United States Government Accountability Office

GAO

Report to Congressional Committees

May 2007

# MILITARY PAY

# Processes for Retaining Injured Army National Guard and Reserve Soldiers on Active Duty Have Been Improved, but Some Challenges Remain


GAO-07-608

# Report Documentation Page

*Form Approved*
*OMB No. 0704-0188*



| 1. REPORT DATE | 2. REPORT TYPE | 3. DATES COVERED |
|---|---|---|
| **MAY 2007** | | **00-00-2007 to 00-00-2007** |

| 4. TITLE AND SUBTITLE | 5a. CONTRACT NUMBER |
|---|---|
| **Military Pay. Processes for Retaining Injured Army National Guard and Reserve Soldiers on Active Duty Have Been Improved, but Some Challenges Remain** | 5b. GRANT NUMBER |
| | 5c. PROGRAM ELEMENT NUMBER |
| 6. AUTHOR(S) | 5d. PROJECT NUMBER |
| | 5e. TASK NUMBER |
| | 5f. WORK UNIT NUMBER |
| 7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) **U.S. Government Accountability Office,441 G Street NW,Washington,DC,20548** | 8. PERFORMING ORGANIZATION REPORT NUMBER |
| 9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES) | 10. SPONSOR/MONITOR'S ACRONYM(S) |
| | 11. SPONSOR/MONITOR'S REPORT NUMBER(S) |

12. DISTRIBUTION/AVAILABILITY STATEMENT
**Approved for public release; distribution unlimited**

13. SUPPLEMENTARY NOTES

14. ABSTRACT

15. SUBJECT TERMS

| 16. SECURITY CLASSIFICATION OF: | | | 17. LIMITATION OF ABSTRACT | 18. NUMBER OF PAGES | 19a. NAME OF RESPONSIBLE PERSON |
|---|---|---|---|---|---|
| a. REPORT **unclassified** | b. ABSTRACT **unclassified** | c. THIS PAGE **unclassified** | **Same as Report (SAR)** | **42** | |

May 2007

# MILITARY PAY

# Processes for Retaining Injured Army National Guard and Reserve Soldiers on Active Duty Have Been Improved, but Some Challenges Remain

GAO Accountability · Integrity · Reliability

Highlights

Highlights of GAO-07-608, a report to congressional committees

## Why GAO Did This Study

In February 2005, GAO reported that weaknesses in the Army's Active Duty Medical Extension (ADME) process caused injured and ill Army National Guard and Reserve (reserve component) soldiers to experience gaps in pay and benefits. During the course of GAO's previous work, the Army implemented the Medical Retention Processing (MRP) program in May 2004 and Community-Based Health Care Initiative (CBHCI) in March 2004. CBHCI allows reserve component soldiers on MRP orders to return home and receive medical care through a civilian health care provider. As directed by congressional mandate, GAO determined whether (1) MRP has resolved the pay issues previously identified with ADME and (2) the Army has the metrics it needs to determine whether it is effectively managing CBHCI program risks. GAO's scope did not include the medical, facilities, or disability ratings issues recently reported by the media at Walter Reed Army Medical Center.

## What GAO Recommends

GAO recommends six new actions aimed at providing Army-wide training standards for MRP, developing performance metrics for CBHCI, and providing short-term solutions to address the Army's lack of integrated systems. In its written comments, the Department of Defense concurred with five of GAO's six recommendations and partially concurred with one.

www.gao.gov/cgi-bin/getrpt?GAO-07-608.

To view the full product, including the scope and methodology, click on the link above. For more information, contact McCoy Williams at (202) 512-9095 or williamsm1@gao.gov.

## What GAO Found

The Army's MRP program has largely resolved the widespread delays in order processing that were associated with ADME. As a result, injured and ill reserve component soldiers retained on active duty through MRP have not experienced significant gaps in pay and benefits. The Army has addressed 17 of the 22 recommendations GAO made previously, which include developing comprehensive guidance for retaining injured and ill reserve component soldiers on active duty, providing a more effective means of tracking the location of soldiers in the MRP program, addressing problems related to inadequate administrative support for processing active duty retention orders, and developing performance measures to evaluate MRP.

Of the five recommendations the Army has not fully implemented, two are related to providing adequate training to reserve component soldiers in the MRP program and Army personnel responsible for managing the program and three deal with improving the Army's order-writing, pay, personnel, and medical eligibility systems.

- Although the Army has issued a soldiers' handbook for soldiers in the MRP program and developed a biannual training conference for Army personnel responsible for managing these soldiers, the Army lacks consistent, Army-wide training standards for injured reserve component soldiers in the MRP program and Army personnel responsible for managing the program.
- Because of an Army-wide system integration challenge that affects all soldiers, not just those in the MRP program, information is not always updated in the order-writing, pay, personnel, and medical eligibility systems as it should be. As a result, 7 of the 25 randomly selected soldiers GAO interviewed reported that their families' medical benefits were temporarily disrupted when they transitioned to MRP orders.
- The lack of integrated systems also caused overpayment problems when soldiers were released from active duty but still had time left on their MRP orders. Over a nearly 3-year period, GAO estimates that the Army overpaid these soldiers by at least $2.2 million.

Although, according to the Army, soldiers participating in CBHCI are at greater risk of being retained on active duty longer than medically necessary, the Army currently lacks the data needed to determine whether it is effectively managing this risk. According to the Army's metrics, soldiers treated by civilian providers through CBHCI are, on average, retained on active duty 117 days longer than soldiers treated at military treatment facilities (MTF). According to the Army, the metrics for soldiers treated at MTFs are skewed lower because of the Army's CBHCI selection criteria—which exclude soldiers whose injuries or illnesses are expected to be treated within 60 days. However, until the Army obtains more comparable information for the patient populations treated through CBHCI and MTFs, the Army cannot reliably determine whether it is effectively managing the program's risk.

# Contents

## Abbreviations

| | |
|---|---|
| ADME | Active Duty Medical Extension |
| CBHCI | Community-Based Health Care Initiative |
| CBHCO | community-based health care organization |
| CONUS | continental United States |
| DFAS | Defense Finance and Accounting Service |
| DIMHRS | Defense Integrated Military Human Resources System for Personnel and Pay |
| DOD | Department of Defense |
| GWOT | Global War on Terrorism |
| HRC | Human Resource Command |
| HRC-A | Human Resource Command-Alexandria |
| IMCOM | Installation Management Command |
| MHO | medical holdover |
| MODS | Medical Operational Data System |
| MRP | Medical Retention Processing |
| MRPU | medical retention processing unit |
| MTF | military treatment facility |
| NDAA | National Defense Authorization Act |

GAO
Accountability * Integrity * Reliability

**United States Government Accountability Office**
**Washington, DC 20548**

May 29, 2007

Congressional Committees

Mobilized Army National Guard and Army Reserve soldiers—or reserve component soldiers—who are injured or become ill in the line of duty are released from active duty and demobilized when their mobilization orders expire unless the Army has taken steps, at the soldiers' request, to extend their active duty service for the purpose of receiving medical treatment. In February 2005 we reported[1] on weaknesses in the Army's Active Duty Medical Extension (ADME) process—the process used by the Army at that time to extend the active duty service of injured or ill Army National Guard and Army Reserve soldiers. We reported that because ADME was designed to accommodate reserve component soldiers injured during annual training exercises and weekend drills and not soldiers mobilized in support of the Global War on Terrorism (GWOT), the Army was overwhelmed by the number of ADME requests. As a result, injured and ill reserve component soldiers experienced gaps in pay and benefits, creating financial hardships for these soldiers and their families.

In response, the Army implemented a new program, known as the Army's Medical Retention Processing (MRP) program, which took the place of ADME for reserve component soldiers returning from operations in support of GWOT activities. In conjunction with MRP, the Army also implemented the Community-Based Health Care Initiative (CBHCI), a program that allows the reserve component soldiers on MRP orders to return home and receive medical care through a civilian health care provider instead of receiving care at one of the Army's military treatment facilities (MTF), which are located at various Army installations throughout the country. Whether a soldier is treated at an MTF or by a civilian provider as part of CBHCI, the Army's goal is 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. However, according to the Army, because soldiers treated though CBHCI are treated by civilian

[1]GAO, *Military Pay: Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers*, GAO-05-125 (Washington, D.C.: Feb. 17, 2005).

providers and managed remotely there is a greater risk that these soldiers may be retained on active duty longer than medically necessary.

The Senate Committee on Armed Services report[2] that accompanied the National Defense Authorization Act (NDAA) for fiscal year 2006[3] directed GAO to periodically monitor the implementation of the MRP program as a follow-up to our February 2005 report.[4] In response to this mandate, we determined whether (1) MRP has resolved the issues we identified previously with ADME and (2) the Army has the metrics it needs to determine whether it is effectively managing the risk that soldiers treated through CBHCI may be retained on active duty longer than medically necessary.

To achieve our objectives, based on the size of the injured or ill reserve component population served, we performed work at four of the top five Army installations and MTFs and four of the Army's top six regional CBHCI operating locations. At these locations, we interviewed Army officials; performed walk-throughs of the Army's processes; reviewed applicable policies, procedures, and program guidance; observed MRP and CBHCI operations; and randomly selected and interviewed 25 injured or ill reserve component soldiers.

One of the locations we visited was Walter Reed Army Medical Center, which has been the focus of recent media accounts and congressional hearings because of significant problems with the Army's medical and physical evaluation processes as well as the facilities used to house injured outpatient soldiers. Because, as directed by the fiscal year 2006 NDAA, we focused on the pay and benefit-related issues we previously reported on, the scope of our work did not include the medical and facilities issues recently identified at Walter Reed.

In addition to the 4 Army installations we visited, we contacted Army officials at 13 other Army installations to obtain information on training provided to those responsible for managing injured or ill reserve component soldiers. To determine whether the Army had overpaid soldiers released early from the MRP program, we selected a stratified

[2]S. Rep. No. 109-69, at 339-40 (May 17, 2005).

