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MILITARY PAY

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

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Highlights

Highlights of GAO-05-322T, a testimony before the Committee on Government Reform, House of Representatives

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Why GAO Did This Study

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

What GAO Recommends

GAO's related report (GAO-05-125) makes 22 recommendations including (1) establishing comprehensive policies and procedures; (2) providing adequate infrastructure and resources; (3) making process improvements to compensate for inadequate, stovepiped systems; and (4) as part of longer term system improvement initiatives, to integrate the Army's order writing, pay, personnel, and medical eligibility systems. In its written response to GAO's recommendations, the Department of Defense briefly described its completed, ongoing, and planned actions for each of the recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-05-322T.

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

What GAO Found

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

Examples of Injured Soldiers with Gaps in Pay and Benefits

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

Source: GAO.

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

The Army recently implemented the Medical Retention Processing (MRP) program, which takes the place of the previously existing process in most cases. MRP, which authorizes an automatic 179 days of pay and benefits, may resolve the timeliness of the front-end approval process. However, MRP has some of the same issues and may also result in overpayments to soldiers who are released early from their MRP orders. Out of 132 soldiers the Army identified as being released from active duty, 15 improperly received pay past their release date—totaling approximately $62,000.

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to discuss the Army's procedures for providing pay and related benefits, including medical benefits, to Army National Guard and Army Reserve soldiers being treated for service-connected injuries or illness. Our related report[1] released today details weaknesses in the Army's control environment, processes, and automated systems needed to provide reasonable assurance that injured and ill reserve component soldiers receive the pay and benefits to which they are entitled without interruption.

In response to the September 11, 2001, terrorist attacks, the Army National Guard and Army Reserve mobilized and deployed soldiers in support of Operations Noble Eagle and Enduring Freedom. When mobilized for up to 2 years at a time,[2] these soldiers performed search and destroy missions against Taliban and al Qaeda members throughout Asia and Africa, fought on the front lines in Afghanistan, and guarded al Qaeda prisoners held at Guantanamo Bay, Cuba. Similarly, reserve component soldiers fought on the front lines in Iraq and are now assisting in peacekeeping and reconstruction operations in Iraq under Operation Iraqi Freedom. Until recently, reserve component soldiers who were mobilized in support of the Global War on Terrorism and were injured or became ill were released from active duty and demobilized when their mobilization orders expired, unless the Army took steps, at the soldier's request, to extend their active duty service—commonly referred to as an active duty medical extension (ADME). During the course of our audit, the Army implemented the Medical Retention Processing (MRP) program, which takes the place of ADME for soldiers returning from operations in support of the Global War on Terrorism[3] but is a similar mechanism for providing pay and related benefits to reserve component soldiers being treated for service-connected injuries or illness.

[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).

[2]For the purpose of this testimony, the term mobilized includes all Army reserve component soldiers called to perform active service.

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

Because the Army did not maintain reliable, centralized data on the number, location, and disposition of mobilized reserve component soldiers who had requested to extend their active duty service because they had been injured or become ill in the line of duty,[4] it was not possible to statistically test controls or the impact control breakdowns had on soldiers and their families. Instead, we relied on a case study and selected site visit approach for this work—performing audit work at 10 Army installations throughout the country, interviewing and obtaining relevant documentation from officials at the Army Manpower Office[5] at the Pentagon, all four of the Army's Regional Medical Commands (RMC) in the continental United States, and the Army Human Resource Command (HRC) in Alexandria, Virginia. We also interviewed 38 reserve component soldiers who served in the Global War on Terrorism and had experienced problems with the ADME process at 4 military installations. Using Army pay and administrative records, we corroborated information provided by soldiers about disruptions in pay and benefits but were not always able to validate other assertions made by injured soldiers about their experiences. Further details on our scope and methodology and the results of the case studies can be found in our related report.

Today, I will summarize the results of our work with respect to (1) the problems experienced by selected injured or ill Army Reserve and National Guard soldiers; (2) the weaknesses in the overall control environment and management; (3) the lack of clear processes; (4) the lack of integrated pay, personnel, and medical eligibility systems; and (5) our assessment of whether the MRP program has resolved deficiencies associated with ADME and will provide effective and lasting solutions.

