military medical treatment facilities and, when unavailable, to make prompt referrals to network providers under the TRICARE program.

''(c) DEADLINE FOR IMPLEMENTATION.—The requirement in subsection (a) shall be implemented for referrals under TRICARE Prime in calendar year 2019.

''(d) EVALUATION AND IMPROVEMENT.—After 2019, the Secretary shall—

''(1) evaluate the referral process described in subsection (a) not less often than annually; and

''(2) make appropriate improvements to the process in light of such evaluations.

''(e) IMPROVEMENT OF SPECIALTY CARE REFERRALS DURING PERMANENT CHANGES OF STATION.—In conducting evaluations and improvements under subsection (d) to the referral process described in subsection (a), the Secretary shall ensure beneficiaries enrolled in TRICARE Prime who are undergoing a permanent change of station receive referrals from their primary care manager to such specialty care providers in the new location as the beneficiary may need before undergoing the permanent change of station.

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

§ 1095g. TRICARE program: waiver of recoupment of erroneous payments caused by administrative error

(a) WAIVER OF RECOUPMENT.—The Secretary of Defense may waive recoupment from an individual who has benefitted from an erroneous TRICARE payment in a case in which each of the following applies:

(1) The payment was made because of an administrative error by an employee of the Department of Defense or a contractor under the TRICARE program.

(2) The individual (or in the case of a minor, the parent or guardian of the individual) had a good faith, reasonable belief that the individual was entitled to the benefit of such payment under this chapter.

(3) The individual relied on the expectation of such entitlement.

(4) The Secretary determines that a waiver of recoupment of such payment is necessary to prevent an injustice.

(b) RESPONSIBILITY OF CONTRACTOR.—In any case in which the Secretary waives recoupment under subsection (a) and the administrative error was on the part of a contractor under the TRICARE program, the Secretary shall, consistent with the requirements and procedures of the applicable contract, impose financial responsibility on the contractor for the erroneous payment.

(c) FINALITY OF DETERMINATIONS.—Any determination by the Secretary under this section to waive or decline to waive recoupment under subsection (a) is a final determination and shall not be subject to appeal or judicial review.

(Added Pub. L. 114–92, div. A, title VII, § 711(a), Nov. 25, 2015, 129 Stat. 864.)

§ 1096. Military-civilian health services partnership program

(a) RESOURCES SHARING AGREEMENTS.—The Secretary of Defense may enter into an agreement providing for the sharing of resources between facilities of the uniformed services and facilities of a civilian health care provider or providers that the Secretary contracts with under section 1079, 1086, or 1097 of this title if the Secretary determines that such an agreement would result in the delivery of health care to which covered beneficiaries are entitled under this chapter in a more effective, efficient, or economical manner.

(b) ELIGIBLE RESOURCES.—An agreement entered into under subsection (a) may provide for the sharing of—

(1) personnel (including support personnel);

(2) equipment;

(3) supplies; and

(4) any other items or facilities necessary for the provision of health care services.

(c) COMPUTATION OF CHARGES.—A covered beneficiary who is a dependent, with respect to care provided to such beneficiary in facilities of the uniformed services under a sharing agreement entered into under subsection (a), shall pay the charges prescribed by section 1078 of this title.

(d) REIMBURSEMENT FOR LICENSE FEES.—In any case in which it is necessary for a member of the uniformed services to pay a professional license fee imposed by a government in order to provide health care services at a facility of a civilian health care provider pursuant to an agreement entered into under subsection (a), the Secretary of Defense may reimburse the member for up to $500 of the amount of the license fee paid by the member.

(Added Pub. L. 99–661, div. A, title VII, § 701(a)(1), Nov. 14, 1986, 100 Stat. 3894; amended Pub. L. 103–337, div. A, title VII, § 712, Oct. 5, 1994, 108 Stat. 2801; Pub. L. 108–375, div. A, title VI, § 607(b), Oct. 28, 2004, 118 Stat. 1946.)

Editorial Notes

AMENDMENTS

2004—Subsec. (c). Pub. L. 108–375 inserted ''who is a dependent'' after ''covered beneficiary'' and substituted ''shall pay the charges prescribed by section 1078 of this title.'' for ''shall pay—

''(1) in the case of a dependent, the charges prescribed by section 1078 of this title; and

''(2) in the case of a member or former member entitled to retired or retainer pay, the charges prescribed by section 1075 of this title.''

1994—Subsec. (d). Pub. L. 103–337 added subsec. (d).