[3]S. 1042, 109th Cong. (2005), enacted as Pub. L. No. 109-163, 119 Stat. 3136 (Jan. 6, 2006).

[4]GAO-05-125.

random sample of all soldiers released early from their MRP orders from May 6, 2004, to November 1, 2006. We also interviewed officials at the Army National Guard Bureau, Army Reserve, and Army Human Resource Command. In addition, we interviewed officials with the Army's Office of the Surgeon General, the office responsible for managing MRP and CBHCI, and requested and analyzed all available data and metrics—including metrics related to (1) soldiers' satisfaction with the Army's MRP and CBHCI programs, (2) the amount of time injured or ill reserve component soldiers had spent on MRP orders, and (3) the timeliness of processing MRP requests. To ensure that the Army data we used to support this report were sufficiently reliable for our analyses, we conducted detailed reliability assessments of the data sets that we used. We restricted these assessments, however, to the specific attributes that were pertinent to our analyses. We did not evaluate the Army's medical evaluation board or physical evaluation board processes or any aspect of soldiers' experiences with these processes. We also did not evaluate the quality of medical care provided or other quality of life issues affecting injured reserve component soldiers.

We performed this work from July 2006 through March 2007 in accordance with generally accepted government auditing standards. Further details on our scope and methodology are included in appendix I. We requested comments on a draft of this report from the Secretary of Defense or his designee. Written comments from the Deputy Under Secretary of Defense (Program Integration) are reprinted in appendix III.

## Results in Brief

The implementation of the Army's MRP program has eliminated the widespread delays associated with processing active duty orders for injured and ill reserve component soldiers. As a result, the Army has resolved the most significant pay and benefits[5] problems we identified previously. According to Army data, since MRP's inception in May 2004, the Army has extended approximately 15,000 reserve component soldiers on active duty using MRP orders. As of January 2007, about 3,300 reserve component soldiers remained on MRP orders. According to the Army's metrics, 98 percent of all MRP orders are processed and updated in the pay system such that soldiers do not miss a payday. The 25 injured reserve

[5]Prior to adoption of the MRP program, when soldiers' active duty orders expired before their ADME orders were approved, the medical eligibility status of these soldiers' families was adversely affected.

component soldiers we interviewed confirmed that they did not experience gaps in pay and associated benefits because of order processing delays. However, some of the soldiers we spoke with experienced problems with pay and associated benefits because of weaknesses in the Army's automated systems that control pay and access to benefits. These problems are not an MRP-specific issue but rather an Army-wide challenge that affects the MRP program.

In response to our prior work in this area, the Army has fully implemented 17 of the 22 recommendations we made previously, including developing comprehensive guidance on managing the retention of injured and ill reserve component soldiers on active duty, implementing improved processes for reserve component soldiers requesting to be retained on active duty, providing a more effective means of tracking soldiers in the MRP program, addressing the problems we identified previously related to inadequate administrative support to process active duty extension or retention orders, and developing performance measures to evaluate MRP. Of the 5 recommendations the Army has not fully implemented, 2 are related to providing adequate training to reserve component soldiers in the MRP program and Army personnel responsible for managing these soldiers, the majority of whom are reserve component soldiers themselves, and 3 deal with improving the Army's order-writing, pay, personnel, and medical eligibility systems.

Providing adequate training and information to injured and ill reserve component soldiers about the MRP program is an important part of allowing them to focus on recovering. Although the Army has issued a soldiers' handbook that provides injured and ill reserve component soldiers with guidance on key policies and standards of conduct when transitioning to MRP orders and most installations offered some type of training or informational briefing for new soldiers in the program, the Army has not established specific Army-wide training standards for MRP units. As a result, the training and information provided varied from installation to installation—with only 4 of the 17 installations we contacted having formalized or documented training programs for soldiers entering the MRP program. In addition, 4 of the 25 soldiers we interviewed did not receive a copy of the soldiers' handbook. Similarly, although the Army has developed a biannual training conference for Army personnel responsible for managing soldiers in the MRP program, this training was often not augmented with adequate on-the-job training or desk procedures at the installation level. For example, at 8 of the 17 installations we contacted, reserve component soldiers responsible for managing injured soldiers in the MRP program were not trained by the soldier they were

replacing because those soldiers had already been released from active duty and were no longer at the installations. Further, only 4 of the 17 installations we contacted had formal, or documented, training for personnel responsible for managing injured and ill reserve component soldiers. Effective training, including on-the-job training, and detailed desk procedures describing the duties associated with the position to be filled could enhance the continuity of care provided to injured reserve component soldiers.

The three remaining open recommendations address actions needed to improve the Army's order-writing, pay, personnel, and medical eligibility systems. These actions are part of a continuing Army-wide systems integration challenge that affects all soldiers, not just those in the MRP program. Because the Army's systems are not integrated and therefore the same or similar data must be manually entered into multiple systems, information that may affect a soldier's pay and access to pay-related benefits is not always appropriately updated in each system. As a result, the injured reserve component soldiers we interviewed reported some problems related to their families' medical eligibility status. According to 7 of the 25 soldiers we interviewed, their families' medical benefits were temporarily disrupted when they transitioned to MRP orders. Although soldiers can resolve disruptions to their pay and benefits by presenting copies of their MRP orders to the appropriate pay, personnel, and medical eligibility staff, some injured soldiers expressed frustration because information on how to resolve these discrepancies was not readily available. According to a few soldiers, their MRP unit commander and unit support staff were unable to help them resolve these discrepancies because they were often reserve component soldiers, were new to their positions, and had no prior experience dealing with the Army's pay and personnel processes. As a result, these soldiers—who were already under considerable stress because of their medical conditions—had to figure out how to resolve discrepancies in pay and associated benefits on their own.

The lack of integrated pay, personnel, and other systems can also cause overpayment problems when soldiers are released from active duty but still have time left on their MRP orders. If the payroll system is not updated appropriately, the Army will continue to pay these soldiers until their MRP orders expire, sometimes months after they have been released from active duty. Although the Army reported that it had implemented a monthly reconciliation process intended to identify and resolve differences between the Army payroll and personnel system, our work indicates that this control has not been effectively implemented. As a result, we identified numerous instances in which the Army overpaid

soldiers released from active duty before the end dates on their MRP orders. The Army was unaware of these overpayments until our testing revealed the problem. Based on our random sample of soldiers released early from MRP, over nearly a 3-year period, we estimate that the Army overpaid these soldiers by at least $2.2 million. As we recently reported,[6] these overpayments can result in collection actions that can create a financial hardship for these injured or ill soldiers and their families.

Although the Army has indicated that soldiers participating in CBHCI are at greater risk of being retained on active duty longer than medically necessary, it currently lacks the data needed to determine whether it is effectively managing this risk. According to the Army's metrics, soldiers treated by civilian providers through CBHCI are, on average, retained on active duty 117 days longer than soldiers treated at MTFs, which could indicate that soldiers treated through CBHCI are being retained on active duty longer than medically necessary. However, it is possible that the metrics for soldiers treated at MTFs are skewed lower because of the Army's CBHCI selection criteria—which exclude soldiers whose injuries or illness are expected to be treated within 60 days. Until the Army obtains more comparable information for the patient populations treated through CBHCI and the MTFs, the Army cannot reliably determine whether it is effectively managing the risk that soldiers treated through CBHCI may be retained on active duty longer than medically necessary.

We are making six new recommendations in this report aimed at improving training for injured reserve component soldiers in the MRP program and the staff responsible for managing these soldiers, developing performance metrics for CBHCI, and providing short-term actions to help address the Army's existing integration problems associated with the systems that control injured reserve component soldiers' access to pay and benefits. The Department of Defense (DOD) concurred with five of our six recommendations and partially concurred with the remaining recommendation to develop metrics that will allow a comparison between the length of stay for soldiers treated through community-based health car organizations (CBHCO) and those treated at MTFs. In its written response, DOD has proposed developing metrics to compare administrative process timelines for CBHCOs and medical retention processing units (MRPU). Although DOD does not provide more specific information on the

[6]GAO, *Military Pay: Hundreds of Battle-Injured GWOT Soldiers Have Struggled to Resolve Military Debts*, GAO-06-494 (Washington, D.C.: Apr. 27, 2006).

proposed metrics, the intent of our recommendation could be satisfied with metrics that allow a comparison of the operating efficiency of these programs if the Army appropriately excluded soldiers whose injuries are expected to be treated within 60 days and thus would not be eligible to participate in CBHCI—which would allow a more meaningful comparison of the two populations.

## 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. Some soldiers choose to be released from duty when their mobilization orders expire and seek care through their private insurers. Eligible soldiers may also seek care through the Department of Veterans Affairs or the transitional medical assistance program.[7] Finally, soldiers may also request to remain on active duty for medical evaluation, treatment, 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.

Prior to May 1, 2004, when the Army implemented MRP, if a soldier became injured or ill while supporting GWOT operations and requested to remain on active duty for medical evaluation and treatment, the Army extended the soldier's active duty orders using its existing ADME process. ADME was designed to accommodate reserve component soldiers injured during annual training, weekend drills, or other activities associated with their Army National Guard or Army Reserve duties that would require care beyond 30 days. At that time, a soldier choosing to be extended on active duty for medical treatment or evaluation submitted an ADME order application packet to the Army Manpower Office at the Pentagon. Officials

[7]Under the transitional assistance management program, prior to October 2004, service members with fewer than 6 years of active service were eligible for health care benefits for 60 days. With 6 years or more of active service, eligibility increased to 120 days. National Defense Authorization Act for Fiscal Year 1991, Pub. L. No. 101-510, § 502(a), 104 Stat. 1485, 1555 (Nov. 5, 1990) (codified at 10 U.S.C. § 1145). In November 2003, Congress increased this 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. 6, 2003). In October 2004, the Congress permanently extended the period of eligibility to 180 days for all categories of service members, Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, Pub. L. No. 108-375, Div. A, §706(a)(1), 118 Stat. 1817, 1983 (Oct. 28, 2004).

in that office evaluated the application packet and determined (1) whether the ADME order should be approved; (2) the length of the extension, if approved; and (3) the MTF to which the soldier should be attached. Army Manpower officials made these determinations based on the information included in the application packets. However, 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, the Army was not prepared and lacked the infrastructure to process the ADME requests. As a result, in our February 2005 report, we documented many instances in which these injured and ill soldiers were inappropriately dropped from active duty status in the automated systems that control pay and access to medical care, resulting in significant hardships for these soldiers and their families.