Summary

Poorly defined requirements and processes for extending injured and ill reserve component soldiers on active duty have caused soldiers to be inappropriately dropped from their active duty orders. For some, this has led to significant gaps in pay and health insurance, which has created

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

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

financial hardships for these soldiers and their families. Based on our analysis of Army Manpower data during the period from February 1, 2004, through April 7, 2004, almost 34 percent of the 867 soldiers who applied to be extended on active duty orders—because of injuries or illness—fell off their orders before their extension requests were granted. For many soldiers, this resulted in being removed from active duty status in the automated systems that control pay and access to benefits, including medical care and access to the Commissary and Post Exchange—which allows soldiers and their families to purchase groceries and other goods at a discount. Through our case study work, we have documented the experiences of 10 soldiers who were mobilized to active duty for military operations in Afghanistan and Iraq. Their stories illustrate the tremendous hardships faced by injured and ill reserve component soldiers applying for ADME. Many of the soldiers we interviewed had incurred severe, permanent injuries fighting for their country including loss of limb, hearing loss, and ruptured disks. Nonetheless, we found that the soldier carries a large part of the burden when trying to understand and successfully navigate the Army's poorly defined requirements and processes for obtaining extended active duty orders.

With respect to the Army's control environment and the management controls over the ADME process, we found that the Army has not provided (1) clear and comprehensive guidance needed to develop effective processes to manage and treat injured and ill reserve component soldiers, (2) an effective means of tracking the location and disposition of injured and ill soldiers, and (3) adequate training and education programs for Army officials and injured and ill soldiers trying to navigate their way through the ADME process. For example, many of the soldiers we interviewed said that neither they nor the Army personnel responsible for helping them clearly understood the process. This confusion resulted in delays in processing ADME orders and for some, meant that they fell from their active duty orders and lost pay and medical benefits for their families.

The Army also lacks customer-friendly processes for injured and ill soldiers who are trying to extend their active duty orders so that they can continue to receive medical care. Specifically, the Army lacks clear criteria for approving ADME orders, which may require applicants to resubmit paperwork multiple times before their application is approved. For example, one Special Forces soldier we interviewed, who lost his leg when a roadside bomb destroyed the vehicle he was riding in while on patrol for Taliban fighters in Afghanistan, missed three pay periods totaling $5,000 because he fell off his active duty orders. Although this soldier was clearly

entitled to a medical extension, according to approving officials at Army Manpower his application was not immediately approved because it did not contain sufficiently current and detailed information to justify this soldier's qualifications for ADME. In addition, the Army has not consistently provided the infrastructure needed—including convenient support services—to accommodate the needs of soldiers trying to navigate their way through the ADME process. This, combined with the lack of clear guidance discussed previously and the high turnover of the personnel who are responsible for helping injured and ill soldiers through the ADME process, has resulted in injured and ill soldiers carrying a disproportionate share of the burden for ensuring that they do not fall off their active duty orders. This has left many soldiers disgruntled and feeling like they have had to fend for themselves. While most of the installations we reviewed took extraordinary steps to keep soldiers in pay status, these steps often involved overriding required internal controls in one or more systems. In some cases, the stopgap measures ultimately caused additional financial hardships for soldiers or put the Army at risk of significantly overpaying soldiers in the long run.

With respect to the Army's automated systems that control soldiers' pay and benefits, overall, we found the current stovepiped, nonintegrated order-writing, personnel, pay, and medical eligibility systems require extensive error-prone manual data entry and reentry. Because the order-writing system does not directly interface with these other systems, once approved, hard copy or electronic copy ADME orders are distributed and used to manually update the appropriate systems. However, the Army's ADME guidance does not address the distribution of ADME orders or clearly define who is responsible for ensuring that the appropriate pay, personnel, and medical eligibility systems are updated. As a result, ADME orders are not sent directly to the individuals responsible for data input, but instead are distributed via e-mail and forwarded throughout the Army and the Department of Defense—eventually reaching individuals with access to the pay, personnel, and medical eligibility systems. Not only is this process vulnerable to input errors, but not sending a copy of the orders directly to the individual responsible for input increases the risk that system updates will not be entered in time to ensure continuation of the pay and benefits to which soldiers are entitled.

