt the following prescription maintenance medications from the requirement of subparagraph (A):

(i) Medications that are for acute care needs.

(ii) Such other medications as the Secretary determines appropriate.

(b) Establishment of Committee.—(1) The Secretary of Defense shall, in consultation with the Secretaries of the military departments, establish a Pharmacy and Therapeutics Committee for the purpose of developing the uniform formulary of pharmaceutical agents required by subsection (a), reviewing such formulary on a periodic basis, and making additional recommendations regarding the formulary as the committee determines necessary and appropriate. The committee shall include representatives of pharmacies of the uniformed services facilities and representatives of providers in facilities of the uniformed services. Committee members shall have expertise in treating the medical needs of the populations served through such entities and in the range of pharmaceutical and biological medicines available for treating such populations. The committee shall function under procedures established by the Secretary under the regulations prescribed under subsection (h).

(2) The committee shall meet at least quarterly and shall, during meetings, consider for inclusion on the uniform formulary under the standards established in subsection (a) any drugs newly approved by the Food and Drug Administration.

(c) Advisory Panel.—(1) Concurrent with the establishment of the Pharmacy and Therapeutics Committee under subsection (b), the Secretary shall establish a Uniform Formulary Beneficiary Advisory Panel to review and comment on the development of the uniform formulary. The Secretary shall consider the comments of the panel before implementing the uniform formulary or implementing changes to the uniform formulary.

(2) The Secretary shall determine the size and membership of the panel established under paragraph (1), which shall include members that represent—

(A) nongovernmental organizations and associations that represent the views and interests of a large number of eligible covered beneficiaries;

(B) contractors responsible for the TRICARE retail pharmacy program;

(C) contractors responsible for the national mail-order pharmacy program; and

(D) TRICARE network providers.

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(d) Procedures.—(1) In the operation of the pharmacy benefits program under subsection (a), the Secretary of Defense shall assure through management and new contractual arrangements that financial resources are aligned such that the cost of prescriptions is borne by the organization that is financially responsible for the health care of the eligible covered beneficiary.

(2) The Secretary shall use a modification to the bid price adjustment methodology in the managed care support contracts current as of October 5, 1999, to ensure equitable and timely reimbursement to the TRICARE managed care support contractors for pharmaceutical products delivered in the nonmilitary environments. The methodology shall take into account the “at-risk” nature of the contracts as well as managed care support contractor pharmacy costs attributable to changes to pharmacy service or formulary management at military medical treatment facilities, and other military activities and policies that affect costs of pharmacy benefits provided through the Civilian Health and Medical Program of the Uniformed Services. The methodology shall also account for military treatment facility costs attributable to the delivery of pharmaceutical products in the military facility environment which were prescribed by a network provider.

(e) Pharmacy Data Transaction Service.—The Secretary of Defense shall implement the use of the Pharmacy Data Transaction Service in all fixed facilities of the uniformed services under the jurisdiction of the Secretary, in the TRICARE retail pharmacy program, and in the national mail-order pharmacy program.

(f) Procurement of Pharmaceuticals by TRICARE Retail Pharmacy Program.—With respect to any prescription filled after January 28, 2008, the TRICARE retail pharmacy program shall be treated as an element of the Department of Defense for purposes of the procurement of drugs by Federal agencies under section 8126 of title 38 to the extent necessary to ensure that pharmaceuticals paid for by the Department of Defense that are provided by pharmacies under the program to eligible covered beneficiaries under this section are subject to the pricing standards in such section 8126.

(g) Definitions.—In this section:

(1) The term “eligible covered beneficiary” means a covered beneficiary for whom eligibility to receive pharmacy benefits through the means described in subsection (a)(2)(E) is established under this chapter or another provision of law.

(2) The term “pharmaceutical agent” means drugs, biological products, and medical devices under the regulatory authority of the Food and Drug Administration.

(3) The term “over-the-counter drug” means a drug that is not subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)).

(4) The term “prescription drug” means a drug that is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)).

(h) Regulations.—The Secretary of Defense shall, after consultation with the other administering Secretaries, prescribe regulations to carry out this section.

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**NOTES**

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**Source**

(Added Pub. L. 106-65, div. A, title VII, Sec. 701(a)(1), Oct. 5, 1999, 113 Stat. 677; amended Pub. L. 106-398, Sec. 1 [[div. A], title X, Sec. 1087(a)(5)], Oct. 30, 2000, 114 Stat. 1654, 1654A-290; Pub. L. 107-107, div. A, title X, Sec. 1048(c)(4), Dec. 28, 2001, 115 Stat. 1226; Pub. L. 108-136, div. A, title VII, Sec. 725, Nov. 24, 2003, 117 Stat. 1535; Pub. L. 108-375, div. A, title VII, Sec. 714, Oct. 28, 2004, 118 Stat. 1985; Pub. L. 110-181, div. A, title VII, Sec. 703(a), Jan. 28, 2008, 122 Stat. 188; Pub. L. 111-84, div. A, title X, Sec. 1073(a)(10), Oct. 28, 2009, 123 Stat. 2473; Pub. L. 112-239, div. A, title VII, Secs. 702, 712(a), Jan. 2, 2013, 126 Stat. 1798, 1802; Pub. L. 113-291, div. A, title VII, §702(a)-(c)(1), Dec. 19, 2014, 128 Stat. 3410; **Pub. L. 114-92, div. A, title VII, §§702, 715(f), Nov. 25, 2015, 129 Stat. 860, 867.**)

**References In Text**

Section 715 of the National Defense Authorization Act for Fiscal Year 2016, referred to in subsec. (a)(2)(A), is section 715 of Pub. L. 114-92, which is set out as a note under this section.

**Amendments**

2015—Subsec. (a)(2)(A). Pub. L. 114-92, §715(f), inserted at end “With respect to members of the uniformed services, such uniform formulary shall include pharmaceutical agents on the joint uniform formulary established under section 715 of the National Defense Authorization Act for Fiscal Year 2016.”

Subsec. (a)(6)(A)(i)(I). Pub. L. 114-92, §702(a)(1)(A), substituted “\$10” for “\$8”.

Subsec. (a)(6)(A)(i)(II). Pub. L. 114-92, §702(a)(1)(B), substituted “\$24” for “\$20”.

Subsec. (a)(6)(A)(ii)(II). Pub. L. 114-92, §702(a)(2)(A), substituted “\$20” for “\$16”.

Subsec. (a)(6)(A)(ii)(III). Pub. L. 114-92, §702(a)(2)(B), substituted “\$49” for “\$46”.

Subsec. (a)(6)(C)(i). Pub. L. 114-92, §702(b)(1), substituted “Beginning October 1, 2016,” for “Beginning October 1, 2013,”.

Subsec. (a)(6)(C)(ii). Pub. L. 114-92, §702(b)(2), added cl. (ii) and struck out former cl. (ii) which read as follows: “If the amount of the increase otherwise provided for a year by clause (i) is less than \$1, the increase shall not be made for such year, but shall be carried over to, and accumulated with, the amount of the increase for the subsequent year or years and made when the aggregate amount of increases carried over under this clause for a year is \$1 or more.”

2014—Subsec. (a)(5). Pub. L. 113-291, §702(a), substituted “the national mail-order pharmacy program” for “at least one of the means described in paragraph (2)(E)” and “shall include cost-sharing by the eligible covered beneficiary as specified in paragraph (6).” for “may include cost sharing by the eligible covered beneficiary in addition to any such cost sharing applicable to agents on the uniform formulary.”

Subsec. (a)(6)(A)(i)(I). Pub. L. 113-291, §702(b)(1)(A), substituted “\$8” for “\$5”.

Subsec. (a)(6)(A)(i)(II). Pub. L. 113-291, §702(b)(1)(B), substituted “\$20.” for “\$17; and”.

Subsec. (a)(6)(A)(i)(III). Pub. L. 113-291, §702(b)(1)(C), struck out subcl. (III) which read as follows: “in the case of nonformulary agents, \$44.”

Subsec. (a)(6)(A)(ii)(II). Pub. L. 113-291, §702(b)(2)(A), substituted “\$16” for “\$13”.

Subsec. (a)(6)(A)(ii)(III). Pub. L. 113-291, §702(b)(2)(B), substituted “\$46” for “\$43”.

Subsec. (a)(9). Pub. L. 113-291, §702(c)(1), which directed amendment of such section by adding par. (9) at the end, was executed by adding par. (9) at the end of subsec. (a), to reflect the probable intent of Congress.

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2013—Subsec. (a)(2)(D). Pub. L. 112-239, Sec. 702(a)(1), (c)(2)(A), substituted “Except as provided in subparagraph (F), no pharmaceutical agent may be excluded” for “No pharmaceutical agent may be excluded” and struck out at end “The Secretary shall begin to implement the uniform formulary not later than October 1, 2000.”

Subsec. (a)(2)(F). Pub. L. 112-239, Sec. 702(a)(2), added subpar. (F).

Subsec. (a)(6)(A). Pub. L. 112-239, Sec. 712(a)(1), added subpar. (A) and struck out former subpar. (A) which read as follows: “The Secretary, in the regulations prescribed under subsection (g), may establish cost sharing requirements (which may be established as a percentage or fixed dollar amount) under the pharmacy benefits program for generic, formulary, and nonformulary agents. For nonformulary agents, cost sharing shall be consistent with common industry practice and not in excess of amounts generally comparable to 20 percent for beneficiaries covered by section 1079 of this title or 25 percent for beneficiaries covered by section 1086 of this title.”

