

February 2005

MILITARY PAY

Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers



G A O

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Highlights of [GAO-05-125](#), a report to congressional requesters

Why GAO Did This Study

In light of the recent mobilizations associated with the Global War on Terrorism, GAO was asked to determine if the Army's overall environment and controls provided reasonable assurance that soldiers who were injured or became ill in the line of duty were receiving the pay and other benefits to which they were entitled in an accurate and timely manner. GAO's audit used a case study approach to provide perspective on the nature of these pay deficiencies in the key areas of (1) overall environment and management controls, (2) processes, and (3) systems. GAO also assessed whether recent actions the Army has taken to address these problems will offer effective and lasting solutions.

What GAO Recommends

GAO makes 20 recommendations for immediate actions including (1) establishing comprehensive policies and procedures, (2) providing adequate infrastructure and resources, and (3) making process improvements to compensate for inadequate, stovepiped systems. In addition, GAO recommends 2 actions, as part of longer term system improvement initiatives, to integrate the Army's order writing, pay, personnel, and medical eligibility systems. In its written response to our recommendations, DOD briefly described its completed, ongoing, and planned actions for each of our 22 recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-05-125.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Gregory D. Kutz at (202) 512-9095 or kutzg@gao.gov.

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What GAO Found

Injured and ill reserve component soldiers—who are entitled to extend their active duty service to receive medical treatment—have been inappropriately removed from active duty status in the automated systems that control pay and access to medical care. The Army acknowledges the problem but does not know how many injured soldiers have been affected by it. GAO identified 38 reserve component soldiers who said they had experienced problems with the active duty medical extension order process and subsequently fell off their active duty orders. Of those, 24 experienced gaps in their pay and benefits due to delays in processing extended active duty orders. Many of the case study soldiers incurred severe, permanent injuries fighting for their country including loss of limb, hearing loss, and back injuries. Nonetheless, these soldiers had to navigate the convoluted and poorly defined process for extending active duty service.

Examples of Injured Soldiers with Gaps in Pay and Benefits

Soldier	Injuries	Days without orders	Missed pay	Effect on soldier
Case Study #1 Enduring Freedom	Kidney problems, knee injury	92	\$11,924	Medical and financial stress requiring counseling
Case Study #2 Iraqi Freedom	Knee and cervical disc injuries	31	\$3,886	Living with in-laws, no way to show income to qualify for rental
Case Study #3 Enduring Freedom	Lost leg, burns, and shrapnel in face	34	\$4,780	Soldier paid bills late and had to borrow money
Case Study #4 Enduring Freedom	Back injuries	45	\$8,206	Soldier paid bills late and had to borrow money
Case Study #5 Enduring Freedom	Knee injury and cancer	122	\$4,238	Unable to work, soldier lived off savings and credit cards

Source: GAO.

The Army's process for extending active duty orders for injured soldiers lacks an adequate control environment and management controls—including (1) clear and comprehensive guidance, (2) a system to provide visibility over injured soldiers, and (3) adequate training and education programs. The Army has also not established user-friendly processes—including clear approval criteria and adequate infrastructure and support services. Many Army locations have used ad hoc procedures to keep soldiers in pay status; however, these procedures often circumvent key internal controls and put the Army at risk of making improper and potentially fraudulent payments. Finally, the Army's nonintegrated systems, which require extensive error-prone manual data entry, further delay access to pay and benefits.

The Army recently implemented the Medical Retention Processing (MRP) program, which takes the place of the previous process in most cases. MRP, which authorizes an automatic 179 days of pay and benefits, may have resolved many of the processing delays experienced by soldiers. However, MRP has some of the same issues and may also result in overpayments to soldiers who are released early from their MRP orders. Out of 132 soldiers the Army identified as being released from active duty, 15 received pay past their release date—totaling approximately \$62,000.

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Abbreviations

ADME	Active Duty Medical Extension
AMEDD	Army Medical Department
AORS	Automated Order Resource System
CBHCI	Community Based Health Care Initiative
DEERS	Defense Enrollment Eligibility System
DJMS-RC	Defense Joint Military Pay System-Reserve Component
DMO	Defense Military Pay Office
FORSCOM	U.S. Army Forces Command
HRC	Human Resource Command
MODS	Medical Operational Data System
MRP	Medical Retention Processing
MRPU	Medical Retention Processing Unit
MTF	Military Treatment Facility
NGB	National Guard Bureau
RCCPDS	Reserve Components Common Personnel Data System
RLAS	Regional Level Application System
RMC	Regional Medical Command
SIDPERS	Standard Installation Division Personnel Reporting System
TAPDB-G	Total Army Personnel Database-Guard
TAPDB-R	Total Army Personnel Database-Reserve
USARC	U.S. Army Reserve Command

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Washington, D.C. 20548

February 17, 2005

The Honorable Tom Davis
Chairman, Committee on Government Reform
House of Representatives

The Honorable Christopher Shays
Chairman, Subcommittee on National Security,
Emerging Threats, and International Relations
Committee on Government Reform
House of Representatives

The Honorable Todd Russell Platts
Chairman, Subcommittee on Government Management,
Finance, and Accountability
Committee on Government Reform
House of Representatives

In response to the September 11, 2001, terrorist attacks, the Army National Guard and Army Reserve mobilized and deployed soldiers in support of Operations Noble Eagle and Enduring Freedom. When mobilized for up to 2 years at a time,¹ these soldiers performed search and destroy missions against Taliban and al Qaeda members throughout Asia and Africa, fought on the front lines in Afghanistan and guarded al Qaeda prisoners held at Guantanamo Bay, Cuba. Similarly, reserve component soldiers fought on the front lines in Iraq and are now assisting in peace-keeping and reconstruction operations in Iraq under Operation Iraqi Freedom. In November 2003 and August 2004, we reported² that the existing processes and controls used to provide pay and allowances to mobilized reserve component soldiers were so cumbersome and complex that neither DOD nor the mobilized Army Guard and Reserve soldiers could be reasonably assured of timely and accurate pay. During the Army National Guard audit, we identified several instances in which injured Guard soldiers experienced gaps in entitled active duty pay and associated medical

¹ For the purpose of this report, the term mobilized includes all Army reserve component soldiers called to perform active service.

² GAO, *Military Pay: Army National Guard Personnel Mobilized to Active Duty Experienced Significant Pay Problems*, [GAO-04-89](#) (Washington, D.C.: Nov. 13, 2003); GAO, *Military Pay: Army Reserve Soldiers Mobilized to Active Duty Experienced Significant Pay Problems*, [GAO-04-911](#) (Washington, D.C.: Aug. 20, 2004).

benefits due to problems with the Army's process for extending their active duty orders. Mobilized reserve component soldiers who are injured or become ill are released from active duty and demobilized when their mobilization orders expire unless the Army takes steps, at the soldier's request, to extend their active duty service—commonly referred to as an active duty medical extension (ADME).

Concerned that these soldiers' problems were symptomatic of a broader problem in providing timely and accurate pay and related health and other benefits to mobilized reserve component soldiers that were injured in the line of duty, you asked us to determine if the Army's ADME process provided reasonable assurance that injured soldiers returning from operations associated with the Global War on Terrorism³ were receiving the pay and other benefits to which they were entitled in an accurate and timely manner. As such, we are reporting on (1) problems experienced by selected injured or ill Army Reserve and National Guard soldiers, (2) weaknesses in the overall control environment and management, (3) the lack of clear processes, and (4) the lack of integrated pay, personnel, and medical eligibility systems. During the course of our audit, the Army implemented the Medical Retention Processing (MRP) program, which takes the place of ADME for soldiers returning from operations in support of the Global War on Terrorism.⁴ Therefore, we also assessed whether the MRP program had resolved deficiencies associated with ADME and would provide effective and lasting solutions.

³ DOD includes Operations Enduring Freedom, Operation Nobel Eagle, and Operation Iraqi Freedom as part of the Global War on Terrorism.

⁴ ADME will still exist for soldiers who are not mobilized as part of the Global War on Terrorism—such as soldiers injured in Bosnia or Kosovo or during annual training exercises.

To achieve our objectives, we performed work at 10 Army installations throughout the country that either mobilized reserve component soldiers or, according to Army data, had significant injured or ill reserve component populations. To determine what impact these problems were having on soldiers and their families and provide perspective on the nature of pay deficiencies, we interviewed 38 reserve component soldiers who served in the Global War on Terrorism and had experienced problems with the active duty medical extension order process at four military installations. Using Army pay and administrative records, we corroborated information provided by soldiers about disruptions in pay and benefits. We were not always able to validate other statements injured soldiers made about other types of problems they experienced. We also interviewed and obtained relevant documentation from officials at the Army Manpower Office⁵ at the Pentagon, all four of the Army's Regional Medical Commands (RMC) in the continental United States, and the Army Human Resource Command (HRC) in Alexandria, Virginia.

We relied on a case study and selected site visit approach for this work, principally because the many previously identified flaws in the existing pay processes had not yet been resolved. Compounding this, the Army did not maintain reliable, centralized data on the number, location, and disposition of mobilized reserve component soldiers who had requested to extend their active duty service because they had been injured or become ill in the line of duty.⁶ Therefore, it was not possible to statistically test controls or the impact control breakdowns had on soldiers and their families.

We performed this work between February 2004 and October 2004 in accordance with generally accepted government auditing standards. The investigative portion of our work was completed in accordance with investigative standards established by the President's Council on Integrity and Efficiency. We also reviewed written and technical comments provided by the Principal Deputy Under Secretary of Defense for Personnel and Readiness, which we have incorporated as appropriate. DOD's comments

⁵ Army Manpower is an organization within the Army Deputy Chief of Staff, G-1, formerly the Army Deputy Chief of Staff for Personnel. The G-1 is the Army's human resource provider, handling human resource programs, policies, and systems. The Army Human Resources Command is a field operating activity that reports directly to the G-1.

⁶ The Army maintained data on soldiers who were currently on ADME orders but did not track soldiers who were applying for ADME or who had been dropped from their active duty orders.

are reprinted in appendix II. Further details on our scope and methodology are included in appendix I.

Results In Brief

The Army lacks an effective control environment and the management controls needed to provide reasonable assurance that injured and ill reserve component soldiers receive the pay and benefits to which they are entitled without interruption. For some soldiers, this resulted in being removed from active duty status in the automated systems that control pay and access to benefits, including medical care. In addition, because these soldiers no longer had valid active duty orders, they did not have access to the post exchange—which allows soldiers and their families to purchase groceries and other goods at a discount. While the Army does not know how many soldiers have experienced problems receiving their pay and benefits, of the 38 reserve component soldiers we interviewed, 24 said that they had experienced gaps in their pay and benefits due to delays in processing extended active duty orders. Although we did not verify the claims of all 24 soldiers, we further developed 10 case studies and verified that they had indeed experienced problems receiving their pay and benefits. For example, while attempting to obtain care for injuries sustained from a helicopter crash in Afghanistan, one Special Forces soldier we interviewed fell off his active duty orders four times. During the times he was off-orders, he was not paid and he and his family experienced delays in receiving medical treatment. In all, he missed 10 pay periods—totaling \$11,924. Although the Army eventually paid him, each time he fell off orders and was not paid, he and his family struggled financially. Many of the soldiers we interviewed had incurred severe, permanent injuries fighting for their country including loss of limb, hearing loss, and ruptured disks. Nonetheless, we found that the soldier carries a large part of the burden when trying to understand and successfully navigate the Army's poorly defined requirements and processes for obtaining extended active duty orders.

The Army lacks an adequate control environment and management controls over ADME, which is one of the mechanisms⁷ it uses to provide medical treatment for injured or ill reserve component soldiers returning from Iraq and Afghanistan when their mobilization orders had expired.

⁷ Some soldiers also elect to be released from duty and choose to seek care through their private insurers or utilize government-provided transitional assistance. Eligible soldiers may also seek care through the Veterans Administration.

ADME, as opposed to other means the Army uses to provide health care, places soldiers on active duty orders, which then entitles soldiers to pay and other active duty benefits.

- First, the Army's guidance for processing ADME orders does not clearly define organizational responsibilities or standards for being retained on active duty orders, how soldiers will be identified as needing an extension, and how and to whom ADME orders are to be distributed. Without clear and comprehensive guidance, the Army is unable to establish straightforward, user-friendly processes that provide reasonable assurance that injured and ill reserve component soldiers receive the pay and benefits to which they are entitled without interruption. In addition, the guidance erroneously requires the personnel cost associated with soldiers on ADME orders to be accounted for as a base operating expense, rather than charged to contingency operations. We believe the cost of treating injured and ill soldiers—including their pay and benefits—who fought in operations supporting the Global War on Terrorism should be recorded as an expense associated with contingency operations to accurately capture the total cost of these operations.
- Second, the Army lacks an integrated personnel system to provide visibility over injured or ill reserve component soldiers and as a result, sometimes loses track of these soldiers. For example, according to one soldier we interviewed, after he was injured in Iraq by a hand-detonated land mine and medically evacuated back to the United States for treatment, the Army called his wife to attempt to locate him. According to the soldier, the Army apparently had no record of his injury and transport out of theater and thought he might be absent without leave, when in fact, he was in an Army hospital in the United States making appointments with Army physicians.
- Finally, the Army has not adequately educated reserve component soldiers about ADME or trained Army personnel responsible for helping soldiers apply for ADME orders. As a result, many of the soldiers we interviewed said that neither they nor the Army personnel responsible for helping them clearly understood the process. This confusion resulted in delays in processing ADME orders and for some, meant that they fell from their active duty orders and lost pay and medical benefits for their families.

The Army lacks customer-friendly processes for injured or ill soldiers who are trying to extend their active duty service through the ADME process—including clear approval criteria and adequate infrastructure and support services. Although the Army’s procedural guidance, discussed previously, describes what forms and documents must be submitted as part of an ADME application, the guidance lacks clear criteria on the specific information that must be contained in each document and well-defined procedures for providing feedback on the status of application packages. As a result, soldiers often had to submit their applications numerous times before obtaining approval. This delay, in turn, caused these soldiers to fall off their active duty orders and, at times, interrupted their pay and benefits. For example, one Special Forces soldier we interviewed, who lost his leg when a roadside bomb destroyed the vehicle he was riding in while on patrol for Taliban fighters in Afghanistan, missed three pay periods totaling \$5,000 because he fell off his active duty orders. Although this soldier was clearly entitled to a medical extension, according to approving officials at Army Manpower, his application was not immediately approved because it did not contain sufficiently current and detailed information to justify this soldier’s qualifications for an active duty medical extension. In addition, at some installations the Army did not have adequate support services to help soldiers complete their ADME applications and obtain the required medical documentation in an efficient and timely manner. For example, one injured soldier we interviewed whose original mobilization orders expired in January 2003 said that he made over 40 trips to various sites at Fort Bragg during the month of January to complete his ADME application.

The financial hardships experienced by injured or ill reserve component soldiers would have been more widespread had individuals within the Army not taken extraordinary steps to keep soldiers in pay status. In fact, 7 of the 10 Army installations we visited had created their own ad-hoc procedures or workarounds to keep soldiers in pay status. One installation we visited issued legitimate, official mobilization orders locally to keep soldiers in pay status. However, in doing so, they created additional problems—which ultimately resulted in garnishing soldiers’ pay to straighten out Army accounting and funding issues. In most other cases, the installations we visited made unauthorized, unsupported adjustments to a soldier’s pay records. While effectively keeping a soldier in pay status in the pay system, this workaround circumvented key internal controls—putting the Army at risk of making improper and, as explained later, potentially fraudulent payments. In addition, because these soldiers are not on official active duty orders, they are not eligible to receive other benefits to which they are entitled, including health coverage for their families. For

some of the soldiers we interviewed, this created significant problems. For example, according to one soldier we interviewed, when he was off active duty orders due to delays in processing his extension and required treatment for nausea and vomiting blood, he was initially refused treatment because he was not on active duty orders. His wife also lost access to health care each time he was off his active duty orders. At the time, his wife was pregnant and was relying on coverage through the military's dependent care insurance for her prenatal visits.