The Army's new MRP program, which went into effect May 1, 2004, and takes the place of ADME for soldiers returning from operations in Iraq and Afghanistan, should resolve many of the front-end processing delays experienced by soldiers applying for ADME by simplifying the application

process. However, MRP has not resolved the underlying management control problems that plague ADME—including problems associated with the lack of guidance, visibility over soldiers, adequate training and education, and manual processes and nonintegrated pay and personnel systems—and in some respects has worsened problems associated with the Army's lack of visibility over injured soldiers. For example, in September and October 2004, the Army did not know with any certainty how many soldiers were on MRP orders, how many had returned to active duty, or how many had been released from active duty early. In addition, although MRP routinely authorizes 179-day extensions and eliminates the need to reapply for new orders every 30 days, as was sometimes the case with ADME, it also presents new challenges.

If the Army treats and releases soldiers from active duty in less than 179 days, our previous work has shown that weaknesses in the Army's process for releasing soldiers from active duty and stopping the related pay before their orders have expired—in this case before their 179 days is up—often resulted in overpayments to soldiers. Although the Army did not have a complete or accurate accounting of soldiers who were treated and released from MRP early, of the 132 soldiers that the Army identified as released from active duty, we found that 15 were improperly paid past their release date—totaling approximately $62,000.

Our companion report includes 22 recommendations focused on addressing the weaknesses we identified in the overall control environment; infrastructure, resources and processes; and automated systems used to manage and treat injured reserve component soldiers. To its credit, in response to these recommendations, the Department of Defense (DOD) has outlined some actions already taken, others that are underway, and further planned actions to address the weaknesses we identified.

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

Poorly defined requirements and processes for extending injured and ill reserve component soldiers on active duty have caused soldiers to be inappropriately dropped from their active duty orders. For some, this has led to significant gaps in pay and health insurance, which has created financial hardships for these soldiers and their families. Based on our analysis of Army Manpower data during the period from February 1, 2004, through April 7, 2004, almost 34 percent of the 867 soldiers who applied to be extended on active duty orders fell off their orders before their extension requests were granted. This placed them at risk of being removed from active duty status in the automated systems that control pay and access to benefits, including medical care and access to the Commissary and Post Exchange—which allows soldiers and their families to purchase groceries and other goods at a discount.

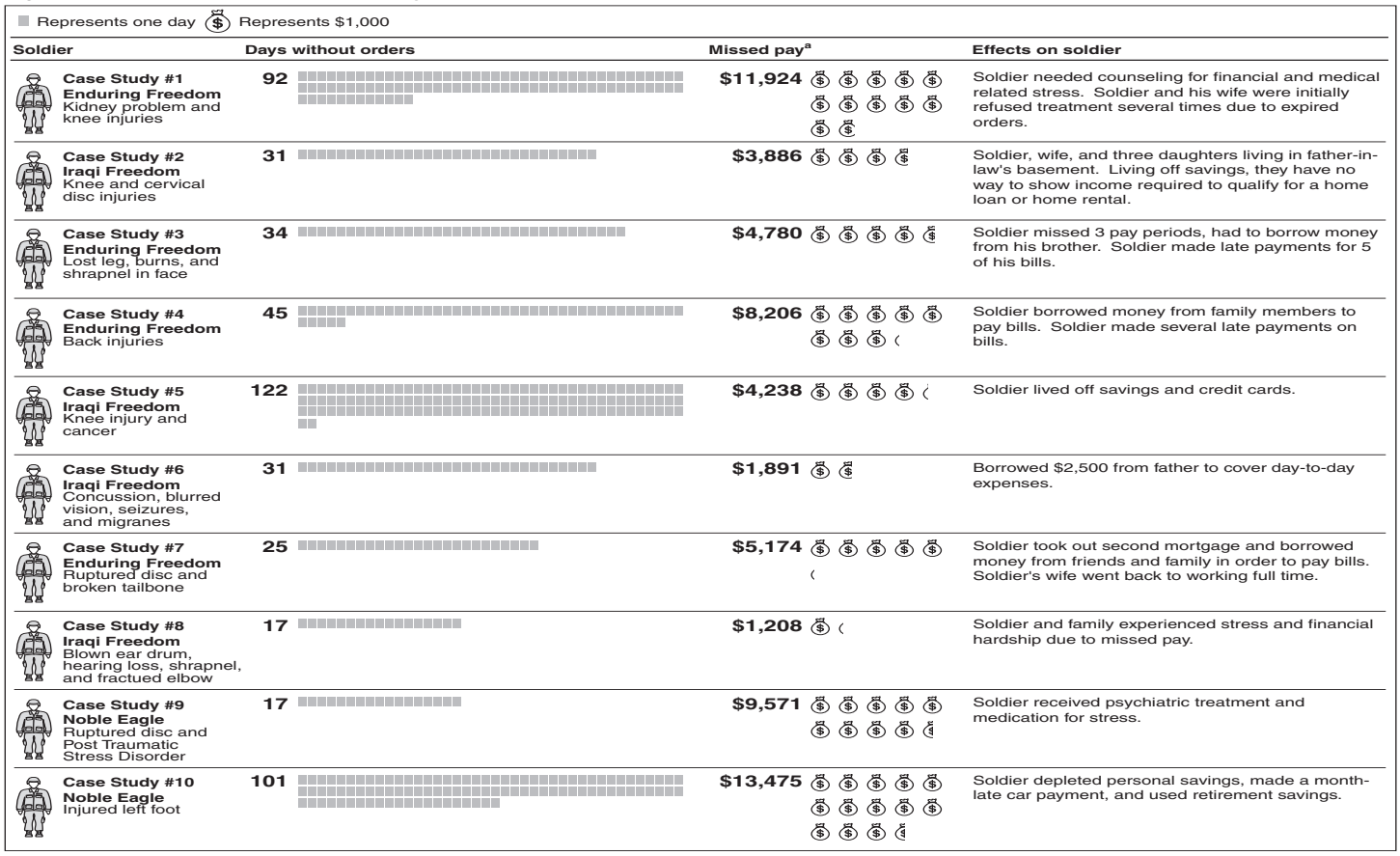
While the Army Manpower Office began tracking the number of soldiers who have applied for ADME and fell off their active duty orders during that process, the Army does not keep track of the number of soldiers who have lost pay or other benefits as a result. Although, logically, a soldier who is not on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