Subsec. (a)(6)(C). Pub. L. 112-239, Sec. 712(a)(2), added subpar. (C).

Subsec. (b)(1). Pub. L. 112-239, Sec. 702(c)(1), substituted “subsection (h)” for “subsection (g)”.

Subsec. (b)(2). Pub. L. 112-239, Sec. 702(c)(2)(B), substituted “The committee” for “Not later than 90 days after the establishment of the Pharmacy and Therapeutics Committee by the Secretary, the committee shall convene to design a proposed uniform formulary for submission to the Secretary. After such 90-day period, the committee”.

Subsec. (d)(2). Pub. L. 112-239, Sec. 702(c)(2)(C), substituted “The Secretary” for “Effective not later than April 5, 2000, the Secretary” and “the managed care support contracts current as of October 5, 1999,” for “the current managed care support contracts”.

Subsec. (g)(3), (4). Pub. L. 112-239, Sec. 702(b), added pars. (3) and (4).

2009—Subsec. (f). Pub. L. 111-84 substituted “after January 28, 2008” for “on or after the date of the enactment of the National Defense Authorization Act for Fiscal Year 2008”.

2008—Subsecs. (f) to (h). Pub. L. 110-181 added subsec. (f) and redesignated former subsecs. (f) and (g) as (g) and (h), respectively.

2004—Subsec. (a)(2)(E)(i). Pub. L. 108-375, Sec. 714(b), inserted before semicolon at end “and additional determinations by the Pharmacy and Therapeutics Committee of the relative clinical and cost effectiveness of the agents”.

Subsec. (a)(6). Pub. L. 108-375, Sec. 714(a), designated existing provisions as subpar. (A) and added subpar. (B).

2003—Subsec. (b)(1). Pub. L. 108-136, Sec. 725(1), substituted “facilities and representatives of providers in facilities of the uniformed services” for “facilities, contractors responsible for the TRICARE retail pharmacy program, contractors responsible for the national mail-order pharmacy program, providers in facilities of the uniformed services, and TRICARE network providers” in second sentence.

Subsec. (c)(2). Pub. L. 108-136, Sec. 725(2), substituted “represent—” for “represent nongovernmental”, inserted “(A) nongovernmental” before “organizations”, substituted “beneficiaries;” for “beneficiaries.”, and added subpars. (B) to (D).

2001—Subsec. (a)(8). Pub. L. 107-107 substituted “October 5, 1999,” for “the date of the enactment of this section”.

2000—Subsec. (a)(6). Pub. L. 106-398, Sec. 1 [[div. A], title X, Sec. 1087(a)(5)(A)], substituted “in the regulations prescribed” for “as part of the regulations established”.

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Subsec. (a)(7). Pub. L. 106-398, Sec. 1 [[div. A], title X, Sec. 1087(a)(5)(B)], substituted “that are not included on the uniform formulary but that are” for “not included on the uniform formulary, but;”.

Subsec. (b)(1). Pub. L. 106-398, Sec. 1 [[div. A], title X, Sec. 1087(a)(5)(C)], substituted “prescribed under” for “required by” in last sentence.

Subsec. (d)(2). Pub. L. 106-398, Sec. 1 [[div. A], title X, Sec. 1087(a)(5)(D)], substituted “Effective not later than April 5, 2000, the Secretary shall use” for “Not later than 6 months after the date of the enactment of this section, the Secretary shall utilize”.

Subsec. (e). Pub. L. 106-398, Sec. 1 [[div. A], title X, Sec. 1087(a)(5)(E)], substituted “The” for “Not later than April 1, 2000, the” and inserted “in” before “the TRICARE” and before “the national”.

Subsec. (f). Pub. L. 106-398, Sec. 1 [[div. A], title X, Sec. 1087(a)(5)(F)], substituted “In this section:” for “As used in this section—” in introductory provisions, “The term” for “the term” in pars. (1) and (2), and a period for “; and” at end of par. (1).

Subsec. (g). Pub. L. 106-398, Sec. 1 [[div. A], title X, Sec. 1087(a)(5)(G)], substituted “prescribe” for “promulgate”.

**Effective Date Of 2013 Amendment**

Pub. L. 112-239, div. A, title VII, Sec. 712(b), Jan. 2, 2013, 126 Stat. 1802, provided that:

“(1) In general.—The cost-sharing requirements under subparagraph (A) of section 1074g(a)(6) of title 10, United States Code, as amended by subsection (a)(1), shall apply with respect to prescriptions obtained under the TRICARE pharmacy benefits program on or after such date as the Secretary of Defense shall specify, but not later than the date that is 45 days after the date of the enactment of this Act [Jan. 2, 2013].

“(2) Federal register.—The Secretary shall publish notice of the effective date of the cost-sharing requirements specified under paragraph (1) in the Federal Register.”

**Regulations**

Pub. L. 110-181, div. A, title VII, Sec. 703(b), Jan. 28, 2008, 122 Stat. 188, as amended by Pub. L. 110-417, [div. A], title X, Sec. 1061(b)(3), Oct. 14, 2008, 122 Stat. 4613; Pub. L. 111-84, div. A, title X, Sec. 1073(c)(12), Oct. 28, 2009, 123 Stat. 2475, provided that: “The Secretary of Defense shall, after consultation with the other administering Secretaries under chapter 55 of title 10, United States Code, modify the regulations under subsection (h) of section 1074g of title 10, United States Code (as redesignated by subsection (a)(1) of this section), to implement the requirements of subsection (f) of section 1074g of title 10, United States Code (as inserted by subsection (a)(2) of this section). The Secretary shall so modify such regulations not later than December 31, 2007.”

[Pub. L. 111-84, div. A, title X, Sec. 1073(c), Oct. 28, 2009, 123 Stat. 2474, provided that the amendment made by section 1073(c)(12) to section 1061(b)(3) of Pub. L. 110-417, included in the credit set out above, is effective as of Oct. 14, 2008, and as if included in Pub. L. 110-417 as enacted.]

**Termination Of Advisory Panels**

Advisory panels established after Jan. 5, 1973, to terminate not later than the expiration of the 2-year period beginning on the date of their establishment, unless, in the case of a panel established by the President or an officer of the Federal Government, such panel is renewed by appropriate action prior to the expiration of such 2-year period, or in the case of a panel established by Congress, its duration is otherwise provided for by law. See sections 3(2) and 14 of Pub. L. 92-463, Oct. 6, 1972, 86 Stat. 770, 776, set out in the Appendix to Title 5, Government Organization and Employees.

**Joint Uniform Formulary For Transition Of Care**

Pub. L. 114-92, div. A, title VII, §715, Nov. 25, 2015, 129 Stat. 866, provided that:

“(a) Joint Formulary.—Not later than June 1, 2016, the Secretary of Defense and the Secretary of Veterans Affairs shall jointly establish a joint uniform formulary for the Department of Veterans Affairs and the Department of Defense with respect to pharmaceutical agents that are critical for the transition of an individual from receiving treatment furnished by the Secretary of Defense to treatment furnished by the Secretary of Veterans Affairs.

“(b) Selection.—The Secretaries shall select for inclusion on the joint uniform formulary established under subsection (a) pharmaceutical agents relating to—

“(1) the control of pain, sleep disorders, and psychiatric conditions, including post-traumatic stress disorder; and

“(2) any other conditions determined appropriate by the Secretaries.

“(c) Report.—Not later than July 1, 2016, the Secretaries shall jointly submit to the appropriate congressional committees a report on the joint uniform formulary established under subsection (a), including a list of the pharmaceutical agents selected for inclusion on the formulary.

“(d) Construction.—Nothing in this section shall be construed to prohibit the Secretary of Defense and the Secretary of Veterans Affairs from each maintaining the respective uniform formularies of the Department of the Secretary.

“(e) Definitions.—In this section:

“(1) 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 House of Representatives and the Senate.

“(2) The term 'pharmaceutical agent' has the meaning given that term in section 1074g(g) of title 10, United States Code.

“(f) Conforming Amendment.—[Amended this section.]”

**Pilot Program On Medication Therapy Management Under TRICARE Program**

Pub. L. 113-291, div. A, title VII, §726, Dec. 19, 2014, 128 Stat. 3419, provided that:

“(a) Establishment.—In accordance with section 1092 of title 10, United States Code, the Secretary of Defense shall carry out a pilot program to evaluate the feasibility and desirability of including medication therapy management as part of the TRICARE program.

“(b) Elements of Pilot Program.—In carrying out the pilot program under subsection (a), the Secretary shall ensure the following:

“(1) Patients who participate in the pilot program are patients who—

“(A) have more than one chronic condition; and

“(B) are prescribed more than one medication.

“(2) Medication therapy management services provided under the pilot program are focused on improving patient use and outcomes of prescription medications.

“(3) The design of the pilot program considers best commercial practices in providing medication therapy management services, including practices under the prescription drug program under part D of title XVIII of the Social Security Act (42 U.S.C. 1395w-101 et seq.).

“(4) The pilot program includes methods to measure the effect of medication therapy management services on—

“(A) patient use and outcomes of prescription medications; and

“(B) the costs of health care.

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“(c) Locations.—

“(1) Selection.—The Secretary shall carry out the pilot program under subsection (a) in not less than three locations.

“(2) First location criteria.—Not less than one location selected under paragraph (1) shall meet the following criteria:

“(A) The location is a pharmacy at a military medical treatment facility.