Manual processes and non-integrated pay and personnel systems affect the Army's ability to generate timely active duty medical extension orders and ensure that soldiers are paid correctly. Overall, we found the current stovepiped, nonintegrated systems were labor intensive and require extensive error-prone manual data entry and reentry. For example, the Army's order-writing system does not directly interface with the personnel, pay, or medical eligibility systems, which all need to be updated in order for soldiers and their families to receive the pay and medical benefits to which they are entitled. Instead, once approved, hard copy or electronic copy ADME orders are distributed and used to manually update the appropriate systems. However, as discussed previously, the Army's ADME guidance does not address the distribution of ADME orders or clearly define who is responsible for ensuring that the appropriate pay, personnel, and medical eligibility systems are updated. As a result, ADME orders are not sent directly to the individuals responsible for data input but instead, are distributed via e-mail and forwarded throughout the Army and the Department of Defense—eventually reaching individuals with access to the pay, personnel, and medical eligibility systems. For example, once an ADME order is processed, it is e-mailed to nine different individuals—four at the National Guard Bureau (NGB), four at the Army Manpower office, and one HRC in Alexandria Virginia—none of which are responsible for updating the appropriate pay and benefit systems. Not only is this process vulnerable to input errors, but not sending a copy of the orders directly to the individual responsible for input further delays a soldier's ability to receive the pay and benefits to which he or she is entitled.

The Army's new MRP program, which went into effect May 1, 2004, and takes the place of ADME for soldiers returning from operations in support of the Global War on Terrorism, should resolve many of the processing delays experienced by soldiers applying for ADME by simplifying the application process. In addition, unlike ADME, the personnel costs associated with soldiers on MRP orders are appropriately linked to the contingency operation for which they served, and therefore will more

appropriately capture these costs related to the Global War on Terrorism. While the front-end approval process appears to be operating more efficiently than the ADME approval process, due to the fact that the first wave of 179-day MRP orders did not expire until October 27, 2004, after the completion of our work, we were unable to assess how effectively the Army identified soldiers that required an additional 179 days of MRP and whether those soldiers will experience pay problems or difficulty obtaining new MRP orders. In addition, because the Army does not maintain reliable data on the current status and disposition of injured soldiers, we could not test or determine whether all soldiers who should be on MRP orders were applying and getting into the system. Further, MRP has not resolved the underlying management control problems that plague ADME—including problems associated with the lack of guidance, visibility over soldiers, adequate training and education, and manual processes and non-integrated pay and personnel systems—and in some respects has worsened problems associated with the Army's lack of visibility over injured soldiers. For example, in September and October of 2004 the Army did not know with any certainty how many soldiers were currently on MRP orders, how many had returned to active duty, or how many had been released from active duty early.

In addition, although MRP authorizes 179 days and eliminates the need to reapply for new orders every 30 days, as was sometimes the case with ADME, it also presents new challenges. If the Army treats and releases soldiers from active duty in less than 179 days, our previous work has shown that weaknesses in the Army's process for releasing soldiers from active duty and stopping the related pay before their orders have expired—in this case before their 179 days is up—often resulted in overpayments to soldiers. Although the Army did not have a complete or accurate accounting of soldiers who were treated and released from MRP early, of the 132 soldiers that the Army identified as released from active duty, we found that 15 received pay past their release date—totaling approximately \$62,000. For example, one soldier who was released from active duty on July 9, 2004 after 43 days on MRP orders was overpaid \$10,595 between July and November. As of the date of this report, we are continuing to investigate soldiers who were overpaid by the Army. Finally, because ADME will continue to be used for soldiers who are not activated or mobilized as part of the Global War of Terrorism—such as soldiers injured in Bosnia or Kosovo or during training exercises—it is still important that the ADME problems we identified are resolved.

We are making 20 recommendations for immediate actions including (1) establishing comprehensive policies and procedures for managing programs for treating reserve component soldiers with service-connected injuries or illnesses—including MRP and ADME, (2) providing adequate infrastructure and resources, and (3) making process improvements to compensate for inadequate, stove-piped systems. In addition, GAO recommends 2 actions, as part of longer term system improvement initiatives, to integrate the Army’s order writing, pay, personnel, and medical eligibility systems.

We are encouraged that the Army has begun to take action to address the problems we identified and are hopeful that it will continue to work toward comprehensive, effective solutions for addressing the recommendations in this report dealing with reserve component soldiers with service-connected injuries or illnesses.

Background

The Army has several mechanisms for providing needed health care services for reserve component soldiers who become injured or ill while mobilized on active duty or during military training. Some soldiers choose to be released from duty and seek care through their private insurers. Eligible soldiers may also seek care through the Veterans Administration (VA) or the military’s transitional medical assistance program.⁸ Finally, soldiers may also request to remain on active duty for medical evaluation, treatment, and/or processing through the Army disability evaluation system. Remaining on active duty entitles soldiers to continue receiving full pay and allowances as well as health care without charge to the soldiers and their dependents.

Until recently, mobilized reserve component soldiers who were receiving medical treatment or evaluations for conditions that made them unfit for duty have fallen into two groups. The first comprises soldiers who are being treated on mobilization orders and is referred to as “medical

⁸ Under the transitional assistance management program, prior to October 2004, service members with fewer than 6 years of active service are eligible for health care benefits for 60 days. With 6 years or more of active service, eligibility increases to 120 days. In November 2003, the Congress increased this time period to 180 days through the end of September 2004. Emergency Supplemental Appropriations Act for Defense and for the Reconstruction of Iraq and Afghanistan, 2004, Pub. L. No. 108-106, § 1117, 117 Stat. 1209, 1218 (Nov. 3, 2003). In October 2004, Congress permanently extended the period of eligibility to 180 days for all categories of service members.

holdover” soldiers. The second group comprises soldiers whose mobilization orders have expired and who have applied and been approved to be extended on active duty for medical treatment or evaluation through ADME orders. Regardless of the classification, the Army’s goals are the same—to ensure that the soldier attains the optimal level of physical or mental condition and to determine whether he or she can be returned to duty, released from active duty, or released from military service. To facilitate this process the Army relies on (1) case managers located at Army Military Treatment Facilities (MTF) who are responsible for helping both active and reserve component soldiers schedule medical appointments and understand what steps he or she needs to take to progress through the treatment or evaluation process (for reserve component soldiers this might include applying for ADME) and (2) garrison support units and medical hold units located at each installation that are responsible for, among other things, helping soldiers apply for ADME.

- **Medical holdover.** This group comprises two categories: (1) soldiers who were mobilized to active duty, but who for medical reasons were non-deployable⁹ and (2) soldiers who were mobilized and deployed but sustained line of duty injuries, which make them not fit to return to duty. These soldiers are being medically treated while on their original mobilization orders. If treatment is not completed and soldiers have not been returned to duty or released from duty at the end of their orders, these soldiers may apply for an ADME order.
- **Active duty medical extension.** This group comprises three categories: (1) soldiers who were previously in medical holdover, either because they were medically non-deployable or had sustained line of duty injuries, but whose medical treatment was not completed before their mobilization orders expired, (2) soldiers identified during demobilization as being not fit for duty due to illnesses or injuries sustained or aggravated while on active duty, and (3) soldiers who sustained injuries during annual training, weekend drills, or other activities associated with their Army National Guard or Army Reserve duties. This third group of soldiers, however, falls outside the scope of our audit.

⁹ While soldiers in medical holdover status may not have had service-connected injuries or illnesses, they would be eligible to apply for an active duty medical extension by virtue of the fact that they have a medical condition that necessitates treatment for more than 30 days beyond the end of their existing active duty orders.

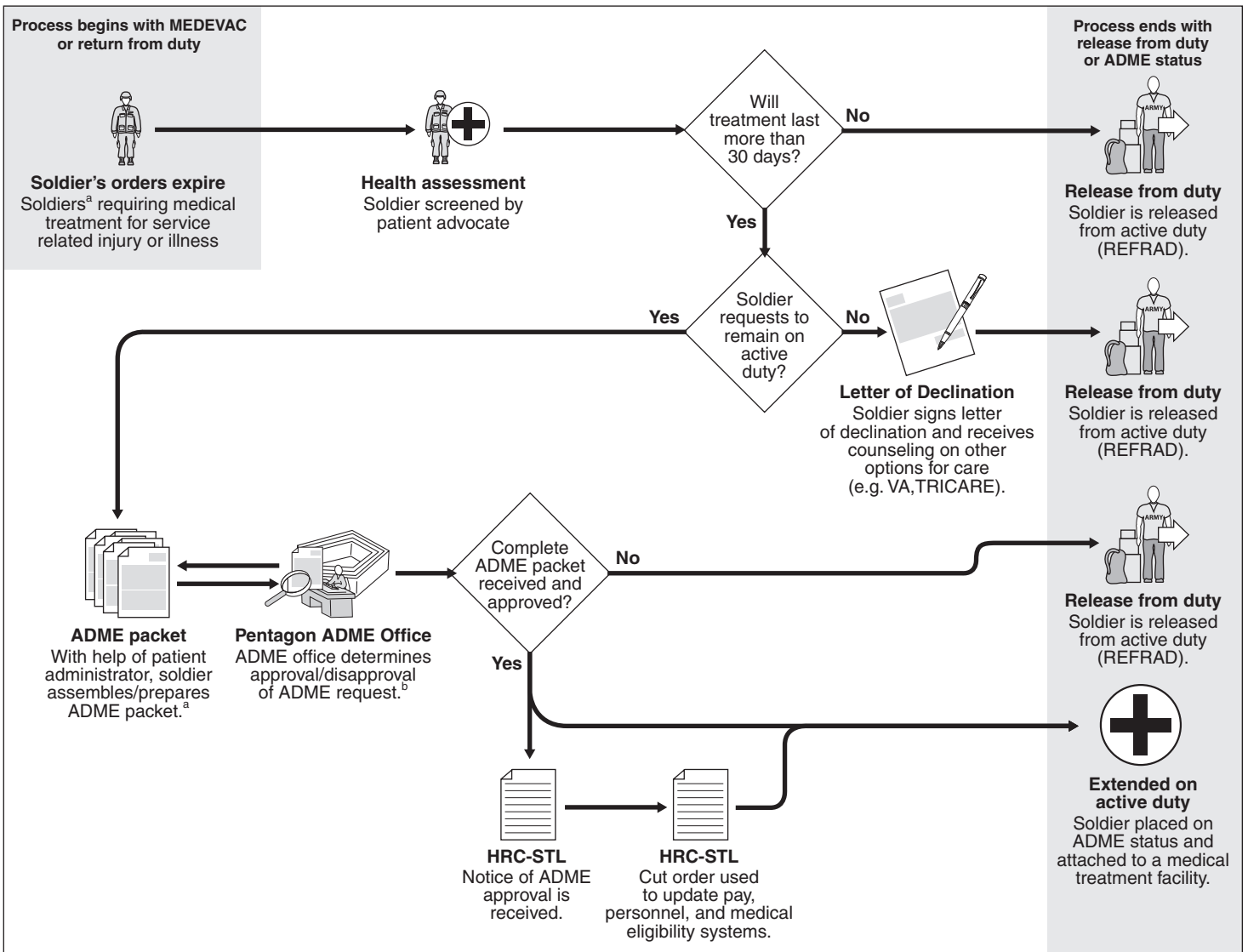
Mobilized reserve component soldiers who are in medical holdover are attached to a medical hold unit¹⁰ and would typically apply for ADME orders through that unit.¹¹ If identified during demobilization, injured or ill soldiers would typically apply for ADME orders through the garrison support unit, which handles the mobilization and demobilization of reserve component soldiers. However, similar to soldiers injured during weekend drills or annual training, mobilized soldiers may also apply for ADME orders through their reserve component home state units.

As shown in figure 1, reserve component soldiers wishing to be extended on active duty for medical treatment or evaluation are to submit an active duty medical extension order application packet to Army Manpower.

¹⁰ Medical hold units handle command and control for active duty and mobilized reserve component soldiers who are not medically fit for duty. These units may sometimes be found at Army military medical treatment facilities, including Army hospitals.

¹¹ According to Procedural Guidance for Reserve Component Soldiers on Active Duty Medical Extension, Section 8b, the soldier's ADME request is required to be submitted through "whoever has command and control over the soldier at the time of request". Some installations chose to have the garrison support unit (GSU) remain as the soldiers command and control authority until their original mobilization orders expired. Therefore, the initial ADME request would be submitted through the GSU instead of the medical hold unit.

Figure 1: Overview of the Army's ADME Application Process—When Operating as Planned



Source: GAO.

^aSoldiers are identified as needing medical treatment through (1) mobilization, (2) demobilization, or (3) when the soldier is medically evacuated out of theater.

^bArmy Manpower will not begin processing a medical extension order request packet until it deems that the packet is complete. Army Manpower does not give notice to the requesting installation if more detailed information is required to begin the evaluation and approval process.

Officials in that office evaluate the application packet and make a determination of (1) whether the soldier will be approved for medical extension orders, (2) the length of medical extension orders, if approved, and (3) the military medical treatment facility to which the soldier will be attached. The officials make these determinations based on the data included in the application packets. According to the medical extension procedural guidance, all application packets are to include:

- An application form that includes demographic information about the soldier and identifies the closest military medical treatment facility to the soldier's home to which the soldier will be attached for treatment;¹²
- A physician's statement describing the soldier's diagnosis, prognosis, and care needed, including length of care needed;¹³
- A physical profile, if available;¹⁴
- A commander's statement that the soldier's illness or injury was incurred or aggravated in the line of duty; and
- A letter of consent to remain on active duty.

Army Manpower officials also told us that soldiers must submit a copy of their original orders, although we did not find that to be explicitly stated in the Procedural Guidance or the Field Operating Guide. Figure 1 depicts the design of the ADME process as it was intended to be implemented. As discussed later in this report, we found numerous breakdowns in the process.

As shown in figure 1, all medical extension application packets were to be transmitted to Army Manpower officials in the Pentagon. If a soldier's application is not approved, the soldier was to be released from active duty and, as discussed previously, was eligible for the Army's transitional

¹² Department of the Army Form 4187, Personnel Action.

¹³ According to the procedural guidance, this is to be a formal memorandum (on letterhead) from the attending physician, which states the current diagnosis; current treatment plan; prognosis; date the soldier is expected to be returned to full duty; and full name, grade, and office telephone number of physician. If available, a physical profile should accompany this statement.

¹⁴ Department of the Army Form 3349, Physical Profile.

medical assistance program or possibly VA benefits. Once Army Manpower officials approve an ADME application, they e-mail a memorandum requesting the extension to the HRC location in St. Louis, Missouri, which processes the ADME orders. HRC-St. Louis, the entity that ultimately forwards copies of the orders to personnel responsible for updating the Army's pay, personnel, and medical eligibility systems, then transmits, via e-mail, a copy of the order back to Army Manpower and the Army National Guard. Army Manpower distributes copies to the medical hold unit, the regional medical command and the soldier. This process, as described by Army Manpower officials, was not set forth in either the ADME Procedural Guidance or the MEDCOM Field Operating Guide.

According to DOD directive, if a soldier—active duty or reserve component, including reserve component soldiers mobilized to active duty—remains medically unfit for duty for a year, the Army is to examine whether the soldier can be returned to duty (RTD), released from active duty (REFRAD), or put before a medical evaluation board and entered into the physical disability evaluation process to determine the likelihood of return to duty.¹⁵ The exceptions are soldiers who have not yet reached an optimal level of medical care and for whom the possibility of return to duty may still be realistic.

The procedural guidance and the field operating guide for ADME do not limit the number of times or the number of total days that soldiers may be on medical extension orders for the purpose of medical treatment or evaluation. Individual medical extension orders can be written for up to 179 days or for shorter periods, as appropriate. They may also be extended beyond the original end date by providing an updated physician's statement detailing the revised healing plan and associated timeframe.