Statutory Notes and Related Subsidiaries

DEVELOPMENT AND UPDATE OF CERTAIN POLICIES RELATING TO MILITARY HEALTH SYSTEM AND INTEGRATED MEDICAL OPERATIONS

Pub. L. 117–81, div. A, title VII, § 724, Dec. 27, 2021, 135 Stat. 1793, provided that:

''(a) IN GENERAL.—By not later than October 1, 2022, the Secretary of Defense, in coordination with the Secretaries of the military departments and the Chairman of the Joint Chiefs of Staff, shall develop and update certain policies relating to the military health system and integrated medical operations of the Department of Defense as follows:

''(1) UPDATED PLAN ON INTEGRATED MEDICAL OPERATIONS IN CONTINENTAL UNITED STATES.—The Secretary of Defense shall develop an updated plan on integrated medical operations in the continental United States and update the Department of Defense Instruction 6010.22, titled 'National Disaster Medical System (NDMS)' (or such successor instruction) accordingly. Such updated plan shall—

''(A) be informed by the operational plans of the combatant commands and by the joint medical estimate under section 732 of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Public Law 115–232; 132 Stat. 1817);

''(B) include an updated bed plan, to include bed space available through the military health system and through hospitals participating in the National Disaster Medical System established pursuant to section 2812 of the Public Health Service Act (42 U.S.C. 300hh–11);

''(C) include a determination as to whether combat casualties should receive medical care under the direct care or purchased care component of the military health system and a risk analysis in support of such determination;

''(D) identify the manning levels required to furnish medical care under the updated plan, including with respect to the levels of military personnel, civilian employees of the Department, and contractors of the Department; and

''(E) include a cost estimate for the furnishment of such medical care.

''(2) UPDATED PLAN ON GLOBAL PATIENT MOVEMENT.—The Secretary of Defense shall develop an updated plan on global patient movement and update the Department of Defense Instruction 5154.06, relating to medical military treatment facilities and patient movement (or such successor instruction) accordingly. Such updated plan shall—

''(A) be informed by the operational plans of the combatant commands and by the joint medical estimate under section 732 of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Public Law 115–232; 132 Stat. 1817);

''(B) include a risk assessment with respect to patient movement compared against overall operational plans;

''(C) include a description of any capabilities-based assessment of the Department that informed the updated plan or that was in progress during the time period in which the updated plan was developed;

''(D) identify the manning levels, equipment and consumables, and funding levels, required to carry out the updated plan; and

''(E) address airlift capability, medical evacuation capability, and access to ports of embarkation.

''(3) ASSESSMENT OF BIOSURVEILLANCE AND MEDICAL RESEARCH CAPABILITIES.—The Secretary of Defense shall conduct an assessment of the biosurveillance and medical research capabilities of the Department of Defense. Such assessment shall include the following:

''(A) An identification of the location and strategic value of the overseas medical laboratories and overseas medical research programs of the Department.

''(B) An assessment of the current capabilities of such laboratories and programs with respect to force health protection and evidence-based medical research.

''(C) A determination as to whether such laboratories and programs have the capabilities, including as a result of the geographic location of such laboratories and programs, to provide force health protection and evidence-based medical research, including by actively monitoring for future pandemics, infectious diseases, and other potential health threats to members of the Armed Forces.

''(D) The current biosurveillance and medical research capabilities of the Department.

''(E) The current manning levels of the biosurveillance and medical research entities of the Department, including an assessment of whether such entities are manned at a level necessary to support the missions of the combatant commands (including with respect to missions related to pandemic influenza or homeland defense).

''(F) The current funding levels of such entities, including a risk assessment as to whether such funding is sufficient to sustain the manning levels necessary to support missions as specified in subparagraph (E).

''(b) INTERIM BRIEFING.—Not later than April 1, 2022, the Secretary of Defense, in coordination with the Secretaries of the military departments and the Chairman of the Joint Chiefs of Staff, shall provide to the Committees on Armed Services of the House of Representatives and the Senate an interim briefing on the progress of implementation of the plans and assessment required under subsection (a).

''(c) REPORT.—Not later than December 1, 2022, the Secretary of Defense shall submit to the Committees on Armed Services of the House of Representatives and the Senate a report describing each updated plan and assessment required under subsection (a).''