We reported that the Army lacked an adequate control environment and management controls over ADME.

- First, the Army's guidance for processing ADME orders did not clearly define organizational responsibilities or standards for being retained on active duty orders, how soldiers would be identified as needing extensions, and how and to whom ADME orders would be distributed. Without clear and comprehensive guidance, the Army was unable to establish straightforward, user-friendly processes that would provide reasonable assurance that injured and ill reserve component soldiers receive the pay and benefits to which they are entitled without interruption.

- Second, the Army lacked integrated order-writing, payroll, personnel, and medical eligibility systems. As a result, the Army lacked visibility over injured or ill reserve component soldiers and sometimes lost track of these soldiers. In addition, because the Army lacked these integrated systems, information did not always flow from one system to the next as it should—resulting in disruptions to pay and benefits as well as overpayments.

- Third, the Army did not adequately educate reserve component soldiers about ADME or train Army personnel responsible for helping soldiers apply for ADME orders. As a result, many of the soldiers we interviewed at the time 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.

Finally, the Army lacked the infrastructure and resources needed to assist soldiers trying to navigate their way through the ADME process. Specifically, the Army lacked the staff needed to process ADME paperwork and help soldiers file their ADME requests.

## Medical Holdover

Reserve component soldiers who were mobilized in support of GWOT operations and are receiving medical treatment or being evaluated for conditions that made them unfit for duty are referred to as medical holdover (MHO) soldiers. MHO soldiers fall into three groups. The first comprises soldiers who are being treated while still on mobilization orders. Depending on the amount of time left on these soldiers' mobilization orders, they may be treated and returned to duty or released from duty before their mobilization orders expire. Soldiers in this group fall outside the scope of our audit. The second group comprises soldiers whose mobilization orders have expired but who have been retained on active duty on MRP orders and are receiving medical treatment or being evaluated at an MTF. The third group comprises soldiers who are on MRP orders and whom the Army has agreed can return home as part of CBHCI and receive medical care through TRICARE—DOD's worldwide network of civilian health care providers—rather than remaining at an Army installation and receiving care through an MTF. The focus of this report is on the management of the second and third group of soldiers and the processes used to retain these soldiers on active duty so that they can receive medical treatment or evaluation.

Regardless of the soldiers' MHO classification, the goals are the same—to ensure that each 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. Once an Army physician determines that a soldier has attained an optimal level of physical and mental condition, the Army determines—as part of its medical and physical evaluation board processes—whether the soldier will be returned to duty or released from military service with or without benefits. The Army's medical and physical evaluation board processes fall outside the scope of our audit and, therefore, we did not evaluate and are not reporting on any aspect of soldiers' experiences with those processes.

## MRP Program

In an effort to correct the problems we identified as part of our work related to ADME, the Army implemented the MRP program on May 1, 2004, for reserve component soldiers mobilized in support of GWOT operations. Since MRP's inception, the Army has processed about 15,000

soldiers through the program. While ADME is still used for Army reserve component soldiers injured or who became ill during training, drills, or military operations not associated with GWOT, all eligible soldiers who were previously on ADME orders were allowed to apply for transfer to MRP orders when their original ADME orders expired.

If the Army determines that a soldier (1) cannot return to duty within 60 days from the time he or she was injured or became ill or (2) can return to duty within 60 days but has 120 days or fewer beyond the return to duty date remaining on his or her mobilization order, the soldier can request to be retained on active duty on MRP orders. MRP requests are processed through Human Resource Command-Alexandria (HRC-A). Once the MRP request packet has been submitted and approved by HRC-A, the injured or ill reserve component soldier is attached to an MRPU that is responsible for command and control of mobilized reserve component soldiers who are not medically fit for duty. The MRPU consists of a unit commander, an executive officer, platoon sergeants, and supply and other administrative support staff. These soldiers are also assigned a case manager located at the MTF who is responsible for helping reserve component soldiers schedule medical appointments and understand what steps they need to take to progress through the treatment or evaluation process—to include applying for new MRP orders if necessary.

According to the Army's MRP procedural guidance, initial and any subsequent MRP orders are written for 179 days. Although the procedural guidance does not limit the number of times or the total number of days that soldiers may be on MRP orders for the purpose of medical treatment or evaluation, according to a DOD directive, if a soldier remains medically unfit for duty for a year, the Army is to examine whether the soldier can be returned to duty, released from active duty, or put before a medical evaluation board and entered into the physical disability evaluation process to determine the likelihood of return to duty.[8]

[8]Soldiers who do not meet medical military retention standards may be placed on the temporary disability retired list or the permanent disabled retired list; may be separated from service with severance; or, in rare cases, may be retained with disabilities if the soldiers are still needed by the military. *DOD Directive 1332.18, Separation or Retirement for Physical Disability* (Nov. 4, 1996); *DOD Instruction 1332.38, Physical Disability Evaluation* (rev. July 10, 2006). *Department of the Army Regulation 635-40, Physical Evaluation for Retention, Retirement, or Separation* (Feb. 8, 2006).

## Community-Based Health Care Initiative

In March 2004, in conjunction with MRP, the Army also implemented CBHCI. CBHCI allows selected reserve component soldiers to return to their homes and receive medical care through TRICARE—DOD's worldwide network of civilian health care providers—rather than remaining at an Army installation and receiving care through an MTF. Unless specifically excluded by the Army's minimum eligibility criteria, all soldiers on MRP orders may be considered for CBHCI. Before a soldier may considered for CBHCI, he or she must

- be able to perform duties within a limited duty profile;
- be unable to return to duty within 60 days;
- be unencumbered by legal or administrative action or holds;
- reside in a state or regional catchment area participating in CBHCI;
- have a residence with a valid street address (not just a PO Box) and phone number that will accommodate the soldier's medical condition;
- volunteer to remain on or extend active duty under MRP status while undergoing medical treatment and adjudication of unresolved medical condition;
- have access to transportation to and from medical appointments, as well as his or her designated place of duty;[9]
- have a preliminary diagnosis and care plan that can be supported by CBHCI (appropriate medical care is available within 50 miles of the soldier's residence); and
- live within 50 miles of a duty location that has duties to be performed within the limits of the soldier's physical profile.

According to Army guidance, in most cases, soldiers should not be considered for CBHCI if their medical problems involve issues not commonly treated by civilian practitioners—including exposure to depleted uranium or chemical, biological, radiological, or nuclear agents or a confirmed or working diagnosis of leishmaniasis.[10]

The Army currently has eight CBHCOs in operation providing coverage for the continental United States (CONUS).The CBHCOs serving CONUS are located in Alabama, Arkansas, California, Florida, Massachusetts, Utah, Virginia, and Wisconsin. Each CBHCO serves the soldiers living in a

[9]Soldiers participating in CBHCI, as well as soldiers who remain at an Army installation to receive medical treatment are expected to perform duties within the limits of their physical profile. For soldiers being treated through CBHCI, this typically involves performing duties at their local Army National Guard or Army Reserve units.

[10]Leishmaniasis is a parasitic disease spread by the bite of infected sand flies.

particular geographic region. For example, the Alabama CBHCO, which is located in Birmingham, Alabama, serves a multistate region comprising Alabama, Kentucky, Mississippi, and Tennessee. The Army has also located smaller CBHCO facilities in Alaska, Hawaii, and Puerto Rico to serve soldiers living outside CONUS. Like soldiers who are being treated at MTFs, soldiers attached to a CBHCO are assigned a case manager who is responsible for helping them schedule medical appointments and understand what steps they need to take to progress through the treatment or evaluation process and a platoon sergeant who is responsible for command and control functions—such as making sure the soldiers are reporting to their assigned duty stations. However, unlike soldiers treated through an MTF, these functions are performed remotely in that the Army physician, case manager, and platoon sergeant are physically located at the CBHCO and the injured or ill soldier is at his or her residence—possibly in another state.

## Significant Progress Made in Resolving Previously Identified Pay Problems, but Some Challenges Remain

The Army's MRP program has resolved most of the pay-related problems we identified previously with ADME. As a result, most reserve component soldiers who request to be retained on active duty to receive medical treatment or evaluation, did not experience delays in obtaining MRP orders and therefore have not experienced significant gaps in pay and benefits. In response to our prior work in this area, the Army has fully implemented 17 of the 22 recommendations we made in our previous report and partially implemented 2 recommendations aimed at improving training for reserve component soldiers in the MRP program and the Army personnel responsible for managing these soldiers. The 3 remaining open recommendations address actions needed to improve the Army's order-writing, pay, personnel, and medical eligibility systems. These actions are part of a continuing Army-wide systems integration challenge that affects all soldiers, including those in the MRP program. Because the Army's systems are not integrated and therefore the same or similar data must be manually entered into multiple systems, information that may affect a soldier's pay and access to medical care is not always appropriately updated in each system. When this happens, it can result in disruptions to pay and benefits or, conversely, overpayments and potentially unauthorized access to benefits. See appendix II for a complete list of prior recommendations and their implementation status.