Effective May 1, 2004, the Army implemented its new MRP program, which takes the place of ADME for soldiers returning from operations in support of the Global War on Terrorism, and transferred the approval process from the Army Manpower office to HRC – Alexandria. ADME will still exist, but

¹⁵ Soldiers who do not meet medical military retention standards may be placed on the temporary disability retired list, the permanent disabled retired list, may be separated from service with severance, or, in rare cases, be retained with a disability if the soldier is still needed by the military. Department of Defense Directive 1332.18, *Separation or Retirement for Physical Disability* (Nov. 4, 1996); Department of Defense Instruction 1332.38, *Physical Disability Evaluation*; (Nov. 14, 1996), See Army Regulation 635-40, *Physical Evaluation for Retention, Retirement, or Separation* (Aug. 15, 1990).

only for Army reserve component soldiers who become injured or ill during annual training, weekend drills, other activities associated with Army National Guard or Army Reserve duty, and military operations not associated with the Global War on Terrorism. Eligible soldiers who were on ADME orders when MRP was implemented were not transferred to MRP orders but if necessary, can apply for MRP when their ADME orders expire. Soldiers eligible for MRP are also eligible to participate in the Army's new Community Based Health Care Initiative (CBHCI) pilot program. The purpose of the initiative is to allow selected reserve component soldiers to return to their homes and receive medical care in their community rather than remaining at the demobilization site. To be selected for the program, soldiers must volunteer to remain on active duty, reside in a state participating in the pilot program, and reside in a community where appropriate medical care is available.

MRP is for soldiers who become injured or ill while on mobilization orders in support of the Global War on Terrorism. Soldiers who are identified within the first 25 days of mobilization as being medically non-deployable for non-service-connected medical conditions will be released from active duty. Soldiers who are injured in the line of duty or become ill during pre-deployment training or while deployed may apply for MRP once the Army has established that (1) the soldier will not return to duty within 60 days or (2) the soldier could return to duty within 60 days, but will not have at least 120 days remaining on his mobilization orders. Soldiers meeting these criteria will be reassigned to the installation Medical Retention Processing Unit (MRPU). Soldiers are to remain assigned to the MRPU until a medical determination is made concerning whether they will return to duty, enter the CBHCI program, be released from active duty, retire, or be discharged. All MRP orders are cut for 179 days, and the Army's implementing instructions state that soldiers will not be extended past 365 days without being entered into the physical disability evaluation process. Further, MRP orders state that separation or REFRAD is required upon completion of medical evaluation or treatment, or for disability separation.

Injured and Ill Reserve Component Soldiers Experience Gaps in Pay and Benefits, Creating Financial Hardships for Soldiers and Their Families











Poorly defined requirements and processes for extending injured and ill reserve component soldiers on active duty have caused soldiers to be inappropriately dropped from their active duty orders. For some, this has led to significant gaps in pay and health insurance, which has created financial hardships for these soldiers and their families. Based on our analysis of Army Manpower data during the period from February 2004 through April 7, 2004, almost 34 percent of the 867 soldiers who applied to be extended on active duty orders fell off their orders before their extension requests were granted. This placed them at risk of being removed from active duty status in the automated systems that control pay and access to benefits, including medical care and access to the post exchange—which allows soldiers and their families to purchase groceries and other goods at a discount.

While the Army Manpower office began tracking the number of soldiers who have applied for ADME and fell off their active duty orders during that process, the Army does not keep track of the number of soldiers who have lost pay or other benefits as a result. Although, logically, a soldier who is not on active duty orders would also not be paid, as discussed later, many of the Army installations we visited had developed ad hoc procedures to keep these soldiers in pay status even though they were not on official, approved orders. However, many of the ad hoc procedures used to keep soldiers in pay status circumvented key internal controls in the army payroll system—exposing the Army to the risk of significant overpayment, did not provide for medical and other benefits for the soldiers dependents, and sometimes caused additional financial problems for the soldier.

Further, because the Army did not maintain any centralized data on the number, location, and disposition of mobilized reserve component soldiers who had requested ADME orders but had not yet received them, we were unable to perform statistical sampling techniques that would allow us to estimate the number of soldiers affected. However, through our case study work, we identified 38 reserve component soldiers who said they had experienced problems with the active duty medical extension order process and subsequently fell off their active duty orders. Of those, 24 said that they had experienced gaps in their pay and benefits. We did not verify the claims of all 24 soldiers; however, based on the information that we obtained from these soldiers, we further developed 10 case studies and verified that they had indeed experienced problems receiving their pay and benefits.

Figure 2 provides an overview of the pay problems experienced by the 10 case study soldiers we interviewed and the resulting impact the disruptions in pay and benefits had on the soldiers and their families. According to the soldiers we interviewed, many were living paycheck to paycheck, therefore, missing pay for even one pay period created a financial hardship for these soldiers and their families.

Figure 2: Effects of Disruptions in Pay and Benefits

■ Represents one day		💰 Represents \$1,000	
Soldier	Days without orders	Missed pay ^a	Effects on soldier
 Case Study #1 Enduring Freedom Kidney problem and knee injuries	92	\$11,924 (12 💰 icons)	Soldier needed counseling for financial and medical related stress. Soldier and his wife were initially refused treatment several times due to expired orders.
 Case Study #2 Iraqi Freedom Knee and cervical disc injuries	31	\$3,886 (4 💰 icons)	Soldier, wife, and three daughters living in father-in-law's basement. Living off savings, they have no way to show income required to qualify for a home loan or home rental.
 Case Study #3 Enduring Freedom Lost leg, burns, and shrapnel in face	34	\$4,780 (5 💰 icons)	Soldier missed 3 pay periods, had to borrow money from his brother. Soldier made late payments for 5 of his bills.
 Case Study #4 Enduring Freedom Back injuries	45	\$8,206 (8 💰 icons)	Soldier borrowed money from family members to pay bills. Soldier made several late payments on bills.
 Case Study #5 Iraqi Freedom Knee injury and cancer	122	\$4,238 (4 💰 icons)	Soldier lived off savings and credit cards.
 Case Study #6 Iraqi Freedom Concussion, blurred vision, seizures, and migranes	31	\$1,891 (2 💰 icons)	Borrowed \$2,500 from father to cover day-to-day expenses.
 Case Study #7 Enduring Freedom Ruptured disc and broken tailbone	25	\$5,174 (5 💰 icons)	Soldier took out second mortgage and borrowed money from friends and family in order to pay bills. Soldier's wife went back to working full time.
 Case Study #8 Iraqi Freedom Blown ear drum, hearing loss, shrapnel, and fractured elbow	17	\$1,208 (1 💰 icon)	Soldier and family experienced stress and financial hardship due to missed pay.
 Case Study #9 Noble Eagle Ruptured disc and Post Traumatic Stress Disorder	17	\$9,571 (10 💰 icons)	Soldier received psychiatric treatment and medication for stress.
 Case Study #10 Noble Eagle Injured left foot	101	\$13,475 (14 💰 icons)	Soldier depleted personal savings, made a month-late car payment, and used retirement savings.

Source: GAO.

^aMissed pay only includes base pay, however, depending on the soldiers location and circumstances, they may be entitled to more than base pay. There is not a direct correlation between the number of

days off orders and the amount of pay missed. This occurs for a variety of reasons, including differences in soldier rank and pay structure.

During our fieldwork, the 10 soldiers described in figure 2 experienced pay problems. While the Army ultimately addressed these soldiers' problems, absent our efforts and consistent pressure from the requesters of the report, it would likely have taken longer for the Army to address these soldiers' problems. To illustrate the tremendous hardships faced by injured and ill reserve component soldiers applying for active duty medical extensions, we have chronicled the experiences of three soldiers who were mobilized to active duty for military operations in Afghanistan and Iraq. Each of these soldiers had an illness and/or injury that was incurred or aggravated while mobilized.

- *Case Study #1.* As a Staff Sergeant with the Virginia Army National Guard, B Company, 3rd Battalion, 20th Special Forces, this soldier was called to active duty in January 2002 for a 1 year tour of duty in Afghanistan, including search and destroy missions seeking Taliban organizations and operatives. In July 2002, while in combat in Afghanistan, he was injured in a helicopter crash and sustained injuries to both knees and suffered kidney problems. He returned to Fort Bragg in October 2002 with his unit to demobilize. As part of this process, he first applied for an active duty medical extension in November—hoping that his orders would be approved before his original mobilization orders expired on January 3, 2003. However, the order to extend him on active duty was not approved until approximately a month after his original mobilization orders expired, resulting in two missed pay periods. Although the nature and extent of his injuries required months of treatment, his original medical extension was only approved for 90 days. As a result, he had to apply for three additional extensions. Each time, delays in processing caused him to fall off orders—during which time he missed an additional 8 pay periods. In all, he missed 10 pay periods totaling approximately \$12,000. Although the Army eventually paid him, each time he fell off orders and was not paid, he and his family struggled financially.

According to the soldier, the late pay caused his credit to be negatively affected. He was delinquent on 10 payments with four creditors, all coinciding with missed pay periods. In addition, because he was often in between orders, on several occasions the soldier's medical treatment was delayed. For example, according to the soldier, he went to an Army medical treatment facility after experiencing nausea and vomiting blood, but because he was off orders and his identification card was not

active, he was initially refused medical treatment. His family also suffered each time he fell off orders. Specifically, his wife lost access to her dependent insurance benefits from the Army's health care contractors. At the time, his wife was pregnant and was relying on the dependent insurance coverage for her prenatal visits. According to the soldier, the stress caused by these circumstances created so much anxiety that he ultimately sought counseling to help him cope with the strain. This soldier's ADME problems were resolved as of April 2004.

- *Case Study #2:* As a Sergeant with the Army National Guard, 72nd Military Police Company in Las Vegas, Nevada, this soldier was mobilized and deployed with his unit in February 2003 for Operation Iraqi Freedom. While in Iraq, he and his unit were responsible for guarding and transporting prisoners to and from Baghdad and Abu Ghraib prison, securing the courthouse and the surrounding perimeter during trials, and suppressing prison riots. In June 2003, during a prison riot, he severely injured his left knee and later sustained a head injury and had to be medically evacuated for treatment. When he arrived at Madigan Army Medical Center at Fort Lewis, Washington, he had surgery on his knee and cervical disk. Because his injuries required treatment beyond February 2004, the date his mobilization orders would expire, he applied for an active duty medical extension in December 2003. However, his application was not approved until April 2004. During most of the time he was off orders, the medical hold unit personnel at Fort Lewis were able to keep him in pay status by working with the local finance staff to manipulate key fields in the Army's pay system. Nonetheless, these ad-hoc workarounds were not always effective, and he missed about three pay periods totaling almost \$3,900. In addition, because he did not have official active duty orders, he and his family did not have access to military base benefits such as the Post Exchange, precluding them from buying groceries and other necessities at a discount, and he was unable to show proof of employment in order to receive a home loan or even rent a house for his family. As a result, the soldier said that he and his wife and three daughters lived in the basement of his father-in-law's house and borrowed \$10,000 from his mother for living expenses. This soldier's ADME problems were resolved as of April 2004.

Case Study #10. As a Specialist with the Army National Guard, 306 Engineers, located in Amityville, New York, this soldier was activated in January 2002 as part of Operation Noble Eagle. She initially reported to Fort Dix, New Jersey, to be mobilized and deployed but was later sent to

Fort Stewart, Georgia, to assist that installation's engineering unit with vehicle repairs. In April 2002, while at Fort Stewart, she injured her left foot during training exercises. While still on her original mobilization orders, she had surgery on her foot. However, a year later, in January 2003, her original mobilization orders were about to expire but she was still having problems walking so she applied for an active duty medical extension. Although her original request was approved on January 18, 2003, for 30 days, her subsequent request was not approved. According to the soldier, she had to reapply for extensions numerous times before finally being approved. During this time she was off orders for a total of 101 days, totaling \$13,475 in late pay. According to the soldier, she depleted her savings and had to use money saved for her retirement to pay her bills. According to the soldier, the 14 pay periods she missed while applying for active duty medical extension orders caused her to pay many of her bills late. This soldier's ADME problems were resolved as of April 2004.

The Army Lacks an Effective Control Environment and Management Controls

The Army lacks an effective control environment and the management controls needed to provide reasonable assurance that injured and ill reserve component soldiers receive the pay and benefits to which they are entitled without interruption. Specifically, the Army has not provided (1) clear and comprehensive guidance needed to develop effective processes to manage and treat injured and ill reserve component soldiers, (2) an effective means of tracking the location and disposition of injured and ill soldiers, and (3) adequate training and education programs for Army officials and injured and ill soldiers trying to navigate their way through the ADME process.

Clear and Complete Guidance Lacking

The Army's implementing guidance related to the extension of active duty orders is sometimes unclear or contradictory—creating confusion and contributing to delays in processing ADME orders. For example, the guidance states that the Army Manpower Office is responsible for approving extensions beyond 179 days but does not say what organization is responsible for approving extensions that are less than 179 days. In practice, we found that all applications were submitted to Army Manpower for approval regardless of number of days requested. At times, this created a significant backlog at the Army Manpower Office and resulted in processing delays. The guidance also is confusing regarding where applications for extensions are to be forwarded. It specifies sending them

to either the National Guard Bureau or the Army Manpower office but provides no further explanation for why an application would be sent to one organization versus the other.

The Army's regulations¹⁶ for addressing the needs of injured and ill active component soldiers are intended to also address the needs of mobilized injured and ill reserve component soldiers because once a reserve component soldier has been on active duty orders in excess of 30 days, he or she is entitled to the same health and other benefits as active component soldiers. Army regulations¹⁷ also state that for soldiers on active duty orders for 30 consecutive days or more, their active duty orders may be extended for the purpose of receiving medical treatment. However, the Army's implementing guidance does not clearly define organizational responsibilities, how soldiers will be identified as needing an extension, how ADME orders are to be distributed, and to whom they are to be distributed. As discussed later, the lack of clear guidance has contributed to the Army's difficulties in (1) maintaining visibility over the status of these soldiers and their applications, (2) training and educating soldiers and Army personnel on the procedures for applying for extensions, and (3) efficiently updating the appropriate pay, personnel, and medical eligibility systems. In addition, according to the guidance, the personnel costs associated with soldiers on ADME orders should be tracked as a base operating cost. However, we believe the cost of treating injured and ill soldiers—including their pay and benefits—who fought in operations supporting the Global War on Terrorism should be accounted for as part of the contingency operation for which the soldier was originally mobilized. This would more accurately capture the total cost of these wartime operations.¹⁸

¹⁶ Army Regulation 40-400, Patient Administration, paragraph 3-2, (Mar. 12, 2001) and Army Regulation 135-381, Incapacitation of Reserve Component Soldiers, paragraph 2-1 (June 1, 1990).

¹⁷ Army Regulation 135-381, Incapacitation of Reserve Component Soldiers, paragraph 7-2 (June 1, 1990).

¹⁸ We did not audit these costs for the purpose of determining if the Army properly recorded them against available funding sources. Instead, we applied DOD's criteria for contingency operations cost accounting in DOD's Financial Management Regulation, Vol. 12, Chapter 23 (February 2001).

The Army Lacks an Effective Means of Tracking the Location and Disposition of Injured and Ill Soldiers

As we have reported in the past, the Army's visibility over mobilized reserve component soldiers is jeopardized by stovepiped systems serving active and reserve component personnel.¹⁹ Therefore, the Army has had difficulty determining which soldiers are mobilized and/or deployed, where they are physically located, and when their active duty orders expire. In the absence of an integrated personnel system that provides visibility when a soldier is transferred from one location to another, the Army has general personnel regulations that are intended to provide some limited visibility over the movement of soldiers. However, when a soldier is on ADME orders, the Army does not follow these or any other written procedures to document the transfer of soldiers from one location to another—thereby losing even the limited visibility that might otherwise be achievable. Further, although the Army has a medical tracking system, the Medical Operational Data System (MODS) that could be used to track the whereabouts and status of injured and ill reserve component soldiers, we found that, for the most part, the installations we visited did not use or update that system. Instead, each of the installations we visited had developed its own stovepiped tracking system and databases.