Because the Army did not maintain any centralized data on the number, location, and disposition of mobilized reserve component soldiers who had requested ADME orders but had not yet received them, we were unable to perform statistical sampling techniques that would allow us to estimate the number of soldiers affected. However, through our case study work, we have documented the experiences of 10 soldiers who were mobilized to active duty for military operations in Afghanistan and Iraq.

Figure 1 provides an overview of the pay problems experienced by the 10 case study soldiers we interviewed and the resulting impact the disruptions in pay and benefits had on the soldiers and their families. According to the soldiers we interviewed, many were living from paycheck to paycheck; therefore, missing pay for even one pay period created a financial hardship for these soldiers and their families. While the Army ultimately addressed

these soldiers' problems, absent our efforts and consistent pressure from the requesters of the report, it would likely have taken longer for the Army to address these soldiers' problems. Further details on these case studies are included in our related report.

Figure 1: Effects of Disruptions in Pay and Benefits



Source: GAO.

The Army Lacks an Effective Control Environment and Management Controls

The Army has not provided (1) clear and comprehensive guidance needed to develop effective processes to manage and treat injured and ill reserve component soldiers, (2) an effective means of tracking the location and disposition of injured and ill soldiers, and (3) adequate training and education programs for Army officials and injured and ill soldiers trying to navigate their way through the ADME process.

Clear and Complete Guidance Lacking

The Army's implementing guidance related to the extension of active duty orders is sometimes unclear or contradictory—creating confusion and contributing to delays in processing ADME orders. For example, the guidance states that the Army Manpower Office is responsible for approving extensions beyond 179 days but does not say what organization is responsible for approving extensions that are less than 179 days. In practice, we found that all applications were submitted to Army Manpower for approval regardless of the number of days requested. At times, this created a significant backlog at the Army Manpower Office and resulted in processing delays. In addition, the Army's implementing guidance does not clearly define organizational responsibilities, how soldiers will be identified as needing an extension, how ADME orders are to be distributed, and to whom they are to be distributed. Finally, according to the guidance, the personnel costs associated with soldiers on ADME orders should be tracked as a base operating cost. However, we believe the cost of treating injured and ill soldiers—including their pay and benefits—who fought in operations supporting the Global War on Terrorism should be accounted for as part of the contingency operation for which the soldier was originally mobilized. This would more accurately allocate the total cost of these wartime operations.[6]

