Stat. 45, provided that a person who would qualify as a dependent under section 1072(2)(G) of title 10 but for the fact that the person's final decree of divorce, dissolution, or annulment was dated on or after Apr. 1, 1985, would be considered to be a dependent under such section until the later of (1) Dec. 31, 1988, and (2) the last day of the two-year period beginning on the date of such final decree, prior to repeal by Pub. L. 100–456, div. A, title VI, § 651(b), Sept. 29, 1988, 102 Stat. 1990, effective Sept. 29, 1988, or 30 days after the Secretary of Defense first makes available a conversion health policy (as defined in section 1076(f) of title 10), whichever is later.

§ 1073. Administration of this chapter

(a) RESPONSIBLE OFFICIALS.—(1) Except as otherwise provided in this chapter, the Secretary of Defense shall administer this chapter for the armed forces under his jurisdiction, the Secretary of Homeland Security shall administer this chapter for the Coast Guard when the Coast Guard is not operating as a service in the Navy, and the Secretary of Health and Human Services shall administer this chapter for the National Oceanic and Atmospheric Administration and the Public Health Service. This chapter shall be administered consistent with the Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. 14401 et seq.).

(2) Except as otherwise provided in this chapter, the Secretary of Defense shall have responsibility for administering the TRICARE program and making any decision affecting such program.

(b) STABILITY IN PROGRAM OF BENEFITS.—The Secretary of Defense shall, to the maximum extent practicable, provide a stable program of benefits under this chapter throughout each fiscal year. To achieve the stability in the case of managed care support contracts entered into under this chapter, the contracts shall be administered so as to implement all changes in benefits and administration on a quarterly basis. However, the Secretary of Defense may implement any such change prior to the next fiscal quarter if the Secretary determines that the change would significantly improve the provision of care to eligible beneficiaries under this chapter.

(Added Pub. L. 85–861, § 1(25)(B), Sept. 2, 1958, 72 Stat. 1446; amended Pub. L. 89–614, § 2(1), Sept. 30, 1966, 80 Stat. 862; Pub. L. 89–718, § 8(a), Nov. 2, 1966, 80 Stat. 1117; Pub. L. 96–513, title V, § 511(34)(A), (C), (35), (36), Dec. 12, 1980, 94 Stat. 2922, 2923; Pub. L. 98–557, § 19(2), Oct. 30, 1984, 98 Stat. 2869; Pub. L. 105–12, § 9(h), Apr. 30, 1997, 111 Stat. 27; Pub. L. 106–65, div. A, title VII, § 725, title X, § 1066(a)(7), Oct. 5, 1999, 113 Stat. 698, 770; Pub. L. 107–296, title XVII, § 1704(b)(1), Nov. 25, 2002, 116 Stat. 2314; Pub. L. 111–383, div. A, title VII, § 711, Jan. 7, 2011, 124 Stat. 4246.)

HISTORICAL AND REVISION NOTES

Revised section	*Source (U.S. Code)*	*Source (Statutes at Large)*
1073	37:402(b).	June 7, 1956, ch. 374, § 102(b), 70 Stat. 251.

The words ''armed forces under his jurisdiction'' are substituted for the words ''Army, Navy, Air Force, and Marine Corps and for the Coast Guard when it is operating as a service in the Navy'' to reflect section 101(4) of this title.

REFERENCES IN TEXT

The Assisted Suicide Funding Restriction Act of 1997, referred to in subsec. (a)(1), is Pub. L. 105–12, Apr. 30, 1997, 111 Stat. 23, which is classified principally to chapter 138 (§ 14401 et seq.) of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see Short Title note set out under section 14401 of Title 42 and Tables.

PRIOR PROVISIONS

A prior section 1073, act Aug. 10, 1956, ch. 1041, 70A Stat. 82, related to right to vote in war-time presidential and congressional election, prior to repeal by Pub. L. 85–861, § 36B(5), Sept. 2, 1958, 72 Stat. 1570, as superseded by the Federal Voting Assistance Act of 1955 which is classified to subchapter I–D (§ 1973cc et seq.) of chapter 20 of Title 42, The Public Health and Welfare.

AMENDMENTS

2011—Subsec. (a). Pub. L. 111–383 designated existing provisions as par. (1) and added par. (2).

2002—Subsec. (a). Pub. L. 107–296 substituted ''of Homeland Security'' for ''of Transportation''.

1999—Pub. L. 106–65, § 725, designated existing provisions, as amended by Pub. L. 106–65, § 1066(a)(7), as subsec. (a), inserted heading, and added subsec. (b).

Pub. L. 106–65, § 1066(a)(7), inserted ''(42 U.S.C. 14401 et seq.)'' after ''Act of 1997''.

1997—Pub. L. 105–12 inserted at end ''This chapter shall be administered consistent with the Assisted Suicide Funding Restriction Act of 1997.''