According to Army officials, when a soldier departs from one unit or installation to another, the Army requires the losing unit to notify the gaining unit about the transfer and provide the gaining unit with a copy of the soldier's orders. However, these procedures are not followed when ADME orders are used to attach a soldier to an MTF for treatment. As a result, the receiving MTF is routinely not notified about the transfer and therefore, has no knowledge that it is now responsible for the injured soldier. Such knowledge is necessary to ensure that the soldier is assigned a case manager and receives the needed medical attention.

Instead, Army Manpower sends a copy of the soldier's ADME orders to the RMC and, according to Army Manpower officials, they expect the RMC to forward a copy of the orders to the gaining MTF. However, as discussed previously, the Army's procedural guidance does not clearly define how ADME orders are to be distributed and does not direct the RMC to further distribute the orders. Further, according to officials at Army RMCs, they are often inundated with e-mails containing multiple ADME order attachments, making it impractical for them to sort through and distribute

¹⁹ GAO, Military Personnel: DOD Actions Needed to Improve the Efficiency of Mobilizations for Reserve Forces, [GAO-03-921](#) (Washington, D.C.: Aug. 21, 2003)

all of them. As a result, we found that ADME orders did not routinely make it to the gaining MTF. According to Army officials at some of the MTFs we visited, this, combined with the fact that some soldiers on ADME orders never report to their new unit, make it difficult to ensure that these soldiers get the treatment they need. As discussed later, nonintegrated systems and a lack of clear guidance on how, to whom, and for what purpose ADME orders are to be distributed have also created delays in updating the Army's pay, personnel, and medical eligibility systems once a soldier's ADME order is approved.

Case Study Illustration: Army Loses Track of Wounded National Guard Soldier

A Specialist with the Nevada Army National Guard, 72nd MP Company, was mobilized on February 10, 2003, to active duty as part of Operation Iraqi Freedom. He and his unit were mobilized through Fort Lewis, Washington, and sent to Iraq. His unit provided security for Abu Ghraib prison, including reopening the prison and securing Iraqi detainees.

On June 27, 2003, while on duty outside the prison near Baghdad, the vehicle in which the soldier was riding was struck by a hand-detonated land mine. The soldier and others in his vehicle were injured. He was medically evacuated from the scene of the attack for treatment of multiple injuries including a blown ear drum with complete hearing loss in his right ear and partial hearing loss in the left, large cuts and bruises over his left eye and forehead, fracture to the left elbow and left wrist, crushed (deformed) right index finger, and shrapnel on the left side of his upper body.

He was flown from Iraq to Kuwait and then to Lundstul Hospital in Germany for additional care. After a week or so at the hospital in Germany, the soldier was cleared to go back to the United States to continue his medical care. According to the soldier, he was told that he must have “closed toe shoes” in order to take the flight home or he would be strapped down to a gurney the entire flight. The soldier only had flip-flops since at the time of the attack, it was necessary to cut off his clothing and shoes to care for his wounds.

After being told by the hospital chaplain that shoes were not available, he was given permission to leave the hospital to obtain shoes and clothing. He proceeded to take the hospital shuttle bus to Ramstien Air Base, approximately 15 minutes away. The soldier told us that he walked approximately 2 miles to the Post Exchange, wearing flip-flops and torn clothing from the attack, along with stitches and slings. Further, he was severely hearing impaired and in pain. After purchasing shoes and toiletry items, at his own expense, he took a cab back to Lundstuhl Hospital.

Once he got to Fort Lewis, Washington, he was transported by bus to Madigan Army Hospital. On or about July 7, 2003, the soldier’s wife told us that personnel from Fort Lewis contacted her at their home in Las Vegas. The Army could not locate the soldier and wanted to know if his spouse knew his location. Personnel from Fort Lewis thought he might be AWOL. He was in fact at the Army hospital at Fort Lewis making medical appointments with physicians. Eventually he was placed on remote care at Nellis Air Force base located near his home in Las Vegas.

On or about July 25, 2003 while on convalescent leave in Las Vegas the family was contacted by a member of the U.S. Army stating that the soldier had been injured in Baghdad and was in a hospital in Germany. The soldier had been in the States for 20 days.

Although MODS, if used and updated appropriately, could provide some visibility over injured and ill active and reserve component soldiers—including soldiers who are on ADME orders, 8 of the 10 installations we visited did not routinely use MODS. MODS is an Army Medical Department (AMEDD) system that consolidates data from over 15 different major Army

and Department of Defense data bases. The information contained in MODS is accessible at all Army MTFs and is intended to help Army medical personnel administer patient care. For example, as soldiers are approved for ADME orders, the Army Manpower office enters data indicating where the soldier is to receive treatment, to which unit he or she will be attached, and when the soldier's ADME orders will expire. However, as discussed previously, the Army has not established written standard operating procedures on the transfer and tracking of soldiers on ADME orders. Therefore, the installations we visited were not routinely looking to MODS to determine which soldiers were attached to them through ADME orders. When officials at one installation did access MODS, the data in MODS indicated that the installation had at least 105 soldiers on ADME orders. However, installation officials were only aware of 55 soldiers who were on ADME orders. According to installation officials, the missing soldiers never reported for duty and the installation had no idea that they were responsible for these soldiers.

Further, although MODS will generate reports that show when a reserve component soldier's orders are within 30, 60, or 90 days of expiration, only two of the locations we visited said that they used MODS for this purpose— noting that they used other local systems in conjunction with MODS. Officials at the other installations discounted the utility of MODS for managing soldiers on ADME orders because the data were often inaccurate or incomplete. Further, MODS does not contain information on who has applied for ADME or the status of ADME applications. Therefore, all of the installations we visited used their own local systems and/or spreadsheets to track the status of soldiers who were nearing the end of their mobilization orders, were applying for ADME, and were on ADME orders.

The Army Lacks Adequate Training and Education Programs

The Army has not adequately trained or educated Army staff or reserve component soldiers about ADME. The Army personnel responsible for preparing and processing ADME applications at the 10 installations we visited received no formal training on the ADME process. Instead, these officials were expected to understand their responsibilities through on-the-job training. However, the high turnover caused by the rotational nature of military personnel, and especially reserve component personnel who make up much of the garrison support units that are responsible for processing ADME applications, limits the effectiveness of on-the-job training. Once these soldiers have learned the intricacies of the ADME process, their mobilization is over and their replacements must go through the same on-

the-job learning process. For example, 9 of the 10 medical hold units at the locations we visited were staffed with reserve component soldiers.

In addition, the Army has not developed nor implemented any ADME training or education for soldiers and their commanders. In the absence of education programs based on sound policy and clear guidance, soldiers have established their own informal methods—using Internet chat rooms and word-of-mouth—to educate one another on the ADME process. Unfortunately, the information they receive from one another is often inaccurate and instead of being helpful, further complicates the process. For example, one soldier was told by his unit commander that he did not need to report to his new medical hold unit after receiving his ADME order. While this may have been welcome news at the time, the soldier could have been considered absent without leave. Instead, the soldier decided to follow his ADME order and reported to his assigned case manager at the installation.

Case Study Illustration: Guard Soldier Loses Pay and Medical Benefits

A Sergeant First Class mobilized on June 23, 2002, under Operation Enduring Freedom orders and was deployed to Afghanistan in August 2002. On September 17, 2002, he was injured and suffered a torn rotator cuff, broken shoulder blade, and torn ligaments in his shoulder. He was medically evacuated back to Fort Bragg and assigned to the 2125th Garrison Support Unit while he was on his original set of mobilization orders. The Sergeant told us that he received very little support from unit officials and had great difficulty getting appointments to see a doctor to get the proper medical forms completed. For example, he did not get to see a doctor for 6 months after surgery to repair his shoulder. He was given guidelines by the unit to use in preparing his ADME packet, but the unit rejected his packet and he was told he used the wrong form—even though he had used the request form included in their own guidelines. The Sergeant indicated that the civilian in charge of the ADME process at the Fort Bragg medical holding unit did not have a real understanding of the process. Further, the soldier stated that the commander of the medical holding company was also unfamiliar with the process.

As a result of these problems, the Sergeant's orders lapsed and he missed one pay period before he was granted ADME. Further, because his active duty orders had expired, according to the soldier, he was not admitted to the base and missed several medical appointments. He also said that, because he was off his active duty orders, his wife had to pay for treatment for an illness out of her own pocket.

Lack of Clear Processes Contributed to Pay Gaps and Loss of Benefits

The Army lacks customer-friendly processes for injured and ill soldiers who are trying to extend their active duty orders so that they can continue to receive medical care. Specifically, the Army lacks clear criteria for approving ADME orders, which may require applicants to resubmit paperwork multiple times before their application is approved. This, combined with inadequate infrastructure for efficiently addressing the soldiers' needs, has resulted in significant processing delays. Finally, while most of the installations we reviewed took extraordinary steps to keep soldiers in pay status, these steps often involved overriding required internal controls in one or more systems. In some cases, the stop gap measures ultimately caused additional financial hardships for soldiers or put the Army at risk of significantly overpaying soldiers in the long run.

The Army Lacks Criteria for Approving ADME Orders

Although the Army Manpower office issued procedural guidance in July of 2000 for ADME and the Army Office of the Surgeon General issued a field operating guide in early 2003, neither provides adequate criteria for what constitutes a complete ADME application package. The procedural guidance lists the documents that must be submitted before an ADME application package is approved; however, the criteria for what information is to be included in each document is not specified. In the absence of clear criteria, officials at both Army Manpower and the installations we visited blamed each other for the breakdowns and delays in the process.

Soldiers applying for ADME orders are required to submit an application package to the Army Manpower office that includes, among other things, (1) evidence that the soldier's injury was sustained in the line of duty and (2) a physician's statement outlining the diagnosis, prognosis, and treatment plan. Officials at the Army Manpower office and many of the Army installations we visited agree that problems with this documentation create one of the greatest barriers to processing ADME orders in a timely manner and ensuring that soldiers do not fall off their active duty orders. However, this is where their agreement ends.

According to Army Manpower officials, delays in processing have resulted for two reasons: (1) soldiers do not apply for ADME until their orders have expired or are about to expire and (2) soldiers do not submit complete application packages. According to Army Manpower statistics, in February 2004, the first month they began tracking application statistics, 34 percent of the applications submitted were received after the soldier's active duty orders had expired and another 47 percent were received within 30 days of

expiration. In addition, they claimed that 87 percent of ADME applications they reviewed were incomplete and therefore could not be processed without additional information.

In contrast, according to officials at the 10 installations we visited, soldiers applying for ADME fall off their active duty orders because (1) Army Manpower does not begin processing application packages until a soldier's active duty orders are set to expire and (2) it is not clear exactly what medical documentation is required for approval and the requirements often change without notice. Officials at the 10 installations we visited said that, generally, they could compile the information needed for an ADME application packet in about a week, but it typically took the Army Manpower office 60 to 90 days to process the application. Further, once the package was submitted, they would receive nothing from Army Manpower indicating that the packet had been received or was being evaluated. Instead, installations would periodically inquire as to the status of the application. It was often only upon inquiry that installation officials would learn that the medical documentation provided was inadequate or that the package was never received.

Case Study Illustration: ADME Extension Denied to Soldier who Lost Leg in Roadside Attack

A Sergeant First Class with B Company, 20th Special Forces, Alabama, was deployed to Afghanistan in September 2002. On February 19, 2003, while on patrol for Taliban fighters, the soldier's vehicle was destroyed by a roadside bomb. He and other members of his unit suffered serious injuries. He lost a leg and was immediately transferred to Germany and then on to Walter Reed Army Medical Center. He had about 15 surgeries on his leg and was receiving physical therapy for his prosthetic leg. When his mobilization orders expired on January 3, 2004, he had to apply for ADME. As with many of the soldiers we interviewed, the Sergeant had difficulty navigating the ADME process, despite the assistance of the Special Forces Liaison. After missing three pay periods and over \$5,000 in pay, ADME was approved through May 31, 2004. While waiting for his medical examination board, which had been cancelled four times, the Sergeant applied for an ADME extension. On June 2, 2004, an e-mail was received from Army Manpower stating that "current and more detailed medical documents were needed to evaluate this soldier's qualifications for ADME." As a result, according to this soldier, who incurred a grave injury in service to his country, he was denied health insurance for his family for over 1 month and had to borrow money from his brother to pay his mortgage. According to the soldier, in July 2004, he completed the medical board process to receive his disability pay, was released from active duty, and returned home.

According to installation officials, the Army Manpower office will not accept ADME requests that contain documentation older than 30 days.

However, because it often took Army Manpower more than 30 days to process ADME applications, the documentation for some applications expired before approving officials had the opportunity to review it. Consequently, applications were rejected and soldiers had to start the process all over again. Although officials at the Army Manpower office denied these assertions, the office did not have policies or procedures in place to ensure that installations were notified regarding the status of soldiers' applications or clear criteria on the sufficiency of medical documentation. For example, one soldier we interviewed at Fort Lewis had to resubmit his ADME applications three times over a 3-month period—each time not knowing whether the package was received and contained the appropriate information. According to the soldier, weeks would go by before someone from Fort Lewis was able to reach the Army Manpower office to determine the status of his application and when they did, he was told each time that he needed more current or more detailed medical documentation. Consequently, it took over 3 months to process his orders during which time he fell off his active duty orders and missed 3 pay periods totaling nearly \$4,000.

In an environment that lacks clear criteria on what constitutes a complete application package and well-defined processes for providing feedback on the status of application packages, it is not surprising that soldiers have fallen out of pay status because their current orders—mobilization or ADME—expired before their ADME orders or ADME extensions came through.

The Army Has Not Consistently Provided the Infrastructure Needed to Support Injured and Ill Soldiers

The Army has not consistently provided the infrastructure needed—including convenient support services—to accommodate the needs of soldiers trying to navigate their way through the ADME process. This, combined with the lack of clear guidance discussed previously and the high turnover of the personnel who are responsible for helping injured and ill soldiers through the ADME process, has resulted in injured and ill soldiers carrying a disproportionate share of the burden for ensuring that they do not fall off their active duty orders to thereby receive the pay and benefits to which they are entitled. This has left many soldiers disgruntled and feeling like they have had to fend for themselves.

As the mobilization orders for the first wave of injured and ill reserve component soldiers coming back from Iraq and Afghanistan began to expire in 2003, according to Army officials, the Army was not prepared and lacked the infrastructure to process their ADME applications. For instance,

case managers now play an important role in ensuring that both reserve component and active Army soldiers receive the medical care they need so that they can return to duty, be released from active duty, or separate from military service. However, in January 2003, the Army had very few case managers to deal with the thousands of injured and ill soldiers—both active duty and reserve component—returning to the Army’s 14 demobilization sites. This mirrors the comments of some of the soldiers we interviewed, who found the ADME application process in disarray and not organized in a fashion that made it easy for soldiers to obtain all the appropriate documents and medical appointments needed to successfully apply for and obtain ADME orders. For example, one injured soldier we interviewed whose original mobilization orders expired in January 2003 recalls making over 40 trips to various sites at Fort Bragg during the month of January to complete his ADME application.

Case Study Illustration: Army Reserve and National Guard Liaisons Assume Responsibility for ADME in the Absence of an Established Infrastructure

In July 2002, one Army Reserve National Guard liaison at Walter Reed Medical Center observed that numerous injured and ill soldiers were falling off orders and were losing pay and benefits. He advised his commander of the problem and unofficially began assisting soldiers with ADME issues.

There wasn’t any funding or furniture for work space because this was not an official office. Therefore, he and a couple of other soldiers rummaged through the trash and found some old office furniture, which they used to establish an operating base from which to work. Since that time, these soldiers have used their own money and own time--making frequent trips to local office supply stores to purchase supplies and keep the office running. According to the soldier who started the office, they have spent about three hundred dollars out of pocket for office supplies.