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

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

As we have reported in the past, the Army's visibility over mobilized reserve component soldiers is jeopardized by stovepiped systems serving active and reserve component personnel.[7] Therefore, the Army has had difficulty determining which soldiers are mobilized and/or deployed, where they are physically located, and when their active duty orders expire. In the absence of an integrated personnel system that provides visibility when a soldier is transferred from one location to another, the Army has general personnel regulations that are intended to provide some limited visibility over the movement of soldiers. However, when a soldier is on ADME orders, the Army does not follow these or any other written procedures to document the transfer of soldiers from one location to another—thereby losing even the limited visibility that might otherwise be achievable. Further, although the Army has a medical tracking system, the Medical Operational Data System (MODS), that could be used to track the whereabouts and status of injured and ill reserve component soldiers, we found that, for the most part, the installations we visited did not use or update that system. Instead, each of the installations we visited had developed its own stovepiped tracking system and databases.

Although MODS, if used and updated appropriately, could provide some visibility over injured and ill active and reserve component soldiers—including soldiers who are on ADME orders—8 of the 10 installations we visited did not routinely use MODS. MODS is an Army Medical Department (AMEDD) system that consolidates data from over 15 different major Army and DOD databases. The information contained in MODS is accessible at all Army Military Treatment Facilities (MTF) and is intended to help Army medical personnel administer patient care. For example, as soldiers are approved for ADME orders, the Army Manpower Office enters data indicating where the soldier is to receive treatment, to which unit he or she will be attached, and when the soldier's ADME orders will expire. However, as discussed previously, the Army has not established written standard operating procedures on the transfer and tracking of soldiers on ADME orders. Therefore, the installations we visited were not routinely looking to MODS to determine which soldiers were attached to them through ADME orders. When officials at one installation did access MODS, the data in MODS indicated that the installation had at least 105 soldiers on ADME orders. However, installation officials were only aware

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

of 55 soldiers who were on ADME orders. According to installation officials, the missing soldiers never reported for duty and the installation had no idea that they were responsible for these soldiers.

The Army Lacks Adequate Training and Education Programs

The Army has not adequately trained or educated Army staff or reserve component soldiers about ADME. The Army personnel responsible for preparing and processing ADME applications at the 10 installations we visited received no formal training on the ADME process. Instead, these officials were expected to understand their responsibilities through on-the-job training. However, the high turnover caused by the rotational nature of military personnel, and especially reserve component personnel who make up much of the garrison support units that are responsible for processing ADME applications, limits the effectiveness of on-the-job training. Once these soldiers have learned the intricacies of the ADME process, their mobilization is over and their replacements must go through the same on-the-job learning process. For example, 9 of the 10 medical hold units at the locations we visited were staffed with reserve component soldiers.

In the absence of education programs based on sound policy and clear guidance, soldiers have established their own informal methods—using Internet chat rooms and word-of-mouth—to educate one another on the ADME process. Unfortunately, the information they receive from one another is often inaccurate and instead of being helpful, further complicates the process. For example, one soldier was told by his unit commander that he did not need to report to his new medical hold unit after receiving his ADME order. While this may have been welcome news at the time, the soldier could have been considered absent without leave. Instead, the soldier decided to follow his ADME order and reported to his assigned case manager at the installation.

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

The Army lacks customer-friendly processes for injured and ill soldiers who are trying to extend their active duty orders so that they can continue to receive medical care. Specifically, the Army lacks clear criteria for approving ADME orders, which may require applicants to resubmit paperwork multiple times before their application is approved. This, combined with inadequate infrastructure for efficiently addressing the soldiers' needs, has resulted in significant processing delays. Finally, while most of the installations we reviewed took extraordinary steps to keep soldiers in pay status, these steps often involved overriding required

internal controls in one or more systems. In some cases, the stopgap measures ultimately caused additional financial hardships for soldiers or put the Army at risk of significantly overpaying soldiers in the long run.

The Army Lacks Criteria for Approving ADME Orders

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

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

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

The Army has not consistently provided the infrastructure needed—including convenient support services—to accommodate the needs of soldiers trying to navigate their way through the ADME process. This, combined with the lack of clear guidance discussed previously and the high turnover of the personnel who are responsible for helping injured and ill solders through the ADME process, has resulted in injured and ill soldiers carrying a disproportionate share of the burden for ensuring that they do not fall off their active duty orders. This has left many soldiers disgruntled and feeling like they have had to fend for themselves. For example, one injured soldier we interviewed whose original mobilization orders expired in January 2003 recalls making over 40 trips to various sites at Fort Bragg during the month of January to complete his ADME application.