1984—Pub. L. 98–557 inserted provisions which transferred authority to administer chapter for the Coast Guard when the Coast Guard is not operating as a service in the Navy from the Secretary of Health and Human Services to the Secretary of Transportation.

1980—Pub. L. 96–513 substituted in section catchline ''of this chapter'' for ''of sections 1071–1087 of this title'', and substituted in text ''this chapter'' for ''sections 1071–1087 of this title'', ''those sections'', and ''them'', ''Secretary of Health and Human Services'' for ''Secretary of Health, Education, and Welfare'', and ''National Oceanic and Atmospheric Administration'' for ''Environmental Science Services Administration''.

1966—Pub. L. 89–718 substituted ''Environmental Science Services Administration'' for ''Coast and Geodetic Survey''.

Pub. L. 89–614 substituted ''1087'' for ''1085'' in section catchline and text.

EFFECTIVE DATE OF 2002 AMENDMENT

Amendment by Pub. L. 107–296 effective on the date of transfer of the Coast Guard to the Department of Homeland Security, see section 1704(g) of Pub. L. 107–296, set out as a note under section 101 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services provided on or after such date, subject to also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105–12, set out as an Effective Date note under section 14401 of Title 42, The Public Health and Welfare.

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, § 8(a), Nov. 2, 1966, 80 Stat. 1117,

cited as a credit to this section, was repealed by Pub. L. 97–295, § 6(b), Oct. 12, 1982, 96 Stat. 1314.

EXTRAMEDICAL MATERNAL HEALTH PROVIDERS DEMONSTRATION PROJECT

Pub. L. 116–283, div. A, title VII, § 746, Jan. 1, 2021, 134 Stat. 3710, provided that:

''(a) DEMONSTRATION PROJECT REQUIRED.—Not later than one year after the date of the enactment of this Act [Jan. 1, 2021], the Secretary of Defense shall commence carrying out a demonstration project designed to evaluate the cost, quality of care, and impact on maternal and fetal outcomes of using extramedical maternal health providers under the TRICARE program to determine the appropriateness of making coverage of such providers under the TRICARE program permanent.

''(b) ELEMENTS OF DEMONSTRATION PROJECT.—The demonstration project under subsection (a) shall include, for participants in the demonstration project, the following:

''(1) Access to doulas.

''(2) Access to lactation consultants or lactation counselors who are not otherwise authorized to provide services under the TRICARE program.

''(c) PARTICIPANTS.—The Secretary shall establish a process under which covered beneficiaries may enroll in the demonstration project to receive the services provided under the demonstration project.

''(d) DURATION.—The Secretary shall carry out the demonstration project for a period of five years beginning on the date on which notification of the commencement of the demonstration project is published in the Federal Register.

''(e) SURVEYS.—

''(1) IN GENERAL.—Not later than one year after the date of the enactment of this Act, and annually thereafter for the duration of the demonstration project, the Secretary shall administer a survey to determine—

''(A) how many members of the Armed Forces or spouses of such members give birth while their spouse or birthing partner is unable to be present due to deployment, training, or other mission requirements;

''(B) how many single members of the Armed Forces give birth alone; and

''(C) how many members of the Armed Forces or spouses of such members use doula, lactation consultant, or lactation counselor support.

''(2) MATTERS COVERED BY SURVEYS.—The surveys administered under paragraph (1) shall include an identification of the following:

''(A) The race, ethnicity, age, sex, relationship status, Armed Force, military occupation, and rank, as applicable, of each individual surveyed.

''(B) If individuals surveyed were members of the Armed Forces or the spouses of such members, or both.

''(C) The length of advanced notice received by individuals surveyed that the member of the Armed Forces would be unable to be present during the birth, if applicable.

''(D) Any resources or support that the individuals surveyed found useful during the pregnancy and birth process, including doula, lactation consultant, or lactation counselor support.

''(f) REPORTS.—

''(1) IMPLEMENTATION 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 to implement the demonstration project.

''(2) ANNUAL REPORT.—

''(A) IN GENERAL.—Not later than one year after the date on which the demonstration project commences, and annually thereafter for the duration of the demonstration project, the Secretary shall submit to the Committees on Armed Services of the House of Representatives and the Senate a report on the cost of the demonstration project and the effectiveness of the demonstration project in improving quality of care and the maternal and fetal outcomes of covered beneficiaries enrolled in the demonstration project.

''(B) MATTERS COVERED.—Each report submitted under subparagraph (A) shall address, at a minimum, the following:

''(i) The number of covered beneficiaries who are enrolled in the demonstration project.

''(ii) The number of enrolled covered beneficiaries who have participated in the demonstration project.

''(iii) The results of the surveys under subsection (e).

''(iv) The cost of the demonstration project.

''(v) An assessment of the quality of care provided to participants in the demonstration project.

''(vi) An assessment of the impact of the demonstration project on maternal and fetal outcomes.

''(vii) An assessment of the effectiveness of the demonstration project.

''(viii) Recommendations for adjustments to the demonstration project.