“(B) The patients participating in the pilot program at such location generally receive primary care services from health care providers at such facility.

“(3) Second location criteria.—Not less than one location selected under paragraph (1) shall meet the following criteria:

“(A) The location is a pharmacy at a military medical treatment facility.

“(B) The patients participating in the pilot program at such location generally do not receive primary care services from health care providers at such facility.

“(4) Third location criterion.—Not less than one location selected under paragraph (1) shall be a pharmacy located at a location other than a military medical treatment facility.

“(d) Duration.—The Secretary shall carry out the pilot program under subsection (a) for a period determined appropriate by the Secretary that is not less than two years.

“(e) Report.—Not later than 30 months after the date on which the Secretary commences the pilot program under subsection (a), 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 program that includes—

“(1) information on the effect of medication therapy management services on—

“(A) patient use and outcomes of prescription medications; and

“(B) the costs of health care;

“(2) the recommendations of the Secretary with respect to incorporating medication therapy management into the TRICARE program; and

“(3) such other information as the Secretary determines appropriate.

“(f) Definitions.—In this section:

“(1) The term ‘medication therapy management’ means professional services provided by qualified pharmacists to patients to improve the effective use and outcomes of prescription medications provided to the patients.

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

**Pilot Program For Refills Of Maintenance Medications For TRICARE For Life Beneficiaries Through The TRICARE Mail-Order Pharmacy Program**

Pub. L. 112-239, div. A, title VII, Sec. 716, Jan. 2, 2013, 126 Stat. 1804, as amended by Pub. L. 113-291, div. A, title VII, §702(c)(2), Dec. 19, 2014, 128 Stat. 3411, provided that:

“(a) In General.—The Secretary of Defense shall conduct a pilot program to refill prescription maintenance medications for each TRICARE for Life beneficiary through the national mail-order pharmacy program under section 1074g(a)(2)(E)(iii) of title 10, United States Code.

“(b) Medications Covered.—

“(1) Determination.—The Secretary shall determine the prescription maintenance medications included in the pilot program under subsection (a).

“(2) Supply.—In carrying out the pilot program under subsection (a), the Secretary shall ensure that the medications included in the program are generally available to a TRICARE for Life beneficiary—

“(A) for an initial filling of a 30-day or less supply through—

“(i) retail pharmacies under clause (ii) of section 1074g(a)(2)(E) of title 10, United States Code; and

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- “(ii) facilities of the uniformed services under clause (i) of such section; and
- “(B) for a refill of such medications through—
  - “(i) the national mail-order pharmacy program; and
  - “(ii) such facilities of the uniformed services.
- “(3) Exemption.—The Secretary may exempt the following prescription maintenance medications from the requirements in paragraph (2):
  - “(A) Such medications that are for acute care needs.
  - “(B) Such other medications as the Secretary determines appropriate.
- “(c) Nonparticipation.—
  - “(1) Opt out.—The Secretary shall give TRICARE for Life beneficiaries who have been covered by the pilot program under subsection (a) for a period of one year an opportunity to opt out of continuing to participate in the program.
  - “(2) Waiver.—The Secretary may waive the requirement of a TRICARE for Life beneficiary to participate in the pilot program under subsection (a) if the Secretary determines, on an individual basis, that such waiver is appropriate.
- “(d) Regulations.—The Secretary shall prescribe regulations to carry out the pilot program under subsection (a), including regulations with respect to—
  - “(1) the prescription maintenance medications included in the pilot program pursuant to subsection (b)(1); and
  - “(2) addressing instances where a TRICARE for Life beneficiary covered by the pilot program attempts to refill such medications at a retail pharmacy rather than through the national mail-order pharmacy program or a facility of the uniformed services.
- “(e) Reports.—Not later than March 31 of each year beginning in 2014 and ending in 2018, 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 program under subsection (a), including the effects of offering incentives for the use of mail order pharmacies by TRICARE beneficiaries and the effect on retail pharmacies.
- “(f) Sunset.—The Secretary may not carry out the pilot program under subsection (a) after September 30, 2015.
- “(g) TRICARE for Life Beneficiary Defined.—In this section, the term ‘TRICARE for Life beneficiary’ means a TRICARE beneficiary enrolled in the Medicare wraparound coverage option of the TRICARE program made available to the beneficiary by reason of section 1086(d) of title 10, United States Code.”

**Education And Training On Use Of Pharmaceuticals In Rehabilitation Programs For Wounded Warriors**

Pub. L. 111-383, div. A, title VII, Sec. 716, Jan. 7, 2011, 124 Stat. 4250, provided that:

- “(a) Education and Training Required.—The Secretary of Defense shall develop and implement training, available through the Internet or other means, on the use of pharmaceuticals in rehabilitation programs for seriously ill or injured members of the Armed Forces.
- “(b) Recipients of Training.—The training developed and implemented under subsection (a) shall be training for each category of individuals as follows:
  - “(1) Patients in or transitioning to a wounded warrior unit, with special accommodation in such training for such patients with cognitive disabilities.
  - “(2) Nonmedical case managers.
  - “(3) Military leaders.
  - “(4) Family members.
- “(c) Elements of Training.—The training developed and implemented under subsection (a) shall include the following:
  - “(1) An overview of the fundamentals of safe prescription drug use.

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- “(2) Familiarization with the benefits and risks of using pharmaceuticals in rehabilitation therapies.
- “(3) Examples of the use of pharmaceuticals for individuals with multiple, complex injuries, including traumatic brain injury and post-traumatic stress disorder.
- “(4) Familiarization with means of finding additional resources for information on pharmaceuticals.
- “(5) Familiarization with basic elements of pain and pharmaceutical management.
- “(6) Familiarization with complementary and alternative therapies.
- “(d) Tailoring of Training.—The training developed and implemented under subsection (a) shall appropriately tailor the elements specified in subsection (c) for and among each category of individuals set forth in subsection (b).
- “(e) Review of Pharmacy.—
  - “(1) Review.—The Secretary shall review all policies and procedures of the Department of Defense regarding the use of pharmaceuticals in rehabilitation programs for seriously ill or injured members of the Armed Forces.
  - “(2) Recommendations.—Not later than September 20, 2011, the Secretary shall submit to the congressional defense committees [Committees on Armed Services and Appropriations of the Senate and the House of Representatives] any recommendations for administrative or legislative action with respect to the review under paragraph (1) as the Secretary considers appropriate.”

**Demonstration Project On Coverage Of Selected Over-The-Counter Drugs Under The Pharmacy Benefits Program**

Pub. L. 109-364, div. A, title VII, Sec. 705, Oct. 17, 2006, 120 Stat. 2280, as amended by Pub. L. 111-383, div. A, title X, Sec. 1075(g)(5), Jan. 7, 2011, 124 Stat. 4377, provided that:

- “(a) Requirement to Conduct Demonstration.—The Secretary of Defense shall conduct a demonstration project under section 1092 of title 10, United States Code, to allow particular over-the-counter drugs to be included on the uniform formulary under section 1074g of such title.
- “(b) Elements of Demonstration Project.—
  - “(1) Inclusion of certain over-the-counter drugs.—(A) As part of the demonstration project, the Secretary shall modify uniform formulary specifications under section 1074g(a) of such title to include an over-the-counter drug (referred to in this section as an ‘OTC drug’) on the uniform formulary if the Pharmacy and Therapeutics Committee finds that the OTC drug is cost-effective and therapeutically equivalent to a prescription drug. If the Pharmacy and Therapeutics Committee makes such a finding, the OTC drug shall be considered to be in the same therapeutic class of pharmaceutical agents as the prescription drug.
    - “(B) An OTC drug shall be made available to a beneficiary through the demonstration project, but only if—
      - “(i) the beneficiary has a prescription for a drug requiring a prescription; and
      - “(ii) pursuant to subparagraph (A), the OTC drug—
        - “(I) is on the uniform formulary; and
        - “(II) has been determined to be therapeutically equivalent to the prescription drug.
  - “(2) Conduct through military facilities, retail pharmacies, or mail order program.—The Secretary shall conduct the demonstration project through at least two of the means described in subparagraph (E) of section 1074g(a)(2) of such title through which OTC drugs are provided and may conduct the demonstration project throughout the entire pharmacy benefits program or at a limited number of sites. If the project is conducted at a limited

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number of sites, the number of sites shall be not less than five in each TRICARE region for each of the two means described in such subparagraph.

“(3) Period of demonstration.—The Secretary shall provide for conducting the demonstration project for a period of time necessary to evaluate the feasibility and cost effectiveness of the demonstration. Such period shall be at least as long as the period covered by pharmacy contracts in existence on the date of the enactment of this Act [Oct. 17, 2006] (including any extensions of the contracts), or five years, whichever is shorter.

“(4) Implementation deadline.—Implementation of the demonstration project shall begin not later than May 1, 2007.

“(c) Evaluation of Demonstration Project.—The Secretary shall evaluate the demonstration project for the following:

“(1) The costs and benefits of providing OTC drugs under the pharmacy benefits program in each of the means chosen by the Secretary to conduct the demonstration project.

“(2) The clinical effectiveness of providing OTC drugs under the pharmacy benefits program.

“(3) Customer satisfaction with the demonstration project.

“(d) Report.—Not later than two years after implementation of the demonstration project begins, the Secretary shall submit to the Committees on Armed Services of the Senate and House of Representatives a report on the demonstration project. The report shall contain—

“(1) the evaluation required by subsection (c);

“(2) recommendations for improving the provision of OTC drugs under the pharmacy benefits program; and

“(3) recommendations on whether permanent authority should be provided to cover OTC drugs under the pharmacy benefits program.