The soldier who started the office had received some information on the process in a related workshop he had taken but no formal training was provided to any of the soldiers working in the office as to how the ADME process worked. Instead, they learned through trial and error. Further, in 2002, there were no case managers at Walter Reed. Consequently, soldiers were responsible for making medical appointments and managing their own care. If soldiers were severely injured they were not capable of preparing an ADME packet and there was no one assigned to assist them. The case manager system, which was established in May of 2004, has helped considerably in this regard. However, the process, and the amount of time it takes to process ADME orders have not improved.

At the time of our site visits some installations were still experiencing difficulties, particularly those that handle mobilization and demobilization of soldiers. For instance, at Fort Lewis, one of the Army’s largest mobilization/demobilization sites, the medical hold unit to which ADME

soldiers are attached has had to move its soldiers on three occasions to different barracks to make room for demobilizing soldiers.

Case Study Illustration: Injured Guard Soldier Sent to Two Bases Where No Medical Treatment Was Available

A Sergeant with G Company, 140th Aviation unit, California, was deployed to Iraq on March 6, 2003. On or about March 27, 2003, the soldier injured his back when he was thrown to the ground during a sandstorm. He re-injured his back in April 2003 loading a helicopter. He was diagnosed with two bulging discs and curvature of the spine. The soldier was medically evacuated to Andrews Air Force Base, Maryland, for medical treatment. While being transported, his stretcher was dropped, further compounding his injuries. After 2 weeks at Andrews, the soldier told us that he received pain medication but no medical treatment. He was then transported to Travis Air Force Base in California to continue his treatment. In October 2003, because he was an Army soldier being treated at an Air Force facility, he was ordered to report to the Army hospital at Fort Lewis, Washington, for further treatment. Upon arrival, he turned over his medical records to Fort Lewis personnel. The records were lost and never found. According to the soldier, he was housed in World War II era barracks. The mess hall was about a one-half mile walk from the barracks—difficult for him to navigate with a cane and even harder for other soldiers with more severe injuries. The barracks were not wheelchair accessible and the more able-bodied soldiers eventually built a wheelchair ramp. During his 3 weeks at Fort Lewis, the soldier received pain medication but no medical treatment. The doctors at Fort Lewis determined that it would be in his best interest to return to Travis for treatment and he was reassigned there. Although this ordeal took place while the soldier was on his original mobilization orders, it illustrates the inadequacies of the infrastructure used to house and treat injured soldiers and the difficulty faced by injured soldiers when they are transferred from one location to another.

Over time, the Army has begun to make some progress in addressing its infrastructure issues. At the time of our visit, we found that some installations had added new living space or upgraded existing space to house returning soldiers. For example, Walter Reed has contracted for additional quarters off base for ambulatory soldiers to alleviate the overcrowding pressure and Fort Lewis had upgraded its barracks to include, among other things, wheelchair accessible quarters. Also, installations have been adding additional case managers to handle their workload. Case managers are responsible for both active and reserve component soldiers, including injured and ill active duty soldiers, reserve component soldiers still on mobilization orders, reserve component soldiers on ADME orders, and reserve component soldiers who have inappropriately fallen off active duty orders. As of June 2004, according to the Army, it had 105 case managers, and maintained a soldier-to-case-manager-ratio of about 50-to-1 at 8 of the 10 locations we visited while conducting fieldwork. Finally, to the extent possible, several of the sites

we visited co-located administrative functions that soldiers would need—including command and control functions, case management, ADME application packet preparation, and medical treatment. They also made sure that Army administrative staff, familiar with the paperwork requirements, filled out all the required paperwork for the soldier. Centralizing document preparation reduces the risk of miscommunication between the soldier and unit officials, case managers, and medical staff. It also seemed to reduce the frustration that soldiers would feel when trying to prepare unfamiliar documents in an unfamiliar environment.

Ad Hoc Procedures to Keep Soldiers in Pay Status Circumvented Key Internal Controls and Created Additional Problems for Soldiers

The financial hardships discussed previously that were experienced by some soldiers would have been more widespread had individuals within the Army not taken it upon themselves to develop ad hoc procedures to keep these soldiers in pay status. In fact, 7 of the 10 Army installations we visited had created their own ad-hoc procedures or workarounds to (1) keep soldiers in pay status and (2) provide soldiers with access to medical care when soldiers fell off active duty orders. In many cases, the installations we visited made adjustments to a soldier's pay records. While effectively keeping a soldier in pay status, this work-around circumvented key internal controls—putting the Army at risk of making improper and potentially fraudulent payments. In addition, because these soldiers are not on official active duty orders they are not eligible to receive other benefits to which they are entitled, including health coverage for their families. Conversely, one installation we visited issued official orders locally to keep soldiers in pay status. However, in doing so, they created a series of accounting problems that resulted in additional pay problems for soldiers when the Army attempted to straighten out its accounting.

Many of the installations we visited made informal agreements with staff at the installation's payroll office to keep soldiers in pay status until their ADME orders could be approved. When a soldier's ADME packet was submitted to Army Manpower, the case manager or medical hold unit commander would ask a trusted coworker at the installation's payroll department to extend the soldier's orders. Installation payroll personnel, who have authorized access to the Army's payroll system, then enter an unauthorized transaction. Specifically, payroll personnel manually adjust the soldier's original mobilization order end date and, in effect, circumvented key controls which are intended to ensure that only valid transactions supported by valid active duty orders are entered into the pay system. While these soldiers are technically not on active duty orders, they continue to be paid as if they were. Subsequently, when the ADME order

was issued and sent to the soldier, it was backdated to the original mobilization order end date. Backdating the ADME order makes it appear as if the soldier has been on orders the entire time. This ad-hoc workaround has three drawbacks. First, the practice of routinely altering pay records without support creates an environment that increases the risk of improper or fraudulent payments. For example, in such an environment, payroll personnel could arrange to extend the order end dates for numerous soldiers, allowing them to receive pay after they have been released from active duty, and, in return, ask for a portion of the fraudulent payment. Second, although soldiers have rarely been denied ADME, if this were to happen, the soldier would then be responsible for repaying the amounts received after the mobilization orders expired—assuming that the case manager or medical hold unit commander tells the finance office that a soldier’s ADME packet was denied. Finally, while the soldier has access to medical care on the installation, his family would not be able to use civilian providers under the Army’s contractor health provider network. For example, if a soldier’s family relies on TRICARE-Remote—DOD’s health care plan intended to treat eligible beneficiaries through private sector health care providers—as their primary health insurance, the family’s benefits cannot be extended without a copy of valid active duty orders. Similarly, without valid active duty orders the family would not have access to other benefits such as the Post Exchange for reduced price groceries.

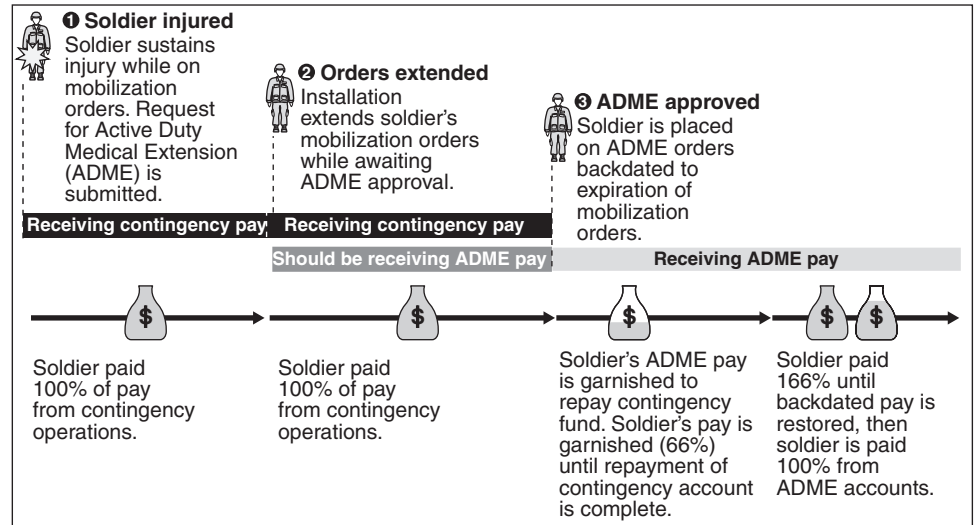
According to Army officials at the installations we reviewed, they understood that exploiting the weaknesses in the Army’s payroll systems was not in line with Army procedures, but, understandably, told us that they were not left with many choices. According to these officials, they were motivated, in part, because it was the right thing to do for the soldier, and, in part, because they feared retribution. They noted that soldiers who fell out of pay status frequently complained to their congressmen or the Inspector General or the installation commander. Such complaints could result in an investigation where installation officials, who were the ones with the most direct contact with the disgruntled soldiers, would be called on to explain the reasons for soldiers’ orders not being processed. Since order processing and approval are actions over which the installation officials had no control, but which they feared they would have to explain, medical hold unit commanders began keeping logs of what specific information was sent to Army Manpower and when it was sent. They also began looking for ways to keep soldiers from falling out of pay status, even if those actions involved circumventing internal controls, in an attempt to

forestall the possibility of undergoing an investigation if someone fell off orders.

In contrast, the installation commander at one installation was unwilling to override key controls in the pay system and instead issued new orders locally to extend the soldiers' mobilization. While this kept the soldier in active duty pay status, it created accounting problems for the installation finance office that ultimately caused pay problems for soldiers. As injured and ill reserve component soldiers requiring ADME neared the end of their original mobilization order end date, the installation's Adjutant General's office would issue new orders to extend soldiers' mobilization. The extension was typically 90 days long, the average amount of time based on their experience that it took to receive ADME orders. However, as discussed previously, the personnel costs associated with soldiers on mobilization orders are recorded in accounts related to contingency operations, whereas, the personnel costs for soldiers on ADME orders are recorded in accounts related to base operations costs. Therefore, when soldiers received their backdated ADME orders, installation payroll and accounting personnel would reallocate costs previously charged to a contingency operations account to the base operating account.

To do this, as shown in figure 3, the payroll office retroactively rescinded the local order used to keep the soldier in pay status, which created a debt in the amount of pay that the soldier received while on that order. Because the soldier then owed the government money, albeit from a contrived debt, a significant portion of the soldier's wages were garnished to pay back the debt as he or she began receiving ADME paychecks, which are accounted for as a base operations expense.

Figure 3: Illustration of Retroactive Rescission of Orders and Resulting Impact on Soldiers



Source: GAO analysis of Army data.

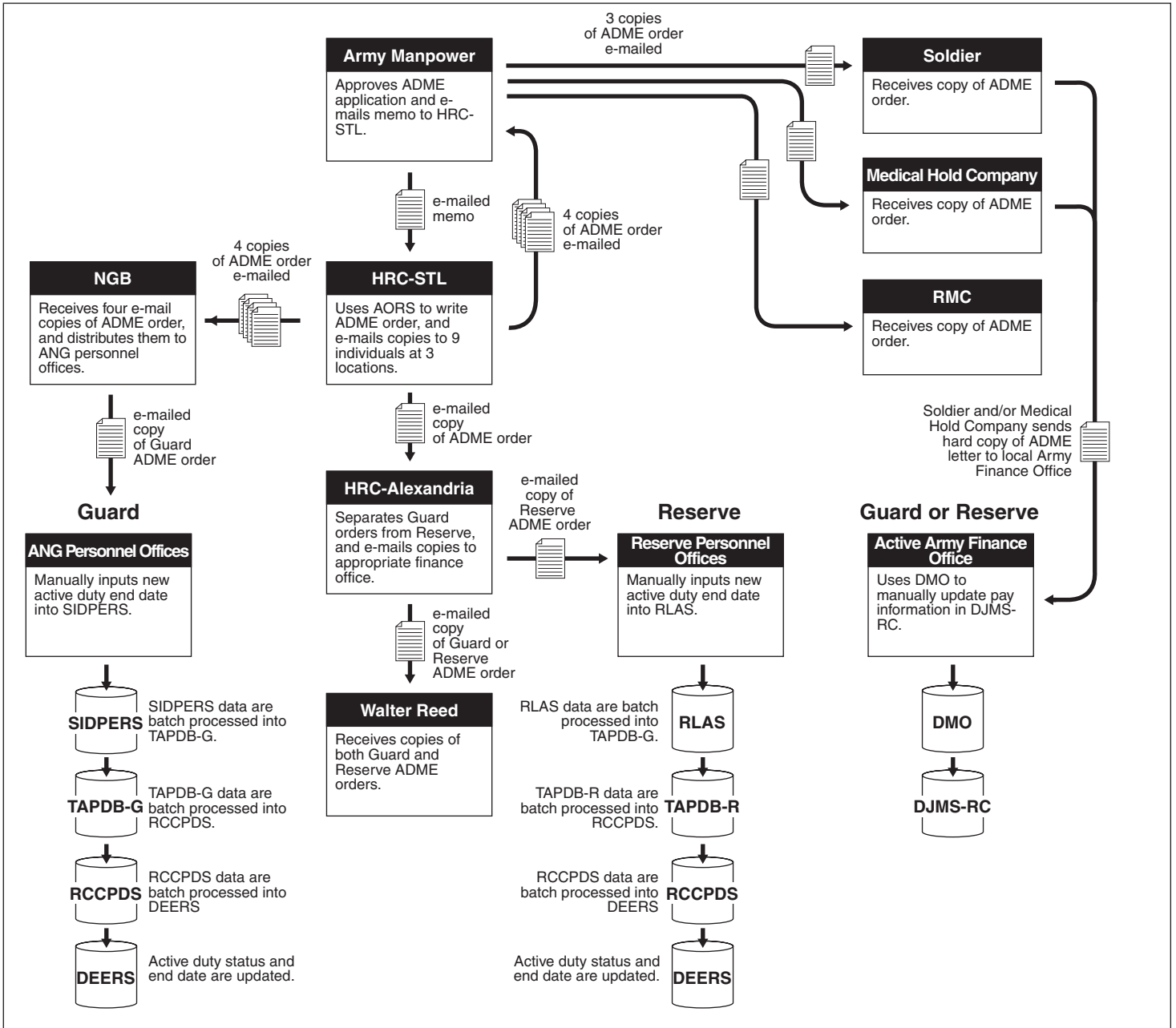
Figure 3 shows that 66 percent of this soldier's paycheck was garnished until the monies owed from pay received and accounted for as a contingency operations expense were repaid in full. For example, one soldier's paycheck suddenly dropped to \$1,550 from \$3,625 without explanation. Upon repayment, the soldier then began receiving 166 percent of his pay until he was compensated for the amount previously garnished. As he later found out, the Army was garnishing his pay to reimburse the contingency operations account. Not surprisingly, this creates serious confusion and a significant cash flow problem for most soldiers until the Army reconciles the two amounts. In addition, the effort required to correct the Army's accounting creates an administrative burden that could have been avoided had the Army adequately addressed its processes to efficiently process soldiers' ADME orders. Finally, as discussed previously, we believe that the cost of treating and paying soldiers whose injuries resulted in support of the Global War on Terrorism should be linked to the contingency operation for which the soldier was originally mobilized. This would more accurately capture the total cost of the operation.

Nonintegrated Systems Contribute to Processing Delays

Manual processes and nonintegrated order writing, pay, personnel, and medical eligibility systems also contribute to processing delays which affect the Army's ability to update these systems and ensure that soldiers on ADME orders are paid in an accurate and timely manner. Overall, we found that the current stove-piped, nonintegrated systems were labor-intensive and require extensive error-prone manual data entry and re-entry. Therefore, once Army Manpower approves a soldier's ADME application and the ADME order is issued, the ADME order does not automatically update the systems that control a soldier's access to pay and medical benefits. In addition, as discussed previously, the Army's ADME guidance does not address the distribution of ADME orders or clearly define who is responsible for ensuring that the appropriate pay, personnel, and medical eligibility systems are updated, so soldiers and their families receive the pay and medical benefits to which they are entitled. As a result, ADME orders were sent to multiple individuals at multiple locations before finally reaching individuals who have the access and authority to update the pay and benefits systems, which further delays processing.