''(ix) The estimated costs avoided as a result of improved maternal and fetal health outcomes due to the demonstration project.

''(x) Recommendations for extending the demonstration project or implementing permanent coverage under the TRICARE program of extramedical maternal health providers.

''(xi) An identification of legislative or administrative action necessary to make the demonstration project permanent.

''(C) FINAL REPORT.—The final report under subparagraph (A) shall be submitted not later than 90 days after the date on which the demonstration project terminates.

''(g) EXPANSION OF DEMONSTRATION PROJECT.—

''(1) REGULATIONS.—If the Secretary determines that the demonstration project is successful, the Secretary may prescribe regulations to include extramedical maternal health providers as health care providers authorized to provide care under the TRICARE program.

''(2) CREDENTIALING AND OTHER REQUIREMENTS.—The Secretary may establish credentialing and other requirements for doulas, lactation consultants, and lactation counselors through public notice and comment rulemaking for purposes of including doulas, lactation consultants, and lactation counselors as health care providers authorized to provide care under the TRICARE program pursuant to regulations prescribed under paragraph (1).

''(h) DEFINITIONS.—In this section:

''(1) The terms 'covered beneficiary' and 'TRICARE program' have the meanings given those terms in section 1072 of title 10, United States Code.

''(2) The term 'extramedical maternal health provider' means a doula, lactation consultant, or lactation counselor.''

RESIDENCY REQUIREMENTS FOR PODIATRISTS

Pub. L. 115–91, div. A, title VII, § 720, Dec. 12, 2017, 131 Stat. 1440, provided that:

''(a) REQUIREMENT.—In addition to any other qualification required by law or regulation, the Secretary of Defense shall ensure that to serve as a podiatrist in the Armed Forces, an individual must have successfully completed a three-year podiatric medicine and surgical residency.

''(b) APPLICATION.—Subsection (a) shall apply with respect to an individual who is commissioned as an officer in the Armed Forces on or after the date that is one

year after the date of the enactment of this Act [Dec. 12, 2017].''

AUTHORIZATION OF PHYSICAL THERAPIST ASSISTANTS AND OCCUPATIONAL THERAPY ASSISTANTS TO PROVIDE SERVICES UNDER THE TRICARE PROGRAM

Pub. L. 115–91, div. A, title VII, § 721, Dec. 12, 2017, 131 Stat. 1440, provided that:

''(a) ADDITION TO LIST OF AUTHORIZED PROFESSIONAL PROVIDERS OF CARE.—The Secretary of Defense shall revise section 199.6(c) of title 32, Code of Federal Regulations, as in effect on the date of the enactment of this Act [Dec. 12, 2017], to add to the list of individual professional providers of care who are authorized to provide services to beneficiaries under the TRICARE program, as defined in section 1072 of title 10, United States Code, the following types of health care practitioners:

''(1) Licensed or certified physical therapist assistants who meet the qualifications for physical therapist assistants specified in section 484.4 of title 42, Code of Federal Regulations, or any successor regulation, to furnish services under the supervision of a physical therapist.

''(2) Licensed or certified occupational therapy assistants who meet the qualifications for occupational therapy assistants specified in such section 484.4, or any successor regulation, to furnish services under the supervision of an occupational therapist.

''(b) SUPERVISION.—The Secretary of Defense shall establish in regulations requirements for the supervision of physical therapist assistants and occupational therapy assistants, respectively, by physical therapists and occupational therapists, respectively.

''(c) MANUALS AND OTHER GUIDANCE.—The Secretary of Defense shall update the CHAMPVA Policy Manual and other relevant manuals and subregulatory guidance of the Department of Defense to carry out the revisions and requirements of this section.''

TERMINATION OF TRICARE STANDARD AND TRICARE EXTRA

Pub. L. 114–328, div. A, title VII, § 701(e), Dec. 23, 2016, 130 Stat. 2187, provided that: ''Beginning on January 1, 2018, the Secretary of Defense may not carry out TRICARE Standard and TRICARE Extra under the TRICARE program. The Secretary shall ensure that any individual who is covered under TRICARE Standard or TRICARE Extra as of December 31, 2017, enrolls in TRICARE Prime or TRICARE Select, as the case may be, as of January 1, 2018, for the individual to continue coverage under the TRICARE program.''

[For definitions of terms used in section 701(e) of Pub. L. 114–328, set out above, see section 703(i) of Pub. L. 114–328, set out as a note below.]

PILOT PROGRAM ON INCORPORATION OF VALUE-BASED HEALTH CARE IN PURCHASED CARE COMPONENT OF TRICARE PROGRAM

Pub. L. 114–328, div. A, title VII, § 701(h), Dec. 23, 2016, 130 Stat. 2188, provided that:

''(1) IN GENERAL.—Not later than January 1, 2018, the Secretary of Defense shall carry out a pilot program to demonstrate and assess the feasibility of incorporating value-based health care methodology in the purchased care component of the TRICARE program by reducing copayments or cost shares for targeted populations of covered beneficiaries in the receipt of high-value medications and services and the use of high-value providers under such purchased care component, including by exempting certain services from deductible requirements.