“(e) Continuation of Demonstration Project.—If the Secretary recommends in the report under subsection (d) that permanent authority should be provided, the Secretary may continue the demonstration project for up to one year after submitting the report.

“(f) Definitions.—In this section:

“(1) The term ‘drug’ means a drug, including a biological product, within the meaning of section 1074g(f)(2) [now 1074g(g)(2)] of title 10, United States Code.

“(2) The term ‘OTC drug’ has the meaning indicated for such term in subsection (b)(1)(A).

“(3) The term ‘over-the-counter drug’ means a drug that is not subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 353(b)].

“(4) The term ‘prescription drug’ means a drug that is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act.”

**Interoperability Of Department Of Veterans Affairs And Department Of Defense Pharmacy Data Systems**

Pub. L. 107-314, div. A, title VII, Sec. 724, Dec. 2, 2002, 116 Stat. 2598, provided that:

“(a) Interoperability.—The Secretary of Veterans Affairs and the Secretary of Defense shall seek to ensure that on or before October 1, 2004, the Department of Veterans Affairs pharmacy data system and the Department of Defense pharmacy data system (known as the ‘Pharmacy Data Transaction System’) are interoperable for both Department of Defense beneficiaries and Department of Veterans Affairs beneficiaries by achieving real-time interface, data exchange, and checking of prescription drug data of outpatients, and using national standards for the exchange of outpatient medication information.

“(b) Alternative Requirement.—If the interoperability specified in subsection (a) is not achieved by October 1, 2004, as determined jointly by the Secretary of Defense and the Secretary of Veterans Affairs, the Secretary of Veterans Affairs shall adopt the Department of Defense

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Pharmacy Data Transaction System for use by the Department of Veterans Affairs health care system. Such system shall be fully operational not later than October 1, 2005.

“(c) Implementation Funding for Alternative Requirement.—The Secretary of Defense shall transfer to the Secretary of Veterans Affairs, or shall otherwise bear the cost of, an amount sufficient to cover three-fourths of the cost to the Department of Veterans Affairs for computer programming activities and relevant staff training expenses related to implementation of subsection (b). Such amount shall be determined in such manner as agreed to by the two Secretaries.”

**Deadline For Establishment Of Committee**

Pub. L. 106-65, div. A, title VII, Sec. 701(b), Oct. 5, 1999, 113 Stat. 680, directed the Secretary of Defense to establish the Pharmacy and Therapeutics Committee required by subsec. (b) of this section not later than 30 days after Oct. 5, 1999.

**Reports Required**

Pub. L. 106-65, div. A, title VII, Sec. 701(c), Oct. 5, 1999, 113 Stat. 680, directed the Secretary of Defense to submit reports to Congress, not later than Apr. 1 and Oct. 1 of fiscal years 2000 and 2001, on the implementation of the uniform formulary required under subsec. (a) of this section, the results of a survey conducted by the Secretary of prescribers for military medical treatment facilities and TRICARE contractors, the operation of the Pharmacy Data Transaction Service required by subsec. (e) of this section, and any other actions taken by the Secretary to improve management of the pharmacy benefits program under this section.

**Study For Design Of Pharmacy Benefit For Certain Covered Beneficiaries**

Pub. L. 106-65, div. A, title VII, Sec. 701(d), Oct. 5, 1999, 113 Stat. 680, required the Secretary of Defense to prepare and submit to Congress, by Apr. 15, 2001, a study on a design for a comprehensive pharmacy benefit for covered beneficiaries under chapter 55 of title 10, who are entitled to benefits under part A, and enrolled under part B, of title XVIII of the Social Security Act, and to provide an estimate of the costs of implementing and operating such design, prior to repeal by Pub. L. 107-107, div. A, title VII, Sec. 723, Dec. 28, 2001, 115 Stat. 1168.

**Footnote**

<sup>1</sup> So in original. Probably should be followed by “and”.

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## § 1078a. Continued health benefits coverage

(a) Provision of Continued Health Coverage.—The Secretary of Defense shall implement and carry out a program of continued health benefits coverage in accordance with this section to provide persons described in subsection (b) with temporary health benefits comparable to the health benefits provided for former civilian employees of the Federal Government and other persons under section 8905a of title 5.

(b) Eligible Persons.—The persons referred to in subsection (a) are the following:

(1) A member of the uniformed services who—

(A) is discharged or released from active duty (or full-time National Guard duty), whether voluntarily or involuntarily, under other than adverse conditions, as characterized by the Secretary concerned;

(B) immediately preceding that discharge or release, is entitled to medical and dental care under section 1074(a) of this title (except in the case of a member discharged or released from full-time National Guard duty); and

(C) after that discharge or release and any period of transitional health care provided under section 1145(a) of this title, would not otherwise be eligible for any benefits under this chapter.

(2) A member of the Selected Reserve of the Ready Reserve of a reserve component of the armed forces who—

(A) is discharged or released from service in the Selected Reserve, whether voluntarily or involuntarily, under other than adverse conditions, as characterized by the Secretary concerned;

(B) immediately preceding that discharge or release, is enrolled in TRICARE Reserve Select; and

(C) after that discharge or release, would not otherwise be eligible for any benefits under this chapter.

(3) A person who—

(A) ceases to meet the requirements for being considered an unmarried dependent child of a member or former member of the uniformed services under section 1072(2)(D) of this title or ceases to meet the requirements for being considered an unmarried dependent under section 1072(2)(I) of this title;

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(B) on the day before ceasing to meet those requirements, was covered under a health benefits plan under this chapter or transitional health care under section 1145(a) of this title as a dependent of the member or former member; and

(C) would not otherwise be eligible for any benefits under this chapter.

(4) A person who—

(A) is an unremarried former spouse of a member or former member of the uniformed services; and

(B) on the day before the date of the final decree of divorce, dissolution, or annulment was covered under a health benefits plan under this chapter or transitional health care under section 1145(a) of this title as a dependent of the member or former member; and

(C) is not a dependent of the member or former member under subparagraph (F) or (G) of section 1072(2) of this title or ends a one-year period of dependency under subparagraph (H) of such section.

(5) Any other person specified in regulations prescribed by the Secretary of Defense for purposes of this paragraph who loses entitlement to health care services under this chapter or section 1145 of this title, subject to such terms and conditions as the Secretary shall prescribe in the regulations.

(c) Notification of Eligibility.—(1) The Secretary of Defense shall prescribe regulations to provide for persons described in subsection (b) to be notified of eligibility to receive health benefits under this section.

(2) In the case of a member who becomes (or will become) eligible for continued coverage under subsection (b)(1) or subsection (b)(2), the regulations shall provide for the Secretary concerned to notify the member of the member's rights under this section as part of prepreparation counseling conducted under section 1142 of this title or any other provision of other law.

(3) In the case of a dependent of a member or former member who becomes eligible for continued coverage under subsection (b)(3), the regulations shall provide that—

(A) the member or former member may submit to the Secretary concerned a written notice of the dependent's change in status (including the dependent's name, address, and such other information as the Secretary of Defense may require); and

(B) the Secretary concerned shall, within 14 days after receiving that notice, inform the dependent of the dependent's rights under this section.

(4) In the case of a former spouse of a member or former member who becomes eligible for continued coverage under subsection (b)(4), the regulations shall provide appropriate notification provisions and a 60-day election period under subsection (d)(3).<sup>1</sup>

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(d) Election of Coverage.—In order to obtain continued coverage under this section, an appropriate written election (submitted in such manner as the Secretary of Defense may prescribe) shall be made as follows:

(1) In the case of a member described in subsection (b)(1), the written election shall be submitted to the Secretary concerned before the end of the 60-day period beginning on the later of—

(A) the date of the discharge or release of the member from active duty or full-time National Guard duty;

(B) the date on which the period of transitional health care applicable to the member under section 1145(a) of this title ends; or

(C) the date the member receives the notification required pursuant to subsection (c).

(2) In the case of a member **described in** subsection (b)(2), the written election shall be submitted to the Secretary concerned before the end of the 60-day period beginning on the later of—

**(A) the date of the discharge or release of the member from service in the Selected Reserve; and**

**(B) the date the member receives the notification required pursuant to subsection (c).**

**(3)(A) In the case of a dependent of a member or former member who becomes eligible for continued coverage under subsection (b)(3), the written election shall be submitted to the Secretary concerned before the end of the 60-day period beginning on the later of—**

**(i) the date on which the dependent first ceases to meet the requirements for being considered a dependent under subparagraph (D) or (I) of section 1072(2) of this title; or**

**(ii) the date the dependent receives the notification pursuant to subsection (c).**

(B) Notwithstanding subparagraph (A), if the Secretary concerned determines that the dependent's parent has failed to provide the notice referred to in subsection (c)(3)(A) with respect to the dependent in a timely fashion, the 60-day period under this paragraph shall be based only on the date under subparagraph (A)(i).

(4) In the case of a former spouse of a member or a former member who becomes eligible for continued coverage under subsection (b)(4), the written election shall be submitted to the Secretary concerned before the end of the 60-day period beginning on the later of—

(A) the date as of which the former spouse first ceases to meet the requirements for being considered a dependent under section 1072(2) of this title; or

(B) such other date as the Secretary of Defense may prescribe.