As shown in figure 4, once Army Manpower officials approve a soldier's ADME application, they e-mail a memorandum to HRC-St. Louis authorizing the ADME order. The Automated Order Resource System (AORS), which is used to write the order, does not directly interface nor automatically update the personnel, pay, or medical eligibility systems. Instead, once HRC-St. Louis cuts the ADME order it e-mails a copy of the order to nine different individuals—four at the Army Manpower office, four at the NGB headquarters, and one at the HRC in Alexandria Virginia—none of which are responsible for updating the pay, personnel, or medical eligibility systems.

Figure 4: Transaction Flow Between the Army's Order Writing, Pay, Personnel, and Medical Eligibility Systems



Source: GAO.

As shown in figure 4, Army Manpower, upon receipt of ADME orders, e-mails copies to the soldier, the medical hold unit to which the soldier is attached, and the RMC. Again, none of these organizations has access to the pay, personnel, or medical eligibility systems. Finally, NGB officials e-mail copies of National Guard ADME orders to one of 54 state-level Army National Guard personnel offices and HRC-Alexandria e-mails copies of Reserve ADME orders to the Army Reserve's regional personnel offices. HRC-Alexandria also sends all Reserve orders to the medical hold unit at Walter Reed Army Hospital. When asked, the representative at HRC-Alexandria who forwards the orders did not know why orders were sent to Walter Reed when many of the soldiers on ADME orders were not attached or going to be attached to Walter Reed. The medical hold unit at Walter Reed that received the orders did not know why they were receiving them and told us that they filed them.

At this point in the process, of the eight organizations that receive copies of ADME orders, only two—the ANG personnel office and the Army Reserve personnel office—use the information to initiate a pay or benefit-related transaction. Specifically, the Guard and Reserve personnel offices initiate a transaction that should ultimately update the Army's medical eligibility system, Defense Enrollment Eligibility System (DEERS). To do this, the Army National Guard personnel office manually inputs a new active duty order end date into the Army National Guard personnel system, Standard Installation Division Personnel Reporting System (SIDPERS). In turn, the data from SIDPERS are batch processed into the Total Army Personnel Database-Guard (TAPDB-G), and then batch processed to the Reserve Components Common Personnel Data System (RCCPDS). The data from RCCPDS are then batch processed into DEERS—updating the soldier's active duty status and active duty order end-date. Once the new date is posted to DEERS, soldiers and family members can get a new ID card at any DOD ID Card issuance facility.²⁰ The Army Reserve finance office initiates a similar transaction by entering a new active duty order end date into the Regional Level Application System (RLAS), which updates Total Army Personnel Database-Reserve (TAPDB-R), RCCPDS, and DEERS through the same batch process used by the Guard.

As discussed previously, the Army does not have an integrated pay and personnel system. Therefore, information entered into the personnel

²⁰ There are over 800 DOD card issuance facilities located in the U.S. on Army installations and with Army National Guard and Reserve units.

system (TAPDB) is not automatically updated in the Army's pay system, Defense Joint Military Pay System-Reserve Component (DJMS-RC).

Instead, as shown in figure 4, after receiving a copy of the ADME orders from Army Manpower, the medical hold unit and/or the soldier provide a hard copy of the orders to their local finance. Using the Active Army pay input system, Defense Military Pay Office system (DMO), installation finance office personnel update DJMS-RC. Not only is this process vulnerable to input errors, but also, not sending a copy of the orders directly to the individual responsible for input further delays a soldier's ability to receive the pay and benefits to which the soldier is entitled.

The Army's New Medical Retention Program Will Not Solve All the Problems Associated with ADME

The Army's new MRP program, which went into effect May 1, 2004, and takes the place of ADME for soldiers returning from operations in support of the Global War on Terrorism, has resolved many of the processing delays experienced by soldiers applying for ADME by simplifying the application process. In addition, unlike ADME, the personnel costs associated with soldiers on MRP orders are appropriately linked to the contingency operation for which they served, and, therefore, will more appropriately capture the costs related to the Global War on Terrorism. While the front-end approval process appears to be operating more efficiently than the ADME approval process, due to the fact that the first wave of 179-day MRP orders did not expire until October 27, 2004, after we completed our work, we were unable to assess how effectively the Army identified soldiers that required an additional 179 days of MRP and whether those soldiers will experience pay problems or difficulty obtaining new MRP orders. In addition, the Army has no way of knowing whether all soldiers that should be on MRP orders are actually applying and getting into the system. Further, MRP has not resolved the underlying management control problems that plagued ADME, and, in some respects, has worsened problems associated with the Army's lack of visibility over injured soldiers. Finally, because the MRP program is designed such that soldiers may be treated and released from active duty before their MRP orders expire, weaknesses in the Army's processes for updating its pay system to reflect an early release date have resulted in overpayments to soldiers.

According to Army officials at each of the 10 installations we visited, unlike ADME, they have not experienced problems or delays in obtaining MRP orders for soldiers in their units. In fact some installation officials have said that the process now takes 1 or 2 days instead of 1 or 2 months. Because there is no mechanism in place to track application processing

times, we have no way of substantiating these assertions. Conversely, we are not aware of any soldier complaints regarding the process, which were commonplace with ADME.

The MRP application and approval process, which rests with HRC–Alexandria, instead of the Army Manpower office, is a simplified version of the ADME process. As with ADME orders, the soldier must request that this process be initiated and voluntarily request an extension on active duty orders. Both the MRP and ADME request packets include the soldier's request form, a physician's statement, and a copy of the soldier's original mobilization orders. However, with MRP, the physician's statement need only state that the soldier needs to be treated for a service-connected injury or illness and does not require detailed information about the diagnosis, prognosis, and medical treatment plan as it does with ADME. As discussed previously, assembling this documentation was one of the primary reasons ADME orders were not processed in a timely manner. In addition, because all MRP orders are issued for 179 days, MRP has alleviated some of the workload on officials who were processing ADME orders and who were helping soldiers prepare application packets by eliminating the need for a soldier to reapply every 30, 60, or 90 days as was the case with ADME.

While MRP has expedited the application process, MRP guidance, like that of ADME, does not address how soldiers who require MRP will be identified in a timely manner, how soldiers requiring an additional 179 days of MRP will be identified in a timely manner, or how soldiers and Army staff will be trained and educated about the new process. Further, because the Army does not maintain reliable data on the current status and disposition of injured soldiers, we could not test or determine whether all soldiers that should be on MRP orders are actually applying and getting into the system. In addition, because MRP authorizes 179 days of pay and benefits regardless of the severity of the injury, the Army faces a new challenge—to ensure that soldiers are promptly released from active duty or placed in a medical evaluation board process upon completion of medical care or treatment and avoid needlessly retaining and paying these soldiers for the full 179 days. However, MRP guidance does not address how the Army will provide reasonable assurance that upon completion of medical care or treatment soldiers are promptly released from active duty or placed in a medical evaluation board process.

MRP has also contributed to the Army's difficulty maintaining visibility over injured reserve component soldiers. Although the Army's MRP implementation guidance requires that installations provide a weekly

report to HRC-Alexandria that includes the name, rank, and component of each soldier currently on MRP orders, according to HRC officials, they are not consistently receiving these reports. Consequently, the Army cannot say with certainty how many soldiers are currently on MRP orders, how many have been returned to active duty, or how many soldiers have been released from active duty before their 179-day MRP orders expired. As discussed previously, if the Army used and appropriately updated the agency's medical tracking system, MODS, the system could provide some visibility over injured and ill active and reserve component soldiers—including soldiers on ADME or MRP orders. However, the Army MRP implementation guidance is silent on the use of MODS and does not define responsibilities for updating the system. According to officials at HRC-Alexandria, they do not update MODS or any other database when they issue MRP orders. They also acknowledged that the 1,800 soldiers reflected as being on MRP orders in MODS, as of September 2004, was probably understated given that, between May 2004 and September 2004, HRC-Alexandria processed approximately 3,300 MRP orders. Further, as was the case with ADME, 8 of the 10 installations we visited did not routinely use or update MODS but instead maintained their own local tracking systems to monitor soldiers on MRP orders.

Not surprisingly, the Army does not know how many soldiers have been released from active duty before their 179-day MRP orders had expired. This is important because our previous work has shown that weaknesses in the Army's process for releasing soldiers from active duty and stopping the related pay before their orders have expired—in this case before their 179 days is up—often resulted in overpayments to soldiers. According to HRC-Alexandria officials, as of October 2004, a total of 51 soldiers had been released from active duty before their 179-day MRP orders expired. At the same time, Fort Knox, one of the few installations that tracked these data, reported it had released 81 soldiers from active duty who were previously on MRP orders—none of whom were included in the list of 51 soldiers provided by HRC-Alexandria. Concerned that some of these soldiers may have inappropriately continued to receive pay after they were released from active duty, we verified each soldier's pay status in DJMS-RC and found that 15 soldiers were paid past their release date—totaling approximately \$62,000. For example, one soldier was released from active duty on July 9, 2004, after 43 days on MRP orders but, as of November 5, 2004, the soldier was still being paid as if he were on active duty. Between July and November he was overpaid \$10,595. Further, if we had not alerted the Army, he may have continued to be paid until November 21, 2004—the date his 179-day MRP orders would have expired—an additional \$1,246, for

a total of \$11,841. According to Army finance officials, they rely on the soldier to bring them a copy of their Certificate of Discharge or Release from Active Duty (DD form 214) so that they can change the order end date in the pay system and stop the soldier's pay. However, when the installation finance personnel do not receive a soldier's DD214, the soldier will continue to be paid until the order end date recorded in the pay system—in this case, the original date on the soldier's MRP orders. In another example, a soldier who was released from active duty on October 7, 2004, continued to receive active duty pay and may have continued to receive pay until January 10, 2005, if we had not brought the issue to the Army's attention—for a total of \$4,500.

Finally, because ADME will still exist for soldiers who are not mobilized in support of the Global War on Terrorism—such as soldiers injured in Bosnia or Kosovo or during annual training exercises—it is still important that the problems we identified related to it are resolved.

Conclusion

The recent mobilization and deployment of Army National Guard and Reserve soldiers in connection with the Global War on Terrorism is the largest activation of reserve component troops since World War II. As such, in recent years, the Army's ability to take care of these soldiers when they are injured or ill has not been tested to the degree that it is being tested now. Unfortunately, the Army has failed this test and the brave soldiers fighting to defend our nation have paid the price. The personal toll that the pay problems experienced by these soldiers and their families and what they have endured cannot be readily measured. But clearly, the hardships they have endured are unacceptable given the substantial sacrifices they have made and the injuries they have sustained. To its credit, the Army's new streamlined medical retention application process has alleviated many of the immediate problems experienced by soldiers under ADME but it also has many of the same limitations. A complete and lasting solution to the pay problems and overall poor treatment of injured soldiers that we identified will require that the Army address the underlying problems associated with its all around control environment for managing and treating reserve component soldiers with service-connected injuries or illnesses and deficiencies associated with its automated systems.

Recommendations of Executive Action

We recommend that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to take the following 22 actions:

Control Environment and Management Controls. Develop and promulgate—with appropriate input from the Regional Medical Commands, hospital commanders, medical hold unit commanders, and case managers— comprehensive, integrated policies and procedures for managing and treating reserve component soldiers with service-connected injuries or illnesses. At a minimum, standard operating procedures, and guidance should be developed that address:

- Specific organizational responsibilities for managing programs that deal with injured or ill reserve component soldiers, including specifying which officials have the ultimate responsibility for the success of these programs.
- Where orders that extend a soldier's active duty status are to be issued, how they are to be distributed, and to whom they are to be distributed—for both command and control purposes and to update the Army's pay, personnel, and medical eligibility systems.
- Standards for being retained on active duty orders, including time frames and criteria for extension or retention beyond one year.
- Criteria that clearly establishes priorities for where a soldier may be attached for medical care (i.e. medical facility has the specialties and the capacity needed to treat the soldier, proximity to soldier's residence).
- Minimum eligibility criteria for soldiers applying for such programs as ADME and MRP.
- Avenues through which soldiers may apply for such programs.
- Specific documentation required to retain or extend active duty orders for medical treatment or evaluation.
- Entitlements of each program for both the soldier and his/her dependents.

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- Correctly link the cost of these programs to the mission or operation in which the soldier was involved.

Require that the officials designated with the responsibility for managing these programs develop performance measures to evaluate the program's success. Such performance measures should be sufficient to enable the Army to:

- Evaluate the efficiency and effectiveness of these programs—including timeliness of application processing, soldier satisfaction, and the length of time soldiers are in the program.
- Take any corrective actions needed to address documented shortcomings in program performance.

Infrastructure, resources, and process improvement. Provide the infrastructure and resources needed to support these programs and make needed process improvements to provide reasonable assurance that:

- Officials responsible for managing and treating injured and ill reserve component soldiers are adequately trained on program requirements, benefits, and processes.
- Reserve component soldiers and unit commanders will be educated on these programs, their requirements, and their benefits.
- The administrative burden on the soldier is alleviated through coordinated, customer-friendly processes and easy access to staff responsible for both the administrative and medical treatment aspects of the programs.
- Paper-intensive application processes are replaced with user-friendly automated processes, to the extent possible, through which soldiers are notified or have easy access to the current status of their application.
- The practice of garnishing soldiers' wages to resolve accounting problems created by the use of retroactive rescissions of soldiers' orders is ended.

Automated systems. In the near term, require that:

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- The gaining MTF is notified and receives a copy of the soldier's orders when a soldier is transferred from one MTF to another for treatment.
 - The information in MODS is routinely updated and utilized to the maximum extent possible to provide visibility over and manage injured and ill reserve component soldiers.
 - New orders extending active duty for injured or ill soldiers are sent directly to the staff responsible for updating the appropriate pay, personnel, and medical eligibility systems.
 - Controls are put in place to provide assurance that the order end date in the pay system is changed to reflect the actual date the soldier was released from active duty when soldiers are released from active duty before their orders expire.

In the long term, design and implement integrated order writing, pay, personnel, and medical eligibility systems that:

- Provide visibility over injured and ill reserve component soldiers.
- Ensures that the order writing system automatically updates the pay, personnel, and medical eligibility systems.

Agency Comments and Our Evaluation

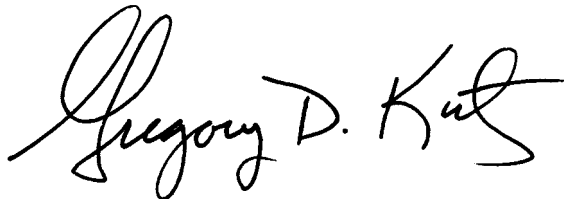
In its written response to a draft of this report, DOD briefly described its completed, ongoing, and planned actions to implement all 22 of our recommendations.

We are encouraged that the Army has begun to take action to address the problems we identified and are hopeful that it will continue to work toward comprehensive, effective solutions for addressing the recommendations in this report dealing with reserve component soldiers with service-connected injuries or illnesses.

Separately in its technical comments, reprinted in appendix II, DOD disagreed with several of the facts and circumstances presented in the report related to non-pay issues and challenged our use of certain case studies. We continue to believe that the information we presented offers valid perspective on the Army's management and treatment of injured reserve component soldiers.

As agreed with your offices, unless you announce its contents earlier, we will not distribute this report further until 30 days from its date. At that time, we will send copies to interested congressional committees, the Secretary of the Army, and the Director of the Office of Management and Budget. We will make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staffs have any questions concerning this report, please contact me at (202) 512-9095 or kutzg@gao.gov, or Diane Handley at (404) 679-1986 or handleyd@gao.gov. Key contributors to this report are acknowledged in appendix III.



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Objective, Scope, and Methodology

We relied on a case study and selected the site visit approach for this work, principally because the many previously identified flaws in the existing pay processes had not yet been resolved and the Army did not maintain reliable, centralized data on the number, location, and disposition of mobilized reserve component soldiers who had requested to extend their active duty service because they had been injured or become ill in the line of duty. Therefore, it was not possible to statistically test controls or the impact control breakdowns had on soldiers and their families.