Over time, the Army has begun to make some progress in addressing its infrastructure issues. At the time of our visits, we found that some installations had added new living space or upgraded existing space to house returning soldiers. For example, Walter Reed Army Hospital has contracted for additional quarters off base for ambulatory soldiers to alleviate the overcrowding pressure, and Fort Lewis had upgraded its barracks to include, among other things, wheelchair accessible quarters. Also, installations have been adding additional case managers to handle their workload. Case managers are responsible for both active and reserve component soldiers, including injured and ill active duty soldiers, reserve component soldiers still on mobilization orders, reserve component soldiers on ADME orders, and reserve component soldiers who have inappropriately fallen off active duty orders. As of June 2004, according to the Army, it had 105 case managers, and maintained a soldier-to-case-manager-ratio of about 50-to-1 at 8 of the 10 locations we visited while conducting fieldwork. Finally, to the extent possible, several of the sites we visited co-located administrative functions that soldiers would need—including command and control functions, case management, ADME application packet preparation, and medical treatment. They also made sure that Army administrative staff, familiar with the paperwork requirements, filled out all the required paperwork for the soldier. Centralizing document preparation reduces the risk of miscommunication between the soldier and unit officials, case managers, and medical staff. It also seemed to reduce the frustration that soldiers would feel when trying to prepare unfamiliar documents in an unfamiliar environment.

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

The financial hardships discussed previously that were experienced by some soldiers would have been more widespread had individuals within the Army not taken it upon themselves to develop ad hoc procedures to keep these soldiers in pay status. In fact, 7 of the 10 Army installations we visited had created their own ad hoc procedures or workarounds to (1) keep soldiers in pay status and (2) provide soldiers with access to medical care when soldiers fell off active duty orders. In many cases, the installations we visited made adjustments to a soldier's pay records without valid orders. While effectively keeping a soldier in pay status, this work-around circumvented key internal controls—putting the Army at risk of making improper and potentially fraudulent payments. In addition, because these soldiers are not on official active duty orders they are not eligible to receive other benefits to which they are entitled, including health coverage for their families. One installation we visited issued official orders locally to keep soldiers in pay status. However, in doing so, they created a series of accounting problems that resulted in additional pay problems for soldiers when the Army attempted to straighten out its accounting. Further details on these ad hoc procedures are included in our related report.