(5) In the case of a person described in subsection (b)(4), by such date as the Secretary shall prescribe in the regulations required for purposes of that subsection.

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(e) Coverage of Dependents.—A person eligible under subsection (b)(1) or subsection (b)(2) to elect to receive coverage may elect coverage either as an individual or, if appropriate, for self and dependents. A person eligible under subsection (b)(3) or subsection (b)(4) may elect only individual coverage.

(f) Charges.—(1) Under arrangements satisfactory to the Secretary of Defense, a person receiving continued coverage under this section shall be required to pay into the Military Health Care Account or other appropriate account an amount equal to the sum of—

(A) the employee and agency contributions which would be required in the case of a similarly situated employee enrolled in a comparable health benefits plan under section 8905a(d)(1)(A)(i) of title 5; and

(B) an amount, not to exceed 10 percent of the amount determined under subparagraph (A), determined under regulations prescribed by the Secretary of Defense to be necessary for administrative expenses; and

(2) If a person elects to continue coverage under this section before the end of the applicable period under subsection (d), but after the person's coverage under this chapter (and any transitional extension of coverage under section 1145(a) of this title) expires, coverage shall be restored retroactively, with appropriate contributions (determined in accordance with paragraph (1)) and claims (if any), to the same extent and effect as though no break in coverage had occurred.

(g) Period of Continued Coverage.—(1) Continued coverage under this section may not extend beyond—

(A) in the case of a member described in subsection (b)(1), the date which is 18 months after the date the member ceases to be entitled to care under section 1074(a) of this title and any transitional care under section 1145 of this title, as the case may be;

(B) in the case of a member described in subsection (b)(2), the date which is 18 months after the date the member ceases to be eligible to enroll in TRICARE Reserve Select;

(C) in the case of a person described in subsection (b)(3), the date which is 36 months after the date on which the person first ceases to meet the requirements for being considered a dependent under subparagraph (D) or (I) of section 1072(2) of this title;

(D) in the case of a person described in subsection (b)(3), except as provided in paragraph (4), the date which is 36 months after the later of—

(i) the date on which the final decree of divorce, dissolution, or annulment occurs; and

(ii) if applicable, the date the one-year extension of dependency under section 1072(2)(H) of this title expires.

(E) in the case of a person described in subsection (b)(4), the date that is 36 months after the date on which the person loses entitlement to health care services as described in that subsection.

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(2) Notwithstanding paragraph (1)(C), if a dependent of a member becomes eligible for continued coverage under subsection (b)(3) during a period of continued coverage of the member for self and dependents under this section, extended coverage of the dependent under this section may not extend beyond the date which is 36 months after the date the member became ineligible for medical and dental care under section 1074(a) of this title and any transitional health care under section 1145(a) of this title.

(3) Notwithstanding paragraph (1)(D), if a person becomes eligible for continued coverage under subsection (b)(4) as the former spouse of a member during a period of continued coverage of the member for self and dependents under this section, extended coverage of the former spouse under this section may not extend beyond the date which is 36 months after the date the member became ineligible for medical and dental care under section 1074(a) of this title and any transitional health care under section 1145(a) of this title.

(4)(A) Notwithstanding paragraph (1), in the case of a former spouse described in subparagraph (B), continued coverage under this section shall continue for such period as the former spouse may request.

(B) A former spouse referred to in subparagraph (A) is a former spouse of a member or former member (other than a former spouse whose marriage was dissolved after the separation of the member from the service unless such separation was by retirement)—

(i) who has not remarried before age 55 after the marriage to the employee, former employee, or annuitant was dissolved;

(ii) who was enrolled in an approved health benefits plan under this chapter as a family member at any time during the 18-month period before the date of the divorce, dissolution, or annulment; and

(iii)(I) who is receiving any portion of the retired or retainer pay of the member or former member or an annuity based on the retired or retainer pay of the member; or

(II) for whom a court order (as defined in section 1408(a)(2) of this title) has been issued for payment of any portion of the retired or retainer pay or for whom a court order (as defined in section 1447(13) of this title) or a written agreement (whether voluntary or pursuant to a court order) provides for an election by the member or former member to provide an annuity to the former spouse.

(h) **TRICARE Reserve Select Defined.**—In this section, the term “TRICARE Reserve Select” means TRICARE Standard coverage provided under section 1076d of this title.

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**NOTES**

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**Source**

(Added Pub. L. 102-484, div. D, title XLIV, Sec. 4408(a)(1), Oct. 23, 1992, 106 Stat. 2708; amended Pub. L. 103-35, title II, Sec. 201(g)(1), May 31, 1993, 107 Stat. 99; Pub. L. 103-337, div. A, title VII, Sec. 702(c), Oct. 5, 1994, 108 Stat. 2798; Pub. L. 104-201, div. A, title X, Sec. 1074(a)(4), Sept. 23, 1996, 110

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Stat. 2658; Pub. L. 105-85, div. A, title X, Sec. 1073(a)(17), Nov. 18, 1997, 111 Stat. 1901; Pub. L. 108-136, div. A, title VII, Sec. 713(a), Nov. 24, 2003, 117 Stat. 1530; Pub. L. 110-181, div. A, title VII, Sec. 705, Jan. 28, 2008, 122 Stat. 189; **Pub. L. 114-92, div. A, title VII, §703, Nov. 25, 2015, 129 Stat. 861.**

**References In Text**

Subsection (d)(3), referred to in subsec. (c)(4), was redesignated subsec. (d)(4) by Pub. L. 114-92, div. A, title VII, §703(c)(1), Nov. 25, 2015, 129 Stat. 861.

**Amendments**

2015—Subsec. (b)(2) to (5). Pub. L. 114-92, §703(a), added par. (2) and redesignated former pars. (2) to (4) as (3) to (5), respectively.

Subsec. (c)(2). Pub. L. 114-92, §703(b), inserted “or subsection (b)(2)” after “subsection (b)(1)”.

Subsec. (c)(3). Pub. L. 114-92, §703(g)(1)(A), substituted “subsection (b)(3)” for “subsection (b)(2)” in introductory provisions.

Subsec. (c)(4). Pub. L. 114-92, §703(g)(1)(B), substituted “subsection (b)(4)” for “subsection (b)(3)”.

Subsec. (d)(2). Pub. L. 114-92, §703(c)(2), added par. (2). Former par. (2) redesignated (3).

Subsec. (d)(3). Pub. L. 114-92, §703(c)(1), redesignated par. (2) as (3). Former par. (3) redesignated (4).

Subsec. (d)(3)(A). Pub. L. 114-92, §703(g)(2)(A), substituted “subsection (b)(3)” for “subsection (b)(2)” in introductory provisions.

Subsec. (d)(4). Pub. L. 114-92, §703(c)(1), (g)(2)(B), redesignated par. (3) as (4) and substituted “subsection (b)(4)” for “subsection (b)(3)” in introductory provisions. Former par. (4) redesignated (5).

Subsec. (d)(5). Pub. L. 114-92, §703(c)(1), (g)(2)(C), redesignated par. (4) as (5) and substituted “subsection (b)(5)” for “subsection (b)(4)”.

Subsec. (e). Pub. L. 114-92, §703(d), (g)(3), inserted “or subsection (b)(2)” after “subsection (b)(1)” and substituted “subsection (b)(3) or subsection (b)(4)” for “subsection (b)(2) or subsection (b)(3)”.

Subsec. (g)(1)(B). Pub. L. 114-92, §703(e)(2), added subpar. (B). Former subpar. (B) redesignated (C).

Subsec. (g)(1)(C). Pub. L. 114-92, §703(e)(1), (g)(4)(A)(i), redesignated subpar. (B) as (C) and substituted “subsection (b)(3)” for “subsection (b)(2)”. Former subpar. (C) redesignated (D).

Subsec. (g)(1)(D). Pub. L. 114-92, §703(e)(1), (g)(4)(A)(ii), redesignated subpar. (C) as (D) and substituted “subsection (b)(4)” for “subsection (b)(3)” in introductory provisions. Former subpar. (D) redesignated (E).

Subsec. (g)(1)(E). Pub. L. 114-92, §703(e)(1), (g)(4)(A)(iii), redesignated subpar. (D) as (E) and substituted “subsection (b)(5)” for “subsection (b)(4)”.

Subsec. (g)(2). Pub. L. 114-92, §703(g)(4)(B), substituted “paragraph (1)(C)” for “paragraph (1)(B)” and “subsection (b)(3)” for “subsection (b)(2)”.

Subsec. (g)(3). Pub. L. 114-92, §703(g)(4)(C), substituted “paragraph (1)(D)” for “paragraph (1)(C)” and “subsection (b)(4)” for “subsection (b)(3)”.

Subsec. (h). Pub. L. 114-92, §703(f), added subsec. (h).

2008—Subsec. (b)(4). Pub. L. 110-181, Sec. 705(a), added par. (4).

Subsec. (d)(4). Pub. L. 110-181, Sec. 705(b), added par. (4).

Subsec. (g)(1)(D). Pub. L. 110-181, Sec. 705(c), added subpar. (D).

2003—Subsec. (b)(1), (2)(A), (3)(A). Pub. L. 108-136 substituted “uniformed services” for “armed forces”.

1997—Subsec. (g)(4)(B)(iii)(II). Pub. L. 105-85 substituted “section 1447(13)” for “section 1447(8)”.

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1996—Subsec. (a). Pub. L. 104-201 substituted “The Secretary” for “Beginning on October 1, 1994, the Secretary”.