## Significant Improvements to Processes and Guidance Result in Fewer Pay Problems

In response to our previous work related to ADME, the Army has implemented a more streamlined, customer-friendly process for requesting MRP orders, implemented comprehensive guidance intended to effectively manage injured and ill reserve component soldiers, provided a more effective means of tracking injured and ill reserve component soldiers in the MRP program, addressed the issues we identified previously related to the Army's capacity to house and manage injured and ill reserve component soldiers, and developed performance measures to evaluate MRP. According to Army officials and injured reserve component soldiers we interviewed, these improvements have virtually eliminated the widespread delays in order processing that were associated with the ADME request process.

Unlike the ADME request process, MRP requests are not processed through the Army Manpower Office at the Pentagon. Instead, once signed and approved by the MRPU commander, MRP requests are sent directly to HRC-A to be processed. The Army Manpower Office, which is a policy-setting organization, was ill-equipped to handle the workload associated with processing ADME orders. As a result, soldiers' active duty orders often expired before ADME orders were approved—creating gaps in pay and benefits. In addition, because all MRP orders are issued for 179 days, MRP has reduced the workload associated with processing orders. ADME orders were often issued with a much shorter duration and therefore soldiers often had to reapply for extensions every 30, 60, or 90 days. According to the metrics recently developed based on our recommendation, the Army has met and surpassed its 98 percent goal of processing all MRP orders on time.[11] However, out of the 25 randomly selected injured or ill reserve component soldiers we interviewed, only 1 reported that he experienced an order processing delay. As a result, the wounded national guardsman stated his family's medical benefits were temporarily disrupted for approximately 2 weeks until the MRP order was processed.

Based on recommendations included in our previous report, the Army has improved its guidance related to retaining soldiers on active duty so that they can receive medical treatment. In July 2006, the Army issued the *Department of the Army Medical Holdover (MHO) Consolidated Guidance*, which includes comprehensive guidance for effectively

[11]The Army defines on time to mean that the MRP order is received and updated in the pay system such that the soldier does not miss a payday.

managing the MRP program. Among other things, the guidance now provides

- specific organizational responsibilities for administering MRP;
- an order distribution list covering the command and control, pay, personnel, and medical eligibility functions;
- eligibility criteria for being retained on active duty, including guidelines for extension of orders beyond 1 year;
- criteria that clearly establish 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);
- minimum eligibility criteria for soldiers applying for MRP and ADME programs;
- avenues through which eligible soldiers may apply for MRP and ADME;
- a list and examples of the specific documentation required to retain or extend active duty orders for the purpose of medical treatment or evaluation; and
- a list of the entitlements available for injured reserve component soldiers and their dependents.

Although the Army continues to lack an integrated personnel system to provide visibility over all soldiers—including injured and ill reserve component soldiers—the Army has, as we recommended, increased use of the Medical Operational Data System (MODS) for this purpose. This, combined with improved guidance related to the distribution of MRP orders, has improved the Army's visibility over injured and ill reserve component soldiers. In response to recommendations included in our previous report, the Army now requires that all Army installations use MODS to track the administrative and clinical status of these soldiers and makes MHO unit commanders responsible for the accuracy of the data. For example, MODS contains information such as the number of days in the program, the MRP order start and end date, the unit the soldier is attached to, and information on the soldier's medical status (e.g., orthopedic, neurological, internal medicine). Previously, installations were not required to use MODS and therefore used their own local databases to track the status of injured and ill soldiers—limiting Army-wide visibility over these soldiers. For example, the Army previously did not know how many reserve component soldiers had been extended on active duty to receive medical treatment or the duration of the extended service. Based on our assessment of the data contained in MODS as of July 25, 2006, the Army has greatly improved the completeness and reliability of MODS data and its ability to monitor the status of injured and ill soldiers. For example,

we traced the data from source documents to MODS for 564 soldiers and noted only 5 cases in which the soldier was not listed in MODS. (Additional information on the procedures used to assess the reliability of MODS data are discussed in app. I.) Further, all the sites we visited used MODS-generated reports to enhance their ability to monitor soldiers whose MRP orders would soon expire. These reports list all soldiers in the MRP program whose orders will expire in 30, 60, or 90 days—alerting Army officials that each soldier may need to submit another request to be retained on active duty for an additional 179-day period.

In addition, new guidance related to maintaining visibility over injured or ill soldiers who are transferred from one MTF to another has improved the Army's ability to monitor the movement of these soldiers. Previously, according to Army officials, when ADME orders were used to attach a soldier to an MTF for treatment, the receiving MTF was not notified in advance of the soldier's arrival. As a result, the receiving MTF had no knowledge that it was responsible for the injured or ill soldier until he or she arrived. Such knowledge is necessary to ensure that the soldier is assigned a case manager and receives appropriate medical attention. Now, according to the Army's MHO guidance, the losing unit's commander must contact the gaining unit's commander and coordinate the movement of injured or ill reserve component soldiers. According to Army officials at the installations we visited, they were not experiencing the problems they had previously related to the transfer of soldiers.

The Army has also addressed most of the problems we identified previously related to inadequate administrative support and resources by taking steps to improve its capacity to house and manage injured and ill reserve component soldiers. The Army has improved its capacity to house and manage injured and ill reserve component soldiers by implementing CBHCI and by increasing the overall number of case managers it has on staff. As discussed previously, CBHCI allows injured and ill reserve component soldiers to return home, while remaining on active duty MRP orders, to receive medical treatment through a civilian provider in DOD's TRICARE network. As of January 2007, of the 3,358 soldiers who the Army reported were on MRP orders, about 1,365—or 41 percent—were receiving care through civilian providers as part of CBHCI. Allowing these soldiers to return home for treatment reduces the number of injured and ill soldiers being housed and treated at Army installations. According to the Army's MHO capacity report, as of January 2007, all of its installations reported having excess capacity. In addition, the Army has reduced its soldier-to-case manager ratios. When we last reported, the Army had 105 case managers and maintained, at best, a 50-to-1 soldier-to-case manager

ratio. As of January 2007, the Army reported having 208 case managers providing coverage to soldiers at Army installations and participating in CBHCI and soldier-to-case manager ratios for each location ranging between 12-to-1 and 24-to-1. As noted previously, we did not evaluate the quality of the medical care or facilities provided or other quality of life issues.

In addition, based on our prior recommendation, the Army has begun to survey injured soldiers about their satisfaction with MRP and CBHCI. According to the results of the first survey given in December 2006, 81 percent of soldiers receiving care at an MTF and 93 percent of soldiers receiving care through CBHCI were either completely satisfied or somewhat satisfied with their case management.

In response to the problems we identified with ADME, the Army has improved the information it provides to injured or ill reserve component soldiers about MRP by creating the *Medical Holdover (MHO) Soldier's Handbook*. The handbook provides injured and ill reserve component soldiers with guidance on key policies and standards of conduct when transitioning to MRP orders—including the role of soldiers' primary care providers and case managers, as well as soldiers' rights and responsibilities related to receiving medical treatment. While the soldier's handbook is a big improvement over the lack of information available to soldiers under ADME, 4 of the 25 soldiers we interviewed reported that they did not receive the handbook. Providing these soldiers with MRP guidance is an important part of easing their burden and allowing them to focus on recovering. In addition, some enhancement could be made to the soldiers' handbook. For example, the Important Numbers section of the handbook does not contain point-of-contact information for soldiers to use if they need to resolve problems associated with pay and benefits—including the Defense Finance and Accounting Service (DFAS) ombudsman responsible for assisting soldiers with pay-related problems. As discussed later, when pay and benefit discrepancies have occurred, some soldiers we interviewed expressed frustration because information on how to resolve these discrepancies was not always readily available.

Further, the Army has not established specific Army-wide training standards for MRP units—a practice common in all other Army units. As a result, the training and information provided to injured reserve component soldiers varied from installation to installation—with only 4 of the 17 installations we contacted having formalized or documented training programs for soldiers entering the MRP program. For example, some installations provided only a general overview of the MRP program while

others provided a series of comprehensive training courses on the program benefits and responsibilities related to MRP and CBHCI. The Army's Systems Analysis and Review team—which was formed in May 2005 to assess the status of each MRP unit and make recommendations for improvement—found similar issues related to training across the installations it reviewed.

Similarly, the Army lacks training standards for the Army personnel responsible for managing injured and ill reserve component soldiers—the majority of whom are reserve component soldiers themselves. According to the new *Department of the Army Medical Holdover* (MHO) *Consolidated Guidance*, the Army Medical Command is responsible for providing training to case manager and CBHCO medical staff and the Installation Management Command (IMCOM) is responsible for training MRPU command and control staff to ensure their competency to perform their duties. According to the Army guidance, MRPU staff are supposed to receive instruction in finance and personnel management. In an effort to address our prior recommendation, IMCOM developed formal training that it offers approximately every 6 months. However, at the sites we contacted, the adequacy of the training provided at the installation upon the arrival of new staff was inconsistent. For example, 8 of the 17 Army installations we contacted about training relied exclusively on the IMCOM training and on-the-job training. However, for 5 of these installations, the reserve component soldier who had previously filled the position was gone before his or her replacement arrived—diminishing the effectiveness of on-the-job training. Further, only 4 of the 17 installations we contacted had a formal or documented training program for personnel responsible for managing injured and ill reserve component soldiers. For example, they provided more structured on-the-job training—requiring that new staff train under the more experienced staff before taking over the position—or, in some cases, installations appointed training officers and provided formal training for newcomers. Effective training, including on-the-job training, and detailed desk procedures describing the duties associated with the position to be filled could enhance the continuity of care provided to injured and ill reserve component soldiers.