''(2) REQUIREMENTS.—In carrying out the pilot program under paragraph (1), the Secretary shall—

''(A) identify each high-value medication and service that is covered under the purchased care component of the TRICARE program for which a reduction or elimination of the copayment or cost share for such medication or service would encourage covered beneficiaries to use the medication or service;

''(B) reduce or eliminate copayments or cost shares for covered beneficiaries to receive high-value medications and services;

''(C) reduce or eliminate copayments or cost shares for covered beneficiaries to receive health care services from high-value providers;

''(D) credit the amount of any reduction or elimination of a copayment or cost share under subparagraph (B) or (C) for a covered beneficiary towards meeting a deductible applicable to the covered beneficiary in the purchased care component of the TRICARE program to the same extent as if such reduction or elimination had not applied; and

''(E) develop a process to reimburse high-value providers at rates higher than those rates for health care providers that are not high-value providers.

''(3) REPORT ON VALUE-BASED HEALTH CARE METHODOLOGY.—Not later than 180 days after the date of the enactment of this Act [Dec. 23, 2016], the Secretary shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report that includes the following:

''(A) A list of each high-value medication and service identified under paragraph (2)(A) for which the copayment or cost share amount will be reduced or eliminated under the pilot program to encourage covered beneficiaries to use such medications and services through the purchased care component of the TRICARE program.

''(B) For each high-value medication and service identified under paragraph (2)(A), the amount of the copayment or cost share required under the purchased care component of the TRICARE program and the amount of any reduction or elimination of such copayment or cost share pursuant to the pilot program.

''(C) A description of a plan to identify and communicate to covered beneficiaries, through multiple communication media—

''(i) the list of high-value medications and services described in subparagraph (A); and

''(ii) a list of high-value providers.

''(D) A description of modifications, if any, to existing health care contracts that may be required to implement value-based health care methodology in the purchased care component of the TRICARE program under the pilot program and the estimated costs of those contract modifications.

''(4) COMPTROLLER GENERAL PRELIMINARY REVIEW AND ASSESSMENT.—

''(A) Not later than March 1, 2021, the Comptroller General of the United States shall submit to the Committees on Armed Services of the Senate and the House of Representatives a review and assessment of the preliminary results of the pilot program.

''(B) The review and assessment required under subparagraph (A) shall include the following:

''(i) An assessment of the extent of the use of value-based health care methodology in the purchased care component of the TRICARE program under the pilot program.

''(ii) An analysis demonstrating how reducing or eliminating the copayment or cost share for each high-value medication and service identified under paragraph (2)(A) resulted in—

''(I) increased adherence to medication regimens;

''(II) improvement of quality measures;

''(III) improvement of health outcomes;

''(IV) reduction of number of emergency room visits or hospitalizations; and

''(V) enhancement of experience of care for covered beneficiaries.

''(iii) Such recommendations for incentivizing the use of high-value medications and services to improve health outcomes and the experience of care for beneficiaries as the Comptroller General considers appropriate.

''(5) REVIEW AND ASSESSMENT OF PILOT PROGRAM.—

''(A) Not later than January 1, 2023, the Secretary shall submit to the Committees on Armed Services of

the Senate and the House of Representatives a review and assessment of the pilot program.

''(B) The review and assessment required under subparagraph (A) shall include the following:

''(i) An assessment of the extent of the use of value-based health care methodology in the purchased care component of the TRICARE program under the pilot program.

''(ii) An analysis demonstrating how reducing or eliminating the copayment or cost share for each high-value medication and service identified under paragraph (2)(A) resulted in—

''(I) increased adherence to medication regimens;

''(II) improvement of quality measures;

''(III) improvement of health outcomes; and

''(IV) enhancement of experience of care for covered beneficiaries.

''(iii) A cost-benefit analysis of the implementation of value-based health care methodology in the purchased care component of the TRICARE program under the pilot program.

''(iv) Such recommendations for incentivizing the use of high-value medications and services to improve health outcomes and the experience of care for covered beneficiaries as the Secretary considers appropriate.

''(6) TERMINATION.—The Secretary may not carry out the pilot program after December 31, 2022.''

[For definitions of terms used in section 701(h) of Pub. L. 114–328, set out above, see section 703(i) of Pub. L. 114–328, set out as a note below.]

IMPROVEMENT OF HEALTH OUTCOMES AND CONTROL OF COSTS OF HEALTH CARE UNDER TRICARE PROGRAM THROUGH PROGRAMS TO INVOLVE COVERED BENEFICIARIES

Pub. L. 114–328, div. A, title VII, §729, Dec. 23, 2016, 130 Stat. 2234, provided that:

''(a) MEDICAL INTERVENTION INCENTIVE PROGRAM.—

''(1) IN GENERAL.—The Secretary of Defense shall establish a program to incentivize covered beneficiaries to participate in medical intervention programs established by the Secretary, such as comprehensive disease management programs, that may include lowering fees for enrollment in the TRICARE program by a certain percentage or lowering copayment and cost-share amounts for health care services during a particular year for covered beneficiaries with chronic diseases or conditions described in paragraph (2) who met participation milestones, as determined by the Secretary, in the previous year in such medical intervention programs.