To obtain an understanding and assess the adequacy of the processes, personnel (human capital), and systems used to provide assurance that mobilized Army Guard and Army Reserve soldiers received entitled pays and associated medical benefits, we reviewed applicable policies, procedures, and program guidance; observed active duty medical extension processing operations; and interviewed cognizant agency officials. With respect to applicable policies and procedures, we obtained and reviewed procedural guidance for reserve component soldiers on active duty medical extension, the U.S. Army Medical Command field operating guide for reserve component soldiers on active duty medical extension, and other pertinent sections of Title 10 USC and DOD and Army regulations. We also used the internal controls standards provided in the *Standards for Internal Control in Federal Government*.¹

We applied the policies and procedures prescribed in these documents to the observed and documented procedures and practices followed by the key DOD components involved in providing active duty pays and medical benefits to reserve component soldiers. We also interviewed officials from the National Guard Bureau, Army Reserve, Army and DOD military pay offices, Army Manpower office, and regional medical commands, as well as installation and military treatment facility commanders to obtain an understanding of their experiences in applying these policies and procedures.

¹ GAO, *Standards for Internal Control in Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington D.C.: November 1999). These standards provide the overall framework for establishing and maintaining effective internal control and for identifying and addressing areas of greatest risk of fraud, waste, abuse, and mismanagement.

With respect to the Army's automated systems, we assessed whether they provided reasonable assurance that once an ADME order was issued, the appropriate pay, personnel, and medical eligibility systems are updated in an accurate and timely manner. To accomplish this, we interviewed and obtained available documentation from individuals responsible for entering ADME order transactions into the Army's order writing, pay, personnel, and medical eligibility systems. Although we requested the written policies and procedures used to update each of these systems, none had been established. We also relied on the extensive work recently performed on related GAO military pay engagements.² We did not test computer security or access controls or test individual transactions.

Because our preliminary assessment determined that the design of current operations used to route soldiers through the active duty medical extension process relied solely on error-prone manual documents and transactions and multiple, nonintegrated systems, we did not statistically test current processes or controls. We selected installations for review based on the reported populations of active duty medical extension and medical holdover soldiers, as well as other specialized traits, including presence of regional medical command. The installations we selected for review were: 6 of the top 7 installations with large active duty medical extension and medical holdover populations; the 4 installations with co-located Regional Medical Commands in the continental United States; 6 of the 15 Army Power Projection Platforms, which mobilize and deploy high priority reserve component in both of the continental armies in the United States (1st U.S. Army is east of the Mississippi River, 5th U.S. Army is west of the Mississippi River, excluding Minnesota); and a reserve training base that has the largest deployments of reserve component soldiers, and which also does not have a medical treatment facility. The installations we visited are listed in table 1.

² GAO, *Military Pay: Army Reserve Soldiers Mobilized to Active Duty Experienced Significant Pay Problems*, [GAO-04-911](#) (Washington, D.C.: Aug. 20, 2004).

Table 1: Audited Installations

Installation	Characteristics
Fort Lewis, Washington	large active duty medical extension and medical holdover populations; Western Regional Medical Command; Power Projection Platform-5 th U.S. Army.
Fort Knox, Tennessee	large active duty medical extension and medical holdover populations -1 st U.S. Army.
Fort Benning, Georgia	large active duty medical extension and medical holdover populations; Power Projection Platform-1 st U.S. Army.
Fort Campbell, Kentucky	large active duty medical extension and medical holdover populations; Power Projection Platform-1 st U.S. Army.
Fort Dix, New Jersey	large active duty medical extension and medical holdover populations; Power Projection Platform-1 st U.S. Army; reserve only
Fort Bragg, North Carolina	large active duty medical extension and medical holdover populations; Power Projection Platform-1 st U.S. Army.
Fort Carson, Colorado	Power Projection Platform-5 th U.S. Army.
Fort Sam Houston, Texas	Great Plains Regional Medical Command.
Fort Gordon, Georgia	Southeast Regional Medical Command.
Walter Reed	North Atlantic Regional Medical Command.

Source: GAO.

At all the installations, we interviewed officials who were responsible for counseling soldiers on the active duty medical extension process, officials who prepared and submitted the medical extension application packets, case managers, primary care managers, medical hold unit commanders, and installation payroll personnel. We obtained documentation on and performed walkthroughs of the process to request an active duty medical extension for a reserve component soldier, the command and control structure of medical hold units, the case management function, installation medical extension tracking systems, and the medical-extension-to-pay system interface. We held interviews with officials from the Army National Guard Bureau, Army Reserve, Army Military Pay Operations, and Army Human Resource Command to augment our documentation and walkthroughs.

In addition, we interviewed officials who process and approve applications for active duty medical extensions at the Army Manpower Office in the Pentagon. We performed interviews and walkthroughs that depict how an

application is processed once received by the office. Specifically, we gained an understanding of how an application is transmitted to the office, what standards were in use to review the approval for sufficiency of documentation, what standards were in use related to the timeliness of the documentation, and how the request is entered into the Army's Medical Operational Data System (MODS) for tracking. We obtained data from that office on the orders processed at the time our fieldwork began in February 2004 and updated data as of October 2004.

Further, we interviewed and discussed active duty medical extension issues with officials from the following offices or commands:

- National Guard Bureau (NGB), Arlington, Virginia
- Army Reserve Affairs Office, Arlington, Virginia
- U.S. Army Reserve Command (USARC), Fort McPherson, Georgia
- 1st U.S. First Army, Fort Gillem, Georgia
- 5th U.S. Army, Fort Sam Houston, Texas
- U.S. Army Forces Command (FORSCOM), Fort McPherson, Georgia

When the Army initiated the new medical retention order process during our fieldwork, we met with officials from the Army Human Resources Command in Alexandria, Virginia, who are responsible for processing those orders and obtained and analyzed copies of their implementing instructions. We discussed these instructions and the medical retention order request process with officials at each of the installations we reviewed. We also requested statistics, as of September 2004, from HRC-Alexandria regarding the number of soldiers currently on MRP orders, returned to active duty, and released from active duty before their 179-day MRP orders expired.

After determining that the HRC-Alexandria data were incomplete, we also requested data from each of the installations we audited on soldiers who were released from active duty before their 179-day MRP orders expired to determine whether the Army continued to pay them after they were released from active duty. For the 132 soldiers identified by the Army, as of the date of this report, as released from active duty, we determined their pay status in DJMS-RC and obtained pay and personnel records for those

soldiers who inappropriately remained in pay status. As of the date of this report, we are continuing to investigate soldiers who were overpaid by the Army. Due to the timing of this report and the fact that the first wave of 179-day MRP orders did not expire until October 27, 2004, we were unable to assess how effectively the Army identified soldiers who required an additional 179 days of MRP and whether those soldiers will experience pay problems or difficulty obtaining new MRP orders. In addition, because the Army does not maintain reliable data on the current status and disposition of injured soldiers we could not test or determine whether all soldiers who should be on MRP orders are actually applying and getting into the system.


During the course of our investigation we identified sources at various forts and facilities, who were familiar with the ADME process. These individuals provided us with the names and contact information of soldiers who were having trouble with the ADME process. To obtain a more detailed understanding of the ADME process challenges associated with it, and problems soldiers faced, we visited four forts and interviewed 38 soldiers at the forts. Based on the information that we obtained at the forts, we further developed 10 case studies. To corroborate the information provided by our 10 case study soldiers, we obtained and reviewed soldiers' official military pay records, mobilization and ADME orders, bank statements, and credit records. Although the information obtained is limited to the 10 soldiers, the soldiers that were chosen highlight a variety of problems that soldiers experienced with the ADME process. As for soldiers' statements regarding non-pay issues, when possible, we corroborated soldiers' statements with Army officials familiar with the soldiers. When we could not readily corroborate their statements by other evidence, we have taken great care to attribute the information to the soldiers we interviewed.

We briefed DOD, Army, and National Guard Bureau officials from the selected sites on the details of our audit, including our findings and their implications. We conducted our fieldwork from February 2004 through October 2004 in accordance with U.S. generally accepted government auditing standards. We requested and received written comments on a draft of this report from the Department of the Army. These comments are presented and evaluated in the "Agency Comments and Our Evaluation" section of this report and are reprinted in appendix II.


Comments From the Department of the Army

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

See comment 1.



OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000



JAN 24 2005

PERSONNEL AND
READINESS


Mr. Gregory D. Kutz
Director, Financial Management and Assurance
U.S. Government Accountability Office
Washington, D.C. 20548

Dear Mr. Kutz:

This is the Department of Defense response to the GAO draft report, "MILITARY PAY: Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers," dated November 5, 2004 (GAO Code 192115/GAO-05-125). The response is provided in two sections: 1) Responses to the GAO's 22 recommendations for executive action and 2) Other relevant comments on portions of the report.


My point of contact is Norma St. Claire, who can be reached at 703-696-8710 or via email at norma.stclaire@osd.pentagon.mil.

Sincerely,



Charles S. Abell
Principal Deputy

Enclosure
As stated



GAO DRAFT REPORT DATED NOVEMBER 5, 2004
GAO-05-125 (GAO CODE 192115)

"MILITARY PAY: GAPS IN PAY AND BENEFITS CREATE
FINANCIAL HARDSHIPS FOR INJURED ARMY NATIONAL
GUARD AND RESERVE SOLDIERS"

DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATIONS

See comment 1.

RECOMMENDATION 1: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff (DCS), Army G-1 to develop and promulgate comprehensive, integrated policies and procedures for managing and treating reserve component soldiers with service-connected injuries or illnesses that address specific organizational responsibilities for managing programs that deal with injured or ill reserve component soldiers, including which officials have the ultimate responsibility for the success of these programs. (p. 31/GAO Draft Report)

DoD RESPONSE: The Department has initiated corrective action. Currently, the G-1 is working with the U.S. Army Forces Command in developing an Army Regulation on all Medical holdovers.

RECOMMENDATION 2: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to develop and promulgate comprehensive, integrated policies and procedures for managing and treating reserve component soldiers with service-connected injuries or illnesses that address where orders that extend a soldier's active duty status are to be cut, how they are to be distributed, and to whom they are to be distributed – for both command and control purposes and to update the Army's pay, personnel, and medical eligibility systems. (p. 31/GAO Draft Report)

DoD RESPONSE: Headquarters, Department of the Army (HQDA), G-1 will work with the Human Resources Command (HRC), the Office of the Chief Army Reserve, the National Guard Bureau, the Defense Finance and Accounting System (DFAS), the Office of the Assistant Secretary of Defense for Reserve Affairs (OASD/RA), and the Defense Manpower Data Center to develop an integrated policy, which will be incorporated into the guidance and implementation of the Army regulation.

RECOMMENDATION 3: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to develop and promulgate comprehensive, integrated policies and procedures for managing and treating reserve component soldiers with service-connected injuries or illnesses that address standards for being retained on active duty orders, including timeframes and criteria for extension or retention beyond one year. (p. 31/GAO Draft Report)

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See comment 1.

DoD RESPONSE: The Department has initiated corrective action. The G-1 is working with the Office of the Surgeon General of the Army and the Physical Disability Agency to develop an integrated policy.

RECOMMENDATION 4: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to develop and promulgate comprehensive, integrated policies and procedures for managing and treating reserve component soldiers with service-connected injuries or illnesses that address criteria that clearly establishes priorities for where a soldier may be attached for medical care (i.e. medical facility has the specialties and the capacity needed to treat the soldier, proximity to soldiers residence). (p. 32/GAO Draft Report)

DoD RESPONSE: HQDA G-1 will work with the Office of the Surgeon General (OTSG)/Medical Command (MEDCOM) on policy and procedural development for medical issues.

RECOMMENDATION 5: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to develop and promulgate comprehensive, integrated policies and procedures for managing and treating reserve component soldiers with service-connected injuries or illnesses that address minimum eligibility criteria for soldiers applying for such programs as Active Duty Medical Extensions (ADME) and Medical Retention Processing (MRP). (p. 32/GAO Draft Report)

DoD RESPONSE: HQDA, G-1, in conjunction with the OTSG, has already established minimum eligibility. The ADME is in the Procedural Guidance on the HQDA, G-1 Website. MRP has been established by the OTSG.

RECOMMENDATION 6: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to develop and promulgate comprehensive, integrated policies and procedures for managing and treating reserve component soldiers with service-connected injuries or illnesses that address avenues through which soldiers may apply for programs such as ADME or MRP. (p. 32/GAO Draft Report)

DoD RESPONSE: This action is almost complete. The ADME process has been posted on the Website since inception July 2000. The MRP is for mobilized RC Soldiers who no longer can meet the deployable standards within the 60 days allowed. MRP is now posted on the HRC website.

RECOMMENDATION 7: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to develop and promulgate comprehensive, integrated policies and procedures for managing and treating reserve component soldiers with service-connected

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See comment 1.

injuries or illnesses that address specific documentation required to be retained or extended on active duty orders for medical treatment or evaluation. (p. 32/GAO Draft Report)

DoD RESPONSE: The Army has completed this action. The ADME program has established specific documentation. The MRP implementation guidance lists specific documents required to be retained or extended on active duty for medical treatment or evaluation.

RECOMMENDATION 8: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to develop and promulgate comprehensive, integrated policies and procedures for managing and treating reserve component soldiers with service-connected injuries or illnesses that address entitlements of each program for both the soldier and his/her dependents. (p. 32/GAO Draft Report)

DoD RESPONSE: HQDA, G-1 will take the necessary action to develop methods to inform Service members of their entitlements.

RECOMMENDATION 9: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to develop and promulgate comprehensive, integrated policies and procedures for managing and treating reserve component soldiers with service-connected injuries or illnesses that address correctly linking of the cost of programs such as ADME and MRP to the mission or operation in which the soldier was involved. (p. 32/GAO Draft Report)

DoD RESPONSE: Establishing the MRP will link all Soldiers to the Global War on Terrorism (GWOT) mission. The HQDA G-1 will work with the Assistant Secretary of the Army, Manpower and Reserve Affairs (Force Management, Manpower and Resources) (ASA(M&RA)FM) and the DFAS to follow through on this recommendation.

RECOMMENDATION 10: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to require that officials designated with the responsibility for managing these programs develop performance measures to evaluate the efficiency and effectiveness of the programs – including timeliness of application processing, soldier satisfaction, and the length of time soldiers are in the program. (p. 32/Draft Report)

DoD RESPONSE: First, concerning the timeliness of the application – the ADME has a tracking system where the Army can track all applications. The MRP is in the process of establishing a tracking system. Secondly, concerning soldier satisfaction – the ASA (M&RA) and Forces Command (FORSCOM) are conducting periodic site visits and performing sensing sessions with the soldiers. Finally, concerning the length of time soldiers are in the program – this data is tracked through the Medical Operational Data System (MODS) Medical holdover (MHO) Module and the Army will enforce utilization of this feature.

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RECOMMENDATION 11: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to require that officials designated with the responsibility for managing these programs develop performance measures to evaluate the program's success and enable the Army to take any corrective actions needed to address documented shortcomings in program performance. (p. 32/Draft Report)

DoD RESPONSE: The ASA (M&RA) and FORSCOM are addressing this recommendation for the MRP. The HQDA, G-1 is addressing this for the ADME with an internal tracking tool designed to assist in developing program performance measures.

RECOMMENDATION 12: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to provide the infrastructure and resources needed to support these programs and make needed process improvements to provide reasonable assurance that officials responsible for managing and treating injured and ill reserve component soldiers are adequately trained on program requirements, benefits and their processes. (p. 32/Draft Report)

DoD RESPONSE: The Army is already engaged in process improvements and will continue to refine the programs and processes.

RECOMMENDATION 13: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to provide the infrastructure and resources needed to support these programs and make needed process improvements to provide reasonable assurance that reserve component soldiers and unit commanders will be educated on these programs, their requirements, and their benefits. (p. 32/Draft Report)

DoD RESPONSE: The HQDA, G-1 will work with the Office of the Chief Army Reserve and the National Guard Bureau to accomplish this task.