## Lack of Integrated Systems Continues to Be a Challenge

The three recommendations from our prior work that the Army has not yet addressed were all aimed at improving the Army's order-writing, pay, personnel, and medical eligibility systems. These actions are part of a continuing Army-wide systems integration challenge that affects all soldiers, including those in the MRP program. Because the Army's systems are not integrated and therefore the same or similar data must be manually

entered into multiple systems, information that may affect a soldier's pay and benefits is not always appropriately updated in each system. When this happens, it can result in disruptions to pay and benefits or, conversely, overpayments and potentially unauthorized access to benefits. DOD has a major system modernization effort under way known as the Defense Integrated Military Human Resources System for Personnel and Pay (DIMHRS), intended to ultimately replace more than 80 legacy systems, including all pay and personnel systems. However, as we have reported,[12] DOD has encountered a number of challenges with DIMHRS, including the program's overly schedule-driven approach and DOD's difficulty in overcoming its long-standing cultural resistance to departmentwide solutions. As a result, the Army is not scheduled to begin implementing DIMHRS until April 2008.

When the Army retains a soldier on active duty by issuing an MRP order, it must update and extend the soldier's active duty pay and benefits status in the appropriate pay, personnel, and medical eligibility systems. However, because these systems are not integrated, information that affects a soldier's pay and access to benefits must be manually entered into each system, which can result in delayed processing or input errors that may cause disruptions in pay and benefits. For example, when a soldier is retained on active duty MRP orders, if information related to the soldier's active duty status and resulting medical eligibility is not promptly updated in the medical eligibility system, it can result in a disruption to the medical benefits available to the soldier's family through TRICARE. According to 7 of the 25 soldiers we interviewed, their families experienced problems getting medical appointments because the soldiers' active duty status was not updated in the medical eligibility system in a timely manner and therefore it appeared as if they and their families were no longer eligible to receive TRICARE benefits.

Although soldiers can resolve disruptions to their pay and benefits by presenting copies of their MRP orders to the appropriate pay, personnel, and medical eligibility staff, some injured soldiers expressed frustration because information on how to resolve pay and benefit discrepancies was not always readily available. According to some of the soldiers we interviewed, their MRP unit commanders and unit support staff were often reserve component soldiers new to their positions and with no prior

[12]GAO, *DOD Systems Modernization: Management of Integrated Military Human Capital Program Needs Additional Improvements*, GAO-05-189 (Washington, D.C.: Feb. 11, 2005).

experience dealing with the Army's pay and personnel processes. As a result, they did not always know how to help soldiers resolve pay and benefit discrepancies, creating an additional burden for soldiers who may already be under considerable stress because of their medical conditions.

The lack of integrated pay, personnel, and other systems can also cause problems when soldiers are released from active duty but still have time left on their MRP orders. When the Army processes orders that affect pay, including MRP orders, the order end date, or stop pay date, is entered into the Army's pay system. If soldiers are released from active duty before their MRP orders expire, the finance officials must manually adjust the stop pay dates recorded in the pay system or else these soldiers will continue to receive active duty pay. As we reported in the past,[13] when the Army initiates collection actions to recoup the debt associated with overpayments such as these, depending on the indebted soldiers' financial situation, these actions can create financial hardships for these soldiers. For example, we reported that hundreds of battle-injured soldiers were pursued for repayment of military debts through no fault of their own, including at least 74 soldiers whose debts had been reported to credit bureaus and private collection agencies at the time we initiated our audit in June 2005.

In response to our previous work in this area, DFAS implemented a process intended to identify discrepancies between the order end date in its reserve component pay system and the active duty release date reflected in the Army's personnel separation system. According to DFAS officials, they perform this comparison monthly and forward any discrepancies to Army installation finance officials to identify and resolve potential overpayments. Although accurately stopping pay when a soldier is released early from active duty is a documented challenge for the Army, the rules governing the use of leave for soldiers on MRP orders present an additional challenge for the Army with respect to overpayments. According to the *Department of the Army Medical Holdover (MHO) Consolidated Guidance*, soldiers on MRP orders must sell back all unused leave before being released from active duty. In contrast, soldiers on regular mobilization orders are not required to sell back their leave and have the option of taking unused leave before being released from active duty. As a result, while these soldiers are on leave, and before they have been released from active duty, DFAS has time to make adjustments to the

[13] GAO-06-494.

stop pay date in the payroll systems and straighten out potential pay issues. This same time is not available to DFAS for soldiers being released from MRP orders.

To determine whether the Army's procedure for detecting potential overpayments has been effective, using MODS data we selected a stratified random sample of all soldiers released early from MRP, from May 6, 2004, through November 1, 2006. For the 380 soldiers we selected, we obtained a copy of each soldier's Certification of Release or Discharge from Active Duty, DD Form 214, and compared the soldier's separation date with the stop pay date recorded in the pay system. If the stop pay date was later than the soldier's separation date, we concluded that the soldier had been overpaid. Based on our analysis we determined that the Army overpaid in 44 of the cases we tested. Overpayments ranged from about $65 to $32,000 with 29 cases being overpaid less than $3,000 and 37 cases being overpaid for less than 30 days. Until we brought it to the Army's attention, Army officials were unaware of these overpayments. In projecting our sample results to the population of 11,575 soldiers released early from MRP orders, we estimate that the Army overpaid 12 percent of these soldiers a total of at least $2.2 million.[14]

## The Army Lacks the Data Needed to Determine Whether It Is Effectively Managing the Additional Risks Associated with CBHCI

Although the Army has identified several factors associated with CBHCI that put soldiers at greater risk of being retained on active duty longer than medically necessary, the Army currently lacks the data needed to determine whether it is effectively managing this risk. According to the Army's metrics, soldiers treated by civilian providers through CBHCI are, on average, retained on active duty 117 days longer than soldiers treated at MTFs—which could indicate that the Army is not managing the added risks associated with CBHCI. However, the metrics used by the Army to compare soldiers treated at the MTFs to those treated through CBHCI may not be comparable. For example, according to Army officials, the metrics for soldiers treated at MTFs may be skewed lower because of the Army's CBHCI selection criteria. Specifically, the CBHCI selection excludes soldiers whose injuries or illnesses are expected to be treated within 60 days. Without more information about the patient populations that constitute these two groups, the Army does not know whether it is

[14]This amount represents the one-sided 95 percent confidence level lower bound from the sample-based estimate.

effectively managing the risk that soldiers treated through CBHCI may be retained longer than medically necessary.

Whether a soldier is treated at an MTF or by a civilian provider as part of CBHCI, the Army's goal is 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. However, according to the Army, there is a greater risk that soldiers treated through CBHCI may be retained on active duty longer than medically necessary. According to the Army, this risk is greater because of (1) the remote physical locations of soldiers being treated from home, which precludes the Army from directly monitoring their medical care and progress, and (2) the reliance on civilian doctors, who may not be as familiar with Army standards of care or MRP program goals. As discussed previously, each soldier participating in CBHCI is assigned an Army physician, case manager, and platoon sergeant who are physically located at a regional CBHCI operating location, whereas the injured or ill soldier is physically located at his or her home—which could be in another state. For example, an Army physician, case manager, and platoon sergeant located at the CBHCO in Birmingham, Alabama, are responsible for managing injured or ill soldiers who live in Alabama, Mississippi, Tennessee, and Kentucky. Unlike soldiers treated at MTFs, soldiers participating in CBHCI are not treated by Army physicians. Instead, the Army physician and case manager assigned to an injured soldier participating in CBHCI review medical documentation provided by the civilian doctor to monitor the soldier's progress toward attaining an optimal level of physical or mental condition. Similarly, the injured soldier's platoon sergeant is not personally overseeing the soldier's well-being. Instead, platoon sergeants located at the CBHCI operating location call the soldiers assigned to them each day—to make sure the soldiers have reported for duty.

To ensure that soldiers are not retained on active duty longer than medically necessary, the Army actively monitors the status of individual soldiers, regardless of whether they are being treated at MTFs or through CBHCI. For example, at each of the four CBHCI regional operating locations we visited, case managers, platoon sergeants, and Army physicians met on a biweekly basis to discuss the status of each soldier approaching 180 days, 270 days, and 365 days on MRP orders, including a discussion of past appointments, scheduled appointments, and the steps remaining in the civilian providers' treatment plans.

Although the Army recently started comparing the average length of stay of soldiers treated by civilian providers through CBHCI with the average length of stay of soldiers treated at MTFs, these metrics may be misleading. According to the Army's metrics, the average length of stay, before being returned to duty or medically separated, for soldiers treated by civilian providers through CBHCI is 288 days whereas the average length of stay for soldiers treated at MTFs is 171 days. These metrics indicate that soldiers treated through CBHCI are retained on active duty 117 days longer than soldiers treated at MTFs—which might indicate that soldiers treated through CBHCI are more likely to be retained on active duty longer than medically necessary. Army officials have suggested that the metrics may not accurately reflect how well they are managing the risk that soldiers treated through CBHCI may be retained on active duty longer than medically necessary. According to the Army's CBHCI selection criteria, soldiers whose injuries are expected to be treated within 60 days are not eligible to participate in CBHCI, causing the metrics for soldiers treated at MTFs to be skewed lower than those for soldiers treated through CBHCI. However, the Army does not track the information needed to identify data that may inappropriately skew its metrics and remove it from its calculation to ensure that the populations of soldiers being treated through MTFs and CBHCI are comparable. Without additional information about the patient populations that make up these two groups, the Army does not know whether it is effectively managing the risk that soldiers treated through CBHCI may be retained on active duty longer than medically necessary.

## Conclusion

Through the corrective actions taken in response to our prior report on this topic, including developing comprehensive MRP guidance, implementing improved MRP applications processes, and developing performance measures to evaluate MRP, the Army has demonstrated its commitment to improving its processes and programs for managing and paying injured reserve component soldiers who request to be retained on active duty to receive medical care. We recognize that it may take several more years to fully address the pay-related problems stemming from weaknesses in the Army's automated systems that control pay and access to pay-related benefits. In the interim, the Army can take several steps in the areas of training, improved CBHCI performance metrics, and payroll and personnel system reconciliation procedures to further improve the implementation and management of its MRP and CBHCI programs.