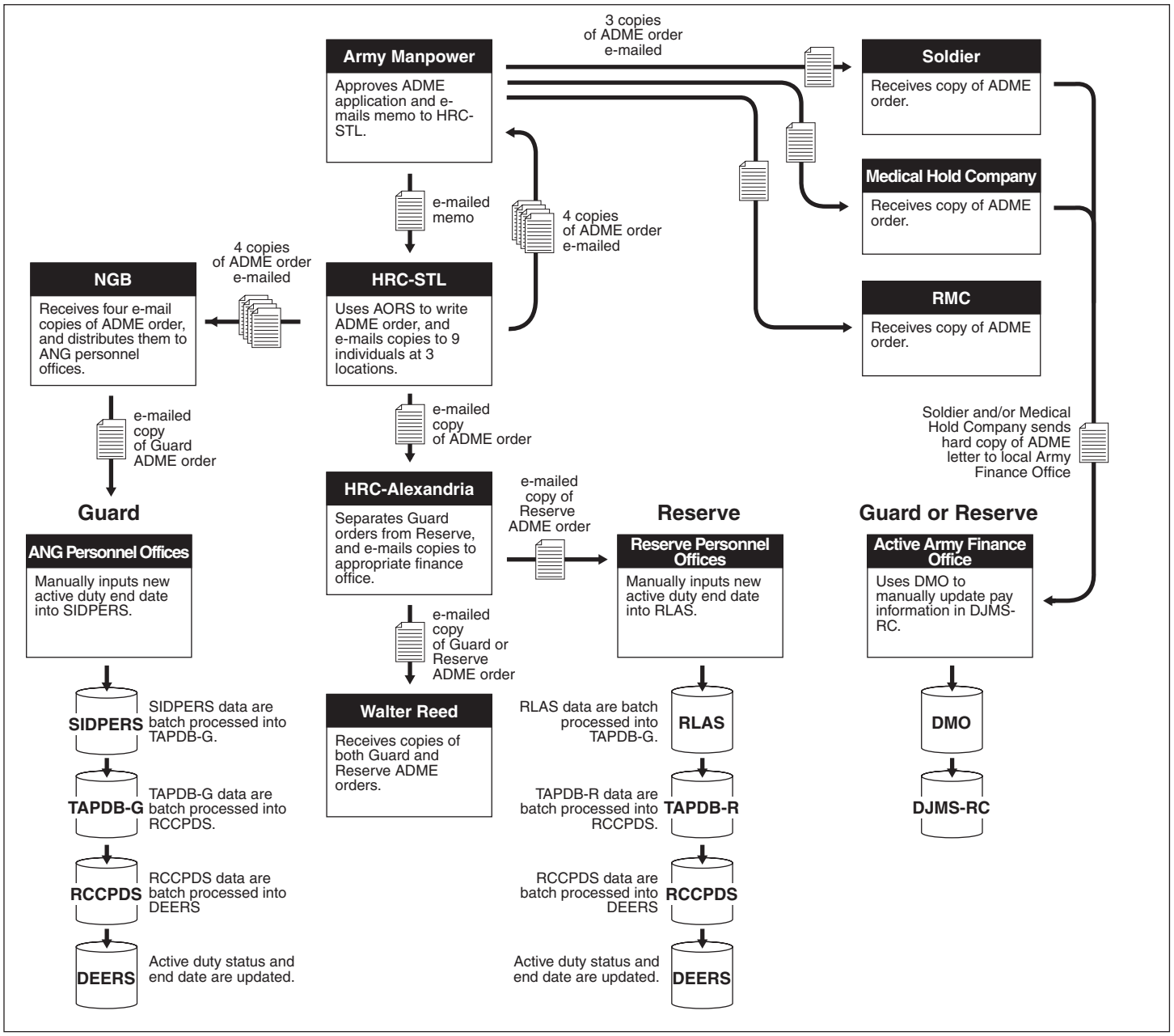
Nonintegrated Systems Contribute to Processing Delays

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

As shown in figure 2, once Army Manpower officials approve a soldier's ADME application, they e-mail a memorandum to HRC-St. Louis

authorizing the ADME order. The Army Personnel Center Orders and Resource System (AORS), which is used to write the order, does not directly interface nor automatically update the personnel, pay, or medical eligibility systems. Instead, once HRC-St. Louis cuts the ADME order it e-mails a copy of the order to nine different individuals—four at the Army Manpower Office, four at the National Guard Bureau (NGB) headquarters, and one at HRC in Alexandria Virginia—none of which are responsible for updating the pay, personnel, or medical eligibility systems.

Figure 2: Transaction Flow Between the Army's Order-Writing, Pay, Personnel, and Medical Eligibility Systems



Source: GAO.

As shown in figure 2, Army Manpower, upon receipt of ADME orders, e-mails copies to the soldier, the medical hold unit to which the soldier is attached, and the RMC. Again, none of these organizations has access to the pay, personnel, or medical eligibility systems. Finally, NGB officials e-mail copies of National Guard ADME orders to one of 54 state-level Army National Guard personnel offices and HRC-Alexandria e-mails copies of Reserve ADME orders to the Army Reserve's regional personnel offices. HRC-Alexandria also sends all Reserve orders to the medical hold unit at Walter Reed. When asked, the representative at HRC-Alexandria who forwards the orders did not know why orders were sent to Walter Reed when many of the soldiers on ADME orders were not attached or going to be attached to Walter Reed. The medical hold unit at Walter Reed that received the orders did not know why they were receiving them and told us that they filed them.

At this point in the process, of the seven organizations that receive copies of ADME orders, only two—the ANG personnel office and the Army Reserve personnel office—use the information to initiate a pay or benefit-related transaction. Specifically, the Guard and Reserve personnel offices initiate a transaction that should ultimately update the Army's medical eligibility system, the Defense Enrollment Eligibility Reporting System (DEERS). To do this, the Army National Guard personnel office manually inputs a new active duty order end date into the Army National Guard personnel system, the Standard Installation Division Personnel Reporting System (SIDPERS). In turn, the data from SIDPERS are batch processed into the Total Army Personnel Database-Guard (TAPDB-G), and then batch processed to the Reserve Components Common Personnel Data System (RCCPDS). The data from RCCPDS are then batch processed into DEERS—updating the soldier's active duty status and active duty order end date. Once the new date is posted to DEERS, soldiers and family members can get a new ID card at any DOD ID Card issuance facility.[8] The Army Reserve finance office initiates a similar transaction by entering a new active duty order end date into the Regional Level Application System (RLAS), which updates Total Army Personnel Database-Reserve (TAPDB-R), RCCPDS, and DEERS through the same batch process used by the Guard.