1994—Subsec. (b)(2)(A). Pub. L. 103-337, Sec. 702(c)(1), inserted before semicolon “or ceases to meet the requirements for being considered an unmarried dependent under section 1072(2)(l) of this title”.

Subsec. (c)(3). Pub. L. 103-337, Sec. 702(c)(2), substituted “dependent” for “child” in two places and “dependent’s” for “child’s” wherever appearing.

Subsec. (d)(2)(A). Pub. L. 103-337, Sec. 702(c)(3), substituted “a dependent” for “a child” in introductory provisions, “the dependent” for “the child” in cls. (i) and (ii), and “a dependent under subparagraph (D) or (l) of section 1072(2) of this title;” for “an unmarried dependent child under section 1072(2)(D) of this title,” in cl. (i).

Subsec. (d)(2)(B). Pub. L. 103-337, Sec. 702(c)(4), substituted “dependent’s” for “child’s” and “dependent” for “child”.

Subsec. (g)(1)(B). Pub. L. 103-337, Sec. 702(c)(5), substituted “a dependent under subparagraph (D) or (l) of section 1072(2) of this title” for “an unmarried dependent child under section 1072(2)(D) of this title”.

Subsec. (g)(2). Pub. L. 103-337, Sec. 702(c)(6), substituted “dependent” for “child” in two places.

1993—Subsec. (b)(3)(C). Pub. L. 103-35, Sec. 201(g)(1)(A), substituted “subparagraph” for “subparagraphs” after “member under”.

Subsec. (d)(2)(A). Pub. L. 103-35, Sec. 201(g)(1)(B), inserted “under” after “coverage”.

**Effective Date Of 2003 Amendment**

Pub. L. 108-136, div. A, title VII, Sec. 713(b), Nov. 24, 2003, 117 Stat. 1531, provided that: “The amendments made by subsection (a) [amending this section] shall apply to members of the uniformed services who are not otherwise covered by section 1078a of title 10, United States Code, before the date of the enactment of this Act [Nov. 24, 2003] and who, on or after such date, first meet the eligibility criteria specified in subsection (b) of that section.”

**1** See References in Text note below.



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recommendations for improving the health-care delivery systems of the uniformed services as the Secretary considers appropriate.”

1984—Subsec. (a)(1). Pub. L. 98-557 substituted reference to other administering Secretaries for reference to Secretary of Health and Human Services.

**Effective Date**

Pub. L. 98-94, title IX, Sec. 933(b), Sept. 24, 1983, 97 Stat. 651, provided that: “Section 1092 of title 10, United States Code, as added by subsection (a), shall take effect on October 1, 1983.”

**Pilot Program On Incentive Programs To Improve Health Care Provided Under The TRICARE Program**

Pub. L. 114-92, div. A, title VII, §726, Nov. 25, 2015, 129 Stat. 871, provided that:

“(a) Pilot Program.—Not later than 180 days after the date of the enactment of this Act [Nov. 25, 2015], the Secretary of Defense shall commence the conduct of a pilot program under section 1092 of title 10, United States Code, to assess whether a reduction in the rate of increase in health care spending by the Department of Defense and an enhancement of the operation of the military health system may be achieved by developing and implementing value-based incentive programs to encourage health care providers under the TRICARE program (including physicians, hospitals, and others involved in providing health care to patients) to improve the following:

“(1) The quality of health care provided to covered beneficiaries under the TRICARE program.

“(2) The experience of covered beneficiaries in receiving health care under the TRICARE program.

“(3) The health of covered beneficiaries.

“(b) Incentive Programs.—

“(1) Development.—In developing an incentive program under this section, the Secretary shall—

“(A) consider the characteristics of the population of covered beneficiaries affected by the incentive program;

“(B) consider how the incentive program would impact the receipt of health care under the TRICARE program by such covered beneficiaries;

“(C) establish or maintain an assurance that such covered beneficiaries will have timely access to health care during operation of the incentive program;

“(D) ensure that there are no additional financial costs to such covered beneficiaries of implementing the incentive program; and

“(E) consider such other factors as the Secretary considers appropriate.

“(2) Elements.—With respect to an incentive program developed and implemented under this section, the Secretary shall ensure that—

“(A) the size, scope, and duration of the incentive program is reasonable in relation to the purpose of the incentive program; and

“(B) appropriate criteria and data collection are used to ensure adequate evaluation of the feasibility and advisability of implementing the incentive program throughout the TRICARE program.

“(3) Use of existing models.—In developing an incentive program under this section, the Secretary may adapt a value-based incentive program conducted by the Centers for Medicare & Medicaid Services or any other governmental or commercial health care program.

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“(c) Termination.—The authority of the Secretary to carry out the pilot program under this section shall terminate on December 31, 2019.

“(d) Reports.—

“(1) Interim report.—Not later than one year after the date of the enactment of this Act, and not less frequently than once each year thereafter until the termination of the pilot program, 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 program.

“(2) Final report.—Not later than September 30, 2019, the Secretary shall submit to the congressional defense committees a final report on the pilot program.

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

“(A) An assessment of each incentive program developed and implemented under this section, including whether such incentive program—

“(i) improves the quality of health care provided to covered beneficiaries, the experience of covered beneficiaries in receiving health care under the TRICARE program, or the health of covered beneficiaries;

“(ii) reduces the rate of increase in health care spending by the Department of Defense; or

“(iii) enhances the operation of the military health system.

“(B) Such recommendations for administrative or legislative action as the Secretary considers appropriate in light of the pilot program, including to implement any such incentive program or programs throughout the TRICARE program.

“(e) Definitions.—In this section, the terms ‘covered beneficiary’ and ‘TRICARE program’ have the meanings given those terms in section 1072 of title 10, United States Code.”

#### **Pilot Program On Certain Treatments Of Autism Under The TRICARE Program**

Pub. L. 112-239, div. A, title VII, Sec. 705, Jan. 2, 2013, 126 Stat. 1800, provided that:

“(a) Pilot Program.—

“(1) In general.—The Secretary of Defense shall conduct a pilot program to provide for the treatment of autism spectrum disorders, including applied behavior analysis.

“(2) Commencement.—The Secretary shall commence the pilot program under paragraph (1) by not later than 90 days after the date of the enactment of this Act [Jan. 2, 2013].

“(b) Duration.—The Secretary may not carry out the pilot program under subsection (a)(1) for longer than a one-year period.

“(c) Report.—Not later than 270 days after the date on which the pilot program under subsection (a)(1) commences, the Secretary shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the pilot program. The report shall include the following:

“(1) An assessment of the feasibility and advisability of establishing a beneficiary cost share for the treatment of autism spectrum disorders.

“(2) A comparison of providing such treatment under—

“(A) the ECHO Program; and

“(B) the TRICARE program other than under the ECHO Program.

“(3) Any recommendations for changes in legislation.

“(4) Any additional information the Secretary considers appropriate.

“(d) Definitions.—In this section:

“(1) The term ‘ECHO Program’ means the Extended Care Health Option under subsections (d) through (f) of section 1079 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.”

**Military Health Risk Management Demonstration Project**

Pub. L. 110-417, [div. A], title VII, Sec. 712, Oct. 14, 2008, 122 Stat. 4501, provided that:

“(a) Demonstration Project Required.—The Secretary of Defense shall conduct a demonstration project designed to evaluate the efficacy of providing incentives to encourage healthy behaviors on the part of eligible military health system beneficiaries.

“(b) Elements of Demonstration Project.—

(1) Wellness assessment.—The Secretary shall develop a wellness assessment to be offered to beneficiaries enrolled in the demonstration project. The wellness assessment shall incorporate nationally recognized standards for health and healthy behaviors and shall be offered to determine a baseline and at appropriate intervals determined by the Secretary. The wellness assessment shall include the following:

(A) A self-reported health risk assessment.

(B) Physiological and biometric measures, including at least—

(i) blood pressure;

(ii) glucose level;

(iii) lipids;

(iv) nicotine use; and

(v) weight.

(2) Population enrolled.—Non-medicare eligible retired beneficiaries of the military health system and their dependents who are enrolled in TRICARE Prime and who reside in the demonstration project service area shall be offered the opportunity to enroll in the demonstration project.

(3) Geographic coverage of demonstration project.—The demonstration project shall be conducted in at least three geographic areas within the United States where TRICARE Prime is offered, as determined by the Secretary. The area covered by the project shall be referred to as the demonstration project service area.

(4) Programs.—The Secretary shall develop programs to assist enrollees to improve healthy behaviors, as identified by the wellness assessment.

(5) Inclusion of incentives required.—For the purpose of conducting the demonstration project, the Secretary may offer monetary and non-monetary incentives to enrollees to encourage participation in the demonstration project.

“(c) Evaluation of Demonstration Project.—The Secretary shall annually evaluate the demonstration project for the following:

(1) The extent to which the health risk assessment and the physiological and biometric measures of beneficiaries are improved from the baseline (as determined in the wellness assessment).

(2) In the case of baseline health risk assessments and physiological and biometric measures that reflect healthy behaviors, the extent to which the measures are maintained.

“(d) Implementation Plan.—The Secretary of Defense shall submit a plan to implement the health risk management demonstration project required by this section not later than 90 days after the date of the enactment of this Act [Oct. 14, 2008].

“(e) Duration of Project.—The health risk management demonstration project shall be implemented for a period of three years, beginning not later than March 1, 2009, and ending three years after that date.