## Recommendations for Executive Action

We reiterate our previous recommendations to design and implement integrated order-writing, pay, personnel, and medical eligibility systems that provide visibility over injured and ill reserve component soldiers and ensure that the order-writing system automatically updates the pay, personnel, and medical eligibility systems. We also recommend that the Secretary of the Army direct the Assistant Secretary of Manpower and Reserve Affairs, in coordination with the Army's Office of the Surgeon General, the Installation Management Command, and the Defense Finance and Accounting Service, to take the following six actions:

- Develop and apply consistent Army-wide standards for installation-level training of new MRPU staff, including the use of desk procedures, to help ensure that they are adequately trained before they assume their new job responsibilities.

- Develop and apply consistent standards for training of reserve component soldiers in the MRP program to ensure that they understand the requirements, benefits, and processes associated with the program.

- Develop and disseminate points of contact, including the names, telephone numbers, and e-mail addresses, for the Army officials responsible for assisting injured or ill reserve component soldiers with resolving discrepancies in pay or benefits. Also include in this information the name, telephone number, and e-mail address of the DFAS ombudsman responsible for assisting injured or ill reserve component soldiers with pay-related issues.

- Require that the local finance offices at Army installations reconcile all discrepancies between the stop pay date recorded in the Army's payroll system and the separation date recorded in the Army's personnel system and adjust the Army's payroll and personnel systems accordingly.

- Evaluate the efficacy of allowing reserve component soldiers to take unused leave before they are released from active duty.

- Develop metrics that will allow comparison between the length of stay for soldiers treated through CBHCI and those treated at MTFs to determine whether the Army is effectively managing the additional risk associated with CBHCI.

## Agency Comments and Our Evaluation

In its written comments on a draft of this report, which are reprinted in appendix III, DOD concurred with five of our six recommendations and partially concurred with the remaining recommendation. DOD partially concurred with our recommendation to develop metrics that will allow a comparison between the length of stay for soldiers treated through CBHCOs and those treated at MTFs. According to DOD, timely access to care for soldiers treated through CBHCOs depends on the willingness of local civilian health care providers to accept TRICARE patients and the variance of the number and type of health care providers available by geographic region; therefore, a soldier's length of stay at a CBHCO cannot be directly compared to MRPUs. We agree that the access to care timeline for soldiers treated by civilian TRICARE providers may be longer than for soldiers treated at MTFs, which is why we have recommended that the Army develop metrics to determine how well it is managing this risk. In its written response, DOD has proposed developing metrics to compare administrative process timelines for CBHCOs and MRPUs. Although DOD does not provide more specific information on the proposed metrics, the intent of our recommendation could be satisfied with metrics that allow a comparison of the operating efficiency of these programs if the Army appropriately excluded soldiers whose injuries are expected to be treated within 60 days and who thus would not eligible to participate in CBHCI, which would allow a more meaningful comparison of the two populations.

Although DOD concurred with our recommendation to reconcile all discrepancies between its payroll and personnel records, in commenting on this recommendation, DOD asserted that the findings in our report reflect one-half of 1 percent of the sample population. However, DOD's assertion is incorrect. As discussed in appendix I, we selected a stratified random sample of 380 soldiers from the population of 11,575 soldiers released from active duty, from May 6, 2004, through November 1, 2006, and before their MRP orders expired. Our use of statistical sampling allowed us to project our sample results to the population of 11,575 soldiers released early from MRP orders. Based on our sampling results, we estimated that the Army overpaid 12 percent of these soldiers a total of at least $2.2 million.[15]

[15]This amount represents the one-sided 95 percent confidence level lower bound from the sample-based estimate. All percentage estimates in this report have a margin of error of plus or minus 5 percent or less.

We will send copies of this report 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 staff have any questions concerning this report, please contact me at (202) 512-9095 or williamsml@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Staff members who made key contributions to this report were Diane Handley, Assistant Director; Francine DelVecchio; Jamie Haynes; and Christopher Spain.

McCoy Williams
Director
Financial Management and Assurance

*List of Congressional Committees*

The Honorable Carl Levin
Chairman
The Honorable John McCain
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Daniel K. Inouye
Chairman
The Honorable Ted Stevens
Ranking Member
Subcommittee on Defense
Committee on Appropriations
United States Senate

The Honorable Ike Skelton
Chairman
The Honorable Duncan Hunter
Ranking Member
Committee on Armed Services
House of Representatives

The Honorable John P. Murtha
Chairman
The Honorable C.W. Bill Young
Ranking Member
Subcommittee on Defense
Committee on Appropriations
House of Representatives

# Appendix I: Objectives, Scope, and Methodology

To determine whether the Army's Medical Retention Processing (MRP) program has resolved the issues we identified previously with the Active Duty Medical Extension (ADME) program, we reviewed applicable policies, procedures, and program guidance; observed MRP operations; and interviewed appropriate agency officials. Specifically, we obtained and reviewed procedural guidance for reserve component soldiers on medical retention processing orders, including the *Department of the Army Medical Holdover (MHO) Consolidated Guidance*, *Medical Holdover (MHO) Soldier's Handbook*, and Department of Defense (DOD) and Army regulations. We also relied on the *Standards for Internal Control in the Federal Government*[1] to provide a framework for assessing the Army's MRP program and its Community-Based Health Care Initiative (CBHCI).

We applied the policies and procedures prescribed in these documents to the observed and documented procedures and practices followed by the key Army and DOD components involved in providing active duty pays and medical benefits to reserve component soldiers. We selected installations for review based on the reported populations of medical retention processing and medical holdover (MHO) soldiers, as well as other specialized traits, including presence of regional medical commands. The installations we selected for review were four of the top five installations based on the size of the MRP and MHO populations. The installations we visited are listed in table 1.

[1]GAO, *Standards for Internal Control in the 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 for fraud, waste, abuse, and mismanagement.

**Table 1: Installations GAO Visited**

| Installation | Characteristics |
|---|---|
| Fort Benning, Georgia | Large medical retention processing and MHO populations; power projection platform—1st U.S. Army. |
| Fort Dix, New Jersey | Large medical retention processing and MHO populations; power projection platform—1st U.S. Army; reserve component only. |
| Fort Lewis, Washington | Large medical retention processing and MHO populations; Western Regional Medical Command; power projection platform—5th U.S. Army. |
| Walter Reed Army Medical Center, Washington, D.C. | Large medical retention processing and MHO populations; North Atlantic Regional Medical Command. |

Source: GAO.

Note: A power projection platform is an Army installation that strategically deploys one or more high-priority active component brigades or larger, mobilizes and deploys high-priority Army reserve component units, or both.

At each installation, we interviewed officials who were responsible for counseling soldiers on the MRP program, officials who prepared and submitted the MRP application packets, case managers, primary care managers, MHO unit commanders, and installation payroll personnel. We obtained documentation on and performed walk-throughs of the process to request an MRP order for a reserve component soldier, the command and control structure of MHO units, the case management function, installation MRP tracking systems, as well as the Medical Operational Data System (MODS) and the medical-extension-to-pay system interface.

We also randomly selected and interviewed 25 injured or ill reserve component soldiers from the installations we visited to ensure that the Army's MRP program was operating as effectively as Army officials had asserted. Specifically, we asked these soldiers questions related to their experiences filing for and receiving MRP orders, accessibility of Army staff administering the program, and whether they had any problems related to their military pay and medical benefits while in the MRP program.

In addition to the 4 Army installations we visited, we contacted Army officials at 13 other Army installations to obtain information on training provided to those responsible for managing and treating injured or ill reserve component soldiers. Specifically, we asked whether the medical retention processing units (MRPU) provided formalized training for new

staff when they arrive at the MRPUs for duty and if so, whether training officers were assigned to coordinate the training.

We also interviewed and obtained documentation on various aspects of MRP with officials from the following offices or commands:

- National Guard Bureau, Arlington, Virginia
- Army Human Resource Command, Alexandria, Virginia
- U.S. Army Reserve Command, Fort McPherson, Georgia
- Army's Office of the Surgeon General, Falls Church, Virginia
- Army G-1, Army Pentagon, Washington, D.C.
- Army Task Force CBHCO-West, Fort Sam Houston, Texas
- Army Task Force CBHCO-East, Fort Jackson, South Carolina
- Defense Finance and Accounting Service (DFAS), Indianapolis, Indiana

As part of our work with the Army's Office of the Surgeon General, we requested and analyzed all available data and metrics related to MRP and CBHCI—including metrics related to (1) soldiers' satisfaction with these programs, (2) the amount of time injured or ill reserve component soldiers had spent on MRP orders (by treatment location), and (3) the timeliness of processing MRP requests.

With respect to the Army's automated systems, we assessed whether they provided reasonable assurance that once an MRP 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 MRP order transactions into the Army's order-writing, pay, personnel, and medical eligibility systems. We did not test computer security or access controls or test individual transactions. To assess the reliability of the Army's MODS, which houses, among other things, information on soldiers in the MRP program, we (1) reviewed existing documentation related to the data sources, such as patient rosters and MRP application packages; (2) interviewed knowledgeable agency officials about the data, including officials at the Office of the Surgeon General, case managers, and MRPU commanders; (3) manually tested the data for missing data items, outliers, and obvious errors; and (4) traced the data from source documents to MODS for 564 soldiers and noted only 5 cases in which the data were lacking. We determined that the data were sufficiently reliable for the purposes of this report.

To determine whether the Army had overpaid reserve component soldiers who were released early from MRP, using MODS data we selected a

stratified random sample of 380 soldiers from the population of 11,575 soldiers released from active duty, from May 6, 2004, through November 1, 2006, and before their MRP orders expired. We stratified the population into two groups based on whether the soldier had been released early from the initial MRP order or an extended MRP order. With this probability sample, each soldier in the population had a known, nonzero probability of being selected. Each selected soldier was subsequently weighted in the analysis to account statistically for all soldiers in the population, including those who were not selected.