PILOT PROGRAM ON CIVILIAN AND MILITARY PARTNERSHIPS TO ENHANCE INTEROPERABILITY AND MEDICAL SURGE CAPABILITY AND CAPACITY OF NATIONAL DISASTER MEDICAL SYSTEM

Pub. L. 116–92, div. A, title VII, § 740, Dec. 20, 2019, 133 Stat. 1465, as amended by Pub. L. 116–283, div. A, title VII, § 741, Jan. 1, 2021, 134 Stat. 3705, provided that:

''(a) IN GENERAL.—Beginning not later than September 30, 2021, the Secretary of Defense shall carry out a pilot program to establish partnerships with public, private, and nonprofit health care organizations, health care institutions, health care entities, academic medical centers of institutions of higher education, and hospitals in collaboration with the Secretary of Veterans Affairs, the Secretary of Health and Human Services, the Secretary of Homeland Security, and the Secretary of Transportation to enhance the interoperability and medical surge capability and capacity of the National Disaster Medical System under section 2812 of the Public Health Service Act (42 U.S.C. 300hh–11).

''(b) DURATION.—The Secretary of Defense shall carry out the pilot program under subsection (a) for a period of not more than five years.

''(c) LEAD OFFICIAL FOR DESIGN AND IMPLEMENTATION OF PILOT PROGRAM.—

''(1) IN GENERAL.—The Assistant Secretary of Defense for Health Affairs shall be the lead official for the design and implementation of the pilot program under subsection (a).

''(2) RESOURCES.—The Assistant Secretary of Defense for Health Affairs shall leverage the resources of the Defense Health Agency for execution of the pilot program under subsection (a) and shall coordinate with the Chairman of the Joint Chiefs of Staff for the duration of the pilot program, including for the duration of any period of design or planning for the pilot program.

''(d) LOCATIONS.—

''(1) IN GENERAL.—The Secretary of Defense shall carry out the pilot program under subsection (a) at not fewer than five locations in the United States that are located at or near an organization, institution, entity, center, or hospital specified in subsection (a) with established expertise in disaster health preparedness and response and trauma care that augment and enhance the effectiveness of the pilot program.

''(2) PHASED SELECTION OF LOCATIONS.—

''(A) INITIAL SELECTION.—Not later than March 31, 2021, the Assistant Secretary of Defense for Health Affairs, in consultation with the Secretary of Veterans Affairs, the Secretary of Health and Human Services, the Secretary of Homeland Security, and the Secretary of Transportation, shall select not fewer than two locations at which to carry out the pilot program.

''(B) SUBSEQUENT SELECTION.—Not later than the end of the one-year period following selection of the locations under subparagraph (A), the Assistant Secretary of Defense for Health Affairs, in con-

sultation with the Secretaries specified in subparagraph (A), shall select not fewer than two additional locations at which to carry out the pilot program until not fewer than five locations are selected in total under this paragraph.

''(3) CONSIDERATION FOR LOCATIONS.—In selecting locations for the pilot program under subsection (a), the Secretary shall consider—

''(A) the proximity of the location to civilian or military transportation hubs, including airports, railways, interstate highways, or ports;

''(B) the proximity of the location to an organization, institution, entity, center, or hospital specified in subsection (a) with the ability to accept a redistribution of casualties during times of war;

''(C) the proximity of the location to an organization, institution, entity, center, or hospital specified in subsection (a) with the ability to provide trauma care training opportunities for medical personnel of the Department of Defense; and

''(D) the proximity of the location to existing academic medical centers of institutions of higher education, facilities of the Department, or other institutions that have established expertise in the areas of—

''(i) highly infectious disease;

''(ii) biocontainment;

''(iii) quarantine;

''(iv) trauma care;

''(v) combat casualty care;

''(vi) the National Disaster Medical System under section 2812 of the Public Health Service Act (42 U.S.C. 300hh–11);

''(vii) disaster health preparedness and response;

''(viii) medical and public health management of biological, chemical, radiological, or nuclear hazards; or

''(ix) such other areas of expertise as the Secretary considers appropriate.

''(4) PRIORITY FOR LOCATIONS.—In selecting locations for the pilot program under subsection (a), the Secretary shall give priority to locations that would facilitate public-private partnerships with academic medical centers of institutions of higher education, hospitals, and other entities with facilities that have an established history of providing clinical care, treatment, training, and research in the areas described in paragraph (3)(D) or other specializations determined important by the Secretary for purposes of the pilot program.