''(2) CHRONIC DISEASES OR CONDITIONS DESCRIBED.—Chronic diseases or conditions described in this paragraph may include diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, coronary artery disease, mood disorders, obesity, and such other diseases or conditions as the Secretary determines appropriate.

''(b) LIFESTYLE INTERVENTION INCENTIVE PROGRAM.—The Secretary shall establish a program to incentivize lifestyle interventions for covered beneficiaries, such as smoking cessation and weight reduction, that may include lowering fees for enrollment in the TRICARE program by a certain percentage or lowering copayment and cost share amounts for health care services during a particular year for covered beneficiaries who met participation milestones, as determined by the Secretary, in the previous year with respect to such lifestyle interventions, such as quitting smoking or achieving a lower body mass index by a certain percentage.

''(c) HEALTHY LIFESTYLE MAINTENANCE INCENTIVE PROGRAM.—The Secretary shall establish a program to incentivize the maintenance of a healthy lifestyle among covered beneficiaries, such as exercise and weight maintenance, that may include lowering fees for enrollment in the TRICARE program by a certain percentage or lowering copayment and cost-share amounts for health care services during a particular year for covered beneficiaries who met participation milestones, as determined by the Secretary, in the previous year with respect to the maintenance of a healthy lifestyle, such as maintaining smoking cessation or maintaining a normal body mass index.

''(d) REPORT.—

''(1) IN GENERAL.—Not later than January 1, 2020, the Secretary shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the implementation of the programs established under subsections (a), (b), and (c).

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

''(A) A detailed description of the programs implemented under subsections (a), (b), and (c).

''(B) An assessment of the impact of such programs on—

''(i) improving health outcomes for covered beneficiaries; and

''(ii) lowering per capita health care costs for the Department of Defense.

''(e) REGULATIONS.—Not later than January 1, 2018, the Secretary shall prescribe an interim final rule to carry out this section.

''(f) DEFINITIONS.—In this section, the terms 'covered beneficiary' and 'TRICARE program' have the meaning given those terms in section 1072 of title 10, United States Code.''

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 for a three-year pilot program to allow TRICARE beneficiaries access to urgent care visits without the need for preauthorization and to a nurse advice line and required submission of a final report to Congress no later than 180 days after the program was completed.

COOPERATIVE HEALTH CARE AGREEMENTS BETWEEN MILITARY INSTALLATIONS AND NON-MILITARY HEALTH CARE SYSTEMS

Pub. L. 111–84, div. A, title VII, §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

''(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, §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, §711, Jan. 28, 2008, 122 Stat. 190, as amended by Pub. L. 112–81, div. A, title VII, §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.

''(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—

''(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.

''(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.''

REGULATIONS TO ESTABLISH CRITERIA FOR LICENSED OR CERTIFIED MENTAL HEALTH COUNSELORS UNDER TRICARE

Pub. L. 111–383, div. A, title VII, § 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, § 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, § 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.).

''(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, § 732, Oct. 17, 2006, 120 Stat. 2296, as amended by Pub. L. 112–81, div. A, title X, § 1062(d)(3), Dec. 31, 2011, 125 Stat. 1585, 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.

''(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, § 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, § 716, Jan. 6, 2006, 119 Stat. 3345, as amended by Pub. L. 112–81, div. A, title X, § 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.

''(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, § 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, § 740, Jan. 6, 2006, 119 Stat. 3359, as amended by Pub. L. 109–364, div. A, title X, § 1071(e)(8), Oct. 17, 2006, 120 Stat. 2402, provided for pilot projects related to encouraging pediatric early literacy among children of members of the Armed Forces conducted at military medical treatment facilites and required a report to Congress on the projects no later than Mar. 1, 2007.

SURVEYS ON CONTINUED VIABILITY OF TRICARE STANDARD

Pub. L. 108–136, div. A, title VII, § 723, Nov. 24, 2003, 117 Stat. 1532, as amended by Pub. L. 109–163, div. A, title VII, § 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, § 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, § 1 [[div. A], title VII, § 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 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, § 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, § 1 [[div. A], title VII, § 721], as amended, set out below.

Pub. L. 106–398, § 1 [[div. A], title VII, § 721], Oct. 30, 2000, 114 Stat. 1654, 1654A–184, as amended by Pub. L. 107–107, div. A, title VII, § 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].''.

Pub. L. 106–65, div. A, title VII, §712(a), (b), Oct. 5, 1999, 113 Stat. 687, required the Secretary of Defense to minimize the authorization and certification requirements to access benefits under the TRICARE program and to submit a report to Congress on actions taken no later than Mar. 31, 2000.