Because we selected a sample of soldiers, our results are estimates of the population and thus are subject to sample errors that are associated with samples of this size and type. Our confidence in the precision of the results from this sample is expressed in 95 percent confidence intervals, which are expected to include the actual results in 95 percent of the samples of this type. All percentage estimates in this report have a margin of error of plus or minus 5 percent or less.

For the 380 soldiers we selected, we obtained[2] a copy of each soldier's Certification of Release or Discharge from Active Duty—DD Form 214—and compared the soldier's separation date with the stop pay date recorded in the DFAS monthly Global War on Terrorism Army National Guard/Reserve payment file from October 2001 through December 2006 containing 80,972,329 component of pay level records. In cases where the Army's pay system showed a pay stop date that occurred after the soldier's separation date, we calculated the amount of the overpayment based on the soldier's base pay per day while on active duty during the period in question. In cases where the pay system did not show a pay stop date and a soldier was still receiving active duty pay, we calculated the amount of the overpayment based on the soldier's base pay per day while on active duty during the period in question up until the date of our test.

To determine whether the Army has effectively managed the risk that soldiers treated through CBHCI may be retained on active duty longer than medically necessary, we reviewed applicable policies, procedures, and program guidance; observed CBHCI operations; interviewed appropriate agency officials; and obtained and analyzed all data and performance

[2]Of the 380 soldiers selected in the sample, we could not obtain 32 soldiers' Certification of Release or Discharge from Active Duty forms. For these soldiers, we used the most conservative approach possible and counted these as non-overpayments.

metrics related to CBHCI operations. The community-based health care organizations (CBHCO) we selected for review (see table 2) were four of the top six CBHCOs based on the number of soldiers.

**Table 2: Community-Based Health Care Organizations Visited**

| CBHCO | States served |
|---|---|
| CBHCO – Alabama | Alabama, Mississippi, Tennessee, and Kentucky. |
| CBHCO – Arkansas | Missouri, Louisiana, Texas, Oklahoma, Kansas, and Nebraska. |
| CBHCO – Massachusetts | Massachusetts, New York, New Hampshire, Vermont, Connecticut, Rhode Island, New Jersey, and Maine. |
| CBHCO – Virginia | Virginia, Maryland, North Carolina, West Virginia, Ohio, Pennsylvania, New Jersey, and the District of Columbia. |

Source: GAO.

At each CBHCO, we interviewed case managers, platoon sergeants, CBHCO commanders, and the Army physicians responsible for determining whether injured or ill soldiers have attained an optimal level of physical or mental condition. We obtained documentation and observed the command and control structure, the case management function, and the systems and procedures used to track soldiers' administrative and medical status. Using Army data, we also analyzed the amount of time injured or ill soldiers were on MRP orders—comparing the length of stay data for soldiers participating in CBHCI with the same data for soldier treated solely at military treatment facilities (MTF).

We briefed DOD, Department of the Army, Army Reserve, 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 July 2006 through March 2007 in accordance with generally accepted government auditing standards. On March 30, 2007, we requested comments on a draft of this report from the Secretary of Defense or his designee. Written comments from the Deputy Under Secretary of Defense (Program Integration) received on May 1, 2007, are summarized and evaluated in the Agency Comments and Our Evaluation section of this report and are reprinted in appendix III.

# Appendix II: Status of Prior Recommendations

Table 3 summarizes the status of the Army's effort to implement the 22 recommendations we made in our February 2005 report entitled *Military Pay: Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers* (GAO-05-125).

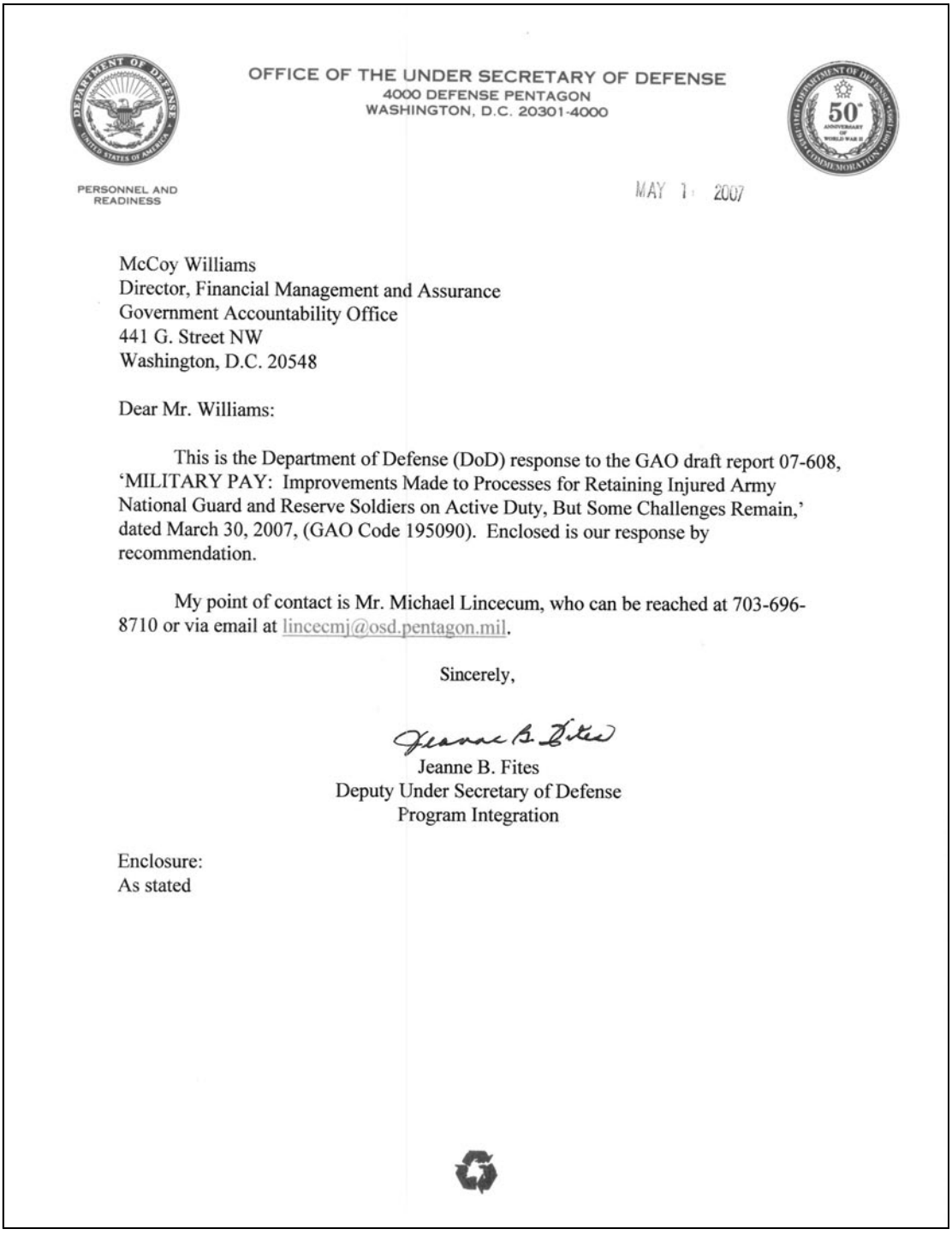
**Table 3: The Status of the Army's Effort to Implement Prior GAO Recommendations**

| Recommendation | Complete | Action |
|---|---|---|
| Develop 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: | | |
| 1. Specific organizational responsibilities for managing programs that deal with injured or ill reserve component soldiers. | X | Issued *Department of the Army Medical Holdover (MHO) Consolidated Guidance.* |
| 2. 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. | X | Issued *Department of the Army Medical Holdover (MHO) Consolidated Guidance.* |
| 3. Standards for being retained on active duty orders, including time frames and criteria for extension or retention beyond 1 year. | X | Issued *Department of the Army Medical Holdover (MHO) Consolidated Guidance.* |
| 4. Criteria that clearly establish priorities for where a soldier may be attached for medical care. | X | Issued *Department of the Army Medical Holdover (MHO) Consolidated Guidance.* |
| 5. Minimum eligibility criteria for soldiers applying for such programs as ADME and MRP. | X | Issued *Department of the Army Medical Holdover (MHO) Consolidated Guidance.* |
| 6. Avenues through which soldiers may apply for such programs. | X | Issued *Department of the Army Medical Holdover (MHO) Consolidated Guidance.* |
| 7. Specific documentation required to retain or extend active duty orders for medical treatment or evaluation. | X | Issued *Department of the Army Medical Holdover (MHO) Consolidated Guidance.* |
| 8. Entitlements of each program for both the soldier and his/her dependents. | X | Issued *Department of the Army Medical Holdover (MHO) Consolidated Guidance.* |
| 9. Correctly linking the cost of these programs to the mission or operation in which the soldier was involved. | X | Issued *Department of the Army Medical Holdover (MHO) Consolidated Guidance.* |
| Require that the officials designated with the responsibility for managing these programs develop performance measures to evaluate the programs' success. Such performance measures should be sufficient to enable the Army to: | | |
| 10. 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. | X | Metrics developed that track timeliness of application processing, soldier satisfaction, and the length of time soldiers are in the program. |
| 11. Take any corrective actions needed to address documented shortcomings in program performance. | X | Systems Analysis Review teams periodically review and report on MRP and CBHCI operations. |
| Provide the infrastructure and resources needed to support these programs and make needed process improvements to provide reasonable assurance that: | | |