“(f) Report.—

(1) In general.—The Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives an annual report on the

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effectiveness of the health risk management demonstration project in improving the health risk measures of military health system beneficiaries enrolled in the demonstration project. The first report shall be submitted not later than one year after the date of the enactment of this Act [Oct. 14, 2008], and subsequent reports shall be submitted for each year of the demonstration project with the final report being submitted not later than 90 days after the termination of the demonstration project.

(2) Matters covered.—Each report shall address, at a minimum, the following:

(A) The number of beneficiaries who were enrolled in the project.

(B) The number of enrolled beneficiaries who participate in the project.

(C) The incentives to encourage healthy behaviors that were provided to the beneficiaries in each beneficiary category, and the extent to which the incentives encouraged healthy behaviors.

(D) An assessment of the effectiveness of the demonstration project.

(E) Recommendations for adjustments to the demonstration project.

(F) The estimated costs avoided as a result of decreased health risk conditions on the part of each of the beneficiary categories.

(G) Recommendations for extending the demonstration project or implementing a permanent wellness assessment program.

(H) Identification of legislative authorities required to implement a permanent program.”

**Availability Of Chiropractic Health Care Services**

Pub. L. 109-163, div. A, title VII, Sec. 712, Jan. 6, 2006, 119 Stat. 3343, provided that:

“(a) Availability of Chiropractic Health Care Services.—The Secretary of the Air Force shall ensure that chiropractic health care services are available at all medical treatment facilities listed in table 5 of the report to Congress dated August 16, 2001, titled ‘Chiropractic Health Care Implementation Plan’. If the Secretary determines that it is not necessary or feasible to provide chiropractic health care services at any such facility, the Secretary shall provide such services at an alternative site for each such facility.

“(b) Implementation and Report.—Not later than September 30, 2006, the Secretary of the Air Force shall—

“(1) implement subsection (a); and

“(2) submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the availability of chiropractic health care services as required under subsection (a), including information on alternative sites at which such services have been made available.”

**Pilot Program For Health Care Delivery**

Pub. L. 108-375, div. A, title VII, Sec. 721, Oct. 28, 2004, 118 Stat. 1988, as amended by Pub. L. 110-181, div. A, title VII, Sec. 707, Jan. 28, 2008, 122 Stat. 189; Pub. L. 110-417, [div. A], title X, Sec. 1061(e), Oct. 14, 2008, 122 Stat. 4613, provided that:

“(a) Pilot Program.—The Secretary of Defense may conduct a pilot program at two or more military installations for purposes of testing initiatives that build cooperative health care arrangements and agreements between military installations and local and regional non-military health care systems.

“(b) Requirements of Pilot Program.—In conducting the pilot program, 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 the installation;

- (2) determine the cost avoidance or savings resulting from innovative partnerships between the Department of Defense and the private sector;
- (3) study the potential, viability, cost efficiency, and health care effectiveness of Department of Defense health care providers delivering health care in civilian community hospitals;
- (4) determine the opportunities for and barriers to coordinating and leveraging the use of existing health care resources, including Federal, State, local, and contractor assets; and
- (5) collaborate with State and local authorities to create an arrangement to share and exchange, between the Department of Defense and non-military health care systems, personal health information and data of military personnel and their families.

“(c) Consultation Requirements.—The Secretary of Defense shall develop the pilot program in consultation with the Secretaries of the military departments, representatives from the military installation selected for the pilot program, Federal, State, and local entities, and the TRICARE managed care support contractor with responsibility for that installation.

“(d) Selection of Military Installation.—The pilot program may be implemented at two or more military installations selected by the Secretary of Defense. At least one of the selected military installations 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 number of members of the Armed Forces on active duty permanently assigned to the military installation is [sic] has increased over the five years preceding 2008.

“(3) One or more cooperative arrangements exist at the military installation with civilian health care entities in the form of specialty care services in the military medical treatment facility on the installation.

“(4) There is a military treatment facility on the installation that does not have inpatient or trauma center care capabilities.

“(5) There is a civilian community hospital near the military installation with—

“(A) limited capability to expand inpatient care beds, intensive care, and specialty services; and

“(B) limited or no capability to provide trauma care.

“(e) Duration of Pilot Program.—Implementation of the pilot program developed under this section shall begin not later than May 1, 2005, and shall be conducted during fiscal years 2005 through 2010.

“(f) Reports.—With respect to any pilot program conducted under this section, the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and of the House of Representatives—

“(1) an interim report on the program, not later than 60 days after commencement of the program; and

“(2) a final report describing the results of the program with recommendations for a model health care delivery system for other military installations, not later than July 1, 2010.”

### **Demonstration Project For Expanded Access To Mental Health Counselors**

Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 731], Oct. 30, 2000, 114 Stat. 1654, 1654A-189, directed the Secretary of Defense, not later than Mar. 31, 2001, to submit to committees of Congress a plan to carry out a demonstration project under which licensed and certified professional mental health counselors who had met eligibility requirements for participation as providers under CHAMPUS or the TRICARE program could provide services to covered beneficiaries under this chapter without referral by physicians or adherence to supervision requirements, and directed the Secretary to

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conduct such project during the 2-year period beginning Oct. 1, 2001, and to submit to Congress a report on such project not later than Feb. 1, 2003.

**Teleradiology Demonstration Project**

Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 732], Oct. 30, 2000, 114 Stat. 1654, 1654A-191, authorized the Secretary of Defense to conduct a demonstration project during the 2-year period beginning on Oct. 30, 2000, under which a military medical treatment facility and each clinic supported by such facility would be linked by a digital radiology network through which digital radiology X-rays could be sent electronically from clinics to the military medical treatment facility.

**Joint Telemedicine And Telepharmacy Demonstration Projects By The Department Of Defense And Department Of Veterans Affairs**

Pub. L. 106-65, div. A, title VII, Sec. 724, Oct. 5, 1999, 113 Stat. 697, as amended by Pub. L. 108-136, div. A, title X, Sec. 1031(h)(2), Nov. 24, 2003, 117 Stat. 1605, authorized the Secretary of Defense and the Secretary of Veterans Affairs, during the three-year period beginning on Oct. 1, 1999, to carry out joint demonstration projects for purposes of evaluating the feasibility and practicability of using telecommunications to provide radiologic and imaging services, diagnostic services, referral services, pharmacy services, and any other health care services designated by the Secretaries.

**Demonstration Program To Train Military Medical Personnel In Civilian Shock Trauma Units**

Pub. L. 104-106, div. A, title VII, Sec. 744, Feb. 10, 1996, 110 Stat. 386, directed the Secretary of Defense to implement, not later than Apr. 1, 1996, a demonstration program to evaluate the feasibility of providing shock trauma training for military medical personnel through an agreement with one or more public or nonprofit hospitals, and to submit to Congress a report describing the scope and activities of the program not later than Mar. 1 of each year in which it was conducted, provided for the termination of the program on Mar. 31, 1998, and required the Comptroller General of the United States to submit to Congress a report evaluating its effectiveness not later than May 1, 1998.

**Demonstration Project On Management Of Health Care In Catchment Areas And Other Demonstration Projects**

Pub. L. 100-180, div. A, title VII, Sec. 731, Dec. 4, 1987, 101 Stat. 1117, directed Secretary of Defense to conduct, beginning in fiscal year 1988 for at least two years, projects designed to demonstrate the alternative health care delivery system under which the commander of a medical facility of the uniformed services is responsible for all funding and all medical care of the covered beneficiaries in the catchment area of the facility and to conduct specific projects for the purpose of demonstrating alternatives to providing health care under the military health care system, directed Secretary not later than 60 days after Dec. 4, 1987, to submit to Congress a report that provides an outline and discussion of the manner in which the Secretary intends to structure and conduct each demonstration project and to develop and submit to Congress a methodology to be used in evaluating the results of the demonstration projects, and submit to Congress an interim report on each demonstration project after such project has been in effect for at least 12 months and a final report on each such project when each project is completed.

**Chiropractic Health Care**

Pub. L. 108-375, div. A, title VII, Sec. 718, Oct. 28, 2004, 118 Stat. 1987, provided that:  
“(a) Establishment.—Not later than 120 days after the date of the enactment of this Act [Oct. 28, 2004], the Secretary of Defense shall establish an oversight advisory committee to provide the Secretary with advice and recommendations regarding the continued development and

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implementation of an effective program of chiropractic health care benefits for members of the uniformed services on active duty.

“(b) Membership.—The advisory committee shall be composed of members selected from among persons who, by reason of education, training, and experience, are experts in chiropractic health care, as follows:

“(1) Members appointed by the Secretary of Defense in such number as the Secretary determines appropriate for carrying out the duties of the advisory committee effectively, including not fewer than three practicing representatives of the chiropractic health care profession.

“(2) A representative of each of the uniformed services, as designated by the administering Secretary concerned.

“(c) Chairman.—The Secretary of Defense shall designate one member of the advisory committee to serve as the Chairman of the advisory committee.

“(d) Meetings.—The advisory committee shall meet at the call of the Chairman, but not fewer than three times each fiscal year, beginning in fiscal year 2005.

“(e) Duties.—The advisory committee shall have the following duties:

“(1) Review and evaluate the program of chiropractic health care benefits provided to members of the uniformed services on active duty under chapter 55 of title 10, United States Code.

“(2) Provide the Secretary of Defense with advice and recommendations as described in subsection (a).

“(3) Upon the Secretary’s determination that the program of chiropractic health care benefits referred to in paragraph (1) has been fully implemented, prepare and submit to the Secretary a report containing the advisory committee’s evaluation of the implementation of such program.