''(e) REQUIREMENTS.—In establishing partnerships under the pilot program under subsection (a), the Secretary, in collaboration with the Secretary of Veterans Affairs, the Secretary of Health and Human Services, the Secretary of Homeland Security, and the Secretary of Transportation, shall establish requirements under such partnerships for staffing, specialized training, medical logistics, telemedicine, patient regulating, movement, situational status reporting, tracking, and surveillance.

''(f) EVALUATION METRICS.—The Secretary of Defense shall establish metrics to evaluate the effectiveness of the pilot program under subsection (a).

''(g) REPORTS.—

''(1) INITIAL REPORT.—

''(A) IN GENERAL.—Not later than 180 days after the commencement of the pilot program under subsection (a), the Secretary shall submit to the appropriate congressional committees a report on the pilot program.

''(B) ELEMENTS.—The report under subparagraph (A) shall include the following:

''(i) A description of the pilot program.

''(ii) The requirements established under subsection (e).

''(iii) The evaluation metrics established under subsection (f).

''(iv) Such other matters relating to the pilot program as the Secretary considers appropriate.

''(2) FINAL REPORT.—Not later than 180 days after the completion of the pilot program under subsection (a), the Secretary shall submit to the appropriate congressional committees a report on the pilot program.

''(h) DEFINITIONS.—In this section:

''(1) The term 'appropriate congressional committees' means—

''(A) The Committee on Armed Services, the Committee on Transportation and Infrastructure, the Committee on Veterans' Affairs, the Committee on Homeland Security, and the Committee on Energy and Commerce of the House of Representatives.

''(B) The Committee on Armed Services, the Committee on Commerce, Science, and Transportation, the Committee on Veterans' Affairs, the Committee on Homeland Security and Governmental Affairs, and the Committee on Health, Education, Labor, and Pensions of the Senate.

''(2) The term 'institution of higher education' means a four-year institution of higher education, as defined in section 101(a) of the Higher Education Act of 1965 (20 U.S.C. 1001(a)).''

ESTABLISHMENT OF HIGH PERFORMANCE MILITARY-CIVILIAN INTEGRATED HEALTH DELIVERY SYSTEMS

Pub. L. 114–328, div. A, title VII, §706, Dec. 23, 2016, 130 Stat. 2206, provided that:

''(a) IN GENERAL.—Not later than January 1, 2018, the Secretary of Defense shall establish military-civilian integrated health delivery systems through partnerships with other health systems, including local or regional health systems in the private sector—

''(1) to improve access to health care for covered beneficiaries;

''(2) to enhance the experience of covered beneficiaries in receiving health care;

''(3) to improve health outcomes for covered beneficiaries;

''(4) to share resources between the Department of Defense and the private sector, including such staff, equipment, and training assets as may be required to carry out such integrated health delivery systems;

''(5) to maintain services within military treatment facilities that are essential for the maintenance of operational medical force readiness skills of health care providers of the Department; and

''(6) to provide members of the Armed Forces with additional training opportunities to maintain such readiness skills.

''(b) ELEMENTS OF SYSTEMS.—Each military-civilian integrated health delivery system established under subsection (a) shall—

''(1) deliver high quality health care as measured by leading national health quality measurement organizations;

''(2) achieve greater efficiency in the delivery of health care by identifying and implementing within each such system improvement opportunities that guide patients through the entire continuum of care, thereby reducing variations in the delivery of health care and preventing medical errors and duplication of medical services;

''(3) improve population-based health outcomes by using a team approach to deliver case management, prevention, and wellness services to high-need and high-cost patients;

''(4) focus on preventive care that emphasizes—

''(A) early detection and timely treatment of disease;

''(B) periodic health screenings; and

''(C) education regarding healthy lifestyle behaviors;

''(5) coordinate and integrate health care across the continuum of care, connecting all aspects of the health care received by the patient, including the patient's health care team;

''(6) facilitate access to health care providers, including—

''(A) after-hours care;

''(B) urgent care; and

''(C) through telehealth appointments, when appropriate;

''(7) encourage patients to participate in making health care decisions;

''(8) use evidence-based treatment protocols that improve the consistency of health care and eliminate ineffective, wasteful health care practices; and

''(9) improve coordination of behavioral health services with primary health care.

''(c) AGREEMENTS.—

''(1) IN GENERAL.—In establishing military-civilian integrated health delivery systems through partnerships under subsection (a), the Secretary shall seek to enter into memoranda of understanding or contracts between military treatment facilities and health maintenance organizations, health care centers of excellence, public or private academic medical institutions, regional health organizations, integrated health systems, accountable care organizations, and such other health systems as the Secretary considers appropriate.