| Recommendation | Complete | Action |
|---|---|---|
| 12. Officials responsible for managing and treating injured and ill reserve component soldiers are adequately trained on program requirements, benefits, and processes. | | Not complete. Although the Army has implemented a biannual training conference for MRPU staff and case managers, improvements to on-the-job and local installation training are needed. |
| 13. Reserve component soldiers and unit commanders will be educated on these programs, their requirements, and their benefits. | | Not complete. Although the Army has issued the *Medical Holdover (MHO) Soldier's Handbook* and most installations provide some type of training or informational briefings for newcomers, a more formalized training program is needed. |
| 14. 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. | X | Application process simplified as well as increase in the number of case managers and improved soldier-to-case manager ratios. |
| 15. 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 applications. | X | Application process simplified, eliminating the need for an automated notification system. Instead of months to process requests, it now takes only a few days. |
| 16. The practice of garnishing soldiers' wages to resolve accounting problems created by the use of retroactive rescissions of soldiers' orders is ended. | X | New simplified processes do not result in MRP order processing delays; therefore, ad hoc procedures that resulted in garnishments are no longer needed. |
| For automated systems, in the near term, require that: | | |
| 17. 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. | X | Requirement included in *Department of the Army Medical Holdover (MHO) Consolidated Guidance*. According to unit commanders, this is no longer a problem. |
| 18. 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. | X | Requirement included in *Department of the Army Medical Holdover (MHO) Consolidated Guidance*. Our data reliability assessment and fieldwork indicated that MODS is routinely updated and used. |
| 19. 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. | X | Requirement included in *Department of the Army Medical Holdover (MHO) Consolidated Guidance*. Our work confirmed that MRP orders are routed correctly. |
| 20. 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. | | Not complete. Although the Army implemented a process to identify and reconcile differences between its payroll and personnel records, our work has shown that the control has not been implemented effectively. |
| In the long term, design and implement integrated order-writing, pay, personnel, and medical eligibility systems that: | | |
| 21. Provide visibility over injured and ill reserve component soldiers. | | Not complete. |
| 22. Ensure that the order-writing system automatically updates the pay, personnel, and medical eligibility systems. | | Not complete. |

Source: GAO analysis of the Army's effort to implement prior GAO recommendations.

# Appendix III: Comments from the Department of Defense



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

PERSONNEL AND READINESS

MAY 1 2007

McCoy Williams
Director, Financial Management and Assurance
Government Accountability Office
441 G. Street NW
Washington, D.C. 20548

Dear Mr. Williams:

This is the Department of Defense (DoD) response to the GAO draft report 07-608, 'MILITARY PAY: Improvements Made to Processes for Retaining Injured Army National Guard and Reserve Soldiers on Active Duty, But Some Challenges Remain,' dated March 30, 2007, (GAO Code 195090). Enclosed is our response by recommendation.

My point of contact is Mr. Michael Lincecum, who can be reached at 703-696-8710 or via email at lincecmj@osd.pentagon.mil.

Sincerely,

Jeanne B. Fites
Deputy Under Secretary of Defense
Program Integration

Enclosure:
As stated

GAO DRAFT REPORT DATED MARCH 30, 2007
GAO-07-608 (GAO CODE 195090)

"MILITARY PAY: IMPROVEMENTS MADE TO PROCESSESS FOR RETAINING INJURED ARMY NATIONAL GUARD AND RESERVE SOLDIERS ON ACTIVE DUTY, BUT SOME CHALLENGES REMAIN"

DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATIONS

RECOMMENDATION 1: The GAO is reiterating a previous recommendation contained in GAO Report 05-125, 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 provides visibility over injured and ill reserve component soldiers and ensures that the order writing system automatically updates the pay, personnel, and medical eligibility systems. (p.32/GAO Draft Report)

DoD RESPONSE: The Army concurs with this recommendation. The Defense Integrated Military Human Resource System (DIMHRS) will provide an integrated orders writing capability for all Army components and DIMHRS integrates well with pay and personnel. DIMHRS will interface with the Defense Eligibility Enrollment Reporting System (DEERS), which determines medical eligibility, and will also interface with a variety of other medical systems. The Army will implement DIMHRS on 1 August 2008.

RECOMMENDATION 2: The GAO recommends that the Secretary of the Army direct the Assistant Secretary of the Army for Manpower and Reserve Affairs, in coordination with the Army's Office of the Surgeon General, the Installation Management Command, and the Defense Finance and Accounting Service, to develop and apply consistent Army-wide standards for installation-level training of the new Medical Retention Processing Unit (MRPU) staff, including the use of desk procedures, to help ensure that they are adequately trained before they assume their new job responsibilities. (p. 33/GAO Draft Report)

DoD RESPONSE: The Army concurs with this recommendation. As part of the Army Action Plan, a job specific training program is being developed for the command, support and care provider positions. Army Installation Command (IMCOM) is also requiring the MRPUs, on IMCOM installations, develop and publish Standard Operating Procedures (SOPs) for repetitive critical tasks. IMCOM will then extrapolate the minimum criteria for each task and issue updated guidance for publication.

Enclosure
Page 1 of 3

RECOMMENDATION 3: The GAO recommends that the Secretary of the Army direct the Assistant Secretary of the Army for Manpower and Reserve Affairs, in coordination with the Army's Office of the Surgeon General, the Installation Management Command, and the Defense Finance and Accounting Service, to develop and apply consistent standards for training of reserve component soldiers in the Military Retention Program (MRP) to ensure that they understand the requirements, benefits, and processes associated with the program. (p. 33/GAO Draft Report)

DoD RESPONSE: The Army concurs with this recommendation. We note that the MHO Soldier's Handbook is currently used as the standard for educating MHO Soldiers on the requirements, benefits and processes associated with the MRP Program. The Army will review this handbook to improve and augment it with additional guidance, as appropriate. An MHO Soldier's Interactive Test is also available to evaluate Soldier comprehension of MHO operations.

RECOMMENDATION 4: The GAO recommends that the Secretary of the Army direct the Assistant Secretary of the Army for Manpower and Reserve Affairs, in coordination with the Army's Office of the Surgeon General, the Installation Management Command, and the Defense Finance and Accounting Service (DFAS), to develop and disseminate to points of contact, including the name, telephone number, and e-mail address, for the Army official(s) responsible for assisting injured or ill reserve component soldiers with resolving discrepancies in pay or benefits. Also include in this information the name, telephone number, and e-mail address of the DFAS ombudsman responsible for assisting injured or ill reserve component soldiers with pay-related issues. (p. 33/GAO Draft Report)

DoD RESPONSE: The Army concurs with this recommendation. The MHO Soldier's Handbook will include all applicable contact information to facilitate expeditious resolution of pay-related issues.

RECOMMENDATION 5: The GAO recommends that the Secretary of the Army direct the Assistant Secretary of the Army for Manpower and Reserve Affairs, in coordination with the Army's Office of the Surgeon General, the Installation Management Command, and the Defense Finance and Accounting Service, to require that the local finance office at Army installations reconcile all discrepancies between the stop pay date recorded in the Army's payroll system and the separation date recorded in the Army's personnel system and adjust the Army's payroll and personnel systems accordingly. (p. 33/GAO Draft Report)

DoD RESPONSE: The Army concurs with this recommendation. The Army is acutely aware of the importance of payroll system reconciliation and implemented a process in February 2004 for improvements. As a result, accuracy rose to 96%, has been sustained above 99% for over a year and these statistics are briefed quarterly to the GAO and the House Government Reform Committee. The findings in this current GAO Report reflect one half percent of the sample population.

Enclosure
Page 2 of 3

RECOMMENDATION 6: The GAO recommends that the Secretary of the Army direct the Assistant Secretary of the Army for Manpower and Reserve Affairs, in coordination with the Army's Office of the Surgeon General, the Installation Management Command, and the Defense Finance and Accounting Service, to evaluate the efficacy of allowing reserve component soldiers to take unused leave before they are released from active duty. (p. 33/GAO Draft Report)

DoD RESPONSE: The Army concurs with this recommendation. The Army encourages Reserve Component Soldiers to take leave prior to demobilization consistent with AR 600-8-10, paragraph 2-2, Leaves and Passes. HQDA, G-1 is currently reviewing the leave policy for Reserve Component Soldiers who separate early using medical retention processing (MRP) orders. Collaboration is also underway with the United States Army Finance Command to reduce or eliminate any possible overpayments to Soldiers due to early release from active duty.

RECOMMENDATION 7: The GAO recommends that the Secretary of the Army direct the Assistant Secretary of the Army for Manpower and Reserve Affairs, in coordination with the Army's Office of the Surgeon General, the Installation Management Command, and the Defense Finance and Accounting Service, to develop metrics that will allow comparison between the length of stay for soldiers treated through Community Based Health Care Initiative (CBHCI) and those treated at military treatment facilities (MTFs) to determine whether the Army is effectively managing the additional risk associated with CBHCI. (p. 33/GAO Draft Report)

DoD RESPONSE: The Army partially concurs. Soldier length of stay at CBHCOs cannot be directly compared to Medical Retention Processing Units (MRPUs). Depending on the willingness of local civilian health care providers to accept TRICARE patients and the variance of the number and type of health care providers available by geographical location, access to care timelines for CBHCO Soldiers are often longer and otherwise difficult to measure and predict. A more practical approach would be to develop metrics to compare administrative process timelines between CBHCOs and MRPUs. The administrative processes for CBHCOs and MRPUs are similar, thus allowing for appropriate comparison and measurement to determine how well Soldiers are being administratively supported.

Enclosure
Page 3 of 3

## GAO's Mission

The Government Accountability Office, the audit, evaluation and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

## Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "Subscribe to Updates."

## Order by Mail or Phone

The first copy of each printed report is free. Additional copies are $2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, D.C. 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

## To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

## Congressional Relations

Gloria Jarmon, Managing Director, JarmonG@gao.gov (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, D.C. 20548

## Public Affairs

Paul Anderson, Managing Director, AndersonP1@gao.gov (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, D.C. 20548