TRICARE MANAGED CARE SUPPORT CONTRACTS

Pub. L. 106–398, §1 [[div. A], title VII, §724], Oct. 30, 2000, 114 Stat. 1654, 1654A–187, provided for the four-year extension of certain TRICARE managed care support contracts in effect, or in the final stages of acquisition, on Sept. 30, 1999.

Pub. L. 106–259, title VIII, §8090, Aug. 9, 2000, 114 Stat. 694, provided for the 2-year extension of certain TRICARE managed care support contracts in effect, or in final stages of acquisition as of Sept. 30, 2000, and authorized future replacement contracts to include a base contract period for transition and up to seven 1-year option periods.

Similar provisions were contained in the following prior appropriation acts:

Pub. L. 106–79, title VIII, §8095, Oct. 25, 1999, 113 Stat. 1254.

Pub. L. 105–262, title VIII, §8107, Oct. 17, 1998, 112 Stat. 2321.

REDESIGN OF MILITARY PHARMACY SYSTEM

Pub. L. 105–261, div. A, title VII, §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 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, §723, Oct. 17, 1998, 112 Stat. 2068, as amended by Pub. L. 106–65, div. A, title X, §1067(3), Oct. 5, 1999, 113 Stat. 774; Pub. L. 106–398, §1 [[div. A], title VII, §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 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, §713, Oct. 17, 1998, 112 Stat. 2060, directed the Secretary of Defense to establish a system, no later than Apr. 1, 1999, for tracking

data and measuring performance in meeting primary care access standards under the TRICARE program.

TRICARE AS SUPPLEMENT TO MEDICARE DEMONSTRATION

Pub. L. 105–261, div. A, title VII, § 722, Oct. 17, 1998, 112 Stat. 2065, as amended by Pub. L. 106–65, div. A, title X, §§ 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, § 703, Nov. 18, 1997, 111 Stat. 1807, directed the Secretary of Defense to conduct a study on the provision to TRICARE beneficiaries of comparative information on the medical assistance provided by a managed care entity and to submit a report to Congress.

DISCLOSURE OF CAUTIONARY INFORMATION ON PRESCRIPTION MEDICATIONS

Pub. L. 105–85, div. A, title VII, § 744, Nov. 18, 1997, 111 Stat. 1820, directed prescription of regulations, no later than 180 days after Nov. 18, 1997, requiring pharmacies and other pharmaceutical dispensers to provide written cautionary information about usage with the medication.

COMPETITIVE PROCUREMENT OF OPHTHALMIC SERVICES

Pub. L. 105–85, div. A, title VII, § 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 eyeware [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, § 101(b) [title VIII, § 8131(a)], Sept. 30, 1996, 110 Stat. 3009–71, 3009–117; Pub. L. 105–85, div. A, title VII, §§ 721–723, Nov. 18, 1997, 111 Stat. 1809, 1810; Pub. L. 106–65, div. A, title VII, § 707, Oct. 5, 1999, 113 Stat. 684; Pub. L. 107–296, title XVII, § 1704(e)(2), Nov. 25, 2002, 116 Stat. 2315; Pub. L. 108–136, div. A, title VII, § 714, Nov. 24, 2003, 117 Stat. 1531; Pub. L. 108–199, div. H, § 109, Jan. 23, 2004, 118 Stat. 438; Pub. L. 112–81, div. A, title VII, § 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 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].

''(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

''(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 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, § 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, § 101(b) [title VIII, § 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 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, § 711, Feb. 10, 1996, 110 Stat. 374, provided that: ''For purposes of this subtitle [subtitle B (§§ 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, § 715, Feb. 10, 1996, 110 Stat. 375, as amended by Pub. L. 106–398, § 1 [[div. A], title VII, § 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, § 1 [[div. A], title VII, § 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, §716, Feb. 10, 1996, 110 Stat. 375, directed the Secretary of Defense to implement a pilot program to provide residential and wraparound services to certain children who are in need of mental health services and to report to Congress no later than Mar. 1, 1998.

EVALUATION AND REPORT ON TRICARE PROGRAM EFFECTIVENESS

Pub. L. 104–106, div. A, title VII, §717, Feb. 10, 1996, 110 Stat. 376, as amended by Pub. L. 112–239, div. A, title VII, §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—

''(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.''

[For termination, effective Dec. 31, 2021, of annual reporting provisions in section 717(c) of Pub. L. 104–106, set out above, see section 1061 of Pub. L. 114–328, set out as a note under section 111 of this title.]

USE OF HEALTH MAINTENANCE ORGANIZATION MODEL AS OPTION FOR MILITARY HEALTH CARE

Pub. L. 103–160, div. A, title VII, §731, Nov. 30, 1993, 107 Stat. 1696, as amended by Pub. L. 103–337, div. A, title VII, §715, Oct. 5, 1994, 108 Stat. 2803; Pub. L. 104–106, div. A, title VII, §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.