RECOMMENDATION 14: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to provide the infrastructure and resources needed to support these programs and make needed process improvements to provide reasonable assurance that the administrative burden on the soldier is alleviated through coordinated, customer-friendly processes and easy access to staff responsible for both administrative and medical treatment aspects of the programs. (p. 32/Draft Report)

DoD RESPONSE: The HQDA, G-1 will work with the appropriate organizations accordingly to accomplish this tasking.

RECOMMENDATION 15: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to provide the infrastructure and resources needed to support

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See comment 1.

these programs and make needed process improvements to provide reasonable assurance that paper-intensive application processes are replaced with user-friendly automated processes, to the extent possible, in which soldiers are notified or have easy access to the current status of their application. (p. 32/Draft Report)

DoD RESPONSE: The HQDA, G-1 will work with the appropriate organizations to provide easy access to the soldiers on the current status of their medical extension or retention processing requests.

RECOMMENDATION 16: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to provide the infrastructure and resources needed to support these programs and make needed process improvements to provide reasonable assurance that the practice of garnishing soldiers' wages to resolve accounting problems created by the use of retroactive rescissions of soldiers' orders is ended. (p. 32/Draft Report)

DoD RESPONSE: The Army will work with the DFAS to implement necessary process improvements.

RECOMMENDATION 17: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to require that the gaining MTF be notified and receive a copy of the soldier's orders when a soldier is transferred from one MTF to another for treatment. (p. 32/Draft Report)

DoD RESPONSE: The HQDA, G-1 will work with the OTSG to implement this recommendation.

RECOMMENDATION 18: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to require that the information in MODS is routinely updated and utilized to the maximum extent possible to provide visibility over and manage injured and ill reserve component soldiers. (p. 32/Draft Report)

DoD RESPONSE: This recommendation has already been implemented.

RECOMMENDATION 19: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to require that new orders extending active duty for injured or ill soldiers are sent directly to the staff responsible for updating the appropriate pay, personnel, and medical eligibility systems. (p. 33/Draft Report)

DoD RESPONSE: For the ADME, the current distribution includes both the Army Reserve and NGB, and a DFAS representative. A Command and Control element will be added to the distribution. The MRP distributes to the Medical Retention Processing Unit's (MRPU's), the

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See comment 1.

Installations, and to the DFAS. The servicing demobilization installation is providing support to the soldier will also be added to the distribution.

RECOMMENDATION 20: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to require that controls are put in place to provide assurance that the order end date in the pay system is changed to reflect the actual date the soldier was released from active duty when soldiers are released from active duty before their orders expire. (p. 33/Draft Report)

DoD RESPONSE: The HQDA, G-1 will work with the appropriate organizations to implement this recommendation.

RECOMMENDATION 21: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to design and implement integrated order writing, pay, personnel, and medical eligibility systems that provide visibility over injured and ill reserve component soldiers. (p. 33/Draft Report)

DoD RESPONSE: The Department's long-term solution is the implementation of the Defense Integrated Military Human Resource System (DIMHRS). Many of the current administrative problems the Army faces today, whether it is with financial records, personnel accountability, medical records, or orders production, directly or indirectly stem from incompatible data systems. To be effective, data must be able to accurately flow among all Army components, and between the Services. This is one of DIMHRS major intents.

RECOMMENDATION 22: The GAO recommended that the Secretary of the Army direct the Deputy Chief of Staff, Army G-1 to design and implement integrated order writing, pay, personnel, and medical eligibility systems that ensure the order writing system automatically updates the pay, personnel, and medical eligibility systems. (p. 33/Draft Report)

DoD RESPONSE: The Department's long-term solution is the implementation of the DIMHRS.

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GAO-05-125 (GAO CODE 192115)

"MILITARY PAY: GAPS IN PAY AND BENEFITS CREATE
FINANCIAL HARDSHIPS FOR INJURED ARMY NATIONAL
GUARD AND RESERVE SOLDIERS"

DEPARTMENT OF DEFENSE COMMENTS
OTHER

GAO document (pages 3, 11, 13, and 24): The report contains incorrect information regarding pay and benefits, specifically in regards to Post Exchange (PX) and Defense Commissary Agency commissary access.

See comment 2.

DoD comment: The report repeatedly refers to Soldiers and/or family members losing their PX and/or commissary benefits if the Soldier was dropped from an active duty status. This information is incorrect. All Soldiers and/or family members in possession of a valid identification card (regardless of active, reserve, or guard status) are entitled to unlimited use of PX facilities at any time. Access to the PX is not limited only to Soldiers on active duty status. In the matter of commissary benefits, prior to November 2003, non-active status Army Reserve and National Guard soldiers assigned to units were authorized 24 visits per year to the commissary. Beginning in November 2003, the Defense Commissary Agency implemented the provisions of the 2004 National Defense Authorization Act, which eliminated restrictions previously in place for Army Reserve and National Guard Soldiers and their families. Recommend revision of the report to remove these incorrect and misleading statements.

GAO document (page 7 – 1st bullet): Defines medical holdover (MHO).

See comment 3.

DoD comment: The definition of "medical holdover" is incorrect. MHO is a generic, broad-based term used to describe mobilized Reserve Component (RC) soldiers in support of the GWOT who were unable to deploy due to pre-existing or new medical conditions, or who developed new medical conditions or aggravated pre-existing medical conditions during deployment. These soldiers are currently non-deployable. Mobilized GWOT soldiers, who were extended under ADME or are now extended under MRP programs, are also MHO soldiers. RC soldiers on ADME from weekend drill, annual training, etc., are not MHO soldiers.

GAO document (page 7 – 2nd paragraph): States that mobilized RC soldiers who are in MHO are attached to a medical hold unit and would typically apply for ADME orders through that unit.

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See comment 4.

DoD comment: MHO soldiers are not assigned nor attached to medical treatment facility (MTF) medical holding units (MHU). It is true some MHO soldiers are assigned to MTF MHUs, but these are normally active compo soldiers who are unable to perform their military operational skill even within the confines of a limited duty profile. Although a few installations, such as Ft. Bragg, did assign their MHO soldiers to the MTF MHU, the Army policy is that MHO soldiers belong to the garrison commander and are assigned to some type of garrison holding unit. Most "holding units" were created out of the Garrison Support Units (GSU) or other garrison units. The implementation of the MRP program created specific derivative unit identification codes (DUIC) for medical retention processing units (MRPU) to which MRP/MHO soldiers are now assigned. The MRPU, which fall under garrison commander and IMAs, are staffed by mobilized soldiers requested by the IMAs to provide command and control to MHOs on the garrison. Non-mobilized ADME soldiers (who are not MHOs) are assigned or attached to the MTF MHUs for medical management.

GAO document (page 10 – 3rd paragraph): States MRP is for soldiers who become injured or ill while on mobilization orders in support of the Global War on Terrorism.

See comment 5.

DoD comment: MHO/MRP also includes soldiers with pre-existing conditions that were not identified within 25 days of mobilization or that were aggravated after mobilization. Soldiers with identified pre-existing conditions during the first 25 days are released from active duty. Soldiers who incur new injuries during the first 25 days may remain on active duty as a MHO.

GAO document (page 22): The report contains contradictory and misleading statements regarding issues with billeting conditions.

See comment 6.

DoD comment: The report refers to medical hold Soldiers at Fort Lewis having to make three separate moves to make room for demobilizing units. While one move has been made recently to free up barracks for returning units, these barracks were only occupied on a temporary basis. Initial medical holdover billets at Fort Lewis were located in World War II era billets located on North Fort Lewis, primarily in the 7C block of buildings. As part of an effort to improve living conditions for medical holdover soldiers, they were relocated to newly renovated permanent barracks on the main post in late CY 2003. These barracks had been made available by the deployment of the 3rd Brigade, 2nd Infantry Division (Stryker Brigade Combat Team) to Iraq, and were expected to be vacated upon the Brigade's return. This move was accomplished in the Fall of 2004 to barracks vacated by the 1st Brigade, 25th Infantry Division (Stryker Brigade Combat Team). Due to re-stationing actions, a final move to new, modular barracks facilities is planned for the March 2005 timeframe. These new facilities will provide a permanent home for those medical holdover soldiers retained at Fort Lewis for their medical care and treatment. Also, the unqualified anecdote contained in the case study on page 23 alleges that handicap accessible facilities were not emplaced until built by soldiers in the Holding company in October 2003. This statement is incorrect. As early as June 2003, barracks utilized by the Garrison medical holdover company were modified by the

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installation Directorate of Public Works with external ramps to first floor doorways, adaptive equipment in bathrooms (floor mats, grab rails, and flexible shower heads), and wider step platforms. These modifications have been made in all subsequently occupied barracks for soldiers with mobility issues.

GAO document (case studies): The report contains two case studies that appear to not have been validated with Fort Lewis.

DoD comment: While the report is clear regarding validation of pay issues presented by soldiers, there appears to have been no validation of the soldier comments regarding accessibility of the barracks at the time of their stay. The presentation of such unqualified statements in a report implies that they are true and correct statements of fact, which in this case is both untrue and misleading. While not specifically identified in the case studies, an initial review indicates additional information is appropriate with regard to certain aspects of the case studies.

In the example of the Sergeant from G Company, 140th Aviation Regiment, the implication is that the soldier was ordered to return to Fort Lewis simply because he was receiving care through an Air Force hospital. In this case, the soldier was identified as an individual who had not properly been recovered into the Army's accountability system and assigned/attached to a unit for management of required personnel and medical actions. While delays in returning the soldier to California to complete his treatment were unfortunate, the soldier was placed on a remote medical treatment program, which both established proper accountability and allowed him to reside at his home of record while his treatment was completed.

In the other two case studies, additional research would be required to properly identify and document their case histories.

GAO document (page 30 – 2nd paragraph): States that the Army does not know how many soldiers have been released from active duty before their 179-day MRP order had expired.

DoD comment: Content is incorrect. The Army MRP guidance specifies the use of MODS as the primary data source for MHO/MRP information. The guidance further specifies that case managers are responsible for the accuracy, timeliness and comprehensive entry of data into MODS. [Guidance: Annex Q (MEDICAL HOLDOVER OPERATIONS) to HQDA OPOD 04-01 and FORSCOM Implementing Instructions].

GAO document (page 32 – 2nd, 3rd and 4th bullets at the top of the page): States that the minimum eligibility criteria for soldiers applying for such programs as ADME and MRP, avenues through which soldiers may apply for such programs, and specific documentation required to be retained or extended on active duty orders for medical treatment or evaluation.

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See comment 7.

See comment 8.

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See comment 9.

DoD comment: These statements are not consistent with DoD policy (DoDI 1241.2, “Reserve Component Incapacitation System Management,” sections 6.6.3, 6.6.3.2, and 6.6.3.3) concerning retention on active duty until found fit or processed through the DES. It is not the soldier’s responsibility to ensure he or she is retained on active duty when injured or ill. It is the service responsibility to ensure the injured or ill RC member is retained on active duty (unless the member requests otherwise) until he or she is either medically cleared or processed through the DES. A more appropriate description of the process is as follows:

- The service should establish criteria to determine at what point the member should continue treatment or proceed through the DES.
- If the member is approaching the expiration of his or her orders and has not been found fit for duty or is still being processed through the DES, then the service shall initiate action to retain the member on active duty unless the member requests to be released from active duty.

GAO document (page 32 – 4th bullet of paragraph 2): States that paper-intensive application processes are replaced with user-friendly automated processes, to the extent possible, in which soldiers are notified or have easy access to the current status of their application.

DoD comment: Content is incorrect. There is not an application process, or at least one submitted by the member. Recommend removing reference to an application. A more appropriate approach would be:

- User-friendly systems will be in place that would allow the soldier to review the status of their extension on active duty.

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GAO Comments

1. See the “Agency Comments and Our Evaluation” section of this report.
2. DOD correctly points out that reserve component soldiers and their families—regardless of their active duty status—are entitled to Post Exchange and commissary benefits, however, the reality is that these soldiers could no longer gain access to the Post Exchange and commissary because they no longer had valid military identification. When a reserve component soldier’s active duty orders expire before new orders are approved, the soldier’s active duty military identification is no longer valid. Similarly, the soldier no longer has a valid reserve duty military identification card because this card was replaced with an active duty identification card upon mobilization. Therefore, when reserve component soldiers are dropped from active duty status before they are officially released from active duty, they have no means of producing valid military identification and gaining access to these facilities.
3. The written comments provided by DOD attempt to clarify the definition of MHO soldiers and the Medical Hold Unit as well as which soldiers are included in MRP. However, DOD’s definition does not differ from our understanding or what we have described in our report. As discussed previously in our report, soldiers who sustained injuries during annual training, weekend drills, or other activities associated with their Army National Guard or Army Reserve duties are eligible for ADME but are not MHO soldiers. Further, these soldiers fall outside the scope of our audit because our report specifically focused on soldiers who were activated for operations in support of the Global War on Terrorism.
4. We agree that Medical Hold units are not typically part of the MTF organization but are extensions of a Garrison Support Unit and that the Installation Management Command has command and control over Medical Hold units. However, we note in a footnote in the draft report on which DOD commented that these units may sometimes be found at Army military medical treatment facilities.
5. We do not believe our report is in conflict with DOD’s comment that MRP units include soldiers with preexisting conditions that were not identified within 25 days of mobilization or who had injuries that were aggravated after mobilization.

6. DOD commented that our reference to medical hold soldiers at Fort Lewis having to make three separate moves to make room for demobilizing units is contradictory and misleading. According to DOD, not all of the moves were made to make room for demobilizing units. Some of the moves were made to improve the quality of the housing provided. We did not attempt to determine the validity or the necessity of any of the moves, however, the inconvenience to the injured soldiers of moving from location to location is the same regardless of the reason.
7. We corroborated the information provided by our 10 case study soldiers with the soldiers' official military pay records, mobilization and ADME orders, bank statements, and credit records. In no case did the statements made by a soldier about gaps in pay differ significantly from the evidence we obtained. As for statements made about infrastructure, accommodations, and other qualitative factors, we attempted to and when possible, we did corroborate soldiers' statements with Army officials familiar with the soldiers. When we could not readily corroborate their statements by other evidence, we have taken great care to attribute the information to the soldiers we interviewed. Testimonial information that we could not corroborate by other evidence was not used as the basis for our conclusions and recommendations.
8. We reaffirm our conclusion that the Army does not know how many soldiers have been released from active duty before their 179-day MRP orders had expired. According to DOD, the Army MRP guidance specifies the use of MODS as the primary data source for MHO/MRP information. The guidance further specifies that case managers are responsible for the accuracy, timeliness and comprehensive entry of data into MODS. The MRP implementing instructions are not sufficiently explicit to satisfactorily deal with the issue of MODS or tracking the status of injured or ill reserve component soldiers. We believe that implementing instructions should contain clear, complete, and comprehensive information needed to carry out Army policies and regulations—instead of providing references to other policies, procedures, and instructions, which can create confusion. More importantly, the Army does not track soldiers that are released from MRP orders before their 179-day orders expire. As discussed in the report previously, HRC-Alexandria officials asserted that, as of October 2004, a total of 51 soldiers had been released from active duty before their 179-day MRP orders expired. At the same time, Fort Knox, one of

the few installations that tracked these data, reported it had released 81 soldiers from active duty who were previously on MRP orders—none of whom were included in the list of 51 soldiers provided by HRC-Alexandria. Thus it is clear that the Army does not know how many soldiers have been released from MRP orders. Further, as stated in the report, the soldiers that were released early from their orders were improperly paid over \$ 62,000, which the Army and DFAS were unaware of until we notified them.

9. As discussed previously in this report, we found that the soldier carries a large part of the burden when trying to understand and successfully navigate the Army's poorly defined requirements and processes for obtaining extended active duty orders. Therefore, we continue to believe that the Army needs (1) policies and procedures that establish minimum eligibility criteria for programs such as ADME and MRP and avenues through which soldiers may apply with Army assistance for such programs and (2) user-friendly processes in which soldiers are notified or have easy access to the status of their active duty extension.

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