''(iv) an enhanced experience of care for covered beneficiaries; and

''(D) ensure that managed care support contracts under the TRICARE program in those locations will—

''(i) establish individual and institutional provider networks that will provide timely access to care for covered beneficiaries, including pursuant to such networks relating to an Indian tribe or tribal organization that is party to the Alaska Native Health Compact with the Indian Health Service or has entered into a contract with the Indian Health Service to provide health care in rural Alaska or other locations in the United States; and

''(ii) deliver high-quality care, better health outcomes, and a better experience of care for covered beneficiaries.

''(d) REPORT PRIOR TO CERTAIN CONTRACT MODIFICATIONS.—Not later than 60 days before the date on which the Secretary of Defense first modifies a contract awarded under chapter 55 of title 10, United States Code, to implement a value-based incentive program under subsection (a), or the managed care support contract acquisition strategy under subsection (c), the Secretary shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on any implementation plan of the Secretary with respect to such value-based incentive program or managed care support contract acquisition strategy.

''(e) COMPTROLLER GENERAL REPORT.—

''(1) IN GENERAL.—Not later than 180 days after the date on which the Secretary submits the report under subsection (d), the Comptroller General of the United States shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report that assesses the compliance of the Secretary of Defense with the requirements of subsection (a) and subsection (c).

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

''(A) Whether the approach of the Department of Defense for acquiring managed care support contracts under the TRICARE program—

''(i) improves access to care;

''(ii) improves health outcomes;

''(iii) improves the experience of care for covered beneficiaries; and

''(iv) lowers per capita health care costs.

''(B) Whether the Department has, in its requirements for managed care support contracts under the TRICARE program, allowed for—

''(i) maximum flexibility in network design and development;

''(ii) integrated medical management between military medical treatment facilities and network providers;

''(iii) the maximum use of the full range of telehealth services;

''(iv) the use of value-based reimbursement methods that transfer financial risk to health care providers and managed care support contractors;

''(v) the use of prevention and wellness incentives to encourage covered beneficiaries to seek health care services from high-value providers;

''(vi) a streamlined enrollment process and timely assignment of primary care managers;

''(vii) the elimination of the requirement to seek authorization for referrals for specialty care services;

''(viii) the use of incentives to encourage covered beneficiaries to engage in medical and lifestyle intervention programs; and

''(ix) the use of financial incentives for contractors and health care providers to receive an equitable share in cost savings resulting from improvements in health outcomes and the experience of care for covered beneficiaries.

''(C) Whether the Department has considered, in developing requirements for managed care support contracts under the TRICARE program, the following:

''(i) The unique characteristics of providing health care services in Alaska, Hawaii, and the territories and possessions of the United States, and in rural, remote, or isolated locations in the contiguous 48 States;

''(ii) The various challenges inherent in developing robust networks of health care providers in those locations.

''(iii) A provider reimbursement rate structure in those locations that ensures—

''(I) timely access of covered beneficiaries to health care services;

''(II) the delivery of high-quality primary and specialty care;

''(III) improvement in health outcomes for covered beneficiaries; and

''(IV) an enhanced experience of care for covered beneficiaries.

''(f) DEFINITIONS.—In this section:

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

''(2) The term 'high-performing networks of health care providers' means networks of health care providers that, in addition to such other requirements as the Secretary of Defense may specify for purposes of this section, do the following:

''(A) Deliver high quality health care as measured by leading health quality measurement organizations such as the National Committee for Quality Assurance and the Agency for Healthcare Research and Quality.

''(B) Achieve greater efficiency in the delivery of health care by identifying and implementing within such network 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.

''(C) 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.

''(D) Focus on preventive care that emphasizes—

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

''(ii) periodic health screenings; and

''(iii) education regarding healthy lifestyle behaviors.

''(E) 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.

''(F) Facilitate access to health care providers, including—

''(i) after-hours care;

''(ii) urgent care; and

''(iii) through telehealth appointments, when appropriate.

''(G) Encourage patients to participate in making health care decisions.

''(H) Use evidence-based treatment protocols that improve the consistency of health care and eliminate ineffective, wasteful health care practices.''

§ 1073b. Recurring reports and publication of certain data

(a) ANNUAL REPORT ON RECORDING OF HEALTH ASSESSMENT DATA IN MILITARY HEALTH RECORDS.—The Secretary of Defense shall issue each year a report on the compliance by the military departments with applicable law and policies on the recording of health assessment data in military health records, including com-

pliance with section 1074f(c) of this title. The report shall cover the calendar year preceding the year in which the report is submitted and include a discussion of the extent to which immunization status and predeployment and postdeployment health care data are being recorded in such records.