''(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, § 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.''

ALTERNATIVE HEALTH CARE DELIVERY METHODOLOGIES

Pub. L. 102–484, div. A, title VII, § 713, Oct. 23, 1992, 106 Stat. 2435, as amended by Pub. L. 103–160, div. A, title VII, § 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.

MILITARY HEALTH CARE FOR PERSONS RELIANT ON HEALTH CARE FACILITIES AT BASES BEING CLOSED OR REALIGNED

Pub. L. 102–484, div. A, title VII, § 722, Oct. 23, 1992, 106 Stat. 2439, as amended by Pub. L. 108–136, div. A, title VII, § 726, Nov. 24, 2003, 117 Stat. 1535; Pub. L. 110–181, div. A, title X, § 1063(i), Jan. 28, 2008, 122 Stat. 324, directed the Secretary of Defense to establish a working group on the provision of military health care to persons who rely on health care facilities at military installations selected for closure or realignment and provided that the working group would terminate on Dec. 31, 2006.

REQUIREMENTS PRIOR TO TERMINATION OF MEDICAL SERVICES AT MILITARY MEDICAL TREATMENT FACILITIES

Pub. L. 101–510, div. A, title VII, § 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, § 732(e)–(g), Dec. 4, 1987, 101 Stat. 1120, 1121, required the Secretary of Defense to enter into an agreement that would provide individuals losing health care coverage under CHAMPUS an option to purchase an insurance plan that provided similar benefits to CHAMPUS.

CHAMPUS REFORM INITIATIVE

Pub. L. 102–484, div. A, title VII, § 712, Oct. 23, 1992, 106 Stat. 2435, as amended by Pub. L. 103–160, div. A, title VII, § 720, Nov. 30, 1993, 107 Stat. 1695; Pub. L. 103–337, div. A, title VII, § 714(c), Oct. 5, 1994, 108 Stat. 2803, provided that the Secretary of Defense could not expand the CHAMPUS reform initiative beyond California and Hawaii until not less than 90 days after the date on which the Secretary certified that expansion to another location was the most efficient method of providing health care to beneficiaries, with an exception for locations adversely affected by military installation closures or realignments.

Pub. L. 102–190, div. A, title VII, § 722, Dec. 5, 1991, 105 Stat. 1406, authorized the Secretary of Defense to enter into a replacement or successor contract upon the termination of the Department of Defense contract in effect on Dec. 5, 1991, under the CHAMPUS reform initiative.

Pub. L. 102–172, title VIII, § 8032, Nov. 26, 1991, 105 Stat. 1178, extended the CHAMPUS reform initiative contract for California and Hawaii until Feb. 1, 1994, and required contracts to be competitively awarded for the geographic expansion of the reform initiative in certain other states and regions.

Pub. L. 101–510, div. A, title VII, § 715, Nov. 5, 1990, 104 Stat. 1584, required the Secretary of Defense to make certain cost-effectiveness certifications to Congress before the CHAMPUS reform initiative underway in California and Hawaii could expand.

Pub. L. 99–661, div. A, title VII, § 702, Nov. 14, 1986, 100 Stat. 3899, as amended by Pub. L. 100–180, div. A, title VII, § 732(a), (c), Dec. 4, 1987, 101 Stat. 1119, directed the Secretary of Defense to conduct a project, beginning no later than Sept. 30, 1988, to test new approaches for delivering health care to beneficiaries 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.

DEFINITIONS

Pub. L. 114–328, div. A, title VII, § 701(i), Dec. 23, 2016, 130 Stat. 2190, provided that: ''In this section [enacting sections 1075 and 1075a of this title, amending sections 1072, 1076d, 1076e, 1079a, 1095f, 1099, and 1110b of this title, and enacting provisions set out as notes under this section and sections 1072 and 1099 of this title]:

''(1) The terms 'uniformed services', 'covered beneficiary', 'TRICARE Extra', 'TRICARE for Life',

'TRICARE Prime', and 'TRICARE Standard', have the meaning given those terms in section 1072 of title 10, United States Code, as amended by subsection (j).

''(2) The term 'TRICARE Select' means the self-managed, preferred-provider network option under the TRICARE program established by section 1075 of such title, as added by subsection (a).

''(3) The term 'chronic conditions' includes diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, coronary artery disease, mood disorders, and such other diseases or conditions as the Secretary considers appropriate.

''(4) The term 'high-value medications and services' means prescription medications and clinical services for the management of chronic conditions that the Secretary determines would improve health outcomes and create health value for covered beneficiaries (such as preventive care, primary and specialty care, diagnostic tests, procedures, and durable medical equipment).

''(5) The term 'high-value provider' means an individual or institutional health care provider that provides health care under the purchased care component of the TRICARE program and that consistently improves the experience of care, meets established quality of care and effectiveness metrics, and reduces the per capita costs of health care.