“(f) Report.—The Secretary of Defense, following receipt of the report by the advisory committee under subsection (e)(3), shall submit to the Committees on Armed Services of the Senate and of the House of Representatives a report containing the following:

“(1) A copy of the advisory committee report, together with the Secretary’s comments on the report.

“(2) An explanation of the criteria and rationale that the Secretary used to determine that the program of chiropractic health care benefits was fully implemented.

“(3) The Secretary’s views with regard to the future implementation of the program of chiropractic health care benefits.

“(g) Applicability of Temporary Organizations Law.—(1) Section 3161 of title 5, United States Code, shall apply to the advisory committee under this section.

“(2) The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the oversight advisory committee under this section.

“(h) Termination.—The advisory committee shall terminate 90 days after the date on which the Secretary submits the report under subsection (f).”

Pub. L. 108-136, div. A, title VII, Sec. 711, Nov. 24, 2003, 117 Stat. 1530, provided that: “The Secretary of Defense shall accelerate the implementation of the plan required by section 702 of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (Public Law 106-398; 114 Stat. 1654A-173) [set out below] (relating to chiropractic health care services and benefits), with a goal of completing implementation of the plan by October 1, 2005.”

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Pub. L. 106-398, Sec. 1 [[div. A], title VII, Sec. 702], Oct. 30, 2000, 114 Stat. 1654, 1654A-173, provided that:

“(a) Plan Required.—(1) Not later than March 31, 2001, the Secretary of Defense shall complete development of a plan to provide chiropractic health care services and benefits, as a permanent part of the Defense Health Program (including the TRICARE program), for all members of the uniformed services who are entitled to care under section 1074(a) of title 10, United States Code.

“(2) The plan shall provide for the following:

“(A) Access, at designated military medical treatment facilities, to the scope of chiropractic services as determined by the Secretary, which includes, at a minimum, care for neuro-musculoskeletal conditions typical among military personnel on active duty.

“(B) A detailed analysis of the projected costs of fully integrating chiropractic health care services into the military health care system.

“(C) An examination of the proposed military medical treatment facilities at which such services would be provided.

“(D) An examination of the military readiness requirements for chiropractors who would provide such services.

“(E) An examination of any other relevant factors that the Secretary considers appropriate.

“(F) Phased-in implementation of the plan over a 5-year period, beginning on October 1, 2001.

“(b) Consultation Requirements.—The Secretary of Defense shall consult with the other administering Secretaries described in section 1073 of title 10, United States Code, and the oversight advisory committee established under section 731 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1092 note) regarding the following:

“(1) The development and implementation of the plan required under subsection (a).

“(2) Each report that the Secretary is required to submit to Congress regarding the plan.

“(3) The selection of the military medical treatment facilities at which the chiropractic services described in subsection (a)(2)(A) are to be provided.

“(c) Continuation of Current Services.—Until the plan required under subsection (a) is implemented, the Secretary shall continue to furnish the same level of chiropractic health care services and benefits under the Defense Health Program that is provided during fiscal year 2000 at military medical treatment facilities that provide such services and benefits.

“(d) Report Required.—Not later than January 31, 2001, the Secretary of Defense shall submit a report on the plan required under subsection (a), together with appropriate appendices and attachments, to the Committees on Armed Services of the Senate and the House of Representatives.

“(e) GAO Reports.—The Comptroller General shall monitor the development and implementation of the plan required under subsection (a), including the administration of services and benefits under the plan, and periodically submit to the committees referred to in subsection (d) written reports on such development and implementation.”

Pub. L. 103-337, div. A, title VII, Sec. 731, Oct. 5, 1994, 108 Stat. 2809, as amended by Pub. L. 105-85, div. A, title VII, Sec. 739, Nov. 18, 1997, 111 Stat. 1815; Pub. L. 106-65, div. A, title VII, Sec. 702(a), Oct. 5, 1999, 113 Stat. 680, directed the Secretary of Defense to develop and carry out a demonstration program for fiscal years 1995 to 1999 to evaluate the feasibility and advisability of furnishing chiropractic care through the medical care facilities of the Armed Forces, to continue to furnish the same chiropractic care in fiscal year 2000, to submit reports to Congress in 1995 and 1998 with a

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final report due Jan. 31, 2000, to establish an oversight advisory committee to assist and advise the Secretary with regard to the development and conduct of the demonstration program, and, not later than Mar. 31, 2000, to submit to Congress an implementation plan for the full integration of chiropractic health care services into the military health care system of the Department of Defense, including the TRICARE program, if the provision of such care was the Secretary's recommendation.

Pub. L. 98-525, title VI, Sec. 632(b), Oct. 19, 1984, 98 Stat. 2543, provided that: "The Secretary of Defense, in consultation with the Secretary of Health and Human Services, shall conduct demonstration projects under section 1092 of title 10, United States Code, for the purpose of evaluating the cost-effectiveness of chiropractic care. In the conduct of such demonstration projects, chiropractic care (including manual manipulation of the spine and other routine chiropractic procedures authorized under joint regulations prescribed by the Secretary of Defense and the Secretary of Health and Human Services and not otherwise prohibited by law) may be provided as appropriate under chapter 55 of title 10, United States Code."

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§ 1095g. TRICARE program: waiver of recoupment of erroneous payments caused by administrative error

(a) Waiver of Recoupment.—The Secretary of Defense may waive recoupment from an individual who has benefitted from an erroneous TRICARE payment in a case in which each of the following applies:

- (1) The payment was made because of an administrative error by an employee of the Department of Defense or a contractor under the TRICARE program.
- (2) The individual (or in the case of a minor, the parent or guardian of the individual) had a good faith, reasonable belief that the individual was entitled to the benefit of such payment under this chapter.
- (3) The individual relied on the expectation of such entitlement.
- (4) The Secretary determines that a waiver of recoupment of such payment is necessary to prevent an injustice.

(b) Responsibility of Contractor.—In any case in which the Secretary waives recoupment under subsection (a) and the administrative error was on the part of a contractor under the TRICARE program, the Secretary shall, consistent with the requirements and procedures of the applicable contract, impose financial responsibility on the contractor for the erroneous payment.

(c) Finality of Determinations.—Any determination by the Secretary under this section to waive or decline to waive recoupment under subsection (a) is a final determination and shall not be subject to appeal or judicial review.

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**NOTES**

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**Source**

(Added Pub. L. 114-92, div. A, title VII, §711(a), Nov. 25, 2015, 129 Stat. 864.)



**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; Pub. L. 113-291, div. A, title VII, §723, Dec. 19, 2014, 128 Stat. 3417; **Pub. L. 114-92, div. A, title VII, §701, Nov. 25, 2015, 129 Stat. 860**, 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) Additional Report.—

“(1) Report required.—Not later than 180 days after the date of the enactment of the Carl Levin and Howard P. ‘Buck’ McKeon National Defense Authorization Act for Fiscal Year 2015 [Dec. 19, 2014], the Secretary shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the status of reducing the availability of TRICARE Prime in regions described in subsection (d)(1)(B).

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

“(A) A description of the implementation of the transition for affected eligible beneficiaries under the TRICARE program who no longer have access to TRICARE Prime under TRICARE managed care contracts as of the date of the report, including—

“(i) the number of eligible beneficiaries who have transitioned from TRICARE Prime to the TRICARE Standard option of the TRICARE program since October 1, 2013;

“(ii) the number of eligible beneficiaries who transferred their TRICARE Prime enrollment to a more distant available Prime service area to remain in TRICARE Prime, by State;

“(iii) the number of eligible beneficiaries who were eligible to transfer to a more distant available Prime service area, but chose to use TRICARE Standard;

“(iv) the number of eligible beneficiaries who elected to return to TRICARE Prime pursuant to subsection (c)(1); and

“(v) the number of affected eligible beneficiaries who, as of the date of the report, changed residences to remain eligible for TRICARE Prime in a new region.

“(B) An estimate of the increased annual costs per affected eligible beneficiary incurred by such beneficiary for health care under the TRICARE program.

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“(C) A description of the efforts of the Department to assess the impact on access to health care and beneficiary satisfaction for affected eligible beneficiaries.

“(D) A description of the estimated cost savings realized by reducing the availability of TRICARE Prime in regions described in subsection (d)(1)(B).

“(c) 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.—

“(A) Except as provided by subparagraph (B), 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—

“(i) in a ZIP code that is in a region described in subsection (d)(1)(B); and

“(ii) within 100 miles of a military medical treatment facility.

“(B) Subparagraph (A)(ii) shall not apply with respect to an affected eligible beneficiary who—

“(i) as of December 25, 2013, resides farther than 100 miles from a military medical treatment facility; and

“(ii) is such an eligible beneficiary by reason of service in the Army, Navy, Air Force, or Marine Corps.

“(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.

“(d) 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

“(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.”

[Pub. L. 113–291, div. A, title VII, §723(b), Dec. 19, 2014, 128 Stat. 3418, which directed amendment of subsec. (b)(3)(A) of section 732 of Pub. L. 112–239, set out above, by substituting “subsection (d)(1)(B)” for “subsection (c)(1)(B)”, was executed by making the substitution in subsec. (c)(3)(A) of section 732 of Pub. L. 112–239, to reflect the probable intent of Congress and the prior amendment by section 723(a)(1) of Pub. L. 113–291, which redesignated subsec. (b) as (c).]