[8]There are over 800 DOD card issuance facilities located in the United States, many of which are located on Army installations and with Army National Guard and Reserve units.

As discussed previously, the Army does not have an integrated pay and personnel system. Therefore, information entered into the personnel system (TAPDB) is not automatically updated in the Army's pay system, the Defense Joint Military Pay System-Reserve Component (DJMS-RC).

Instead, as shown in figure 2, after receiving a copy of the ADME orders from Army Manpower, the medical hold unit and/or the soldier provide a hard copy of the orders to their local finance office. Using the Active Army pay input system, the Defense Military Pay Office system (DMO), installation finance office personnel update DJMS-RC. Not only is this process vulnerable to input errors, but it is time consuming and further delays the pay and benefits to which the soldier is entitled.

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

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

According to Army officials at each of the 10 installations we visited, unlike ADME, they have not experienced problems or delays in obtaining MRP orders for soldiers in their units. In fact some installation officials have

said that the process now takes 1 or 2 days instead of 1 or 2 months. Because there is no mechanism in place to track application processing times, we have no way of substantiating these assertions. We are not aware of any soldier complaints regarding the process, which were commonplace with ADME.

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

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

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

Not surprisingly, the Army does not know how many soldiers have been released from active duty before their 179-day MRP orders had expired. This is important because our previous work has shown that weaknesses in the Army's process for releasing soldiers from active duty and stopping the related pay before their orders have expired—in this case before their 179 days is up—often resulted in overpayments to soldiers. According to HRC-Alexandria officials, as of October 2004, a total of 51 soldiers had been released from active duty before their 179-day MRP orders expired. At the same time, Fort Knox, one of the few installations that tracked these data, reported it had released 81 soldiers from active duty who were previously on MRP orders—none of whom were included in the list of 51 soldiers provided by HRC-Alexandria. Concerned that some of these soldiers may have inappropriately continued to receive pay after they were released from active duty, we verified each soldier's pay status in DJMS-RC and found that 15 soldiers were improperly paid past their release date—totaling approximately $62,000.

Actions to Improve the Accuracy, Timeliness, and Availability of Entitled Pay and Benefits

A complete and lasting solution to the pay problems and overall poor treatment of injured soldiers that we identified will require that the Army address the underlying problems associated with its all-around control environment for managing and treating reserve component soldiers with service-connected injuries or illnesses and deficiencies related to its automated systems. Accordingly, in our related report (GAO-05-125) we made 20 recommendations to the Secretary of the Army for immediate action to address weaknesses we identified including (1) establishing comprehensive policies and procedures, (2) providing adequate infrastructure and resources, and (3) making process improvements to compensate for inadequate, stovepiped systems. We also made 2 recommendations, as part of longer term system improvement initiatives, to integrate the Army's order-writing, pay, personnel, and medical eligibility systems. In its written response to our recommendations, DOD briefly described its completed, ongoing, and planned actions for each of our 22 recommendations.

Concluding Comments

The recent mobilization and deployment of Army National Guard and Reserve soldiers in connection with the Global War on Terrorism is the largest activation of reserve component troops since World War II. As such, in recent years, the Army's ability to take care of these soldiers when they are injured or ill has not been tested to the degree that it is being tested now. Unfortunately, the Army was not prepared for this challenge and the brave soldiers fighting to defend our nation have paid the price. The personal toll this has had on these soldiers and their families cannot be readily measured. But clearly, the hardships they have endured are unacceptable given the substantial sacrifices they have made and the injuries they have sustained. While the Army's new streamlined medical retention application process has improved the front-end approval process, it also has many of the same limitations as ADME. To its credit, in response to the recommendations included in our companion report, DOD has outlined some actions already taken, others that are underway, and further planned actions to address the weaknesses we identified.

Contacts and Acknowledgments

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