''(6) The term 'value-based health care methodology' means a methodology for identifying specific prescription medications and clinical services provided under the TRICARE program for which reduction of copayments, cost shares, or both, would improve the management of specific chronic conditions because of the high value and clinical effectiveness of such medications and services for such chronic conditions.''

§ 1073a. Contracts for health care: best value contracting

(a) AUTHORITY.—Under regulations prescribed by the administering Secretaries, health care contracts shall be awarded in the administration of this chapter to the offeror or offerors that will provide the best value to the United States to the maximum extent consistent with furnishing high-quality health care in a manner that protects the fiscal and other interests of the United States.

(b) FACTORS CONSIDERED.—In the determination of best value under subsection (a)—

(1) consideration shall be given to the factors specified in the regulations; and

(2) greater weight shall be accorded to technical and performance-related factors than to cost and price-related factors.

(c) APPLICABILITY.—The authority under the regulations prescribed under subsection (a) shall apply to any contract in excess of $5,000,000.

(Added Pub. L. 106–65, div. A, title VII, § 722(a), Oct. 5, 1999, 113 Stat. 695.)

COMPTROLLER GENERAL REVIEW OF DEFENSE HEALTH AGENCY OVERSIGHT OF TRANSITION BETWEEN MANAGED CARE SUPPORT CONTRACTORS FOR THE TRICARE PROGRAM

Pub. L. 115–232, div. A, title VII, § 737, Aug. 13, 2018, 132 Stat. 1821, provided that:

''(a) BRIEFING AND REPORT ON CURRENT TRANSITION.—

''(1) IN GENERAL.—The Comptroller General of the United States shall provide to the Committees on Armed Services of the Senate and the House of Representatives a briefing and a report on a review by the Comptroller General of the oversight conducted by the Defense Health Agency with respect to the current transition between managed care support contractors for the TRICARE program. The briefing shall be provided by not later than July 1, 2019.

''(2) ELEMENTS.—The briefing and report under paragraph (1) shall each include the following:

''(A) A description and assessment of the extent to which the Defense Health Agency provided guidance and oversight to the outgoing and incoming managed care support contractors for the TRICARE program during the transition described in paragraph (1) and before the start of health care delivery by the incoming contractor.

''(B) A description and assessment of any issues with health care delivery under the TRICARE program as a result of or in connection with the transition, and, with respect to such issues—

''(i) the effect, if any, of the guidance and oversight provided by the Defense Health Agency during the transition on such issues; and

''(ii) the solutions developed by the Defense Health Agency for remediating any deficiencies in managed care support for the TRICARE program in connection with such issues.

''(C) A description and assessment of the extent to which the Defense Health Agency has reviewed any lessons learned from past transitions between managed care support contractors for the TRICARE program, and incorporated such lessons into the transition.

''(D) A review of the Department of Defense briefing provided in accordance with the provisions of the Report of the Committee on Armed Services of the House of Representatives to Accompany H.R. 5515 (115th Congress; House Report 115–676) on TRICARE Managed Care Support Contractor Reporting.

''(b) REPORT ON FUTURE TRANSITIONS.—Not later than 270 days after the completion of any future transition between managed care support contractors for the TRICARE program, the Comptroller General shall submit to the committees of Congress referred to in subsection (a)(1) a report on a review by the Comptroller General of the oversight conducted by the Defense Health Agency with respect to such transition. The report shall include each description and assessment specified in subparagraphs (A) through (C) of subsection (a)(2) with respect to such transition.

''(c) TRICARE PROGRAM DEFINED.—In this section, the term 'TRICARE program' has the meaning given that term in section 1072 of title 10, United States Code.''

VALUE-BASED PURCHASING AND ACQUISITION OF MANAGED CARE SUPPORT CONTRACTS FOR TRICARE PROGRAM

Pub. L. 114–328, div. A, title VII, § 705, Dec. 23, 2016, 130 Stat. 2201, as amended by Pub. L. 115–91, div. A, title VII, § 715, Dec. 12, 2017, 131 Stat. 1438; Pub. L. 116–92, div. A, title VII, § 716, Dec. 20, 2019, 133 Stat. 1453, provided that:

''(a) VALUE-BASED HEALTH CARE.—

''(1) IN GENERAL.—The Secretary of Defense shall develop and implement value-based incentive programs as part of any contract awarded under chapter 55 of title 10, United States Code, for the provision of health care services to covered beneficiaries to encourage health care providers under the TRICARE program (including physicians, hospitals, and other persons and facilities involved in providing such health care services) to improve the following:

''(A) The quality of health care provided to covered beneficiaries under the TRICARE program.

''(B) The experience of covered beneficiaries in receiving health care under the TRICARE program.

''(C) The health of covered beneficiaries.

''(2) VALUE-BASED INCENTIVE PROGRAMS.—

''(A) DEVELOPMENT.—In developing value-based incentive programs under paragraph (1), the Secretary shall—

''(i) link payments to health care providers under the TRICARE program to improved per-