''(2) PRIVATE SECTOR CARE.—Memoranda of understanding and contracts entered into under paragraph (1) shall ensure that covered beneficiaries are eligible to enroll in and receive medical services under the private sector components of military-civilian integrated health delivery systems established under subsection (a).

''(3) VALUE-BASED REIMBURSEMENT METHODOLOGIES.—The Secretary shall incorporate value-based reimbursement methodologies, such as capitated payments, bundled payments, or pay for performance, into memoranda of understanding and contracts entered into under paragraph (1) to reimburse entities for medical services provided to covered beneficiaries under such memoranda of understanding and contracts.

''(4) QUALITY OF CARE.—Each memorandum of understanding or contract entered into under paragraph (1) shall ensure that the quality of services received by covered beneficiaries through a military-civilian integrated health delivery system under such memorandum of understanding or contract is at least comparable to the quality of services received by covered beneficiaries from a military treatment facility.

''(d) COVERED BENEFICIARY DEFINED.—In this section, the term 'covered beneficiary' has the meaning given that term in section 1072 of title 10, United States Code.''

§ 1097. Contracts for medical care for retirees, dependents, and survivors: alternative delivery of health care

(a) IN GENERAL.—The Secretary of Defense, after consulting with the other administering Secretaries, may contract for the delivery of health care to which covered beneficiaries are entitled under this chapter. The Secretary may enter into a contract under this section with any of the following:

(1) Health maintenance organizations.

(2) Preferred provider organizations.

(3) Individual providers, individual medical facilities, or insurers.

(4) Consortiums of such providers, facilities, or insurers.

(b) SCOPE OF COVERAGE UNDER HEALTH CARE PLANS.—A contract entered into under this section may provide for the delivery of—

(1) selected health care services;

(2) total health care services for selected covered beneficiaries; or

(3) total health care services for all covered beneficiaries who reside in a geographical area designated by the Secretary.

(c) COORDINATION WITH FACILITIES OF THE UNIFORMED SERVICES.—The Secretary of Defense may provide for the coordination of health care services provided pursuant to any contract or agreement under this section with those services provided in medical treatment facilities of the uniformed services. Subject to the availability of space and facilities and the capabilities of the medical or dental staff, the Secretary may not deny access to facilities of the uniformed services to a covered beneficiary on the basis of whether the beneficiary enrolled or declined enrollment in any program established under, or operating in connection with, any contract under this section. Notwithstanding the preferences established by sections 1074(b) and 1076 of this title, the Secretary shall, as an incentive for enrollment, establish reasonable preferences for services in facilities of the uniformed services for covered beneficiaries enrolled in any program established under, or operating in connection with, any contract under this section.

(d) COORDINATION WITH OTHER HEALTH CARE PROGRAMS.—In the case of a covered beneficiary who is enrolled in a managed health care program not operated under the authority of this chapter, the Secretary may contract under this section with such other managed health care program for the purpose of coordinating the beneficiary's dual entitlements under such program and this chapter. A managed health care program with which arrangements may be made under this subsection includes any health maintenance organization, competitive medical plan, health care prepayment plan, or other managed care program recognized pursuant to regulations issued by the Secretary.

(e) CHARGES FOR HEALTH CARE.—(1) The Secretary of Defense may prescribe by regulation a premium, deductible, copayment, or other charge for health care provided under this section. In the case of contracts for health care services under this section or health care plans offered under section 1099 of this title for which the Secretary permits covered beneficiaries who are covered by section 1086 of this title and who participate in such contracts or plans to pay an enrollment fee in lieu of meeting the applicable deductible amount specified in section 1086(b) of this title, the Secretary may establish the same (or a lower) enrollment fee for covered beneficiaries described in section 1086(d)(1) of this title who also participate in such contracts or plans. Without imposing additional costs on covered beneficiaries who participate in contracts for health care services under this section or health care plans offered under section 1099 of this title, the Secretary shall permit such covered beneficiaries to pay, on a quarterly basis, any enrollment fee required for such participation. Except as provided by paragraph (2), a premium, deductible, copayment, or other charge prescribed by the Secretary under this subsection may not be increased during the period beginning on April 1, 2006, and ending on September 30, 2011.

(2) Beginning October 1, 2012, the Secretary of Defense may only increase in any year the annual enrollment fees described in paragraph (1) by an amount equal to the percentage by which