(b) PUBLICATION OF DATA ON PATIENT SAFETY, QUALITY OF CARE, SATISFACTION, AND HEALTH OUTCOME MEASURES.—(1) The Secretary of Defense shall publish on a publically available Internet website of the Department of Defense data on all measures that the Secretary considers appropriate that are used by the Department to assess patient safety, quality of care, patient satisfaction, and health outcomes for health care provided under the TRICARE program at each military medical treatment facility. Such data shall include the core quality performance metrics adopted by the Secretary under section 728 of the National Defense Authorization Act for Fiscal Year 2017.

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

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

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

(Added Pub. L. 108–375, div. A, title VII, §739(a)(1), Oct. 28, 2004, 118 Stat. 2001; amended Pub. L. 114–92, div. A, title VII, §712, Nov. 25, 2015, 129 Stat. 864; Pub. L. 114–328, div. A, title VII, §728(b)(1), Dec. 23, 2016, 130 Stat. 2234; Pub. L. 115–91, div. A, title X, §§1051(a)(5), 1081(d)(3), Dec. 12, 2017, 131 Stat. 1560, 1600.)

REFERENCES IN TEXT

Section 728 of the National Defense Authorization Act for Fiscal Year 2017, referred to in subsec. (b)(1), is section 728 of Pub. L. 114–328, which amended this section and enacted provisions set out as notes under section 1071 of this title.

AMENDMENTS

2017—Pub. L. 115–91, §1081(d)(3), amended directory language of Pub. L. 114–328, §728(b)(1). See 2016 Amendment notes below.

Subsecs. (a) to (c). Pub. L. 115–91, §1051(a)(5), redesignated subsecs. (b) and (c) as (a) and (b), respectively, and struck out former subsec. (a) which related to annual report on the Force Health Protection Quality Assurance Program.

2016—Pub. L. 114–328, §728(b)(1)(B), as amended by Pub. L. 115–91, §1081(d)(3), inserted ''and publication of certain data'' after ''reports'' in section catchline. Amendment was executed as the probable intent of Congress, notwithstanding directory language amending the section heading of section ''1073b(c)''.

Subsec. (c)(1). Pub. L. 114–328, §728(b)(1)(A), as amended by Pub. L. 115–91, §1081(d)(3), substituted ''The Secretary'' for ''Not later than 180 days after the date of the enactment of the National Defense Authorization Act for Fiscal Year 2016, the Secretary'' and inserted at end ''Such data shall include the core quality performance metrics adopted by the Secretary under section 728 of the National Defense Authorization Act for Fiscal Year 2017.''

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

EFFECTIVE DATE OF 2017 AMENDMENT

Pub. L. 115–91, div. A, title X, §1081(d), Dec. 12, 2017, 131 Stat. 1599, provided that the amendment made by section 1081(d)(3) is effective as of Dec. 23, 2016, and as if included in Pub. L. 114–328 as enacted.

INCLUSION OF DENTAL CARE

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

INITIAL REPORTS

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

§ 1073c. Administration of Defense Health Agency and military medical treatment facilities

(a) ADMINISTRATION OF MILITARY MEDICAL TREATMENT FACILITIES.—(1) In accordance with paragraph (5), by not later than September 30, 2021, the Director of the Defense Health Agency shall be responsible for the administration of each military medical treatment facility, including with respect to—

(A) provision and delivery of health care within each such facility;

(B) management of privileging, scope of practice, and quality of health care provided within each such facility;

(C) budgetary matters;

(D) information technology;

(E) health care administration and management;

(F) supply and equipment;

(G) administrative policy and procedure;

(H) military medical construction; and

(I) any other matters the Secretary of Defense determines appropriate.

(2) In addition to the responsibilities set forth in paragraph (1), the Director of the Defense Health Agency shall, commencing when the Director begins to exercise responsibilities under that paragraph, have the authority—

(A) to direct, control, and serve as the primary rater of the performance of commanders or directors of military medical treatment facilities;

(B) to direct and control any intermediary organizations between the Defense Health Agency and military medical treatment facilities;

(C) to determine the scope of medical care provided at each military medical treatment facility to meet the military personnel readiness requirements of the senior military operational commander of the military installation;

(D) to identify the capacity of each military medical treatment facility to support clinical readiness standards of health care providers established by the Secretary of a military department or the Assistant Secretary of Defense for Health Affairs;